Norfolk and Norwich
University Hospitals
NHS Foundation Trust

Annual Report and Accounts 2017-18

Norfolk and Norwich University Hospitals NHS Foundation Trust

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

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Performance Report

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

Chairman's Statement

The story of our hospitals over the last year has been one of increased demand and pressure as our local population ages. Advancements in public health and medical technologies, along with improvements in living conditions, mean that people are living longer and, in many cases, healthier lives than ever before, particularly at advanced ages.

The growth in life expectancy has put pressure on our health system, increasing the demand for care, services and technologies to prevent and treat the diseases and the chronic conditions associated with old age.

We have the oldest population of any teaching hospital in the country and we see, at first hand, how much care and support people need as they age and reach the end of life. In Norfolk and Waveney 1 in 4 of our population are over the age of 65 compared to about 20 per cent nationally. In North Norfolk the numbers are even greater with 39 per cent of the local population aged over 65 years.

Whilst all of us need to take responsibility for our own lives, we have to make public services work harder and better for patients.

This is the intent with the Norfolk and Waveney STP which moving forward with plans for services to work more closely together for the benefit of patients. This work is being led by Patricia Hewitt, a former Health Secretary, who was appointed as the independent chair in June 2017.

The increase in demand is coinciding with a tight fiscal situation in the NHS. The King's Fund describes acute providers as being caught between a 'rock and a hard place'. Increased emergency demand means less capacity for our elective work which translates into longer waits for patients and less income for the Trust.

To accommodate the increase in emergency cases we have also had to invest substantial funds to expand our emergency department, with a £1m contribution from national monies. This will deliver great benefits for our patients in years to come by providing more specialist care for younger and older patient groups, as well as those with mental health problems.

Despite a demanding year, our teams have continued to deliver high quality care and a positive patient experience. In the Friends and Family Test, we consistently score highly with 98 per cent of our patients rating us either satisfied or very satisfied despite our Trust being exceptionally busy. We have also been rated us highly in the national patient cancer survey. This is extremely important given our role as a major cancer centre treating over 6,000 patients each year.

January 2018, we were delighted to welcome Jeremy Hunt, Secretary of State for Health and Social Care to the Trust where he met with a cross section of staff. Mr Hunt was able to see the work that had been undertaken to reduce infection rates and mortality. Mr Hunt's subsequent public statement referred to staff at NNUH 'blazing a trail' in patient safety.

One of the benefits of the PFI arrangements at our Trust is that our facilities are kept in a first class condition. During the last year, eight wards have been refurbished – which are home to nearly 300 beds. This has enabled us to introduce a range of new features on hospital wards to enhance patient care at the hospital.

In addition to finance, a shortage of skilled staff is our main challenge. Our link with the University of East Anglia continues to develop, and is hugely successful in delivering highly motivated and skilled employees. We also have an award winning apprenticeship programme which helps us to grow and develop our workforce.

In terms our research activities, we have been awarded a contract extension to host National Institute for Health Research (NIHR) clinical research delivery across East Anglia for an extra 3 years. This will help to support the dedicated clinical research staff across the region who are working hard on research to benefit patients. We are committed to championing research and feel privileged to run the NIHR regional clinical research network and be at the forefront of research to benefit patients.

In looking back over the last year, it has been one the most difficult winters we have faced in some years and I would like to congratulate our staff on their unstinting work in the face of service pressures and the fantastic support they give to our patients. Whatever the situation, our role is to ensure the NHS is always here for people who need it and our staff certainly fulfil that expectation.

John Fry
Chairman

Chief Executive's Statement

I feel enormously proud to work with such passionate and committed teams who have been under real pressure over the last year. I would like to publicly thank our staff for their continuing hard work to provide the best possible care to all our patients.

Hospital Standard Mortality Ratio
One of the most outstanding actions that the Trust has achieved over the last 12 months is to achieve a significant fall in our hospital standard mortality ratio. We want to be a low mortality hospital. The latest available three month HSMR at the time of writing from Dr Foster relates to the period Dec 17 to Feb18 and is 90.5. This below the expected range, on track against the trajectory we have set ourselves and is a significant achievement. Everything that staff are doing to manage patients' care better, more services working seven days a week and the investment in palliative care services, more high dependency beds, and appropriate coding for complexity, is all contributing to this improvement. We want to keep on track and achieve our next goal of having an HSMR of 85 by the end of March 2019. It's a really important aspiration for us all and I'm sure our patients would think that too.

Positive staff feedback
Given the increasing demand for our services, our staff have been working exceptionally well and that makes the results of the national staff survey incredibly important to us. Over recent years we have been investing ever increasing levels of effort into understanding the results and using them to take action. We want all of our staff to feel safe, supported and motivated at work and the staff survey provides a valuable indicator and tool.

Here at NNUH our results for 2017 appear to buck the national trend with a majority of the key findings demonstrating improvement. For example, 18 of the 32 key findings have improved significantly over the last two years.

This is really encouraging and is evidence that we are on the right track in terms of staff support. This is, however, just one stage of our journey and we have further to go. It is also good to know that our patients continue to rate us highly in the Friends and Family Test, despite the pressure on our services.

Staff being able to raise concerns contributes to us providing the safest, highest quality care for our patients, and a supportive environment in which to work for all our colleagues. That is why we have provided several routes for staff to raise concerns. Our staff governors were appointed as Freedom to Speak Up (FTSU) Guardians in 2017. They have a key role in helping to raise the profile of how members of staff can raise concerns and provide confidential advice and support to staff in relation to concerns they have about patient safety and/or the way their concern has been handled.

In addition, we have set up a new and additional way of raising concerns via the Speak in Confidence system. This system allows staff to raise issues anonymously (using a personal email if preferred) directly with Executive Directors or the Speak Up Guardians.

CQC report
We are awaiting the results of the report from the Care Quality Commission from the initial inspection in October 2017 and the subsequent follow up visits which happened over the following months.

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

When the Quadram Institute opens in 2018, it will be at the forefront of combined research into food science, gut biology and health. NNUH staff will be part of an institute which will develop solutions to worldwide challenges in food-related disease and human health.

Finance
We are operating in a tough financial climate and ended the year with a deficit of £19.6m.

Whilst we have been able to deliver quality improvements and meet high levels of emergency demand, this comes at a cost. We have seen our elective income fall as our emergency workload has risen, particularly in the latter part of the year. Our teams are putting a renewed focus on productivity and cost savings as we start the new financial year for 2018/19.

Performance
Our cancer performance this year is the best in three years and we have made great progress with some complicated cancer pathways, such as head and neck cancer, lung cancer, and gynaecological cancer. Patient feedback has also been outstanding with NNUH rated in the top 20 percent of Trusts in eight key areas.

Overall, our services performed well through most of 2017 until we experienced a spike in demand during the winter period going into 2018 with over 180 ambulances arriving on some days. This has affected the Emergency Department performance due to the increase in the number of emergency admissions and means we have performed below the national four hour target. This has also affected our ability to meet the national RTT (Referral to Treatment) target.

During this busy period, although patients have required a relatively short length of stay (average 7 days), the hospital has been full to capacity at times requiring use of escalation areas.

The introduction of the Older People's Emergency Department and tripling the size of our Paediatric Emergency Department have been recognised as leading changes in clinical practice. We are also adding a mental health suite which will provide more specialised care for mental health patients arriving at ED in crisis. There is also a raft of improvements being taken forward to support patients with mental health needs following our establishment of a Mental Health Board at NNUH.

We have again performed well on infection control and meeting our targets in this area. In February 2017 the Trust was inspected by infection control representatives from NHS Improvement. It is extremely pleasing to report that the Trust is GREEN rated for infection prevention and control.

For our waiting lists, for non-admitted, admitted, day cases and outpatients, keeping pace with demand is challenging, which is mainly down to a lack of capacity. This has been recognised as a countywide issue and we are working with Commissioners, primary care and other Trusts in the county through the STP.

Building capacity
We continue to make plans for expanding our capacity both at the N&N and Cromer. Plans are going well for the Interventional Radiology Unit (IRU) and the Cardiac Catheter Labs which will be built by adding another floor to east outpatients at the N&N. Our aim is to have the new unit up and running during 2019. At Cromer & District Hospital the local community is getting behind our plans to create a new medical and cancer unit in one of the older buildings on the site.

Patients are also benefiting from an increase in critical care facilities at the N&N as an additional eight high dependency unit (HDU) beds have been added to the current facilities at the hospital, marking a 40 per cent increase in capacity.

We have also expanded our palliative care service, recruiting extra doctors and nurses to run the service seven days a week.

The Quadram Institute is going up rapidly and it should be ready for occupation in September 2018 and this will provide a massive capacity boost for our endoscopy service and will double our capacity from 20,000 procedures a year to 40,000.

It will provide state of the art facilities for patient care, juxtaposed with world leading research facilities.

Plans are also being developed for the Ambulatory Care and Diagnostic centre (ACAD) which is a much bigger scheme. ACAD is essentially about setting up a diagnostic centre for cancer referrals.

Digital Agenda

The digital agenda is about looking at how we can modernise the tools for the job. We have a lot of work to do in this field to meet our aspirations of being leaders in digital technology. We have already had some success, for example with the electronic prescribing and Medication Administration (EPMA) system which is working well, saving lives and improving healthcare.

We also need to consider how we link the Patient Administration Systems with the other hospitals too. To help us do this we have appointed a Chief Information Officer, Anthony Lundrigan.

Uniquely in the country we are sharing this appointment with the Sustainability and Transformation Plan (STP) across Norfolk and Waveney, so this is a UK first. This role will help NNUH on our journey and also the STP.

Despite sustained pressure particularly around the rising number of emergency admissions, we have continued to produce an impressive array of developments and achievements within an environment of testing financial demands.

Our ultimate goal is to ensure that without exception our patients receive excellent clinical outcomes and a positive experience whilst in our care. It makes me proud to see the dedication and determination of all our staff and volunteers to deliver those excellent standards.

Mark Davies
Chief Executive

Overview of Performance

Welcome to our 2017/18 annual report which describes our achievements during the year, covering our service improvements, finances and performance in key areas. Our Quality Account provides a more in-depth report on how we are continuously improving quality, safety and patient experience in our hospitals.

Purpose of the overview section

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

Purpose and Activities

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

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

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

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

Brief History

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

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

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

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

Key Issues and Risks

The whole of the NHS has been under pressure over the last year, and this winter has been particularly challenging, particularly for Trusts with older populations. We have experienced a spike in admissions with high numbers of sick patients being admitted from January – March 2018, particularly in the age groups 70-79 years. Overall our performance is improving month on month and we have had success in meeting our cancer waiting times. Treating large numbers of emergency patients on our elective wards is hampering our efforts to treat elective patients and our meet RTT waiting time targets, as well as affecting our income. We do well on managing stranded patients (those with length of stay over 14 days) compared to other Trusts across the country.

We know that we are one of the most efficient teaching hospitals in the country and we are looking at what further steps we can take using the Model Hospital data developed by NHS Improvement. From a cost point of view, the review found that when compared with other same treatments at other hospitals, we are giving excellent value for money. Despite our efforts our deficit position at the end of 2017/18 £ £19.6m. For more information on finances see page 40.

Strategy

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

Our Objectives

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

The strategy to meet these objectives:

- Develop a new diagnostic and outpatient facility (known as ACAD)
- Develop our digital capability and capacity
- Develop services at Cromer Hospital
- Support the Divisions to adopt best practice and reduce unnecessary variation
- Support a 24 hour seven days a week acute hospital service
- Maintain and strengthen our tertiary (region wide) specialist services

- Become a recognised centre of excellence for neurosciences, heart attack and cancer services; develop these services and the supporting clinical services such as interventional services, diagnostics and critical care
- Play a leading part in the development of the Quadram Institute.
- Collaborate with our acute hospital partners to help ensure clinical services remain or become sustainable across Norfolk
- Work closely with the Norfolk and Waveney STP to help ensure NNUH is financially sustainable
- Develop our work with primary and social care to help improve how we look after patients with long-term conditions and reduce the increase in emergency admissions.

Work has continued on plans to implement these strategies. Progress in 2017/18 includes:

- Finalisation of the Full Business Case for investment in new Interventional Radiology and Cardiology services
- Appointment of a new Chief Information Officer (shared with the STP) to progress the digital agenda and our information systems
- Agreement of cancer and stroke strategies and appointment of new posts to deliver these
- Agreement of new plans for Cromer Hospital in partnership with Macmillan Cancer
- Development of new models for Urology, Cardiology and Radiology across Norfolk
- Commencement of a masterplan for future investment in estates
- NNUH has lead role for IM&T, cancer and maternity services across Norfolk STP
- Planning for services to move to the new Quadram Institute in the summer of 2018
- Refinement of ACAD to focus primarily on a diagnostic centre for cancer referrals
- Expansion of our critical care facilities
- Investment in the infrastructure of the Emergency Department
- Successful work in reducing acute admissions.

Leadership appointments

John Hennessey has been appointed as the new Chief Finance Officer (acting in post since March 2018 and appointed in May 2018) following the departure of James Norman.

Frances Bolger, Head of Midwifery, was appointed as Acting Director of Nursing following a move to a national organisation by Emma McKay.

A new post of Chief Information Officer has been created, which has been filled by Anthony Lundrigan. Uniquely in the country we are sharing this appointment with the Sustainability and Transformation Plan (STP) across Norfolk and Waveney, so this is a UK first. This role will help NNUH on our journey and also the STP.

For more information, see the Director's section on page 51.

Emergency Preparedness, Resilience and Response' (EPRR)

The Trust needs to be able to plan for and respond to a wide range of incidents and emergencies that could affect health or patient care. These could be anything from extreme weather conditions to an infectious disease outbreak or a major transport accident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act 2004 and the NHS Act 2006 (as amended).

This work is referred to in the health service as ‘Emergency Preparedness, Resilience and Response’ (EPRR).

All NHS funded services must have robust and well tested arrangements in place to respond to and recover from these situations. The minimum requirements which commissioners and providers of NHS funded services must meet are set out in the current NHS England Core Standards for EPRR (Core Standards). The Trust is audited annually on these core standards and In 2017 The Trust was fully compliant.

Going Concern Statement

As part of reviewing the financial sustainability of the organisation, we have considered the scale of the financial challenges facing the Trust over the next 12 month period, in particular the revenue cash support required. Our operational plan forecasts a deficit of £55m for 2018/19 and it is recognised that the plan contains demanding cost improvement targets. The revenue support funds required of @£48m are subject to agreement by the Department of Health and Social Care, for which no agreement has been received to date. However our experience of Department of Health and Social Care practice is that they approve funding requirements on a monthly basis – not in advance. The Directors have considered the associated risks and significant uncertainty over the revenue support required and based on past experience and the vital role that the hospital plays we expect that the revenue support needed will be made available.

Our expectation is also informed by the anticipated continuation of the provision of service in the future, as evidenced by inclusion of financial provision for that service in published documents. Contracts for Service, being the NHS Standard Contract 2018/19 have been signed with the Trust’s main Commissioners.

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

Expansion in state of the art critical care facilities at NNUH

Patients are benefiting from an increase in critical care facilities at NNUH as an expansion in the critical care complex takes place.

The expansion has added an additional eight high dependency unit (HDU) beds added to current facilities at the hospital and fully operational by the end of February 2018, marking a 40% increase in capacity.

Patients may receive care within the Critical Care Complex (CCC) at NNUH if they are seriously ill requiring intensive treatment and close monitoring, or if they are having major surgery and intensive care can help them to recover. Around 1600 patients utilise the facilities on the unit each year and numbers of patients requiring this type of treatment are increasing each year.

Over the past two winters, an expansion of facilities has been tested with an extension into a dedicated area of theatre recovery. This has evidenced a strong demand for expanded facilities, with positive impacts on both patient experience and planned operations.

Dr Tim Leary, Service Director for Critical Care at NNUH explains: “This expansion in our facilities will help to reinforce our resilience, ensuring we can treat fluctuating numbers of emergency cases whilst elective surgery goes ahead as planned.

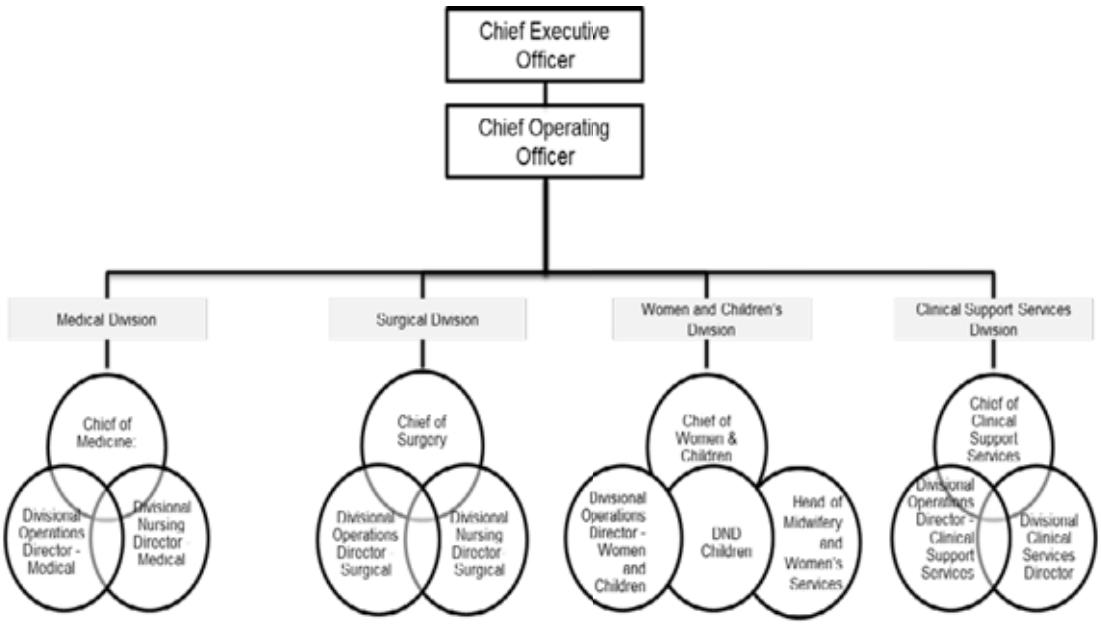
“We know that coming into hospital for an operation can be an anxious time for patients. Through this new initiative we’ll be doing everything we can to ensure that as far as possible operations go ahead as planned even when we are seeing large numbers of emergency patients who must be treated immediately.”

Performance Analysis

How we measure performance

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

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

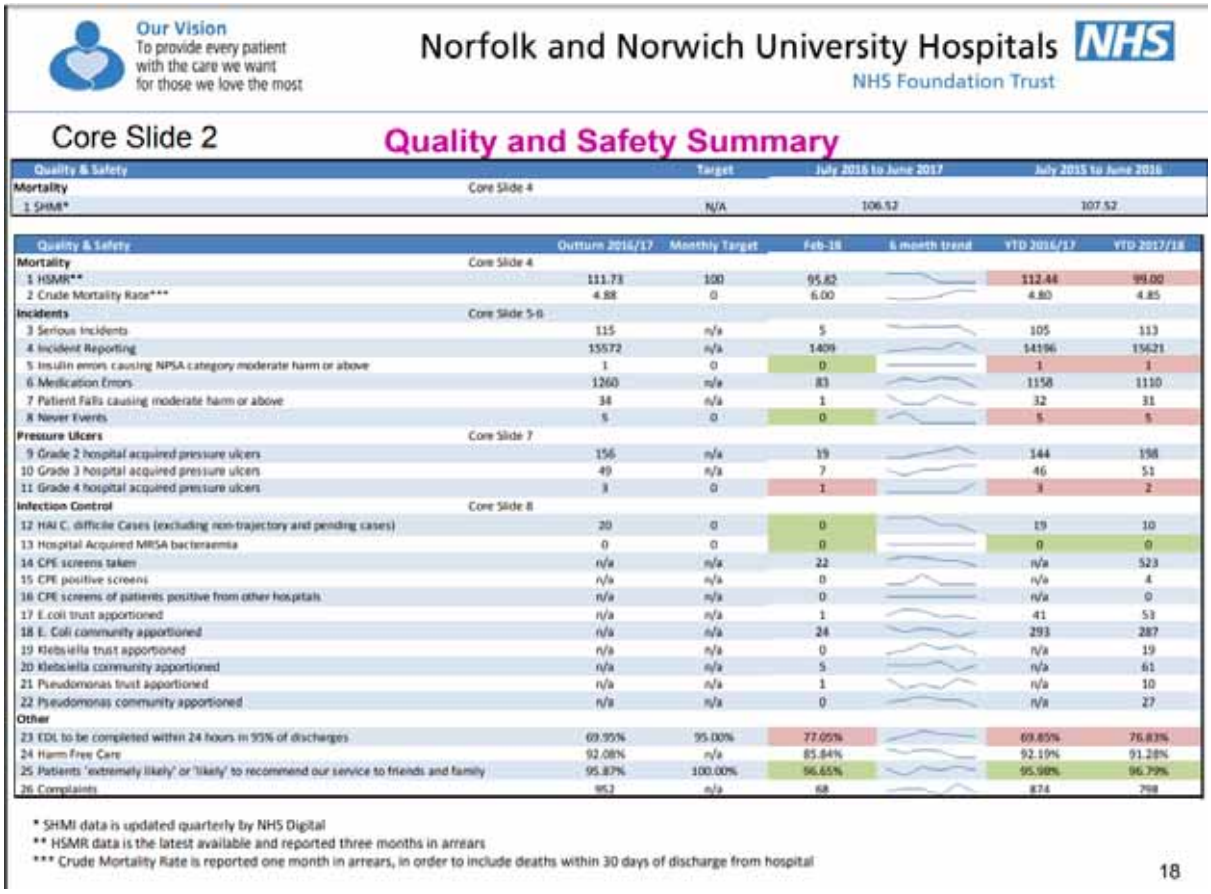


Integrated Performance Analysis

A 46-slide monthly integrated performance report is produced by the Trust which provides details of how the Trust is performing on key targets such as infection control, cancer waiting time targets, the A&E target, and the 18 week RTT target, plus finance and staffing issues.

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

Example of a summary slide from the integrated performance report:



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

Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

Core Slide 2

Quality and Safety Summary

Quality & Safety		Target	July 2016 to June 2017	July 2015 to June 2016
Mortality	Core Slide 4			
1 SHMI*		N/A	106.52	107.52

Quality & Safety		Outturn 2016/17	Monthly Target	Feb-18	6 month trend	YTD 2016/17	YTD 2017/18
Mortality	Core Slide 4						
1 HSMR**		111.73	100	95.82		112.44	99.00
2 Crude Mortality Rate***		4.88	0	6.00		4.80	4.85
Incidents	Core Slide 5-6						
3 Serious Incidents		115	n/a	5		105	113
4 Incident Reporting		15572	n/a	1409		14196	15621
5 Insulin errors causing NPSA category moderate harm or above		1	0	0		1	1
6 Medication Errors		1260	n/a	83		1158	1110
7 Patient Falls causing moderate harm or above		38	n/a	1		32	31
8 Never Events		5	0	0		5	5
Pressure Ulcers	Core Slide 7						
9 Grade 2 hospital acquired pressure ulcers		156	n/a	19		144	158
10 Grade 3 hospital acquired pressure ulcers		49	n/a	7		46	51
11 Grade 4 hospital acquired pressure ulcers		3	0	1		3	2
Infection Control	Core Slide 8						
12 HAI C. difficile Cases (excluding non-trajectory and pending cases)		20	0	0		19	10
13 Hospital Acquired MRSA bacteraemia		0	0	0		0	0
14 CPE screens taken		n/a	n/a	22		n/a	523
15 CPE positive screens		n/a	n/a	0		n/a	4
16 CPE screens of patients positive from other hospitals		n/a	n/a	0		n/a	0
17 E.coli trust apportioned		n/a	n/a	1		41	53
18 E. Coli community apportioned		n/a	n/a	24		293	287
19 Klebsiella trust apportioned		n/a	n/a	0		n/a	19
20 Klebsiella community apportioned		n/a	n/a	5		n/a	61
21 Pseudomonas trust apportioned		n/a	n/a	1		n/a	10
22 Pseudomonas community apportioned		n/a	n/a	0		n/a	27
Other							
23 EDL to be completed within 24 hours in 95% of discharges		69.95%	95.00%	77.05%		69.85%	76.83%
24 Harm Free Care		92.08%	n/a	85.84%		92.19%	91.28%
25 Patients 'extremely likely' or 'likely' to recommend our service to friends and family		95.87%	100.00%	96.65%		95.98%	96.79%
26 Complaints		952	n/a	68		874	798

* SHMI data is updated quarterly by NHS Digital
** HSMR data is the latest available and reported three months in arrears
*** Crude Mortality Rate is reported one month in arrears, in order to include deaths within 30 days of discharge from hospital

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

Our cancer performance this year is the best in three years and we have made great progress with some complicated cancer pathways. Overall, our services performed well through most of 2017 until we experienced a spike in demand during the winter period. This has affected the Emergency Department performance due to the increase in the number of emergency admissions and means we have performed below the national four hour target. This has also affected our ability to meet the national RTT (Referral to Treatment) target.

KPIs, Risk and Uncertainty

The Trust has a Risk Management Strategy which sets out the accountability and reporting arrangements to the Board of Directors for risk management within the Trust.

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

The Hospital Management Board oversees the identification and mitigation of key risks arising from or relevant to the operation of the Trust. Each of the Management Board committees and governance sub-boards have Terms of Reference and they report regularly to the Management Board on areas of risk or issues that require escalation. For more information, see the Annual Governance Statement on page 109.

Committee structure

The Trust has the following committees which report to the Trust Board:

- Charitable Funds Committee
- Quality and Safety Committee
- Audit Committee
- Nominations and Remuneration Committee
- Finance and Investments Committee

The Trust's sub-committees focus on particular risks and manage issues, reporting to the Management Board. The committees are as follows:

- Divisional Performance Committee
- Procurement Board
- Financial Improvement and Productivity Board
- Clinical Safety and Effectiveness Sub-Board
- Non-Clinical Safety Sub-Board
- Workforce Sub-Board
- Children's Board
- Cancer Board
- Mental Health Board
- Clinical Information Management and Technology Board
- Risk Committee
- Research Oversight Board
- Caring and Patient Experience
- Capital and Estates Committee

Operational governance meeting

During the busy winter period, an Emergency Preparedness, Resilience and Response (EPRR) governance meeting was established which meet 2/3 times a week with key staff from the executive directors, divisional leads and operations centre.

The aim was to manage risk and ensure any additional actions were taken to support patient safety, such as booking additional bank staff, opening additional beds or supporting staff welfare with measures such as free hot drinks.

Long term trend analysis

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

There are three main schemes under development, plus the development of the Quadram Institute which when completed later in 2018 will house the largest endoscopy unit in Europe. The Trust's critical care facilities and Emergency Department have also been expanded during 2017/18. See pages 23 for more details.

Expanding interventional radiology and cardiology

The first scheme involves extending part of the hospital building to accommodate additional space for interventional radiology and cardiology. The new Integrated Radiology Unit suite will be built on a new floor above the existing unit in outpatients east. Planning permission has already been granted and the business case has been submitted to NHS Improvement. This is the number one priority for the Trust Board as it links with our plans for thrombectomy. We aim to be the second thrombectomy service in the Eastern Region working in partnership with Addenbrooke's at Cambridge. As a result, our clinical teams are involved in talks about how we develop our approach to stroke and neurosciences.

Cromer & District Hospital

At Cromer & District Hospital the local community is getting behind our plans to create a new medical and cancer unit in one of the older buildings on the site.

ACAD

We are developing plans for an Ambulatory Care and Diagnostic Centre to focus primarily on diagnostics for cancer referrals

Expansion of Children's Emergency Department at NNUH seeing benefits for young patients in Norfolk

Young patients in Norfolk are now benefiting from an expansion of the Children's Emergency Department at the Norfolk and Norwich University Hospital (NNUH).

The new unit, which opened its doors to its first patients in mid-December, has tripled in size with plans to introduce further treatment areas in the future.

Other improvements include a larger waiting room designated for both younger and older children, enhanced clinical facilities, an expansion in the delivery of mental health care for children in the emergency department and an enhanced office area for staff.

Laura Hall, Children's Emergency Department Lead Sister said: "We're delighted to have opened our newly expanded and refurbished Children's Emergency Department. For children and their families, coming into hospital as an emergency patient can be a stressful time. The expansion of the unit is already proving very beneficial to our younger patients and has enabled us to continue to deliver first class care. Increasing the size of the unit means a reduction in waiting times for our younger patients visiting A&E, and enhanced privacy for those patients who require it when they are receiving care."

Patient Care

Quality of care
The Care Quality Commission (CQC) last inspected our Trust in October 2017 with a number of follow up visits and we are awaiting the publication of the report.

Prior to that, the Trust the was inspected in November 2015 and the report was issued in March 2016. No areas of the Trust were rated as 'Inadequate'. In its report the CQC judged the Trust to be 'Good' for the domain of Caring, but 'Requires Improvement' in the domains of 'Safety, Effectiveness, Well-led and Responsiveness'. The overall rating for the Trust was therefore that it 'Requires Improvement' to ensure full compliance with the registration requirements of the Care Quality Commission.

For more information of the quality of care, see the quality report on page 125.

Respect, dignity and safeguarding

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

Development and Performance

UK's first Older People's Emergency Department
We experienced a very busy year in the Emergency Department and, in common with many acute trusts across the country, we did not meet the national target of 95 per cent of patients waiting less than four hours in A&E from arrival to admission or discharge, achieving 81.02% for the year which has since risen to 92.3% after the end of the winter pressures in April 2018.

Our position has been greatly affected by greater numbers of emergency admissions amongst the older age ranges which make up our local population. This has been combined with difficulties in patient flow in terms of discharging older patients who need enhanced care on leaving hospital.

There are a number of steps we have taken to improve performance and the most significant is the establishment of the UK's first Older People's Emergency Department which currently caters for patients aged over 80 years. The service has received national recognition and it will be able to cater for a wider age range as the service develops. The Over the last year, there have been many changes to the care available for older patients at NNUH. Older People's Ambulatory Care (OPAC) allows many older patients admitted as an emergency to receive a comprehensive assessment and be discharged much earlier than previously.

A second new service, the Older People's Assessment Service (OPAS) now allows GPs direct access to a booked appointment with a specialist geriatrician within 48 hours of referral.

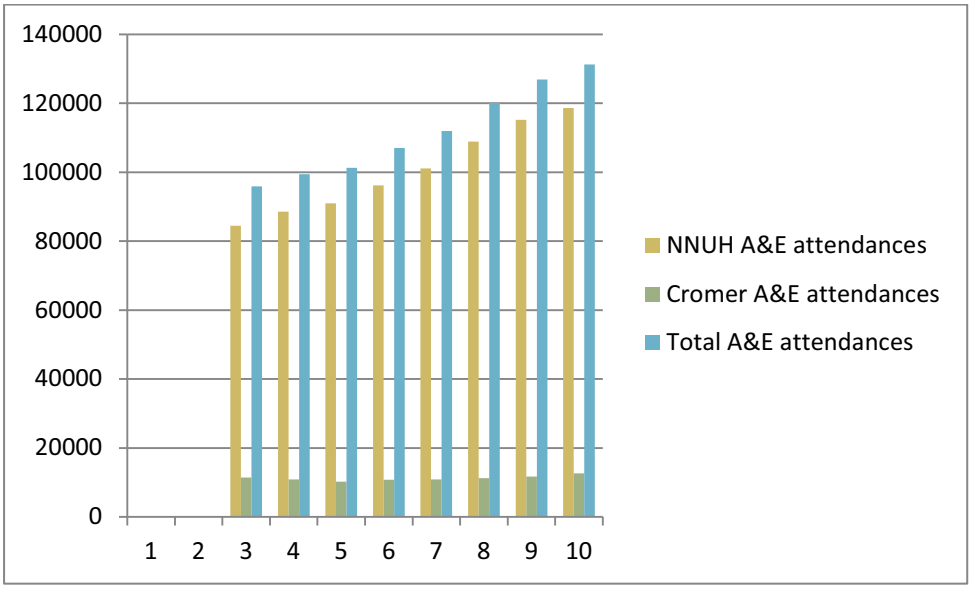
This replaces the traditional outpatient clinic appointment, as well as the traditional long wait for that to happen. Now, when a patient over 80 years old arrives at the NNUH emergency department, they will go straight to OPED, where there will be a multi-disciplinary team consisting of Emergency Department Consultants, Consultant Geriatricians, Emergency and Older People's Medicine Nurses waiting to provide care for them. Patients who require a longer admission will still then be admitted directly to one of the specialist older people's wards.

The ultimate aim of these projects is to ensure that all patients can receive the "gold standard" of care as quickly as possible: a Comprehensive Geriatric Assessment (CGA) within 48 hours of referral or immediately on presentation at the NNUH. CGAs have been shown to identify an older person's risk of frailty by assessing their medical conditions, mental health, level of independence and social circumstances, saving time for the patient, improving their immediate care and preventing problems for the future.

As well as a new Older People's Emergency Department (OPED), we have also relocated the Paediatric Emergency Department, tripling its size to improve the experience of its youngest patients.

In addition a new mental health suite is being established in the space vacated by the children's ED to provide specialist care to those who present with mental health problems. Patients will be seen by a joint team from NNUH and mental health professionals from Norfolk and Suffolk Foundation Trust.

Emergency Department performance



Attendances at A&E at the N&N rose from 115,118 in 2016/17 to 118,587 in 2017/18. At Cromer Hospital there were 11,676 in 2016/17 compared to 12,655 in 2017/18. Altogether, attendances increased from 126,864 in 2016/17 to 131,242 in 2017/18. The N&N performance across the year for A&E is 81.02% which has improved rapidly as winter in 2017/18 has receded with performance in April 2018 rising to 91%.

Improvements in Discharge

The Integrated Discharge Team was set up in March 2016 to improve the discharge process; improve the efficiency of patient flow across the Trust; and support the ward teams.

The team has achieved impressive results, improving the discharge experience and recovery times for patients; forging better relationships with community providers such as care homes, the Community Hospitals and Social Services and saving the Trust in excess of £3.3m as a result of a number of projects and new initiatives to improve services. Various patient flow initiatives, including the implementation of the Clinical Utilisation Review (CUR) software tool across the Trust, and the partnership with the Care Homes Selections (CHS) team (who support more rapid discharge to nursing and residential homes), have significantly improved both the quality and speed of discharge for patients across the Trust.

The core Integrated Discharge Team comprises 29 discharge co-ordinators and 13 complex discharge nurses working on continuing healthcare, and 5 specialist nurses involved in general discharge planning. The team is based in a Discharge Hub behind the hospital Operations Centre, and provides a "single point of access" for all discharge related referrals and queries. All the main health system partners are co-located in the Discharge Hub - Social Services, Norfolk First Support (who help patients with re-ablement),Community Liaison Team (who link the community hospitals and other community-based services to NNUH), Mental Health Liaison Team, Care Homes Selections team and District Direct.

Care Home Selections Team

The Care Homes Selections team has four advisers helping patients, and their families, to locate and secure long and short-term nursing and residential care, in the community. CHS have reduced delays to discharge by an average of 9 days for the patients who use their services.

Red2Green

The Red2Green and "Get Up Get Dressed Get Moving" initiatives are also supported by the Integrated Discharge Team. Red2Green is a national initiative to progress care within the hospital, and to ensure all unnecessary delays to discharge are reduced and removed. The "Get Up Get Dressed Get Moving" campaign encourages patients to recover more quickly in hospital and maintain their mobility and muscle mass after a period of acute illness.

District Direct

NNUH is also the first Trust in the country to work in partnership with local District Councils to provide housing and district council services for patients before they leave hospital. The pilot service is called "District Direct" and involves District Council housing officers being based at the hospital as part of the Integrated Discharge Team. The services offered include housing adaptations in both social and private housing, service for the homeless, general housing queries, debt advice and tackling social isolation issues. Long term funding for this successful pilot is currently under discussion.

The Integrated Discharge Team also work closely with the wards to support the use of the Clinical Utilisation Review (CUR) software tool which provides live data on the suitability of the level of care being provided. NNUH are reporting Delayed Transfers of Care from this system, as well as data 3 times a day on the readiness of patients for discharge.

Red2Green delays data is also reported, as well as the progress on each ward towards successful delivery of the SAFER bundle (a range of nationally endorsed good practice measures to improve patient flow).

Discharge to Assess

The introduction of the Discharge to Assess (Pathway 3) in March 2017 for patients potentially eligible for Continuing Health Care (CHC) funding has been an enormous success. A health economist evaluation of the project demonstrated significant financial savings for the health system, as well as the obvious qualitative benefits to patients of having their needs assessed in a more community focused environment. Previously the CHC assessment process was lengthy with patients waiting in an acute hospital bed sometimes weeks beyond the optimum date for their discharge. Work is now underway on the development of Discharge to Assess (Pathways 1 & 2) which cover patients returning home or to rehabilitation beds in the community to continue their recovery once the acute phase of their illness is over. The extension of the Clinical Utilisation Review (CUR) software tool to community hospitals, which is being considered for 2018, will also provide useful data on the management of patient flow across our whole health system and on the efficacy of the Discharge to Assess developments.

Ward refurbishment

Easton, Mattishall, Gateley, Guist, Edgefield are the first five wards at the Norfolk and Norwich University Hospital to be officially reopened as part of a multi-million pound project which is refurbishing eight wards across the hospital. The refurbishment project is introducing a range of new features on hospital wards to enhance patient care at NNUH, and is being carried out by Serco. As part of the refurbishment programme, more wards across the hospital will be refurbished during the year.

Expansion in Palliative Care

An expansion of the palliative care service has increased the number of patients who can be referred to the palliative care team and ensures that the highest standards of end of life care are achieved seven days a week.

The trust has recruited additional specialist nurses and consultants to now deliver a seven-day service, as well an end of life educator post. These roles will enhance end of life care for NNUH patients and ensure that individualised care is always provided.

The service also offers rapid response palliative care assessment to patients in the A+E department and acute oncology services to ensure that patient's symptoms are controlled as soon as they come to hospital, and so patients are facilitated to go home if that is their wish. The palliative care service can now also offer daily Symptom Management and Supportive Care Clinics to ensure that patients can be seen much earlier in their disease, for assessment and support.

Expansion in critical care facilities

Patients are benefitting from an increase in critical care facilities which have added an additional eight high dependency unit (HDU) beds to current facilities at the hospital, marking a 40% increase in capacity.

Patients may receive care within the Critical Care Complex (CCC) at NNUH if they are seriously ill requiring intensive treatment and close monitoring, or if they are having major surgery and intensive care can help them to recover. Around 1600 patients utilise the facilities on the unit each year and numbers of patients requiring this type of treatment are increasing each year.

Over the past two winters, an expansion of facilities has been tested with an extension into a dedicated area of theatre recovery. This has evidenced a strong demand for expanded facilities, with positive impacts on both patient experience and planned operations.

The additional critical care facility is situated within Gissing Ward. The ward's proximity to the critical care complex meant that it was in a prime position to become an extension of the unit. The new beds will predominantly care for surgical elective patients requiring HDU care following surgery.

The new unit will feature the latest equipment and technology to support the care of critically ill patients.

Part of the new unit has also been allocated as a dedicated critical care teaching area, specifically designed around the elective surgical patient. This area is providing an in-situ simulation suite for training doctors, nurses and other healthcare professionals.

A portion of the teaching space will be set up to mirror a patient bed space, making the simulation of real-life situations on the unit much easier.

The Critical Care team is also expanding in terms of medical and nursing staff to lead the extended unit.

NNUH research team presented with award for Meniere's disease clinical trial

A team from NNUH has been presented with an award in recognition of its role in a clinical trial to find a treatment for Meniere's disease.

The award was received from INC Research, a global contract research organisation which monitors the work of clinical research teams. Meniere's disease is an uncommon disorder that affects the inner ear. It can cause vertigo, tinnitus, hearing loss and a feeling of pressure deep inside the ear.

The NNUH research has been led by clinical research nurse Catherine Wright who said: "We have been running a number of clinical trials on behalf of a US company called Otonomy, with their investigational drug OTO-104."

OTO-104 is a suspension of dexamethasone in a solution, that gels at body temperature. OTO-104 is being developed for the treatment of vertigo associated with Meniere's disease, which is considered the most debilitating symptom of the disease. OTO-104 is a slow-release treatment which stays in the ear for a prolonged period of time.

Catherine said: "The first study we were involved with was a phase two study. During this study we recruited patients with a diagnosis of Meniere's disease. Patients were given OTO-104 injections into the ear, and we were interested in looking at the safety aspects of the injection."

HSMR (Hospital Standardised Mortality Ratio)
We have a whole hospital approach to reducing HSMR and data is already showing our HSMR is moving towards 90 (the HSMR in February 2018 was 95.82) which means that we have taken a significant step to become a low mortality hospital which is an overall measure of patient safety. The other key piece of evidence in our progress on quality and safety is our continued low infection rates. For more information on HSMR, see the Quality Report on page 125.

Mental Health Service Developments at NNUH
We have been working in partnership with the Norfolk and Suffolk NHS Foundation Trust (NSFT) in the expansion of the Mental Health Liaison Team based at NNUH to deliver a more robust service for people come into NNUH who also have presenting mental health needs.

Expansion of NSFT's Mental Health Liaison Team based at NNUH
The Mental Health Liaison Team is a multi-disciplinary team staffed with a range of healthcare professionals. The expansion of the service and the increase in team staff numbers has been commissioned by the North and South Norfolk CCGs in partnership with NNUH, NSFT and MIND.

The team is made up of Mental Health Nurses, Consultant Psychiatrists, Clinical Psychologists, Assistant Practitioners and Administration staff members. This is an evolving team and service, with further developments to be rolled out over the next year.

In addition to the partnership working between NNUH and NSFT, the Mental Health Liaison Service is working in partnership with MIND to ensure the service provided is most suited to the needs of those arriving at NNUH.

As part of the team's role, the Mental Health Liaison Service will also deliver specialist training and education to NNUH staff across the hospital. The aim is to enhance awareness and understanding of common mental health needs that typically accompany many physical health conditions.

New Matron role to enhance patient care
A new Matron/Head for Clinical Practice has been appointed for the Mental Health Liaison Service which is the first jointly funded role between NSFT and NNUH, confirming the ambition for greater understanding of how Mental Health is something that matters to everyone.

Mental Health Liaison Team working with Dementia Support Services
With the expansion of the Mental Health Liaison Team, it has also allowed for the partnership work with the Dementia Support Team at NNUH to continue and develop.

The Dementia Support Team is made up of three Dementia Support Workers and one Dementia Support Nurse. These two teams will be able to share their expertise and knowledge in a range of medical and psychosocial approaches to help meet the care and treatment needs of those individuals who are living with dementia and who are staying in hospital.

Following referrals from ward staff, the Dementia Support Team gets to know each patient individually whilst they are in hospital to understand their needs and what they and the ward teams can do to make their stay as positive as possible. The team focuses on using meaningful activities which provide cognitive stimulation and enhance wellbeing which could include listening to music or taking part in arts and crafts.

Mental health services in the Emergency Department

NNUH is currently creating a mental health suite to support patients coming into ED who also have presenting mental health needs. Improving staff and patient safety by ensuring the environment is more appropriate is underway, this includes reducing the need for patients to wait in the current ED environment which can provide over stimulation because of its lighting and noise, the addition of safer furniture, panic strips and also a base for the Mental Health Liaison Team to work from to support timely assessment of an individual's mental health needs. The Trust is working in partnership with NSFT to ensure the environmental works meet required regulations to support staff and patient safety.

Mental Health Board at NNUH

The Mental Health Board, which was launched at the end of 2017, meets to further enhance the care we deliver for patients who arrive at NNUH with mental health needs.

The board is made up of NNUH Medical Director, Peter Chapman, senior divisional representatives from the Trust, and key stakeholders with responsibility for commissioning or providing mental health and support services to NNUH across all patient groups.

The Mental Health Board has been introduced to support patients and to ensure they receive the most appropriate care for their needs. The Board carries out immediate appraisal of current arrangements for care of patients with mental health needs in the Trust, and discusses recommendations for the development and provision of services in the Trust for patients with mental health needs.

Performance against key health targets

Cancer

Our performance this year is the best in three years and we have made great progress with some complicated cancer pathways. We would like to congratulate several of our teams – head and neck cancer, lung cancer, and gynaecological cancer - who have made tremendous efforts on behalf of their patients to deliver a gold standard of cancer care.

Patients have rated us highly in the national patient cancer survey and our results place us in the top 20 per cent of Trusts in the country in eight of the subject areas. We also perform well on the 62 day cancer target compared to other Trusts, despite the operational pressures we have experienced, we continue to be a world leader in the use of robotic cancer surgery and have seen a significant increase in the number of patients participating in clinical trials.

In our cancer strategy, we predicted a rise in demand which is coming to fruition with more activity in sites such as breast, colorectal, skin, urology, and prostate. Our performance has been maintained for two week wait referrals even though we are seeing more than 2,000 patients a month.

Our 31 day target has been met with the best performance in seven years at 98.83% and our 31 day subsequent surgery target was achieved for the first time since 2013/14.

In fact we met all the cancer targets in the month of December 2017 for the first time in four years. Our aim in 2018/19 is to have more consistent performance across all targets and meet them all, every month.

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

We opened our expanded chemotherapy day unit – the Weybourne Unit - in April 2017 which increased capacity from 14 chairs to 24, reducing waiting times for treatment and providing a much improved patient and staff environment.

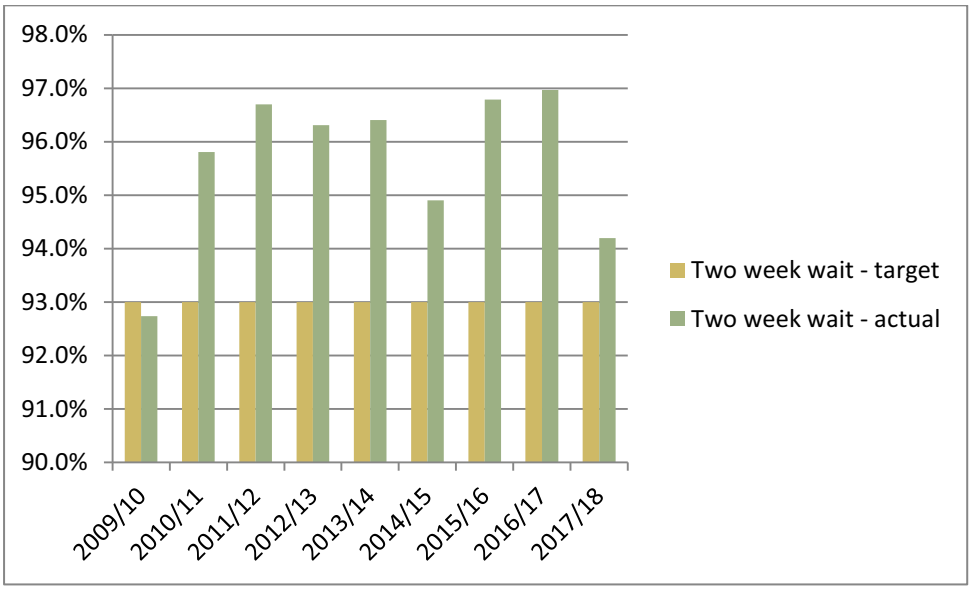
We have also introduced an Integrated Care Pathway Project Team, funded by Macmillan Cancer Support, to assess cancer patient's individual needs and signpost them to support at key points in their cancer journey. During the year, the project reached a big milestone by assessing its 500th patient.

Since the project launched in January 2017, the team has been using tools from the Cancer Recovery Package to support patients by improving the advice and information they receive from diagnosis, during their treatment journey, and after they finish treatment.

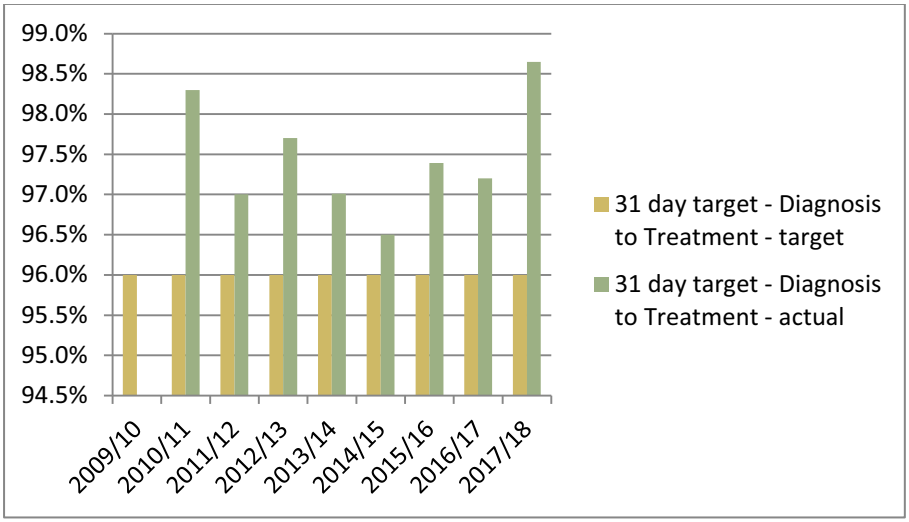
The team is working with organisations such as Active Norfolk and Public Health England to promote healthy lifestyles and physical and mental wellbeing during and after cancer.

The Macmillan Integrated Care Pathway Project Team's work is in addition to the support provided to patients during their treatment by the clinical team and specialist nurses who are in regular contact with patients about aspects of their treatment and wellbeing.

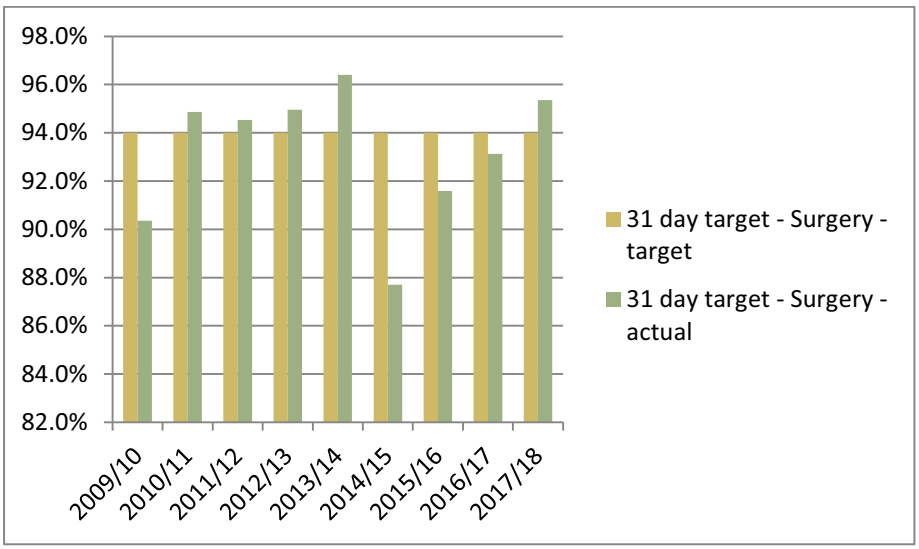
For two week waits, we exceeded the target by achieving 94.2% (target is 93%). This was despite an increase in referrals of nearly 9% which now number over 2,000 a month.



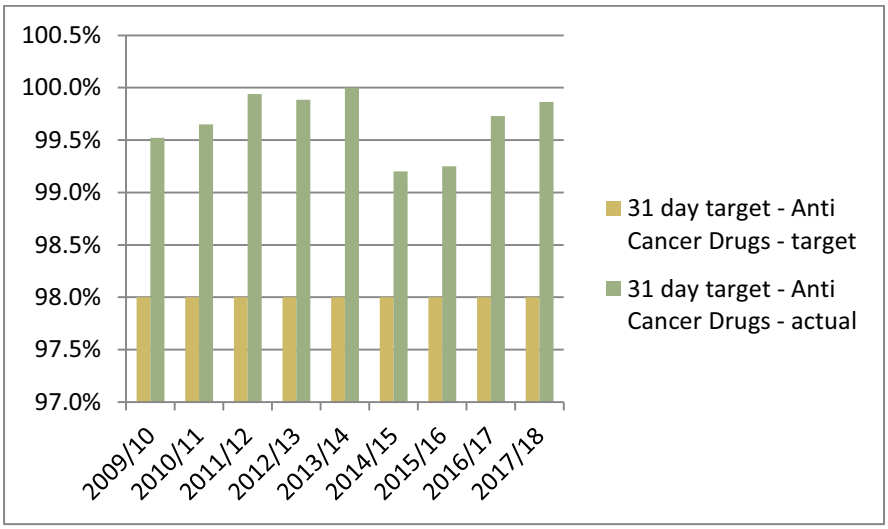
For the 31 day target for diagnosis to treatment, we achieved 98.6% which is above the target of 96%.



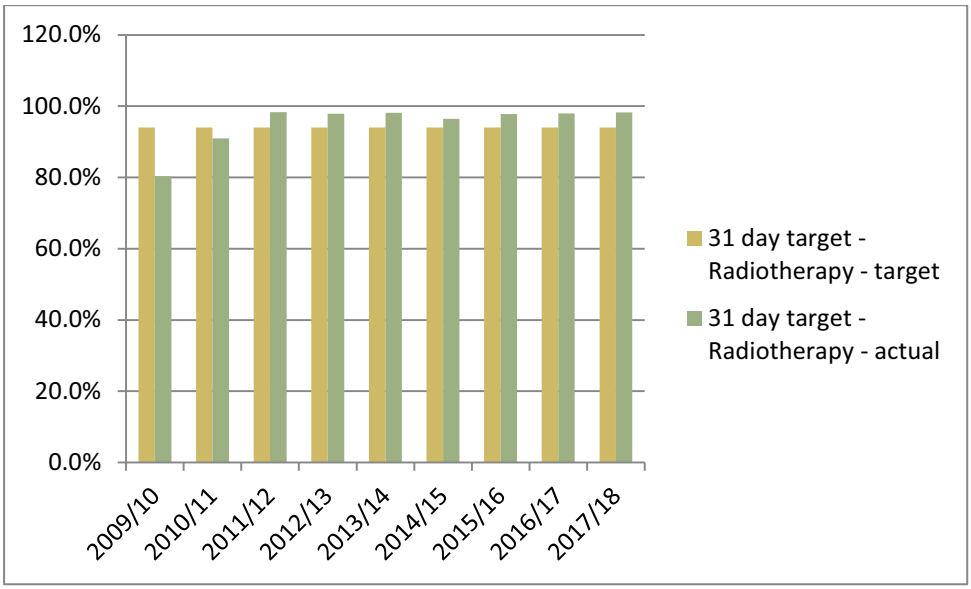
For 2016/17, we achieved 95.4% against the target of 94% for the 31 day target for surgery which is better than last year.

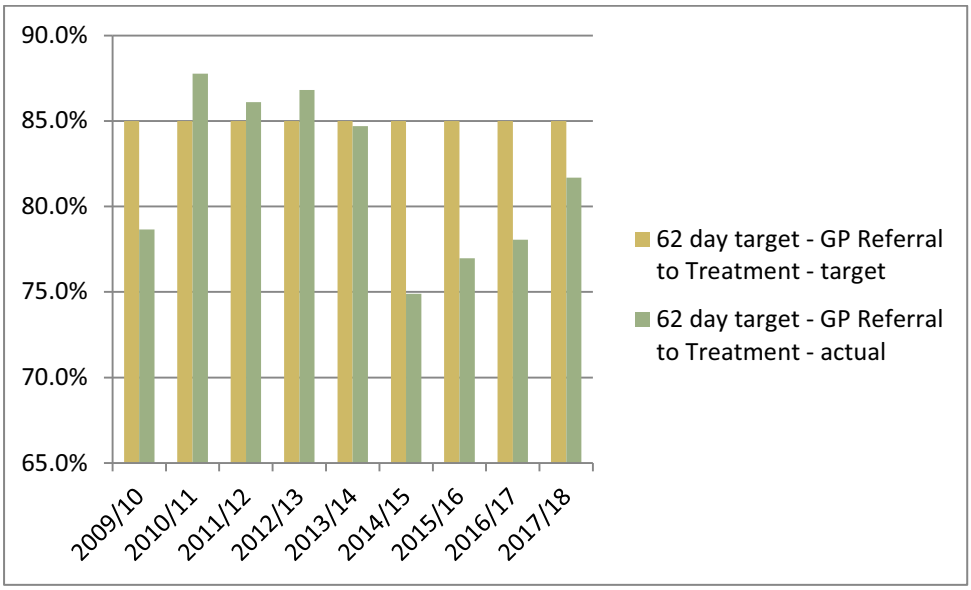


For the 31 day target for anti-cancer drugs, we achieved 99.9% against a target of 98%.

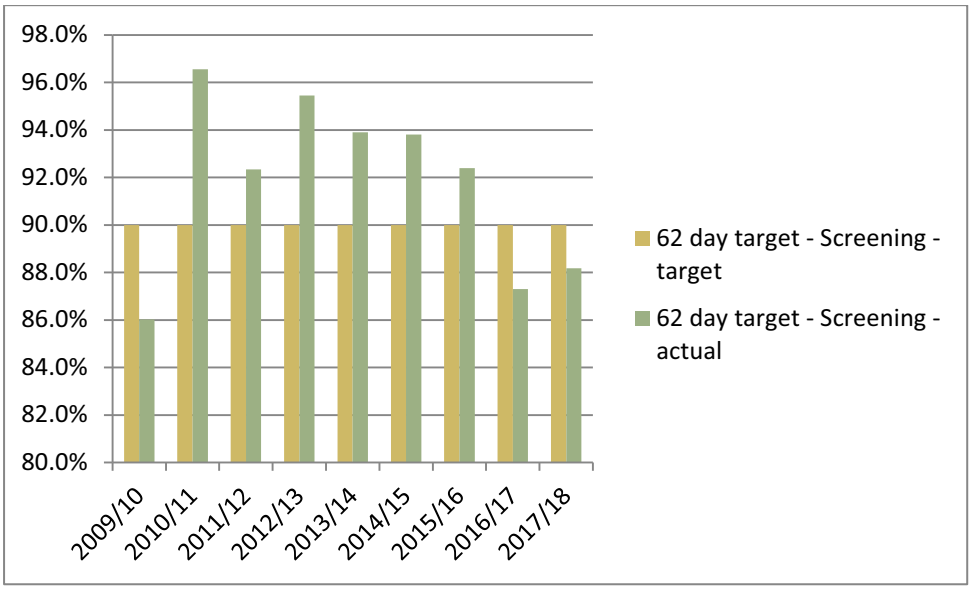


For the 31 day target for radiotherapy, we achieved 98.3% against the target of 94%.





The 62 day target for GP referral to treatment was not achieved with 81.7% achieved against the target of 85%. This was an improvement on last year's performance of 72.12%.



The 62 day target for consultant screening was not achieved with 88.2% against a target of 90%. This was an improvement on last year's performance of 87.3%.

NNUH staff survey results show significant improvement

A national survey of NHS employees shows that staff at NNUH have rated the Trust more highly in 18 out of 32 key findings, demonstrating a significant improvement over the last two years.

The improvements include staff recommending the hospital as both a place to work and a place to receive care, feeling supported in the workplace and satisfied with opportunities to work flexibly.

A total of 3500 NNUH staff responded to the 2017 national NHS staff survey which is about 50 per cent of employees.

Chief Executive Mark Davies said: “The staff survey is really important to us as it provides a comprehensive picture of staff views of what it’s like to work at NNUH, and how we’re doing compared to recent years. Having well supported and motivated staff helps us to provide excellent care for our patients. This year's results show we are making clear progress and the results are moving in the right direction.

"I would like to say a very big thank you to staff for the support they provide to patients and colleagues on a daily basis, which makes NNUH such a special place to work. Together we are committed to creating a supportive environment for all our teams and we will use these results to take that work forward."

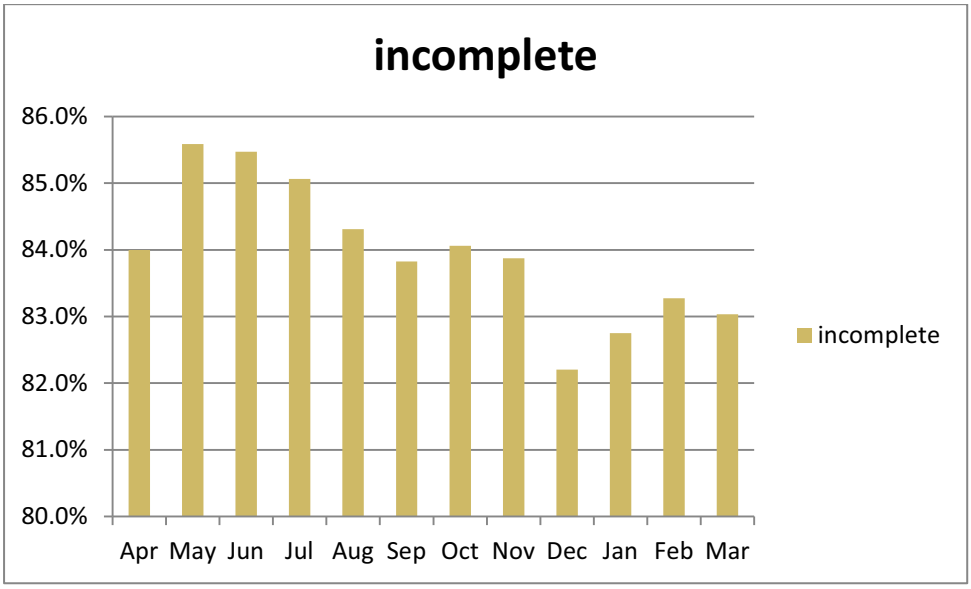
Referral to Treatment waiting times

The Trust has seen an ongoing demand for its services in recent years. The compound annual growth rate over the last five years has seen two week wait referrals for cancer rise 10% year on year, with RTT demand rising by 3.9% and emergency admissions up 2.7% during this period. This has placed the Trusts capacity under continuing pressure and means we have missed the RTT target.

During the course of the last 12 months a significant amount of work has been undertaken with commissioners and the wider healthcare system to manage the demand coming into the hospital and utilise capacity more efficiently. As a result RTT referrals reduced on the previous year by 3.5%.

In RTT terms what this has seen is a reduction in the waiting list size as part of a managed programme of recovery but a waiting list profile where, owing to the urgent nature of demand for cancer, routine waiting patients have incurred longer waits for some specialties.

We continue to work collectively with partner agencies and through the STP to address parity of provision, the sharing of capacity and development of patient pathways across the local healthcare system.

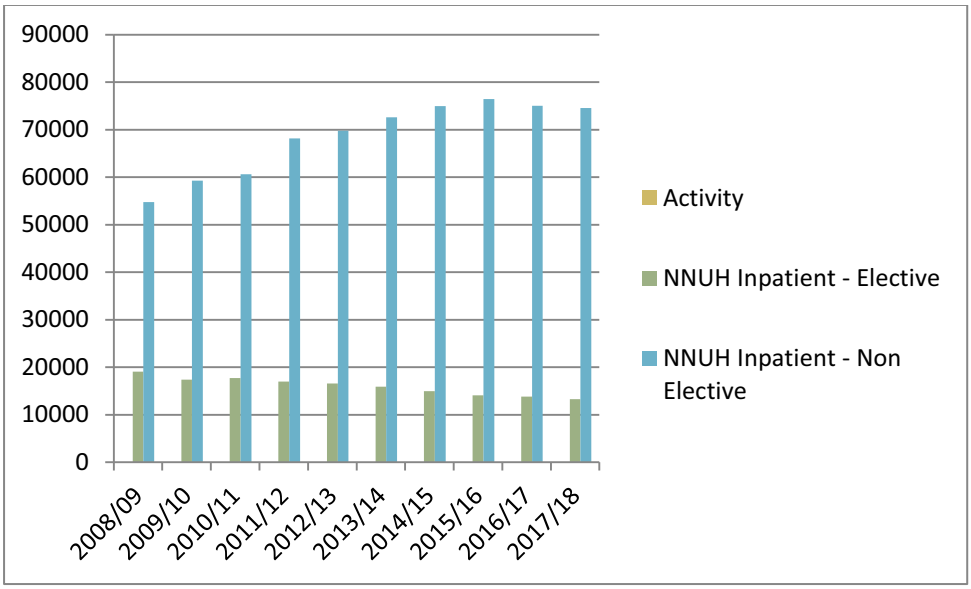


Incomplete pathways represent those patients who have been referred on to consultant-led referral to treatment (RTT) pathways, but whose treatment had not yet started at the end of the reporting period. The volume of incomplete pathways is often referred to as the size of the RTT waiting list. These patients will be at various stages of their pathway, for example, waiting for diagnostics, an appointment with a consultant, or for admission for a procedure.

Across the year, between 82.2% and 85.6% of patients were on incomplete pathways. The NHS England operational standard is that 92% of patients on incomplete pathways should have been waiting no more than 18 weeks from referral. This means we have missed the RTT target and patients face longer waits for treatment.

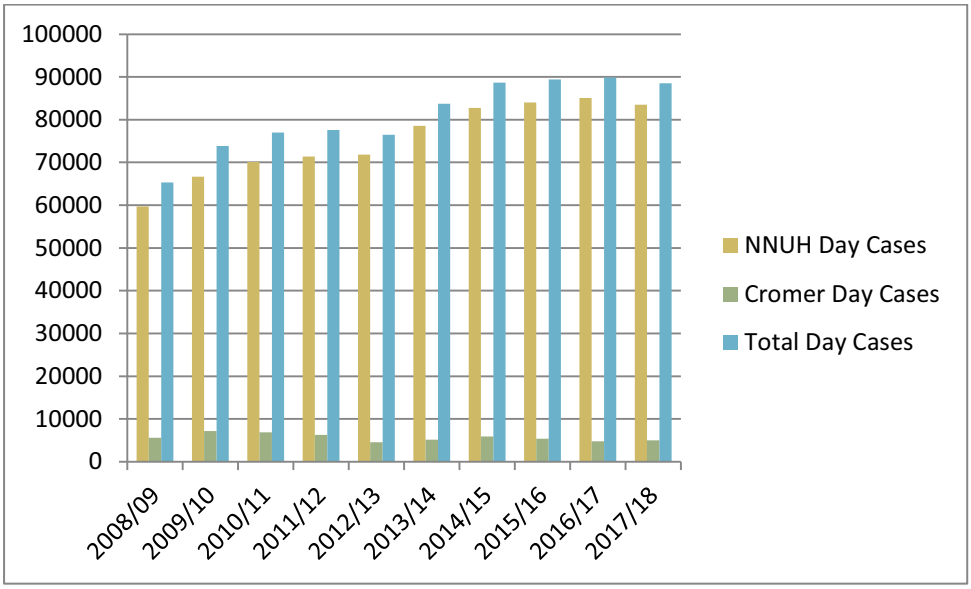
Inpatient cases

The number of elective inpatient cases fell from 13,825 in 2016/17 to 12,256 in 2017/18 whilst the number of non-elective inpatient cases (emergency admissions) was also slightly down from 75,011 in 2016/17 to 74,552 in 2017/18.

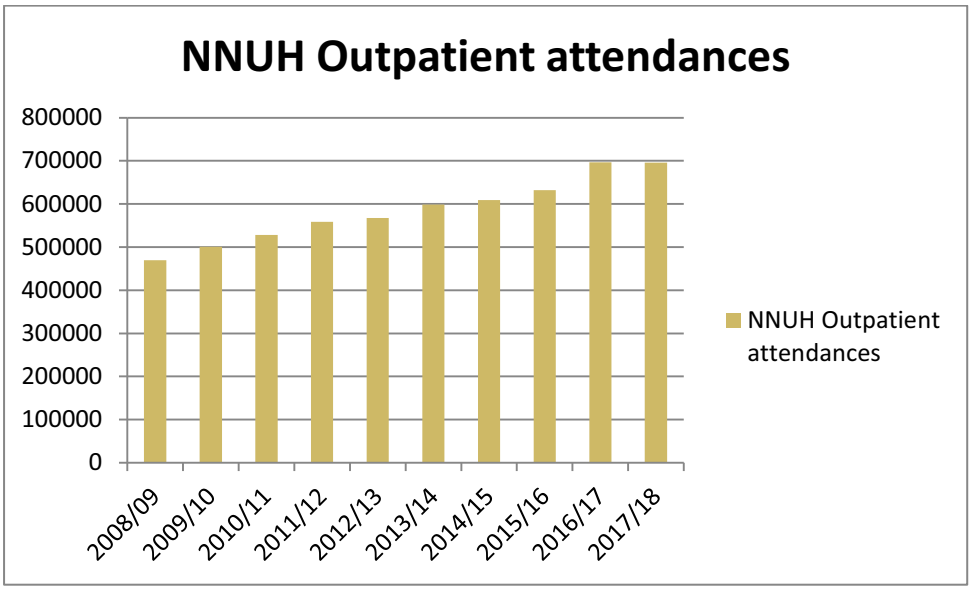


Day Cases

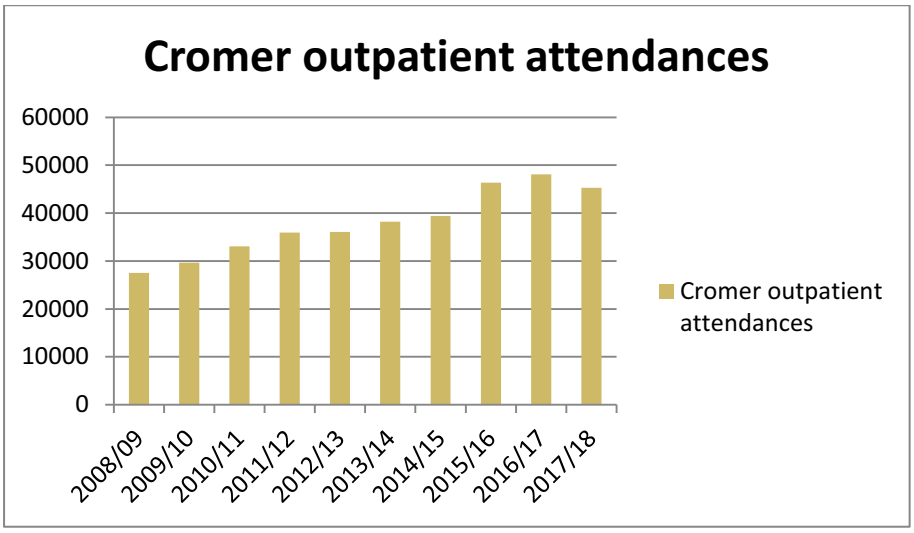
In 2017/18, there were 83,526 day cases at NNUH, 5,017 at Cromer Hospital with a total of 88,543, compared to 89,827 in 2016/17.



Outpatient Services



At the N&N hospital there were 215,475 new outpatient attendances in 2017/18, compared to 215,662 in 2017/18, with 480,772 follow ups in 2017/18 compared to 481,122 in 2016/17.



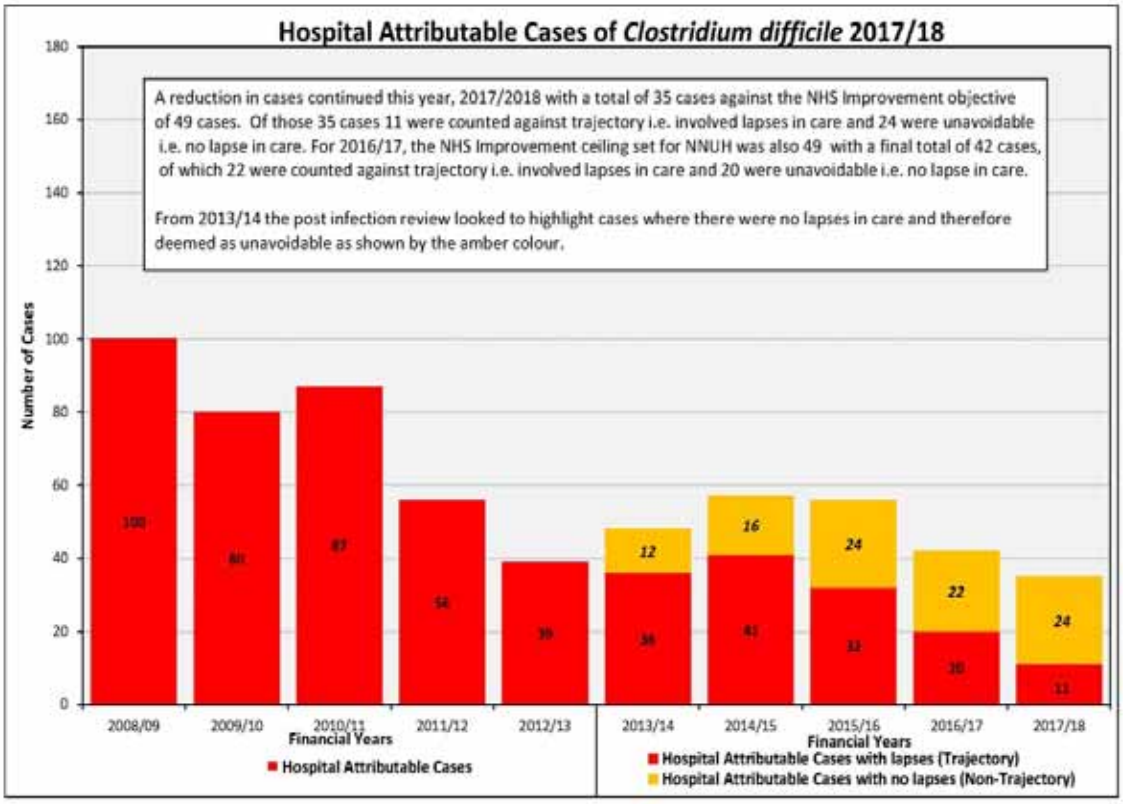
At Cromer Hospital we saw 12,439 new outpatients in 2017/18 compared to 13,883 in 2016/17 and 32,813 follow up appointments in 2017/18 compared to 34,183 in 2016/17.

Overall, there were 741,449 outpatient appointments in 2017/18 compared to 744,850 in 2016/17.

Healthcare Acquired Infections

MRSA bacteraemia: The DH ceiling set for the hospital was zero. The trust met this objective, there was no hospital acquired MRSA bacteraemia in 2017/18

Clostridium difficile:



Our Financial Performance

During the year we experienced a number of significant operational challenges, both local to us and reflected nationally and as a consequence our financial results for 2017/18 were not as originally planned. The impact of the challenges required us to formally reforecast our plan in year from a small surplus to a deficit of £27.3m. The reforecast was discussed and agreed with our regulators, NHS Improvement. Our final reported actual position was a deficit of £19.6m.

The deficit reflects the operational challenges, in particular the ongoing levels of non-elective demand and the resultant impact on our elective capacity. This was exacerbated through the pressures of winter, and together reduces our income. It also adversely impacts our access target performance which in turn reduces the amount of Sustainability and Transformation Fund income we can earn. These key performance issues, along with the constant downward financial pressure and unprecedented demands upon the expenditure base are the main drivers for not being able to achieve our original plan of a surplus of £3.6m.

Our turnover is £586m, and our actual deficit for this financial year is £19.6m, an improvement on the reforecast plan agreed with our regulators.

Financial Improvement

Our financial improvement plan required us to deliver £33.6m of savings, representing 5.7% of turnover. On closure of the financial year we were successful in delivering savings of £30.1m, of which £17.3m was recurrent. There has been a continuing focus on reducing premium pay costs and working hard on productivity and associated improvements. This has been underpinned by an enhanced governance and delivery programme with inbuilt quality and safety safeguards.

Cash Management

We have focused on cash management in order to ensure that our cash is used most effectively in order to minimise the amount and timing of borrowings from the DH. We have also been able to secure the most favourable interest charge rate on in-year borrowings. Our end of year borrowing was £52.4m; an increase of £36.4m in year.

Capital Expenditure

We invested £9.4m in new and replacement capital assets during the year (2016/17: £6.9m).

To support this investment we bid for, and received, £3.3m Public Dividend Capital (PDC) funding to purchase a linear accelerator (£1.7m), A&E alterations (£1.0m), and cyber security upgrade (£0.6m).

In addition to the PDC funded purchases, the most notable investments were for the Quadram Institute (£2.0m as part of a total investment project of £8.58m), expansion of our High Dependency Unit (£0.8m), and a refresh of our network hardware (£0.6m).

Overseas operations

We do not have any overseas operations.

Charitable Funding

We are fortunate to be supported by the Norfolk and Norwich University Hospital Charity, The Friends of Norfolk and Norwich Hospital Charity and The Friends of Cromer Hospitals. In addition we are again fortunate to receive support from many external charities and organisations. In 2017/18 we benefited from £1.7m of donated assets (2016/17: £0.2m).

Operational Future

As we look to the future, the NHS remains exposed to an unavoidable cost improvement requirement if it is to maintain services, as we face inevitable cost pressures and a real-term reduction in tariff and non-tariff funding. There has been and continues to be an increased reliance on non-recurrent income which puts pressure on the underlying financial position.

Accordingly the achievement of operational targets and sustainable financial stability in an increasingly difficult climate will be a significant challenge and will take some time.

Nevertheless, we have ambition to improve for the benefit of our patients and with a relentless focus on patient safety and care.

Financial Accounts 2017/18

The full accounts are attached at the end of this document.

Social and community report

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

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

Patient Feedback

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

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

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

Insight

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

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

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

Organisations come together to highlight dementia support at NNUH information fayre

Over twenty public sector and community providers joined NNUH to mark Dementia Awareness Week 2017 at the NNUH Dementia Information Fayre.

Organisations held information stands to highlight what dementia support they have to offer in Norfolk to those living with dementia and their families and carers. Teams from NNUH were also on hand to show what dementia support the hospital offers including stands hosted by NNUH Library, Allied Health Professionals (AHP), Nursing, Research and Dementia Support.

As part of the day, those visiting the fayre also attended various talks for the public hosted by Dr Muhammad Rafiq, Consultant Neurologist and Honorary Senior Lecturer at NNUH, Heather Edwards, Lead of Come Singing and Music Mirrors, Lorna Wilson, NNUH Head Librarian, Dr Jay Foden, NNUH Older People's Medicine Speciality Registrar and Dr Sarah Housden, Senior Lecturer, School of Health Sciences, UEA.

Liz Yaxley, Dementia Services Manager said: "The fayre really highlighted just how much is going on in Norfolk when it comes to supporting those living with dementia and their families and carers. NNUH has the largest Older People's Medicine department in the country and we wanted to hold an event that gave those affected by dementia access to information about the extensive projects and initiatives going on in the local area."

Carers' Strategy

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

Volunteer work to improve the Patients' Experience

We currently have almost 700 volunteers and work with a wide variety of external voluntary groups to support us and enhance the experience of our patients.

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

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

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

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

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

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

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

New roles currently being established are:

Palliative Care

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

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

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

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

Young People
We are working with the UEA and INTO to recruit 70 international students into volunteer placements for NHS70. We are working to provide not only health and social care volunteering placements, but also administrative, reception and support service opportunities to students who are keen to enhance their career paths.

Pets As Therapy Dogs
Following the sign off of the Standard Operating Procedure (SOP) to introduce the Pets as Therapy service to the Trust, voluntary services have now recruited and trained five PAT volunteers.

Research provides evidence that dogs can have a positive effect on a patients' wellbeing and assist a speedier recovery. The companionship of a dog and their handler can decrease loneliness, stimulate conversation, encourage movement and social interaction.

The visiting PAT Teams will be Buddy and his owner Angela, Abbee and her owner Wendy, Minty and her owner Sophia, Lily and her owner Anne plus Stella with her handler Carole.

The volunteers and their dogs are currently allocated to Heydon ward on a three month pilot and are proving a huge success! Ward Sister Andree Glaysher commented that the atmosphere on the ward was totally transformed and that both staff and patients had really benefited from the visit. One patient remarked that meeting the dogs was "Worth coming into hospital for."

The project will expand to other wards following evaluation.

Investing in Volunteers
Similar to "Investors in People" the voluntary services team have recently undertaken the re-accreditation process for the IiV award (renewable every 3 years). The process requires an organiasation to produce an initial self-assessment then carry out any service developments identified before they receive a three day visit from an assessor. The assessor is required to scrutinise evidence based practice and interview a selection of volunteers and staff.

Those interviewed represented a range of ages and lengths of service, ranging from those who have volunteered for 15 or more years to those recently recruited (within the last 6 months) and included both genders and varying ethnicities. NNUH promotes volunteering to people with disabilities, both physical and learning; therefore the volunteers spoken to during the assessment also represented people with a range of disabilities.

All volunteer roles were represented in the sampling: Wards; Clinics; Administration; Meet & Greet/Reception; Patient Experience; Meal Time Assistants; Administrative Support; Bleep Buddies; Settle In Service; and Older People's Medicine etc.

64 volunteers were interviewed face to face and additionally, volunteers were able to complete the online survey and 149 responses were received.

Due to the very diverse nature of the organisation's involvement of volunteers 14 members of staff were also interviewed to reflect different departments/sites and the different activities that volunteers support across the NNUH: Those interviewed were the Voluntary Services Manager, Director of Workforce (VSM's Line Manager); Volunteer coordinator; Matrons, Nurse Managers, Clinic Managers, Secretaries; Dementia Support Worker; Assistant Practitioner; Admin Managers, Risk Administrator; Security Manager and Governor.

NNUH voluntary services received a very positive report from the assessor and are delighted that they were successful in achieving the award. NNUH are the only organisation in the country to receive the accreditation for a fifth time.

Patient Information Forum

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

The Fundraising Connection

The N&N Hospitals Charity is the Trust's official registered charity. Its objective is to improve the health and wellbeing of NHS patients who use the services of the Trust's hospitals. The charity makes grants to pay for equipment, facilities or amenities which enhance and supplement what the Trust is able to provide with its NHS funds.

This year (2017/18) the N&N Hospitals gave grants to the Trust of £1,700,843, the money having been raised largely through the generosity and tireless efforts of donors and supporters in the local community as well as the Trust's own staff. The charity has either bought or contributed to :

- 2,159,057k for the purchase of equipment
- 102,122k for patient welfare and amenities
- 233,750k for staff education & training
- 4,7571k for research
- 368,547k for staff welfare and amenities.

The charities major projects for 2018/19 include:

- the refurbishment and remodelling of the Davidson Unit at Cromer Hospital
- supporting the planned new Interventional Radiology Unit
- two integrated laparoscopic theatres

For more information about our charity please visit www.nnuh.nhs.uk

We are also grateful to a number of other charities for their continuing support:

- The Friends of Norfolk & Norwich University Hospital
- Big C
- Macmillan Cancer Support
- Norfolk Heart Trust
- Cromer Community & Hospital Friends

Environmental responsibility

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

Complaints handling

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

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

Anti-bribery legislation

In order to ensure the NHS (including our Trust) provides a transparent view of how taxpayers' money is spent, new guidance has come into force which outlines key areas of potential conflict and guides staff on how to manage them

From 1st June 2017, Managing Conflicts of Interest in the NHS came into effect, introducing consistent principles and rules for managing actual and potential conflicts of interest, providing simple advice to staff and organisations about what to do in common situations and supporting good judgement about how interests should be approached and managed

The guidance is supported by an updated Trust policy: Conflicts of Interest and Business Conduct Policy and area on the staff intranet which was accompanied by a communications campaign with staff.

Blow your whistle on oesophageal cancer

Patients who have survived oesophageal cancer are taking part in a ‘Blow your whistle’ awareness day at the Norfolk and Norwich University Hospital at 11am on Saturday 29th April 2017. The aim is to encourage this activity at all sporting events in future so that it becomes an established way to raise awareness for oesophageal cancer.

NNUH Consultant Surgeon Mr Edward Cheong said: “Oesophageal cancer is a very aggressive cancer that affects the gullet and it is vital that it is caught early when treatments are more likely to be effective. Many patients ignore the symptoms such as persistent indigestion, acid reflux and difficulty swallowing. We are launching this awareness campaign to encourage people to be aware of symptoms and seek medical advice at an early stage.

“This is the first event of its kind and we hope it will grow every year and become part of sporting events.”

Approval of the Performance Report

I confirm my approval of the Performance Report:

Mark Davies
Chief Executive

Date: 25th May 2018

Accountability Report

Directors' Report

Board of Directors

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

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

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

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

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

Who is on the Board of Directors?

Executive Directors

Chief Executive

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

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

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

Director of Workforce
Jeremy Over was appointed as Director of Workforce from October 2014 and has over ten years' experience working at a senior level in NHS HR. Jeremy is responsible for our staff learning and development and Human Resources functions including recruitment, payroll and workplace health, safety and well-being. Jeremy chairs our Workforce & Education and Non-Clinical Safety Sub-Boards.

Acting Chief Nurse
Frances Bolger was appointed to the Board as our Acting Chief Nurse in February 2018 following the departure of Mrs McKay. Frances is a registered General Nurse and Midwife. Frances was Head of Midwifery at the Trust before taking up the Acting post. The Director of Nursing is responsible for nursing leadership in the Trust and for providing professional nursing guidance to the Board. Frances chairs our Caring and Patient Experience sub-board.

Interim Chief Finance Officer
John Hennessey was appointed to the Board as our Interim Chief Finance Officer in February 2018 following the departure of Mr Norman. John is an experienced Finance Director with many years of experience in the NHS. The CFO is responsible for overseeing the financial systems and processes of the Trust.

Non-Executive Directors

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

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

Mark Jeffries is a solicitor and former senior partner of the national law firm Mills & Reeve LLP. Mark is Non-Executive Director of R G Carter Holdings Ltd and N W Brown Group Ltd and Chairman of Evolution Academy Trust. Mark was appointed as a Non-Executive Director in November 2011, reappointed from November 2014 and again from November 2017 to November 2018. Mark is a member of the Nominations and Remuneration Committee, Audit Committee and Quality and Safety Committee. Mark is also chair of the Charitable Funds Committee.

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

Professor David Richardson is Vice-Chancellor of the University of East Anglia. David was appointed as Non-Executive Director from September 2014 and reappointed by the Council of Governors in September 2017. David is a Microbiologist with particular research interests in the biochemistry of environmentally and medically important bacteria. David is a member of the New Anglia LEP Board and the Norwich Research Partners LLP. David is a member of our Finance and Investments Committee.

Angela Robson is a chartered accountant who has worked at JP Morgan and Goldman Sachs and is now Deputy Vice-Chancellor of Norwich University of the Arts. Angela is a Trustee of the Theatre Royal and a Director of the Diocesan Board of Finance. Angela was appointed as a Non-Executive Director for a three year term in November 2011, reappointed by the Council of Governors from November 2014 and again from November 2017 to November 2018. Angela is Chair of the Audit Committee and is a member of the Nominations and Remuneration Committee.

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

Changes during the Year

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

- James Norman was appointed as Chief Finance Officer in January 2017 and left the Trust in January 2018;
- Emma McKay was appointed as Director of Nursing in November 2012 and left the Trust in January 2018.

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

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

The Chief Executive is responsible for:

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

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

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

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

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

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

Compliance with this requirement is promoted through use of a 'toolkit' issued by NHS Employers, NHS Confederation and NHS Providers following consultation with the CQC. Annual checks are conducted against national registers and through a process of annual declarations and the Board can accordingly confirm that all its director level appointments meet the 'fit and proper persons test'.

The Board's Committees

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

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

Audit Committee:

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

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

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

Auditor Independence and Non-Audit Services

The Audit Committee reviews and monitors the external auditor's independence and objectivity and considerations of avoiding conflicts of interests formed a specific consideration taken into account in appointing the external auditors. The Trust has a policy by which any non-audit services provided by the external auditor are approved. During 2017/18 KPMG LLP have not been commissioned to provide any services to the Trust in addition to undertaking the external audit of financial statements and assurance work on the Quality Report.

KPMG LLP is also the external auditor of Norfolk and Norwich University Hospitals NHS Foundation Trust Charitable Funds of which the Trust Board of Directors is the Corporate Trustee. The fees in respect of this engagement in 2017/18 are set out in note 6 of the financial statements.

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

Statement as to disclosure of the auditors

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

Code of Governance

The Norfolk and Norwich University Hospitals NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

Main Activities of the Audit Committee during the Year Ended 31 March 2018

The Audit Committee met on 4 occasions during the year ended 31 March 2018.

The focus of the Committee was on:

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

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

During the course of the year the Audit Committee received audit reports from the internal auditors, RSM, in accordance with an agreed Audit Plan and including regular reports on follow-up of recommendations from previous audits. The Audit Plan for 2017/18 included audits relating to monitoring of sickness and absence, discharge planning processes, business continuity, data quality, payroll management and procurement.

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

In December 2016 the Committee reviewed and agreed the External Audit Annual Plan for the 2016/17 audit. The financial performance of the Trust for 2016/17 was reviewed by the Auditors during April and May 2017 and presented to the Committee in May 2017. In accordance with this established annual cycle, financial performance for 2017/18 is subject to external audit review during April and May, for review of the Accounts by the Committee in May 2018.

Nominations and Remuneration Committee:

The Board Nominations and Remuneration Committee has a membership consisting of Non-Executive Directors and the Chief Executive. It is Chaired by John Fry. The other members of the Committee are Mark Jeffries, Tim How, Angela Robson, Sally Smith, Geraldine O'Sullivan and Mark Davies. The Secretary to the Committee is the Board Secretary.

The Committee has duties and responsibilities that are detailed in agreed Terms of Reference, reflecting the provisions of the FT Code of Governance. It meets as required and usually no less than twice a year. During 2017/18 the Committee has met on three occasions. In accordance with its Terms of Reference, the Committee has reviewed the size, structure and composition of the Board of Directors. The Committee decided to make no recommendations for change to the Council of Governors.

In the case of Executive Director vacancies, the Committee is responsible for identifying suitable candidates to fill vacancies as they arise. During the period of this report the Committee oversaw the process for recruitment of Mr Hennessey as our Interim Chief Finance Officer and approved the Terms and Conditions of appointment. This appointment was achieved with the assistance of recruitment agents, following a national recruitment search. The Committee also approved the appointment of Ms Bolger as Acting Chief Nurse. The Committee has also approved the process for recruitment to substantive posts of both Chief Nurse and Chief Finance Officer, in both cases involving open advert and use of recruitment specialists.

The Committee considers levels of remuneration for executive directors and other senior posts that come within the Committee's remit, by reference to other organisations and NHS Foundation Trusts in particular. During 2017/18, following consideration of national benchmarking data and national NHS pay-awards, the Committee reviewed and approved revision to remuneration for the executive directors, as reported in the Remuneration Report.

In the case of Non-Executive Director vacancies, the Committee is responsible for advising the Council of Governors on the relevant qualities and attributes required to supplement those already on the Board. The Committee has reviewed the schedule of Non-Executive terms of office and has made appropriate recommendation to the Governors accordingly, in relation to potential vacancies to arise during 2018/19.

Quality and Safety Committee:
The Quality and Safety Committee of the Board was established in October 2015 to provide additional capacity for Non-Executive led scrutiny and assurance to the Board concerning quality and safety matters. The Committee has a membership of 7, including three Non-Executive Directors, Chief Executive, Chief Operating Officer, Director of Nursing and Medical Director. The Committee routinely meets 5 times a year.

Matters considered by the Committee during 2017/18 have included the operation of the Trust's clinical governance systems and processes, including our procedures for learning from incidents and from mortality. A significant area of focus of the Committee has also been on service developments associated with improving quality and safety, for example through reviewing our Stroke Strategy, the pathway for patients with fractured neck of femur and our Cancer Strategy. As these initiatives have been implemented during the year the emerging quality improvements have started to become apparent and to be reflected in our quality and performance monitoring metrics.

The Committee has also scrutinised quality and safety related issues including our processes for complying with the Duty of Candour requirements, improving palliative care and the Clinical Quality Impact Assessment (QIA) process to protect quality and safety whilst making financial savings and productivity improvements.

The Committee also received updates concerning the processes for use of 'escalation areas' at times of peak demand, the development of reports concerning safe staffing levels, and the response of the Trust to recommendations and feedback from the CQC. Each of these areas is scheduled to be an ongoing area of focus for the Committee during 2018/19.

A feature of the work of the Committee has been that it routinely begins each meeting with a visit to a clinical area relevant to the items for consideration at that meeting. This provides an opportunity to provide additional context, scrutiny and to meet with staff. During 2017/18 such visits have included the new High Dependency Unit on Gissing Ward (in the context of reviewing the care of critically-ill and deteriorating patients), Maternity Unit - ante-natal clinic, post-natal ward and Delivery Suite (in the context of reviewing our Maternity Strategy) and two visits to the A&E Department (in the context of reviewing work undertaken in response to a Warning Notice from the CQC). The visits to A&E included 'before and after' consideration of the creation of the Older Peoples ED and the Children's ED. In April 2018 the Committee also visited the Day Procedure Unit (DPU) and General Medical Day Unit (GMDU) as part of reviewing quality concerns with regard to use of escalation areas at time of peak pressure in the hospital.

Finance and Investments Committee:
The Finance and Investments Committee of the Board was established in October 2015 to provide additional capacity for Non-Executive led scrutiny and assurance to the Board concerning finance and investments. The Committee has a membership of 7, including three Non-Executive Directors, Chief Executive, Chief Operating Officer, Chief Finance Officer and Director of Strategy.

Matters considered by the Committee during 2017/18 have included review of the Trust's financial plans for the forthcoming year, cash management, productivity and efficiency initiatives and planned capital investments. The Committee provided scrutiny to our financial planning and governance processes during the year, including development of cost improvement projects. Having been released from Financial Special Measures in March 2017, 2017/18 was a difficult year for the Trust from a financial perspective.

Whilst we were successful in achieving our financial Control Total trajectories in Q1 and Q2, we did not meet the operational conditions which meant we did not receive the full STF funding for Q1 and Q2. The Committee oversaw the process for re-forecasting for the full year to reflect, not least, the financial impact of what has been nationally recognised as the most difficult winter in the history of the NHS. The Committee has also played a key role in developing our financial plans for 2018/19, ensuring that assumptions around clinical activity and income and cost control are balanced between being appropriately challenging and realistic.

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

Name of Director	Number of Attendances
Mr John Fry	10
Ms Frances Bolger[1]	2
Mr Peter Chapman	11
Mr Mark Davies	11
Mr John Hennessey[2]	1
Mr Tim How	11
Mr Mark Jeffries	11
Mrs Emma McKay[3]	9
Mr James Norman[4]	8
Dr Geraldine O'Sullivan	11
Mr Jeremy Over	11
Mr Richard Parker	11
Prof David Richardson	8
Mrs Angela Robson	11
Miss Sally Smith QC	11

[1] Ms Bolger was appointed as Acting Chief Nurse in February 2018.
[2] Mr Hennessey was appointed as Interim Chief Finance Officer in February 2018.
[3] Mrs McKay stood down as Director of Nursing in January 2018.
[4] Mr Norman stood down as Chief Finance Officer in January 2018.

Attendance at meetings of the Audit Committee

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

	26 May 2017	20 September 2017	13 December 2017	9 March 2018
Mrs Angela Robson (Chair of Committee)	✓	✓	✓	✓
Mr Mark Jeffries (Non-Executive Director)	✓	✓	✓	✓
Dr Geraldine O'Sullivan (Non-Executive Director)	✓	✓	✓	✓

Nominations & Remuneration Committee

	30 June 2017	23 February 2018	23 March 2018
Mr John Fry (Chairman and Chair of Committee)	✓	✓	✓
Mr Mark Davies (Chief Executive)	✓	✓	✓
Mr Tim How (Non-Executive Director)	✓	✓	✓
Mr Mark Jeffries (Non-Executive Director)	✓	✓	✓
Dr Geraldine O'Sullivan (Non-Executive Director)			✓
Mrs Angela Robson (Non-Executive Director)	✓	✓	✓
Miss Sally Smith QC (Non-Executive Director)	X	✓	✓

Quality and Safety Committee – meeting and attendance

The Quality and Safety Committee routinely meets bi-monthly and met on 5 occasions during the year.

	20 April 2017	29 June 2017	19 October 2017	21 December 2017	7 February 2018
Miss S Smith QC (Chair of Committee and Non-Executive Director)	✓	✓	✓	✓	✓
Ms Frances Bolger (Acting Chief Nurse)					✓
Mr Peter Chapman (Medical Director)	✓	✓	✓	✓	✓
Mr Mark Davies (Chief Executive)	✓	✓	✓	✓	✓
Mr Mark Jeffries (Non-Executive Director)	✓	✓	✓	✓	✓
Mrs Emma McKay (Director of Nursing)	✓	✓	✓	X	
Dr Geraldine O'Sullivan (Non-Executive Director)	✓	✓	✓	✓	✓
Mr Richard Parker (Chief Operating Officer)	X	✓	X	✓	X

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

	28 June 2017	27 September 2017	24 October 2017	10 January 2018	14 March 2018
Mr Tim How (Chair of Committee and Non-Executive Director)	✓	✓	✓	✓	✓
Mr Mark Davies (Chief Executive)	✓	✓	✓	✓	X
Mr John Fry (Chairman)	✓	✓	✓	✓	✓
Mr Simon Hackwell (Director of Strategy)					✓
Mr John Hennessey (Interim Chief Finance Officer)					✓
Mr James Norman (Chief Finance Officer)	✓	✓	✓	✓	
Mr Richard Parker (Chief Operating Officer)	✓	✓	✓	✓	✓
Professor David Richardson (Non-Executive Director)	X	X	✓	X	✓

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

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

During the course of the year, the Board reviewed its capacity, and that of the management team, to address the current and future challenges facing the Trust. During 2017/18 additional posts were established to strengthen our finance team and clinical governance and risk management teams.

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

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

- the Board maintains its Register of Interests which is publicly available on the Trust's website. Mr Jeffries has declared his role as Non-Executive Director with R G Carter

(Holdings) Ltd and accordingly takes no part in discussion or decision of matters that may relate to the relationship between this party and the Trust. Otherwise the Board can confirm that there are no material conflicts of interest in the Board;

- the Board is satisfied that its Directors are appropriately qualified to discharge their functions;
- the Board is satisfied as to its own balance, completeness and appropriateness to the requirements of the Foundation Trust;
- the Board's Committee and governance structure is appropriate and its progress and efficacy is regularly reviewed;
- the Board considers that it has an appropriate balance of expertise and experience and it has access to specialist advice, as required.

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

The Norfolk and Norwich University Hospitals NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

During the year, the Trust commissioned an independent review by PWC of the Trust's Leadership and Governance, in accordance with best practice and the NHSI/CQC Well-led Framework. This was a follow-up to the similar review conducted by PWC in 2015, at which time they were appointed through an open process of competitive tender and selected by panel including NHSI. PWC reported in October 2017 and concluded *"the Trust has made substantial progress over the past two years. There is stronger clinical leadership and a more open and collaborative leadership culture that supports clinical and operational improvement. This progress is recognised across the Trust"*.

The independent conclusions of PWC are discussed in more detail in the Annual Governance Statement, as are the arrangements in place in the Trust to ensure that its services are well-led. As requested and appropriate to a developmental review, PWC made some recommendations for the Trust. Reflecting on the on-going changes made in the Trust however, the PWC team concluded *"like all Trusts, the Trust still faces significant challenges, but the changes made provide a strong foundation to deliver further quality, operational and financial improvements".*

NNUH receives nearly £1m to enhance Emergency Department

NNUH has received nearly £1m in funding aimed at easing pressure on emergency departments.

The £998,900 funding is being used to join up the entrances for the Urgent Care Centre (UCC) and the Emergency Department (ED) to create a new, single point of entry for patients.

Development of the site will see an increase in the number of UCC consulting rooms, an expansion of Paediatric Emergency Department facilities as well as expanded waiting and toilet facilities.

The UCC operates as part of the ED and, over the past 12 months, has built a stable GP workforce with a GP clinical lead sourced from local primary care. Expanding the workforce with dedicated, in-house trained Advanced Care Practitioners is planned for the coming year.

The existing UCC sees an average of 40 patients each day and treats patients with minor illnesses that require urgent medical attention but are not immediately life-threatening.

The new space will provide clear separation of adults and paediatrics on arrival, and will join both parts of the ED with covered inside walkways. The adult side will lead directly to the GP streaming area and three additional consulting rooms, plus additional ancillary accommodation will be provided.

The £998,900 allocated to NNUH is part of £20.74m awarded to 27 hospitals across England.

The funding, which was announced by the Secretary of State for Health Jeremy Hunt, will also support wider plans set out by NHS England to improve A&E performance in England by 2018.

Council of Governors

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

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

- Received the Trust's Annual Report and Accounts
- Expressed views for consideration by the Directors in preparing the Trust's strategic plans
- Agreed the remuneration of the NEDs
- Reappointed Angela Robson, Mark Jeffries and Professor Richardson as Non-Executive Directors

The term of office for Governors is three years and the appointment of both staff and public Governors is by election by the members. These elections are held once a year and are administered on our behalf by the UK Engage and in accordance with the election rules set out in our Constitution. As at March 2018 the Governors were:

Public Governors

- Erica Betts — Breckland
- Nick Brighouse — South Norfolk
- Diane DeBell — Norwich
- Nina Duddleston — Breckland
- Carol Edwards — North Norfolk
- Sarah Ellis — Norwich
- Ines Grote — Great Yarmouth and Waveney
- Prof Rosalynd Jowett — Norwich
- Janet King — Broadland
- Mary Pandya — Rest of England
- Trevor Plunkett — Broadland
- Dr John Rees — Broadland
- Jane Scarfe — South Norfolk
- Joy Stanley — Breckland
- Penny Sutton — King's Lynn and West Norfolk

Staff Governors

- Mr John Nolan — Medical and Dental
- Sue Burt — Nursing and Midwifery
- Terry Davies — Contractors and Volunteers
- Sheila Ginty — Nursing and Midwifery
- Vikki Worman — Admin and Clerical

Partner Governors

- Dr Anoop Dhesi North Norfolk Clinical Commissioning Group
- Cllr Shelagh Gurney Norfolk County Council
- Vacant University of East Anglia

Changes during the year:

The following Governors stood down from the Council in 2017/18:

- Ed Aldus Clinical Support
- Mr Neil Burgess Medical and Dental
- Keith Jarvis North Norfolk
- David McNeil Broadland

The following governors were not re-elected at the election in autumn 2017:

- Brian Cushion Broadland
- John Labouchere Breckland
- Paul Postle Norwich

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

Performance of the Council of Governors and its Committee
During the year, the Governors have been regularly briefed on a wide range of matters affecting the Trust including:

- Quality standards on our wards
- The development of our strategic plans
- Our performance against national standards
- Plans for the development of the Quadram Institute
- Creation of new Older People's Emergency Department and expansion of the Paediatric Emergency Department.

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

Attendance at formal meetings of the Council of Governors
The Council of Governors held four scheduled formal meetings in 2017/18. Attendance at Council meetings was as set out below:

	20 April 2017	26 July 2017	12 October 2017	24 January 2018
Mr Ed Aldus	X	✓	X	
Ms Erica Betts	✓	✓	✓	✓
Mr Rob Boyce				✓
Mr Nick Brighouse	✓	✓	✓	✓
Mr Neil Burgess	✓			
Ms Sue Burt	✓	✓	✓	X
Mr Brian Cushion	✓	✓	✓	
Mr Terry Davies	X	✓	✓	✓

Prof Diane DeBell	✓	✓	✓	✓
Dr Anoop Dhesi	✓	X	X	X
Ms Nina Duddleston	✓	✓	✓	✓
Ms Carol Edwards	✓	✓	✓	X
Ms Sarah Ellis	✓	✓	✓	✓
Miss Sheila Ginty	✓	✓	✓	✓
Mrs Ines Grote	✓	✓	✓	✓
Cllr Sheila Gurney		X	X	✓
Mr Keith Jarvis	✓	✓	✓	
Prof Rosalynd Jowett				✓
Ms Janet King	✓	✓	✓	✓
Mr John Labouchere	✓	✓	✓	
Mr David McNeil	✓			
Mr John Nolan				✓
Ms Mary Pandya	X	X	X	✓
Mr Trevor Plunkett				✓
Mr Paul Postle	✓	✓	✓	
Dr John Rees				✓
Ms Jane Scarfe	✓	✓	✓	✓
Mrs Joy Stanley				✓
Miss Penny Sutton				X
Cllr Brian Watkins	✓			
Ms Vikki Worman	✓	✓	✓	✓

Lead Governor

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

Appointments and Remuneration Committee of the Council of Governors

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

The work of the Committee is supported by the Board Secretary. As at April 2018, Membership of the Committee is:

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

The Committee is responsible for making recommendations to the Council of Governors with respect to the appointment or reappointment of Non-Executive Directors. This year the Committee has recommended the reappointment of Angela Robson, Mark Jeffries and Professor Richardson as Non-Executive Directors.

The Committee is also responsible for overseeing the remuneration of our non-executive directors and making any recommendations for change to the Council. In 2017/18 the Committee recommended changes to the remuneration of the non-executive directors consistent with the nationally agreed pay award for non-medical NHS staff.

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

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

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

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

The membership has grown since we achieved Foundation Trust status and an annual recruitment campaign maintains the public membership above the 15,000 minimum set by the Council of Governors. By the end of March 2018 we had 17,567 Public Members.

We have a Membership Strategy for which the objectives in 2017/18 were to:

- continue the communication and involvement programme with members
- hold elections in the following constituencies: Breckland, Broadland, Great Yarmouth and Waveney, Norwich, King's Lynn and West Norfolk, North Norfolk, and South Norfolk, plus the medical, admin and clerical, and nursing and midwifery staff constituencies:
- develop strong and representative public membership reflecting the diversity of the population.

	Membership at 2007/08	Membership at 2017/18
Staff	5,000	7,500
Public	5,000	17,567
Total	10,000	25,067

The Trust's Membership Strategy is being revised in spring 2018 and work is underway to collect views from members, governors, and staff.

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

Communicating and involving our members

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

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

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

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

- Six governors have helped with judging the staff awards.
- A talk about the Quadram Institute took place for members on 27 April 2017.
- A talk on dementia took place during National Dementia Week on 15 May 2017.
- The Open day and fete took place on 9 June 2017 and was attended by 5,000 people.
- The governors have attended a series of ward opening events following the refurbishment of individual wards.
- Governors attended an STP stakeholder event on 7 September 2017.
- The North Norfolk governor Carol Edwards was appointed as the chair of the Cromer & District Hospital fundraising committee.
- An exhibition was held about the expansion plans for Cromer Hospital on 25 October 2017.
- The Christmas Faye took place on 7 December 2017.
- An induction event took place for new governors on 16 January 2018.

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

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

Political and charitable donations
No political or charitable donations have been made by the Trust in 2017/18 financial year or previous year.

Income disclosures required by Section 43(2A) of the NHS Act 2006
During 2017/18 income from the provision of goods and services for the purposes of the health service in England was greater than the income from the provision of goods and services for any other purposes. Accordingly the requirement of the Act has been met. Health service income amounted to £584.0m of the total income of £585.7m (2016/17 £562.2m of the total income of £564.1m).

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

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

Accounts and Statement of the responsibility of the Accounting Officer
The accounts for the year ended 31/03/2018 can be found at the back of this annual report. The statement of the responsibility of the accounting officer can be found on page 107.

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

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

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

Remuneration report

Annual Report on remuneration

Major decisions on senior managers' remuneration

Remuneration for the Trust's most senior managers (Executive Directors who are members of the Board of Directors) is determined by the Board of Director's Nominations and Remuneration Committee. The Nominations and Remuneration Committee determined that no amendments to incumbent executives' pay should be made in 2017/18, other than a 1% uplift mirroring the recommendations made by the national pay review bodies in the NHS which were in turn accepted by the government. This would not be applied to the CFO who had only recently established a starting salary with the Trust.

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

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

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

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

No substantial changes to senior managers' remuneration were made during 2017/18, other than a 1% uplift mirroring the recommendations made by the national pay review bodies in the NHS which were in turn accepted by the government.

Signed by Chair of Remuneration Committee on 25th May 2018 Chairman – John Fry

Senior Managers' remuneration policy

Future Policy

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

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

Accompanying notes:

(1) There have been no additions or changes to the components of the remuneration package during 2017/18
(2) There are no significant differences between the remuneration policy for senior managers and the general policy for employees' remuneration
(3) The remuneration policy does not include provision for performance-related bonuses or other such schemes

Annual Report on remuneration

Service Contracts

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

Name & Title	Date of Contract	Unexpired Term		Notice Period
PM Davies, Chief Executive	14/08/2015	n/a	n/a	6 Months
R Parker, Chief Operating Officer	01/01/2016	n/a	n/a	6 Months
J Hennessey, Interim Chief Finance Officer (appointed 26 February 2018)	26/02/2018	n/a	n/a	6 Months
JM Over, Director of Workforce	13/10/2014	n/a	n/a	6 Months
PG Chapman, Medical Director	01/04/2015	n/a	n/a	6 Months
FL Bolger, Acting Director of Nursing (appointed 31 January 2018)	31/01/2018	n/a	n/a	6 Months
J Fry, Chairman	01/05/2016	30/04/2019	13 months	3 Months
EJ McKay, Director of Nursing (until 30 January 2018)	01/12/2012	n/a	n/a	n/a
JN Norman, Chief Finance Officer (until 31 January 2018)	02/01/2017	n/a	n/a	n/a
T How, Non-Executive Director	01/08/2016	31/07/2019	16 Months	3 Months
RM Jeffries, Non-Executive Director	01/11/2017	31/10/2018	7 Months	3 Months
A Robson, Non-Executive Director	01/11/2017	31/10/2018	7 Months	3 Months
D Richardson, Non-Executive Director	01/09/2017	31/08/2020	29 Months	3 Months
SE Smith, Non-Executive Director	01/09/2015	31/08/2018	5 Months	3 Months
GH O'Sullivan, Non-Executive Director	01/11/2016	31/10/2019	19 Months	3 Months

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

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

Nominations and Remuneration Committee

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

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

The Committee met three times during 2017/18, on 30 June 2017, 23 February 2018 and on 23 March 2018. The meetings were quorate. The work of the Committee included consideration of NHS pay awards over recent years and 'market rate' comparison informed by data from a survey of foundation trusts nationally, coordinated by the Foundation Trust Network (NHS Providers) of which we are a member.

No significant awards were made to past Directors during the 12 months ended 31 March 2018.

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

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

Disclosures required by the Health and Social Care Act

There was a total of 8 Executive Directors in office during the year and 7 Non – Executive Directors, including the Chairman. In aggregate the Directors received reimbursement of expenses of £6,941 with claims from 9 directors. In 2016/17, 15 directors had been in office, being 7 executive directors and 8 non-executive directors. In aggregate they received reimbursement of expenses of £34,105 with claims from 7 directors.

No significant awards were made to past Directors during the 12 months ended 31 March 2018.

The Governor role is unpaid. When the Council of Governors was established it was agreed that governors were entitled to claim travel expenses for attending meetings. There were 15 public governors in 2017/18 and four governors claimed £693. (In 2016/17, three governors claiming expenses totalling £611.)

Remuneration – Audited

Name and title	12 months ended 31st March 2018				12 months ended 31st March 2017			
	Salary (bands of £5,000) £'000	All Taxable Benefits Rounded to the nearest £100 £	Pension Related Benefits (bands of £2,500) £'000	Total (bands of £5,000) £'000	Salary (bands of £5,000) £'000	All Taxable Benefits Rounded to the nearest £100 £	Pension Related Benefits (bands of £2,500) £'000	Total (bands of £5,000) £'000
PM Davies, Chief Executive	225 - 230	400	40 - 42.5	270 - 275	225 - 230	13400	82.5 - 85	325 - 330
R Parker, Chief Operating Officer	140 - 145	100	42.5 - 45	185 - 190	140 - 145	0	252.5 - 255	395 - 400
JN Norman, Chief Finance Officer (appointed 2 January 2017, until 31 January 2018)	250 - 255	100	0	250 - 255	40 - 45	0	0	40 - 45
EJ McKay, Director of Nursing (until 30 January 2018)	90 - 95	200	30 - 32.5	120 - 125	110 - 115	100	67.5 - 70	180 - 185
JM Over, Director of Workforce	120 - 125	100	32.5 - 35	155 - 160	120 - 125	100	27.5 - 30	150 - 155
PG Chapman, Medical Director	185 - 190	0	70 - 72.5	260 - 265	180 - 185	0	162.5 - 165	345 - 350
J Fry, Chairman	50 - 55	0	0	50 - 55	45 - 50	100	0	45 - 50

GH O'Sullivan, Non-Executive Director	10 - 15	0	0	10 - 15	5 - 10	0	0	5 - 10
T How, Non-Executive Director	10 - 15	0	0	10 - 15	10 - 15	0	0	10 - 15
RM Jeffries, Non-Executive Director	10 - 15	0	0	10 - 15	10 - 15	0	0	10 - 15
A Robson, Non-Executive Director	10 - 15	0	0	10 - 15	10 - 15	0	0	10 - 15
D Richardson, Non-Executive Director	10 - 15	0	0	10 - 15	10 - 15	0	0	10 - 15
SE Smith, Non-Executive Director	10 - 15	0	0	10 - 15	10 - 15	0	0	10 - 15
FL Bolger, Acting Director of Nursing (appointed 31 January 2018)	15 - 20	0	0	15 - 20				
*J Hennessey, Interim Chief Finance Officer (appointed 26 February 2018)	0	0	0	0				

*John Hennessey was appointed as the Chief Financial Officer from 26 February 2018 for a six month period of secondment from another NHS hospital trust who continue to employ and remunerate him directly during this period. A secondment agreement is in place to formally authorise his status at NNUH as an executive member of the Board of Directors for the six month duration. The salary earned for his secondment in 2017/18 is in the salary band of £10,000-15,000.

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

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

Fair Pay Multiple

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

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

	2017 - 18	**2016 - 17**
Band of Highest Paid Director's Total Remuneration (£'000)	225 - 230	225 - 230
Median Total (£)	28,268	27,745
Remuneration Ratio	8.05	8.20

The banded remuneration, of the highest paid director in the Trust in the financial year 2017/18 was £225-230k (2016/17: £225k-£230k). This was 8.05 times (2016/17 – 8.20 times) the median remuneration of the workforce which was £28,268 (2016/17 - £27,745). In 2017/18, 0 (2016/17: 0) employees received remuneration in excess of the highest paid director. Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

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Total Pension Entitlement

Name and title	Real increase in pension at age 60 (bands of £2,500) £'000	Real increase in pension lump sum at age 60 (bands of £2,500) £'000	Total accrued pension at age 60 at 31 March 2018 (bands of £5,000) £'000	Lump Sum at age 60 related to accrued pensions at 31 March 2018 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2017 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2018 £'000
PM Davies, Chief Executive	2.5 - 5	7.5 - 10	85 - 90	260 - 265	1,891	129	2,039
R Parker, Chief Operating Officer	2.5 - 5	0 - 2.5	45 - 50	125 - 130	787	63	858
EJ McKay, Director of Nursing (until 30 January 2018)	0 - 2.5	0 - 2.5	25 - 30	60 - 65	366	29	405
JM Over, Director of Workforce	2.5 - 5	0 - 2.5	25 - 30	60 - 65	283	42	328
PG Chapman, Medical Director	2.5 - 5	10 - 12.5	60 - 65	185 - 190	1,289	154	1,456
FL Bolger, Acting Director of Nursing (appointed 31 January 2018)	5 - 7.5	15 - 17.5	30 - 35	95 - 100	519	111	635

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

The Cash Equivalent Transfer Value (CETV) is the actuarially assessed capitalised value of the pension scheme benefits accumulated by a member at a particular point in time. The benefits valued are the member's accumulated benefits and any contingent spouse's pension payable from the scheme. CETV's are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Bonus

The Trust is required by NHSI to disclose any payments that fall with the definition of "Performance Related Bonuses", and it has been determined by the Department of Health that Clinical Excellence Awards (CEA) meet this definition. As such they have been disclosed as a "Bonus". Clinical Excellence awards are given to recognise and reward the exceptional contribution of NHS consultants, over and above that normally expected in a job, to the values and goals of the NHS and to patient care. Clinical Excellence Awards are administered at a national level by the Advisory Committee on Clinical Excellence Awards. These payments were previously classified within Other Remuneration. There have been no new Clinical Excellence Awards payable to the Directors in 2017/18, however the Medical Director is in receipt of clinical excellence awards as part of his remuneration package that were determined in previous years.

Signed on behalf of the Board on 25th May 2018 Chief Executive – Mark Davies

Staff Report

Introduction

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

Analysis of average staff numbers

The information below shows the average staff numbers within the Trust from April 2017 to March 2018.

Average number of employees (WTE basis)	2017/18	2017/18	2017/18	2016/17	2016/17	2016/17
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
Medical and dental	**1,034**	466	568	**958**	417	541
Ambulance staff	**-**	-	-	**-**	-	-
Administration and estates	**559**	525	34	**481**	375	106
Healthcare assistants and other support staff	**2,623**	2,177	446	**2,559**	2,188	371
Nursing, midwifery and health visiting staff	**2,119**	1,871	248	**2,042**	1,829	213
Nursing, midwifery and health visiting learners	**-**	-	-	**11**	4	7
Scientific, therapeutic and technical staff	**569**	499	70	**481**	415	66
Healthcare science staff	**396**	361	35	**437**	417	20
Social care staff	**-**	-	-	**-**	-	-
Other	**-**	-	-	**-**	-	-
Total average numbers	**7,300**	**5,899**	**1,401**	**6,969**	**5,645**	**1,324**

Note: Staff breakdowns aligned to NHSI reporting requirements as follows:

'Permanently employed' – staff with a permanent (UK) employment contact directly with the entity (this will include executive directors but exclude non-executive directors)
'Other' – staff engaged on the objectives of the entity that do not have a permanent (UK) employment contract with the entity. This includes employees on short-term contracts of employment, agency/ temporary staff, locally engaged staff overseas, and inward secondments from other entities.

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

This table shows the gross cost of staff, analysed between those who are employed on permanent contracts and others (criteria as per previous table):

	2017/18			2016/17		
	Total	**Permanent Staff**	**Other**	**Total**	**Permanent Staff**	**Other**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Salaries and wages	**258,773**	222,017	36,756	**241,371**	201,857	39,514
Social security costs	**24,011**	21,061	2,950	**22,708**	18,991	3,717
Appenticeship Levy	**957**	957	0	**0**	0	0
Pension cost - defined contribution plans employer's contributions to NHS pensions	**31,342**	27,639	3,703	**29,429**	24,611	4,818
Termination benefits	**61**	61	0	**0**	0	0
Temporary staff - agency/contract staff	**9,631**		9,631	**20,266**		20,266
Total gross staff costs	**324,775**	**271,735**	**53,040**	**313,774**	**245,459**	**68,315**

Note: Staff breakdowns aligned to NHSI reporting requirements as follows:

'Permanantly employed' – staff with a permanent (UK) employment contact directly with the entity (this will include executive directors but exclude non-executive directors)

'Other' – staff engaged on the objectives of the entity that do not have a permanent (UK) employment contract with the entity. This includes employees on short-term contracts of employment, agency/ temporary staff, locally engaged staff overseas, and inward secondments from other entities.

NNUH staff riding through the night for hospital charity

Members of staff from NNUH have taken on ‘Ride the Night”- a 100km charity cycle ride. Money raised has gone towards the recently launched “Gynae VOiCE” campaign, which is part of the hospital charity and aims to raise money for the Gynaecology Oncology department at NNUH.

Hilary Turnbull, NNUH Gynaecology Oncology Consultant, Dr Libby Prior, NNUH Obstetric and Gynaecology Registrar and Dr Eilbhe Whelan, an Obstetric and Gynaecology Registrar who has recently started a Gynaecology-Oncology MD in London, will be cycling from Windsor, all the way to London and then back to Windsor again to cross the finish line.

The trio joined thousands of other women on the cycle ride.

Hilary said: “We’ve all done crazy events in the past to raise money for various hospital and cancer appeals including the 3-peaks challenge, the London Marathon and other sporting events. However none of us have cycled through London in the dark, and in fancy dress!”

Over the next few years, the Gynae VOiCE campaign is hoping to raise money to buy a new piece of surgical equipment to advance laparoscopic endometrial cancer procedures, and also to support more local events for the Norfolk gynaecology cancer patient support group, ‘Pandora’s Box’.

Breakdown of male and female staff as at 31 March 2018:

	Male	Female
Executive Director	7	1
Non-Executive Director	4	3
Other staff	1,555	6,300

Sickness Absence

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

The 12 month rolling sickness average to February 2018 is 4.03%, this maintains a significant reduction of 8.4% on the peak of September 2016.

The 12-month rolling sickness reductions across the NNUH are considerable, and have reached up to 11% during the last 12 months. This equates to the equivalent of 37 additional staff (headcount) being available every day, with all the evidence pointing to the positive impact of the new Attendance policy and the Know Your Staff approach to people management.

In June 2017, the NNUH won the Social Partnership Forum (SPF) sponsored Health Professional Management Association (HPMA) 'Working in Partnership' award for its work in respect of the Attendance policy.

The award recognises the excellent partnership working with the trade unions and the approach taken to the management of attendance through the introduction of a new Attendance policy. The messages of 'know your staff; outcome focused; people before process; and, trust, relationships, engagement and empowerment have been well received.
On the back of the HPMA social partnership award, NHS Employers have been keen to highlight our approach to attendance management as a beacon for others to consider. NHS Employers has:

- Developed a video with our staff, reflecting NNUH's experience on people management. This is promoted by NHS Employers on their website.

- Headlined NNUH as part of a national Health and Wellbeing Sickness absence webinar.

Local Counter Fraud Service (LCFS)

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

We take all necessary steps to counter fraud and bribery in accordance with guidance or advice issued by NHS Protect. This process is detailed in the organisation's Anti-Fraud and Bribery Policy.

Staff engagement
One of our top priorities is to encourage the best from our staff, whilst at the same time maintaining their health, safety and wellbeing at work. Our approach to staff engagement is to involve our colleagues in discussions about key issues and this is reflected in the different ways in which we communicate and consult with staff. It is also about listening to staff feedback from the NHS Staff Survey and responding to that feedback accordingly. We offered every member of staff the opportunity to take part in the annual NHS Staff Survey and 3,500 staff completed the survey over October and November 2017.

We have regular meetings with staff side representatives to share information and consult with representatives at monthly Joint Staff Consultative Committee and Pay and Conditions of Service Committee.

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

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

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

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

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

During November 2017 the NNUH launched *SpeakInConfidence*, an online communications platform as an additional route for staff to raise a concern in confidence with Executive Directors and Freedom to Speak up Guardians (FSTUGs). The online system enables any employee to initiate dialogue directly with individual members of the Exec Team and our FTSUGs, which maybe anonymous if preferred, in relation to any concerns that they might have.

Disability Confident

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

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

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

During 2017 the Trust were successful in retaining the Level 2 Disability Confident Employer status.

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

Employees who develop a disability during the course of their employment receive support from the Workplace Health and Wellbeing Team, advice from Human Resources Department, and support from their line manager. Options are explored for making reasonable adjustments to the person's work activities which might include a change to working hours, duties or use of equipment. The aim is to keep the employee in work and all opportunities are explored, including redeployment.

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

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

NNUH staff members celebrate double-win at City College Norwich Apprentice Awards

Two members of staff who have undertaken apprenticeships at NNUH have celebrating wins at the City College Norwich Apprentice Awards 2018.

Tara Box, NNUH Nursing Assistant on the Acute Medical Unit was named Health Apprentice of the Year and Jamil Ahmed, NNUH Receptionist in Gastroenterology was named as Business Apprentice of the Year.

The awards, which were held on Monday 5th March at the International Aviation Academy, celebrate the achievements of individuals who have undergone apprenticeships in conjunction with City College Norwich.

Tara said: “I'm really happy to not only have been nominated, but to also have won the award. It’s made me feel so proud of myself that on top of full time work and being a mum I managed to study and achieve this as well. I chose to do the apprenticeship because I would eventually like to qualify as a registered nurse in the future, and I’d like to thank all my colleagues here at NNUH who have supported me so far.”

Jamil said: “Winning this award was very exciting and unexpected! Prior to starting my apprenticeship in June 2016 I was doing a traineeship where I spent a month with the Gastroenterology team. I enjoyed my time with them so much I was offered an apprenticeship with the reception team. The reason why I chose to do my apprenticeship at NNUH was because I knew I could develop my knowledge and have the opportunity to grow and progress within the trust.”

Equality and diversity

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

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

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

NHS Staff Survey 2017

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

The results from the NHS Staff Survey 2017 showed that NNUH is one of the most improved NHS hospitals in the country compared to 2016. 18 of the 32 key findings have improved 'statistically significantly' over the past 2 years (10 over the last 12 months) and none of the key findings deteriorated to a lower category.

Our overall indicator score of staff engagement from the Staff Survey 2017 demonstrated a increase compared to 2016 and was below (worse than) average when compared with other acute trusts. Our score was 3.75 out of 5 (the scale being 1 to 5 - 1 being poorly engaged staff and 5 being highly engaged staff). The national 2017 average score was 3.75.

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

Our response rate to the 2017 survey was 47%, with over 3,500 returned questionnaires, which was above average for acute trusts in England.

	2016 Survey		**2017 Survey**		**Trust Improvement / Deterioration**
Response Rate	**Trust**	**National Average**	**Trust**	**National Average**	
	46%	43%	47%	44%	Increase of 1% in response rate

The Trust's top five ranking scores in the 2017 survey for which the Trust compares most favourably with other acute trusts in England are shown below:

	2016 Survey		2017 Survey		Trust Improvement /Deterioration
Top five 2017 ranking scores	**Trust**	**National Average**	**Trust**	**National Average**	
Key Finding 15 Percentage of staff satisfied with the opportunities for flexible working patterns (the higher the score the better)	52%	51%	54%	51%	Improvement of 2%
Key Finding 23 Percentage of staff experiencing physical violence from staff in last 12 months (the lower the score the better)	2%	2%	2%	2%	No Change
Key Finding 21 Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion (the higher the score the better)	88%	87%	87%	85%	Deterioration of 1%
Key Finding 32 Effective use of patient/ service user feedback (the higher the score the better – 1 being Ineffective use of feedback and 5 being Effective use of feedback)	3.58	3.72	3.76	3.71	Improvement of 0.18

Key Finding 22 Percentage of staff experiencing physical violence from patients, relatives or the public in last 12 months (the lower the score the better)	16%	15%	14%	15%	Improvement of 2%

Our bottom five ranking scores from the 2017 survey for which the Trust compares least favourably with other acute Trusts in England were:

	2016 Survey		**2017 Survey**		**Trust Improvement / Deterioration**
Bottom five 2017 ranking scores	**Trust**	**National Average**	**Trust**	**National Average**	
Key Finding 13 Quality of non-mandatory training, learning or development (the higher the score the better – 1 being Low-quality training and 5 being High-quality training)	3.94	4.05	3.97	4.05	Improvement of 0.03
Key Finding 27 Percentage of staff/ colleagues reporting most recent experience of harassment, bullying or abuse (the higher the score the better)	40%	45%	41%	45%	Improvement of 1%
Key Finding 29 Percentage of staff reporting errors, near misses or incidents witnessed in the last month(the higher the score the better)	88%	90%	88%	90%	No change

Key Finding 4 Staff motivation at work (the higher the score the better - 1 being Not enthusiastic/ absorbed and 5 being Enthusiastic/ absorbed)	3.82	3.94	3.84	3.92	Improvement of 0.02
Key Finding 10 Support from immediate managers (the higher the score the better - 1 being Unsupportive managers and 5 being Supportive managers)	3.65	3.73	3.65	3.74	No change

Taking action:
Action is being taken at both divisional and corporate levels, having undertaken consultation with trade union representatives and our governors to understand their perspectives on the feedback reflected in the staff survey.

We will build on the staff survey results to identify and bring together an action plan in helping make the hospital the best possible place to work and help achieve our aspirations around the highest level of staff experience and engagement.

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

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

We are really encouraged that our results from the NHS Staff Survey 2017 showed that NNUH is one of the most improved NHS hospitals in the country compared to 2016.

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

Off payroll engagements

The Trust has a policy that all substantive staff are paid through payroll unless there are exceptional circumstances. No Board members were engaged on an interim and off-payroll basis during the period 1 April 2017 to 31 March 2018.

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

Off payroll engagements as of 31 March 2018 for more than £245 per day lasting for longer than six months	
No. of existing engagements as of 31 March 2018	0
Of which:	
No. that have existed for less than one year at the time of reporting.	0
No. that have existed for between one and two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

The existing arrangement outlined above, has been subject to an assessment as to whether assurance needs to be sought that the individual is paying the right amount of tax, and where necessary, that assurance has been sought.

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months	
No. of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	0
Of which:	
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018	
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure ***must*** include both off-payroll and on-payroll engagements.	8

Staff exit packages

There were 5 new staff exit packages in the year ended 31 March 2018 (2016/17: 1).

Staff exit packages for the year ended 31 March 2018				
	Number of compulsory redundancies	Number of other departures agreed		Total number of exit packages by cost band
<£10k	-	1		1
£10k - £25k	-	2		2
£25k - £50k	-	1		1
£50k - £100k	-	1		1
£100k - £150k	-	-		-
£150k - £200k	-	-		-
>£200k	-	-		-
	-	5		5

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

Of the 5 non-compulsory departures 1 being contractual payments in lieu of notice totalling £91k, and 4 being voluntary redundancies totalling £61k. Total cost of exit packages for all staff including senior executives is £152k (2016/17 £4k).

Workplace Health & Wellbeing (Occupational Health)

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

Over the past year, the team have been supporting the Trust in its work towards NHS England's National CQUIN (Commissioning for Quality and Innovation) target relating to Improving Staff Health and Wellbeing. As part of this programme, we developed in consultation with our Staff Experience Working Group and Health & Safety Committee a new Health & Wellbeing Strategy which was fully approved by Hospital Management Board in July 2017. The key elements of this strategy is to develop a preventative programme in addition to the reactive support that we currently have available to staff.

This programme consists of four objectives:

- To take positive action on health & wellbeing for staff
- Reduce the number of staff who experience musculoskeletal problems as a result of their work
- Reduce the number of staff who experience work related stress and improve mental wellbeing
- Prevent influenza transmission to staff

It was recognised by Hospital Management Board that a key to this programmes success was ensuring that the Workplace Health & Wellbeing (WHWB) team had appropriate skilled resource to assist the organisation in its implementation and so recruitment processes commenced following approval.

As a result, we were delighted to welcome a Health & Wellbeing co-ordinator to our team who commenced employment in November 2017 and preventative musculoskeletal and mental wellbeing resource commenced in the organisation in January 2018. Work commenced on implementing the strategy on appointment of these resources.

New children's sensory room at NNUH with thanks to Lions

NNUH has opened a new therapeutic sensory room, which will provide a relaxing environment to young patients undergoing intensive treatment.

The facility has been made possible by a £8,750 donation from the Lions club, who this year, will be celebrating 100 years of voluntary service. Lions groups from across Norfolk have come together to raise the money and mark their anniversary milestone in an extra special way.

The equipment in the room includes an LED projector which casts colour onto the walls, floor and ceiling, and a fibre optic light which shines beautiful colours around the ceiling, and special floor cubes.

The room also has a sensory music system playing soothing sounds, a number of stimulating and reflective toys and padded safety mats. In addition, the Lions have funded a special Sensory Wagon which is portable and can come to a patient’s bed side.

Health & Wellbeing – positive action
The Health & Wellbeing Co-ordinator has now created an annual plan of health & wellbeing events to raise awareness of how important it is that we look after ourselves in order to look after others.

The HWB newsletter has been refreshed and provides key information on wellbeing, case studies from staff members, promotes our regular activities such as the running club, staff choir, walking group, yoga sessions and Schwartz rounds. We have also increased our social media presence as a way to engage with our staff members. Our @HWBNNUH twitter account has increased in activity and in addition, a closed Facebook group has been developed – which is growing in membership.

In addition, we are recruiting volunteer Health & wellbeing departmental champions.

Since January 2018, a number of Health & Wellbeing events have been undertaken. We commenced the New Year by promoting the Public Health One You campaign. This event considered several elements of wellbeing but had a particular focus on physical activity. We had a number of physical activity providers who supported the event and provided taster sessions on activities as well as providing staff with a number of passes to access their facilities. In addition, our Trust Running club (which is led by a member of the WHWB team) ran a further Couch 2 5K course which was well attended by staff.

'Time to Talk' day in February raised the importance of talking about mental health and a number of staff contacts were made by the team during this event. As a result, they have engaged with local departmental areas to consider some of the localised demands on their teams and work a programme to aid prevention.

A fantastic series of events were arranged in various trust locations for Nutrition and hydration week in March 2018 – highlighting the importance to staff about hydration as well as healthy food and drink. This included tasters of nutritious healthy foods and drinks for our staff to try.

Our next big campaign will take place in May featuring mental health awareness week where we plan to launch our mental wellbeing plan for 2018.

Mental wellbeing
In July 2017, after almost a year of planning and training, NNUH introduced monthly Schwartz Rounds which is an evidenced based programme to support the emotional demands on healthcare workers. This programme is enabling staff to reflect on aspects of our work and re-charge their emotional batteries and is so important for us to continue providing great care to our patients. Each time those gathered are reminded of why we do the job that we do.

As indicated earlier, the WHWB team was also been joined by a HWB practitioner in January, whose key focus is to deliver our mental wellbeing initiative over the course of this next year. Since the arrival of this resource, we have developed a mental wellbeing plan for staff which will include a series of interactive workshops for employees, line managers as well as departmental specific sessions to assist staff in dealing with stress, develop personal and team strategies as well as considering situations within their work areas to improve the psychological demands of our roles. The roll out of this plan will commence in the next financial year. In addition, through the support of our divisional areas, we are commencing a series of Mental Health First Aid programmes which commences in May 2018.

Our hospital choir (which is also led by a member of the WHWB team) continues and is a valuable resource to our mental wellbeing provision in aiding stress relieve to those who belong to the group as well as those who listen to their weekly rehearsals. The group has represented the Trust in several health related charity concert events namely The Nook appeal, Keeping Abreast Charity and the United Norfolk Renal patients' charity as well as taking part in the Norfolk and Norwich celebration service in Norwich cathedral. This group of staff are pleased to represent the Trust in this way.

Musculoskeletal prevention
Our staff physio service which was secured during the last financial year (16_17) has been extended since January 2018 to allow two of the physios to dedicate one day each per week to preventative activity where they are able to visit departments to review their working practice, suggest education or recommend adaptations to reduce the risk of staff receiving a musculoskeletal injury. Numerous visits to departments have been made since January and those staff are now receiving bespoke preventative education either through seminars or poster advice.

Prevent influenza transmission
A full influenza vaccination campaign was undertaken from October 2017 – February 2018 where 77% of our frontline staff received their vaccination. This level fully achieves the challenging target from NHS England of 70%.

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

In other aspects of work, our full five year assessment review of the Faculty of Occupational Medicine SEQOHS (Safe, Effective, Quality OH Service) accreditation programme site assessment was undertaken in July 2017. We were delighted that we have once again been awarded the accreditation. In fact we were congratulated on an excellent assessment and did not receive any recommendations for improvement to practice which is a very rare occurrence.

As far as external business is concerned, we have been delighted to continue to our success with our current customers and gaining some significant new contracts during this last year. We have faced some external contract challenges due to some organisations re-aligning their occupational health provision or mergers taking place but the additional contracts that have been awarded has resulted in our income position remaining. Our team have expanded due to the new business acquired and we have been ensuring that all team members have successful inductions so that all our customers receive a high quality service. Towards the end of this financial year, our full time Occupational Health Consultant decided to move on to pastures new. In a time when expert OH Consultants are not widely available, we are delighted that we have been able to secure the recruitment of a new Consultant and we look forward to Dr Rob Hardman joining our team in May 2018.

The Head of Workplace Health and Wellbeing, Hilary Winch has continued to work with other regional OH leads on the regional and national streamlining project which endeavours to allow information to be transferred between NHS organisations on staff members who are moving employment.

The aim is to reduce both cost in repeated activities and time of OH services regionally and allow more proactive intervention to take place. This programme is now being overseen by NHS Employers and NHS Improvement nationally and Hilary represents the OH Workstream for our region on a national basis.

Health & Wellbeing / Staff Experience Working Group
Our staff experience group has met on a monthly basis. These meetings have been designed to consult with staff members on some key areas of work being considered and undertaken as well as members of the group working on areas which are felt would improve our overall staff experience. All work in this last year has been focused around the following three key elements

- Better Physical Working Environments for Staff
- Caring for Colleagues as we do for Patients
- Great Leadership and Management at Every Level

Some examples of work programmes undertaken by this group consist of:

Rest Areas
Members of the group have commenced a project where the rest areas for staff are being reviewed. In particular, the areas available for staff in the summer months and the ability to spend their break outside have been considered as it is often noted that staff sit on the floor or grass areas as there is no designated staff facility. A trial of using some of the courtyard areas with bistro style furniture has been undertaken last summer and proved to be very successful. The group are planning to roll this out further next summer so that more staff can benefit from this experience.

Flexible Retirement Policy Review
A sub group of this group formed a working party to review the organisations flexible retirement policy which is aimed at providing a more consistent approach to workers if they want to consider a retire and return option. An improved process has been designed with a wealth of information being made available to staff when considering this option on a new retirement hub section of the intranet.

Monthly PRIDE award scheme based on our Trust Values: People-focused, Respect, Integrity, Dedication and Excellence
Some members of the staff experience working group review the monthly nominations and make decisions regarding winners. Each month there are up to two members of staff one team who receive recognition. The NNUH PRIDE awards are being supported by Barnham Broom Hotel which is providing an 'Afternoon Tea for Two' or ' Fitness Voucher' for individual winners with hospital service provider Serco providing the winning teams with cake and fruit to share. This initiative continues to be really well received.

In addition to the other work programmes, the group have been consulted on and kept updated with the progress of the PRIDE values into action programme, speak up guardians, leadership training opportunities and the new leaders forum that has been established within the organisation.

Staff Development

Apprenticeships

Our hospitals award winning apprenticeship programme was established in 2010 and continues to go from strength to strength with 98% of our new apprentices going onto employment with 92% staying within the Trust.

The 'Grow Your Own' workforce strategy has been significantly developed over the last year with the introduction of the Apprenticeship Levy. There have been a record number of new apprenticeship posts being offered, 101, and also an increase in existing staff accessing the training as part of their CPD, 165. The total number of staff on programme is 266 – of which 56 are 16-18 years old, which generates an additional £56k.

The Apprenticeship Levy is a tax set at 0.5% of an employer's annual wage bill paid to HMRC monthly through PAYE. The levy can only be used to pay for Apprenticeship Frameworks/Standards and end point assessments. The rigid funding rules have been challenging for the Trust, however we have strived to utilise as much of the funds as possible to develop new and existing staff, and this will continue as new Standards are released over the coming year.

We offer a wide range of apprenticeship Frameworks/Standards from entry level, intermediate Level 2, Advanced Level 3, to Higher frameworks at Level 4 and Level 5 and increasingly Level 6 (degree) and Level 7 (Masters).

Working in partnership with the University of East Anglia we were the first in the country to start the Part-time Executive MBA (Senior Leaders Masters Apprenticeship) with 24 senior colleagues commencing in February 2018.

Clinically our Assistant Practitioners undertake the Level 5 Higher Apprenticeship for Assistant Practitioners, and we have 9 staff who have completed their Assistant Practitioner training and have progressed onto the Registered Nursing Degree Apprenticeship (Level 6) on a 2 year top-up pathway through the University of East Anglia, and the University of Suffolk.

Our Apprenticeships are structured and the apprentices are well supported by their teams, their Mentor, the education provider and the apprenticeship team. We have clear evidence that apprenticeships offer a pathway through to Higher registered training such as Nursing, Midwifery, ODP, Biomedical Science, Audiology, and Management, and in the future will include Physiotherapy, Podiatry, Occupational Health, and Speech and Language.

Two apprentices who came through the '**Prince's Trust 'Get Into' Programme**', and a '**Traineeship'** were awarded 'Apprentice of the Year' with City College, one for Health and one Business & Administration which was a fantastic achievement and recognition that access to work programmes are the start of career pathways.

School visits / Career information sessions
The Apprenticeship team has an excellent relationship with local schools, colleges and sixth forms and over the last year have attended events that enabled over 5250 students, parents and teachers to gain a better understanding of the Trust, the wider NHS and the wide variety of differing career opportunities available within it. This is a 42% increase in activity from 2016/17. The Team are working with the Trusts Central Recruitment team and a variety of departments across the organisation to promote career pathways as new apprenticeships are released and opportunities arise**.** During 2017/18 the team also increased involvement with primary schools and will continue to grow these professional relationships in 2018/19.

Prince's Trust 'Get into Health' Programme
Work continues with the Prince's Trust 'Get into' programme. This programme supports young people aged between 16 and 30 years who have been long term unemployed and offers them the opportunity to undertake a supported development programme including work experience.

This year has seen a review of the programme and the development of a four week rotational programme supported by ourselves, Serco, Norfolk Community Health and Care and Social Care. Sixteen young people commenced the programme in February 2018 with 15 successfully completing a 4 day placement in each of the identified organisations. Two of these young people have already successfully secured apprenticeships.

The placement element of the programme enabled the candidates to gain an understanding of each of the organisations, develop their skills, confidence and self-esteem in a supportive environment and complete a Level 1 Award in Preparing to Work in Adult Social Care with Steadfast the identified Training provider.

Step Into Health

Following the success of our Step Into Health Programme NHS Employers has now adopted the programme and are working nationally with other Trusts encouraging them to pledge their support to service leavers and the wider armed forces community. NHS Employers have, with the support of a National Programme Lead, developed a portfolio of supporting guidance, resources and networking opportunities bringing employer representatives together. There are now 45 trusts nationally pledged to support Step into Health with a potential of a further 7 in the coming months.

In January 2018 an event was held to celebrate the success of the Step Into Health and to launch the programme nationally. This event was attended by the Duke of Cambridge who's charity The Royal Foundation worked closely with us in the pilot stage of the programme.

We continue to support the programme and offer advice and guidance to other Trusts interested in supporting the programme. Information days for service leavers, veterans and spouses have been planned and advertised for 2018 and 2019.

We have achieved a Silver Award for the Employer Responsive Scheme and will be applying for Gold Award again this year.

Job Centre Plus

Regular 'taster' days continue to be held over the year, in partnership with Serco, to enable Job Centre Plus customers the opportunity to gain an understanding of the NHS and the work opportunities available to them.

PRIDE Values into Action

Responding to our staff survey results in 2016, where staff expressed that NNUH could be a much better place to work, we have embarked on an organisational development programme to;

- Create a consistently values-led culture - translating values into tangible behaviours
- Make NNUH a better place to work – act on teamwork, bullying, involvement
- And making NNUH a better place to be cared for

The 2016 staff survey results were used to target a number of areas for improvement over the last year, such as;

- Together, translate and communicate our PRIDE values into a behaviour framework, providing standards for how teams work together, recruiting the best people, celebrating achievements and supporting our development

- Integrated communications campaign was used to cascade, reinforce and embed our PRIDE values. The summer edition of Pulse marked a year of our PRIDE awards, celebrating and recognising outstanding examples of where individuals and teams have made a special difference to the lives of patients and colleagues through living our PRIDE values
- To make NNUH an 'employer of choice' and more attractive to potential employees, all recruitment adverts were updated to include the PRIDE Values and a Values-based Recruitment training package developed
- Our Values were built into our policies, induction, appraisal and development to support and develop individuals and teams
- It has been made it easier to notice, appreciate and Speak Up about values and behaviour
- We continue to involve colleagues and use patients feedback in how we improve their experiences of NNUH as a place to work and be cared for
- New and improved opportunities provided to support staff and line managers with programmes, activities and initiatives that promote health and well-being within the Trust, such as the introduction of the Scwartz rounds
- Values-led leadership training was launched to help managers support and sustain our PRIDE values culture
- Clear Leadership and Management Development overview to support leadership pathways, career development and Talent Management

The results of the 2017 staff survey are really encouraging, showing that the NNUH is one of the most improved hospitals in the country.

Health and Safety

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

The main projects for the year 2017/18 were:

- Continued work on compliance with legislation concerning "sharps" safety devices and reduction of injuries during usage of sharps
- In- depth review of fire risk assessments and safety controls on Trust premises and working with NFRS in the wake of the Grenfell fire to ensure building requirements are met
- Introducing more accessible methods of safety training for staff
- Improving waste streams in relation to legal compliance and environmental protection.

Training

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

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

Incidents

There are five categories of health and safety related incidents that are reported most frequently for staff. These are slips, trips and falls, needle-stick and sharps injury, patient moving and handling, verbal aggression and physical aggression. There was a 3% decrease in reported staff safety incidents compared with the previous year.

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

During 2017/2018, the Health and Safety Department reported 17 staff injuries to the Health and Safety Executive. These were due to the employee sustaining fractures during work related activities or being absent for or requiring a change of duties for more than seven days. This is a decrease in reportable incidents of 26% on the previous year.

The number of RIDDOR incidents is reflected as an incidence rate against the national average. The Trust's overall incidence rate is 227 per 100,000 employees. The national incidence rate for healthcare in 2017 was 320.

More detail on health and safety performance is included within the Health and Safety Annual Report that is presented to the Trust Health and Safety Committee in April 2018.

NHS Improvement's Single Oversight Framework

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

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

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

The Single Oversight Framework applied from Quarter 3 of 2016/17. Prior to this, Monitor's *Risk Assessment Framework* (RAF) was in place.

NHS Improvement has assessed the Trust as being within segment 3, which includes providers receiving mandated support for significant concerns. It reflects the Voluntary Licence Undertakings given by the Trust, as detailed in the Annual Governance Statement 2017/18 included in this Annual Report.

This segmentation information is the Trust's position at 31 March 2018. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

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

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

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

Signed:

Mark Davies, Chief Executive Date: 25th May 2018

UK’s first Older People’s Emergency Department introduced at NNUH

NNUH has announced innovative plans to transform the way it delivers emergency care by introducing the UK’s first Emergency Department that is entirely dedicated to patients over the age of 80.

Over the last year, there have been many changes to the care available for older patients at NNUH. Older People’s Ambulatory Care (OPAC) allows many older patients admitted as an emergency to receive a comprehensive assessment and be discharged much earlier than previously.

A second new service, the Older People's Assessment Service (OPAS) now allows GPs direct access to a booked appointment with a specialist geriatrician within 48 hours of referral. This replaces the traditional outpatient clinic appointment, as well as the traditional long wait for that to happen. Now, when a patient over 80 years old arrives at the NNUH emergency department, they will go straight to OPED, where there will be a multi-disciplinary team consisting of Emergency Department Consultants, Consultant Geriatricians, Emergency and Older People’s Medicine Nurses waiting to provide care for them. Patients who require a longer admission will still then be admitted directly to one of the specialist older people’s wards. But for other patients, these new services should have a significant impact.

The ultimate aim of these projects is to ensure that all patients can receive the “gold standard” of care as quickly as possible: a Comprehensive Geriatric Assessment (CGA) within 48 hours of referral or immediately on presentation at the NNUH. CGAs have been shown to identify an older person's risk of frailty by assessing their medical conditions, mental health, level of independence and social circumstances, saving time for the patient, improving their immediate care and preventing problems for the future.

Annual Governance Statement for the year ended 31 March 2018

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

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

Capacity to handle risk
The Trust has a Risk Management Strategy which sets out the accountability and reporting arrangements to the Board of Directors for risk management within the Trust. This has made available to all Trust staff through our intranet documents management system (TrustDocs) and is accompanied by a Risk Management Policy. Operational responsibility for the implementation of risk management has been delegated to our Director of Nursing and other named staff.

During 2017/18 our processes for risk management were subject to Internal Audit review. This resulted in a 'reasonable assurance' rating – providing assurance to the Board that the controls in place in this area are suitably designed and consistently applied, with some recommendations on how we improve further and ensure that the control framework is effective.

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

Whilst we have established processes for learning from incidents and patient feedback, the focus of our risk management approach is on proactively identifying and avoiding risks rather than simply reacting to risks which have materialised.
To enhance our capacity and capability in this regard, during 2017/18 we have appointed an Associate Director of Quality and Safety, with responsibilities including the system of risk management in the Trust.

The Management Board's Risk Committee has also continued to operate in accordance with its defined Terms of Reference, providing additional momentum to enhancing our arrangements for the identification and management of risk and development of the Trust's Risk Maturity.

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

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

In 2017/18 we have also been actively involved with the GIRFT (Getting It Right First Time) initiative. GIRFT is hosted by NHSI and is focussed on encouraging standardisation of best practice across the NHS, to promote better patient outcomes and improved efficiency. One of our medical consultants is the national GIRFT clinical lead for Dermatology, several of our specialities have hosted GIRFT inspections this year (including Upper GI/Thoracic Surgery, ENT and Ophthalmology) and we hosted a seminar for senior Trust staff with the NHSI Regional Productivity Director to share information on possible opportunities for best practice improvements.

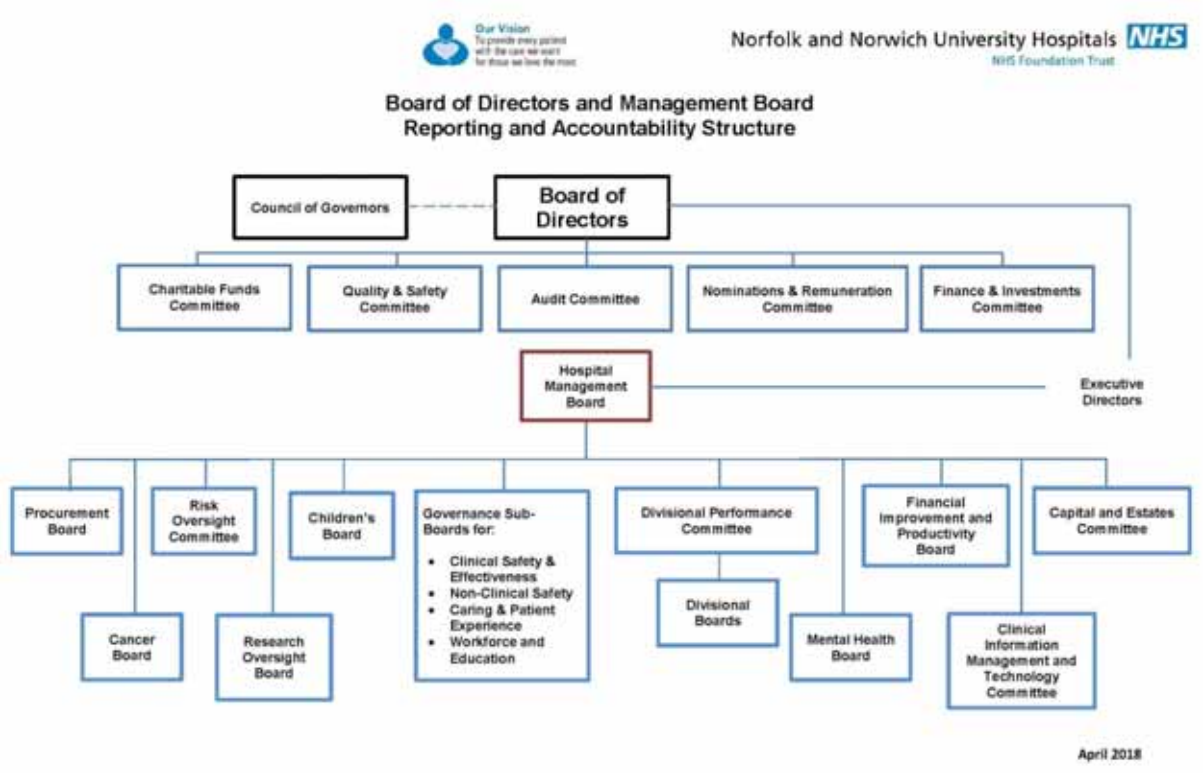
Reduction of risk and maintenance of quality are promoted by constantly reinforcing a culture of openness and transparency and encouraging staff to identify opportunities to learn from patient feedback and to improve the care and services we provide. Our processes for managing risk were specifically reviewed by PWC as part of their Independent Review of Leadership and Governance in the Trust, which was commissioned by the Trust and reported in October 2017. The PWC review was conducted in accordance with the CQC/NHSI Well-Led Framework and PWC reported *"The changes that the Trust has made to its risk management processes in the last 12-18 months have strengthened the profile of risk management across the Trust, increased the Board's visibility and oversight of risk management and improved the infrastructure for identifying and managing risk".*

The risk and control framework

The Board of Directors meets bi-monthly in public and at every meeting it receives reports which detail risk, financial and performance issues and, where required, the action being taken to reduce identified high level risks.

This reporting to the Board of Directors is supported through the Trust's governance structure, in particular through the Hospital Management Board with its Committees and Governance Sub – Boards. Each month the Board receives the High Risk Tracker, which summarises the highest-rated risks on the Trust Risk Register.

The Board of Directors has established four Committees, in addition to a Charitable Funds Committee. The Board receives regular reports from each of its Committees and the overall governance and assurance structure is as illustrated below.



The Board's Audit Committee has responsibility to oversee the maintenance of an effective system of integrated governance, risk management and internal control, across the Trust's activities. The Terms of Reference for the Trust's Audit Committee are based on the model set out in the NHS Audit Committee Handbook (2014) and the Committee is tasked with reviewing the adequacy of the structures, processes and responsibilities within the Trust for identifying and managing key risks. The Audit Committee's Annual Report sets out the ways in which it has carried out its responsibilities during 2017/18.

Information and assurance is provided to the Board through:

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

Risk is assessed at all levels in the organisation from the Board of Directors to individual wards and departments. This ensures that both strategic and operational risks are identified and addressed and risk assessment information is held in an organisation-wide Risk Register.

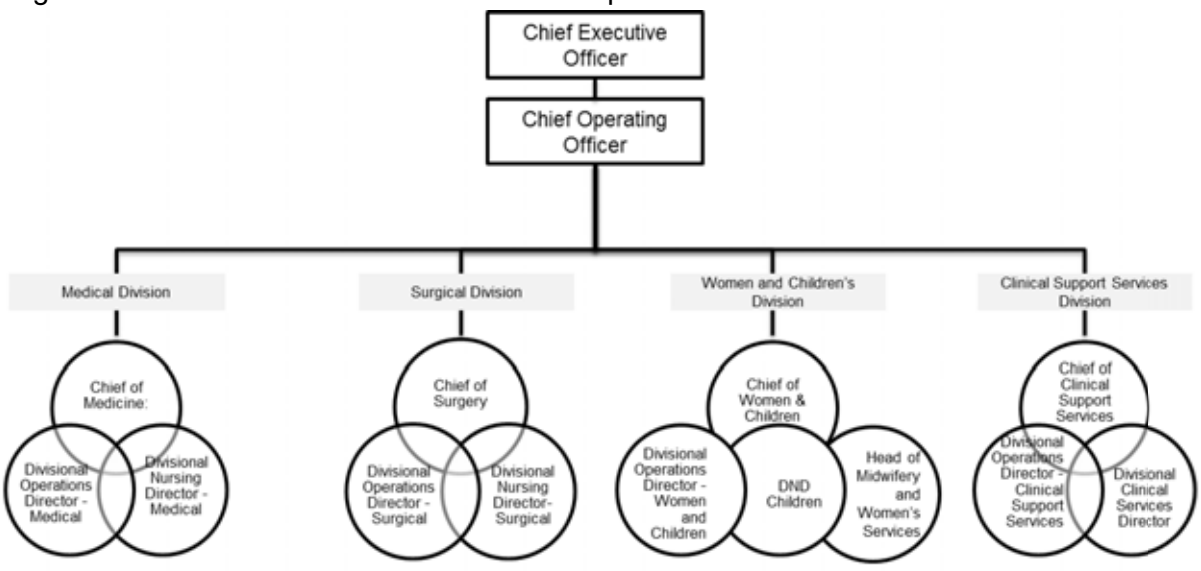
A risk scoring matrix is used to ensure that a consistent approach is taken to assessing and responding to clinical and non-clinical risks and incidents. Those risks with a high residual risk rating (following the impact of appropriate mitigating actions) are detailed in a High Risk Tracker – reported to both the Board of Directors and Management Board through the Integrated Performance Report.

The Hospital Management Board is tasked through its Terms of Reference with assisting me in effectively discharging my duties as Accounting Officer and with overseeing the identification and mitigation of key risks arising from or relevant to the operation of the Trust. It oversees the work of four Governance Sub-Boards, the remits of which are collectively constructed so as to be consistent with the inspection regime of the Care Quality Commission under the following headings:

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

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

Each of the Management Board committees and governance sub-boards have Terms of Reference and they report regularly to the Management Board on areas of risk or issues that require escalation. Our clinically-led divisional structure forms a key part of our management and governance structure and each of the divisions is represented on the Management Board. The divisional structure is represented below:



In March 2017 our Internal Auditors reviewed our divisional governance arrangements and confirmed that the Board can take *"substantial assurance"* that the controls in this area are suitably designed, consistently applied and operating effectively.

During 2017/18 leadership and governance arrangements in the Trust have been subject to formal independent review by PWC, in accordance with the NHSI/CQC Well-led

Framework. PWC reported in October 2017 and key findings of particular relevance to our risk and control framework are that:

- The devolved clinical leadership model is in line with good practice and is benefitting the Trust as divisions take action to address issues and make improvements;
- The executive team has a good understanding of the priority areas to further build on the progress made;
- Governance processes are well-designed however there is a need to clarify leadership and accountability for quality improvement and to ensure that governance processes at service level are operating effectively.

With changes made to the composition of the Executive team in 2017/18 we have clarified that executive responsibility for clinical governance rests with the Medical Director. The schedule of Executive portfolios ('Who Leads on What') will continue to be reviewed periodically as part of the ongoing Executive Team Development Programme, so that there remains clarity and assurance over capacity and capability with regard to leadership for Quality Improvement.

In terms of development of leadership capacity, capability and effectiveness at service level, during 2017/18 we have invested in creating new roles for 'governance support' in each of the divisions. The Trust has also commissioned a review by the King's Fund of the Trust's Organisational Development. During 2018/19 we intend to commission a programme of externally facilitated development work for our divisional and service leadership teams, which will serve to address the point identified by PWC and further strengthen our devolved leadership and governance structure.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. Executive Leadership for E&D at both service and staff level is clearly identified and there are established reporting lines through both the Workforce Sub-Board and Caring and Patient Experience Sub-Board.

The last published report from a full inspection by the Care Quality Commission (CQC) was issued in March 2016. The overall rating for the Trust was that it 'Requires Improvement' to ensure full compliance with the registration requirements of the Care Quality Commission. In its report the CQC judged the Trust to be 'Good' for the domain of Caring, but 'Requires Improvement' in the domains of 'Safety, Effectiveness, Well-led and Responsiveness'.

An action plan relating to recommendations made by the CQC was established. This was subject to Internal Audit review, providing *reasonable assurance* that the control framework in place for delivery of the Action Plan was suitably designed and consistently applied.

A further inspection took place on 10-11 October 2017 and the report from this is awaited. Initial feedback from the CQC confirmed:

- There was evidence of a good reporting culture with incidents and safeguarding concerns being handled well.
- Staffing levels were improved across several areas.

A number of areas of specific concern were however raised by CQC and the Trust received a Warning Notice from the CQC on 31 October requiring improvement in a number of specific areas:

i) The area for the Children's ED in A&E

ii) The layout and size of the A&E Department
iii) The facilities in ED for care of patients with mental health issues
iv) Documentation in the medical records particularly with regard to patients with mental health issues or lacking mental capacity
v) Staff training in ED with regard to the Mental Capacity Act
vi) Systems for infection prevention and control

Concerning items (i) and (ii), plans for expanding our Emergency Department were already at an advanced stage when the warning notice was received and building work to create Europe's first Older People's Emergency Department (OPED) and a new Children's Emergency Department (CED) was completed by the New Year. This involved relocating a series of wards within the hospital to vacate space for the ED expansion but the new facilities were open and operational when the CQC re-inspected in January 2018. With regard to item (iii) regarding facilities for mental health care, relocation of the CED has vacated space for a bespoke mental health facility to be built within the ED and this building work is due to complete by July 2018.

With regard to item (iv) (documentation of care for vulnerable patients), the Management Board has established a Mental Health Board with multi-organisational, multi-disciplinary and NED representation to oversee systems, processes and standards of mental health care in the Trust.

With regard to item (v) (Mental Capacity Act and Safeguarding training), this has been addressed by creation of a new role for a Mental Capacity Matron and compliance with relevant training was in excess of the target 90% when the CQC re-inspected in March 2018.

With regard to item (vi), infection prevention and control, the Trust invited an inspection by the NHSI Lead for Infection Prevention and Control and this was conducted in February 2018 and confirmed the Trust's GREEN IP&C status.

To provide Board assurance with regard to actions taken in response to the CQC warning notice, the ED and the OPED and CED (once operational) were visited by the Board's Quality and Safety Committee.

Significant Risks

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

- High levels of elective and emergency demand relative to the available operational capacity pose risks for delivery of the Trust's targets for A&E, cancer and 18-weeks;
- The impact of persistent high levels of demand on staff resilience and morale;
- Variability and unpredictability in levels of emergency demand, allied with agreement not to delay offload from ambulances, creates peaks of pressure in the ED;
- Variability and unpredictability in levels of demand for inpatient beds, creates pressure to open escalation areas within the hospital at short notice creating pressures on available staffing and on standards of patient experience and quality;
- The requirement to make very significant financial savings (>£30M) to limit the Trust's financial deficit, reduces the flexibility to maintain and develop services for patients and staff;
- Lack of capital available for investment in services for patients and staff, creates a current and future risk with regard to physical capacity and equipment obsolescence and breakdown;

- The absence of agreed system-wide strategic plans to balance demand and capacity in the Acute sector and to ensure financial sustainability poses significant risk to our ability to counter the current and future challenges facing the Trust.

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

NHSI (Monitor), the independent regulator of Foundation Trusts, investigated the Trust's non-achievement of the national operational performance targets in 2015/16 and concluded that it had reasonable grounds to suspect that the Trust was in breach of its Provider Licence, which requires achievement of relevant national targets. Monitor accepted voluntary Undertakings from the Trust to take "all reasonable steps" with respect to the delivery of improvement plans to achieve the national targets and concluded that implementation of these Undertakings would *"secure that the breaches in question do not continue or recur".* These undertakings were replaced by an undated version in November 2017. Representatives of the Trust continue to meet monthly with NHSI to discuss the actions taken to mitigate the imbalance between the level of patient demand and the capacity in the Trust to meet the demand.

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

As part of the PWC Independent Review of Leadership and Governance in the Trust (October 2017), PWC concluded that "*the structure and content of the BAF supports the Board to focus on sources of assurance to assess risks to delivery of the four strategic objectives*" and that "*The Board Assurance Framework (BAF) is well-structured and is used effectively to focus the Board and its sub-committees on the Trust's strategic risks*".

A key element of the Undertakings given to NHSI is that the Trust should set out a long-term strategy to address the increasing demand and capacity pressures it faces. In compliance with the Undertakings the Trust has developed plans to expand its capacity to treat patients, most particularly in the first instance through the creation of a new Interventional Radiology Unit.

Creation of the IRU is the Norfolk, Great Yarmouth and Waveney STP 'top priority' for capital funding but unfortunately, our applications for capital funding to build the IRU have been unsuccessful to date.

To address the risks facing the Trust in the longer term, the Trust has been working with STP partners with a view towards developing longer term strategic plans to balance demand and capacity and to promote financial sustainability. The Trust has developed a plan to create a new Ambulatory Care and Diagnostic centre to meet the projected increase in patient need but currently the necessary capital funding is not available. We will continue to work with partners to try to mitigate this risk.

Incident Reporting and Raising Concerns

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

The Quality and Safety Committee receives regular reports with regard to the rate of incident reporting in the Trust and the investigation and learning from incidents. During 2017/18, there has also been concern raised by the CQC with regard to the efficacy of the Trust's line management and 'Speak Up' procedures, whereby staff can raise concerns about the quality of the Trust's services. This concern raised by the CQC is consistent with feedback from Trust staff through the National Staff Survey which suggests a relatively low level of confidence in raising concerns without fear of retribution.

The Trust has commissioned an independent review from the Kings Fund concerning the Trust's organisational development, culture and staff experience with a view to establishing an OD programme to improve the Trust and the experience of its staff. At the time of writing, the Board is awaiting receipt of the feedback from the Kings Fund so that we can plan our programme of improvements to be implemented through 2018/19.

Patient Involvement in Risk

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

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

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

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

Patients and external partners provide a further crucial part of our quality assurance and risk control processes, through our programme of Quality Assurance Audits. These consist of small teams making unannounced audit inspections of wards and departments in the Trust, reviewing compliance with a series of pre-determined standards. A number of such teams include an external inspector, providing independent assurance of the rigor and fairness of the QAA process. During 2016/17 we reviewed and revised our QAA process, to strengthen its coverage across inpatient and out-patient areas. The revised scheme was approved by our Quality and Safety Committee and the results from the QAA programme are reported to the Board and are published. We are reviewing the scheme to establish whether the changed process has been successful or whether there are alternatives and the Quality and Safety Committee will be reviewing this during 2018/19.

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

The work of Lord Carter has been developed by the NHSI Model Hospital Team which produces benchmarked information across specialties and service areas. In March 2018, we hosted a seminar for senior Trust staff with the NHSI Regional Productivity Director to share information on possible opportunities for best practice efficiency and economy improvements. This information shows that the Trust has consistently low cost services other than with regard to the PFI agreement.

Based on this national data the Trust is successful in implementing the Board's commitment to optimising the effective and efficient use of the Trust's resource base. In 2017/18 however the Trust reported a significant deficit of c£20m.

During 2016/17, the Trust volunteered to take part in the NHSI financial improvement programme and was placed in Financial Special Measures (FSM). On 15 March 2017 the NHSI Executive Director of Regulation confirmed formally that the Trust was being released from FSM on the grounds that we have *"demonstrated a robust CIP governance structure; have a cohesive and substantive management team in place; and have demonstrated delivery and remain on track to deliver against [our] recovery plan"*.

Our financial plan for 2017/18 involved a wide-ranging efficiency and cost-savings programme to generate a savings target in excess of £30M. Achievement of the financial plan also required delivery of very significant increases in clinical activity and income. The winter of 2017/18 was however the worst in the 70 year history of the NHS. Very high levels of emergency demand caused significant disruption to our elective surgery programme and nationally elective surgery was effectively suspended for a significant period during the winter. High levels of emergency activity also create additional costs through the need for employment of additional temporary staff, opening escalation areas and treating large numbers of acutely unwell patients.

As a result of the above, it became apparent during the year that achievement of our financial plan was not going to be possible whilst at the same time maintaining our commitments to the quality and safety of patient care. Our Finance and Investments

Committee accordingly recommended to the Board that we should re-forecast to a £27.3M deficit. This recommendation was accepted by the Board and in the end we managed to constrain the deficit to £20M.

Whilst it is positive that we were able to limit the deficit, its underlying drivers cannot be avoided. Chief amongst these is the cost of the PFI and we are in discussion with our regulators as to whether the Trust may be entitled to join the group of other Trusts who receive central government assistance with similar costs.

As part of providing assurance to the Board that resources are used economically, efficiently and effectively, the Audit Committee oversees the internal audit plan which undertakes relevant projects during the year. During 2017/18, the internal auditors undertook a two part review of our Cost Improvement Programme (Part 1 – Planning and Part 2 – Delivery).

The conclusion of the internal auditors was that the Board could take 'substantial assurance', that the controls in this area are suitably designed, consistently applied and operating effectively.

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

Whilst recognising the significant financial challenges ahead, after making enquiries, the directors have a reasonable expectation that the Norfolk and Norwich University Hospitals NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. It does so on the understanding that appropriate borrowing facilities will be available to the Trust from the Department of Health. For this reason, the Trust continues to adopt the going concern basis in preparing its accounts.

Our expectation is informed by the anticipated continuation of the provision of our services in the future, as evidenced by inclusion of financial provision for those services in Contracts for Service, being the NHS Standard Contract 2018/19 signed with the Trust's main Commissioners.

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

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

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

Annual Quality Report

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

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

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

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

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

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

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

Information Governance and Cyber Security

The IG Toolkit is a framework which allows organisations to assess themselves or be assessed against Information Governance policies and standards. The Trust is required to score 95% in Information Governance Awareness training, which is satisfactory (Level 2 or above evidenced for all requirements) on the toolkit. Despite focus on the toolkit over the last 12 months, the Trust scored 76% which is below the necessary standard. The Trust did not attain Level 2 in Requirement 112 (IG Training) of the IG Toolkit and an action plan is in place to resolve this anomaly.

Information governance (IG) training is mandatory for all staff members and is renewed on an annual basis. The Trust continued to raise awareness of Information Governance and the importance of protecting personal information with its staff members through a comprehensive training programme particularly. To complement this learning, a wealth of policies, guidance and best practice are made available to staff members via the Trust's intranet. In light of the new General Data Protection Regulations (GDPR) coming into effect in May 2018 the Trust has been working extensively to ensure that it complies with the legislation and has had both internal & external readiness assessments undertaken to ensure that an appropriate plan of work is adhered to.

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

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

The Trust experienced and reported 5 level 2 SIRIs to the ICO in the financial year 2017-18. The ICO concluded no further action was required for three incidents and the two outstanding incidents are currently under investigation both locally and by the Information Commissioner's Office.

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

Category	Breach Type	Total
A	Corruption or inability to recover electronic data	4
B	Disclosed in Error	11
C	Lost in Transit	2
D	Lost or stolen hardware	0
E	Lost or stolen paperwork	1
F	Non-secure Disposal – hardware	0
G	Non-secure Disposal – paperwork	1
H	Uploaded to website in error	0
I	Technical security failing (including hacking)	0
J	Unauthorised access/disclosure	1
K	Other	0

The NHS as a whole was caught out with the zero day exploit (Wannacry) in May 2017 although the Trust had minimal disruption in comparison to many others, the residual effect during the Wannacry incident was that its endoscopy services was affected over the weekend of the cyber incident but services were restored quickly to ensure continuity to our patients. It is widely known that further cyber incidents are a certainty; it is a case of when not if.

The last 12 months have seen a number of new legislative and statutory requirements:- GDPR, Network & Information Security Directive, Caldecott 2 and Cyber Essentials. All of these outline further enhancements that the Trust will be required to undertake to close the gap. Basic cyber security policies, process and procedures are in place at the Trust however, the new legislation brings a completely new level of detail and focus on the Cyber agenda.

In accordance with best practice, the Trust is undertaking further gap analysis, which we believe, will find further investment is required in people, process, and technology to ensure on-going compliance with this new legislation.

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

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

Review of effectiveness

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

The Board of Directors has met regularly and kept arrangements for internal control under review through discussion and approval of policies and practice and monitoring of outcomes agreed as indicators of effective controls.

The Board reviews a monthly Integrated Performance Report covering a wide range of performance metrics – these show the key relevant national priority and regulatory indicators, with additional sections devoted to safety, clinical effectiveness and patient experience. This monthly integrated summary is supplemented by more detailed briefings

on any areas of adverse performance. The selection of appropriate metrics is subject to regular review by the Board, with changes in priorities or areas of concern reflected in that selection. In October 2017, PWC reviewed the information received by the Board to support its internal control processes and confirmed its view that "*The IPR is clear and accessible, providing the Board with the relevant data and information to assess performance and hold the Trust to account for delivery against plan. The document is the focus for effective discussion and challenge on performance at Board meetings*".

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

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

Internal Audit
In addition to Clinical Audit, the Internal Audit plan is a risk based programme of reviews based on areas of management concern, emerging risks, and national and historical experience. During 2017/18 we have specifically endeavoured to increase the impact and value of our Internal Function, through increasing the involvement of the Management Board and Divisional leaders in identifying priorities and overseeing the implementation of Internal Audit recommendations.

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

In addition to the planned programme of work, internal audit provides advice and assistance to senior management on control issues and other matters of concern. The Internal Audit function also provides an anti-fraud service to the Trust and during 2017/18 we have continued a programme of work to implement an electronic web-based system for the transparent reporting of potential conflicts of interest.

Based on the work undertaken in 2017/18, the Head of Internal Audit has concluded that *"the organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective".*

Conclusion

My review confirms that Norfolk and Norwich University Hospitals NHS Foundation Trust has a sound system of internal controls that supports the achievement of its policies, aims and objectives. No significant internal control issues have been identified. Capacity however remains a significant risk for the Trust and its ability to achieve key performance targets. This is evident in a number of the most significant challenges that we face – in the pressure on our ED; in the need to use escalation space over the winter; and in the demoralising effect that our staff can experience when we do not have the capacity to provide the quality of service to which we all aspire.

The Board is committed to addressing these challenges through its strategic plans for capacity expansion. During 2018/19, we will see the fruit of these in the opening of the world leading Quadram Institute, which will allow for relocation of our Endoscopy Unit and clinical research facility, and will be a major step forward for the Norwich Research Park. Our capacity to develop our services to meet the ongoing needs of our patient population on a sustainable basis will require the availability of relevant capital funding and close liaison with our partners across the STP.

During 2017/18, the independent PWC team concluded *"like all Trusts, the Trust still faces significant challenges, but the changes made provide a strong foundation to deliver further quality, operational and financial improvements".*

The Head of Internal Audit also concluded *"the organisation has an adequate and effective framework for risk management, governance and internal control. However, our work has identified further enhancements to the framework of risk management, governance and internal control to ensure that it remains adequate and effective".*

I have taken careful note of both the above opinions which accord with my own assessment that whilst much has been done, there is still more to do.

Signed:

Mark Davies
Chief Executive **Date: 25 May 2018**

Approval of the Accountability Report

I confirm my approval of the Accountability Report.

Mark Davies
Chief Executive

Date: 25th May 2018

Quality Report 2017/18

Chief Executive's Statement on Quality

Information about this Quality Report

We have made significant progress this year in patient safety with our key achievement being a reduction in our mortality rate which is at an all-time low. This is an issue which is very close to my heart and when I first came to NNUH the HSMR was 115. We set ourselves a target of getting to 90, and two years later I am delighted to say that we have achieved our aim (the HSMR for the latest available 3 month period is 90.5). Our target for March 2019 is to have an HSMR of 85 and this is the right target for a big acute teaching hospital. The effort that everyone has made for the benefit of our patients is incredible.

Our track record on infection prevention and control has been impressive and the efforts of our teams have been recognised in the NHSI inspection on Infection Prevention and Control. The inspector did a thorough assessment and thanks to the hard work of the IP&C and other teams we passed the inspection with a full green rating. We are also pleased to see a year on year fall in the number of c-diff cases which follows our success in tackling hospital-attributable Methicillin Resistant Staphylococcus aureus (MRSA), where we have had only one case of hospital acquired MRSA case in the last six years.

We are working hard to keep up with the demand for care and our performance on cancer targets – the best in three years - is critical for our success as a major cancer centre. Many of our services run seven days a week and we also use temporary facilities to keep pace with demand. In the longer term, we are developing permanent solutions to help solve the pressures on our capacity which will, in turn, help us to improve on our access targets. Our plans include an extension of the N&N building to expand facilities for interventional radiology, and cardiac catheter labs. During 2017/18, we expanded our critical care facilities adding an additional eight high dependency beds which translates into a 40% increase in capacity.

A new medical and cancer unit is also being developed at Cromer & District Hospital where one of the older buildings on site will be refurbished. There are also longer term plans to build an Ambulatory Care and Diagnostic Centre (ACAD). Building work on the Quadram Institute will be complete by the end of the summer and will house the largest endoscopy unit in Europe as well as being at the forefront of combined research into food science, gut biology and health.

Another area where we have expanding our capacity is in the Emergency Department where we have created the UK's first Older People's Emergency Department which has received national recognition. This change has been combined with a tripling of the size of our Paediatric Emergency Department and we are also creating additional facilities for mental health patients who seek help at ED.

Research and innovation are a key part of our mission and we maintain close links with the University of East Anglia. Together we are capable of leading the world in innovative techniques. A good example would be the Norfolk Diabetes Prevention Study which drew to a close in 2017 after successfully recruiting 13,000 volunteers through 135 GP practices in the three counties for five years.

Participants at highest risk of developing Type 2 Diabetes were invited to take part in a three and a half year lifestyle intervention programme run at seven centres throughout Norfolk and Suffolk. We expect the results to have a significant impact when they are published.

With rising demand and a tight fiscal situation – our deficit for 2017/18 will be £19.6m - there is no doubt that the environment in which we work will continue to be challenging. I am confident that by supporting a culture of learning and improvement we will provide our patients with the safe, high quality care and experience they deserve.

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

Mark Davies

Chief Executive **25th May 2018**

Priorities for improvement

The 2016/17 Quality Report detailed the Trust's intention to align priorities to the Quality and Safety Improvement Strategy and to reflect the new two year NHS Standard Sub Contract by setting priorities for both 2017/18 and 2018/19. Each of the priorities sits within one of the three domains of patient safety, clinical effectiveness, and patient experience; assurance in relation to these priorities is provided by the relevant assurance sub-board reporting to the Management Board.

In selecting the priorities, the Trust took into account feedback from a range of different stakeholder groups, including staff, patients, the public and commissioners. This feedback has continued to be received in a variety of forms, including survey responses, complaint letters, quality monitoring from commissioners, internal reviews of the quality of care provided across services, and staff suggestions. As part of this continuous process of review 2018/19 priorities have been updated and added to as described in Table 1 below.

Table 1

Domain	Priority for 2018/19	Changes from 2017/18
Safety	Reduce medication errors focussing on insulin	No change
	Prompt recognition and treatment of deteriorating patient	Redefined from focusing solely on sepsis and will include Acute Kidney Injury (AKI) and avoidable cardiac arrest
	Increase safety through improved teamwork and better communication	**New priority.**
	Improvement in frailty provision and care	**New priority.**
	Keeping patients safe from hospital acquired thrombosis.	**Remove for 2018-19.** Thrombosis priority as this measure has been consistently achieved in the last year
	Incident reporting and management	**Remove for 2018-19.** Duty of candour compliance consistently achieved. This priority has been replaced with a more focused priority relating to human factors training and improving teamwork and communication

Effectiveness	Improve quality of care through research	No change
	7 day services - All patients admitted as an acute or emergency admission receive the same high quality of care irrespective of the time or day of the week they are admitted	Changes QP from previous year which was specific for timely review of all patients.
	Keeping patients safe from infection	Changes to include gram negatives and CPE
Care and Patient Experience	Improved continuity of care and experience through reduced ward moves and reduced numbers of outliers	No change
	Improved discharge processes and communication	Added communication to emphasise EDL as at present but also OPD communication according to required electronic format
	To improve our care to those at the end of their life	**New priority.**
	To improve the assessment and quality of care for patients in Mental Health crisis	**New priority.**
	Treat Patients with Dignity and Respect	**Remove for 2018-19.** This remains a high priority but the Trust has consistently achieved over 95% for patients extremely likely or likely to recommend us. This is replaced by the more specific priority in relation to improving continuity of care by reducing ward and bed moves

Patient Safety – No Change: Reduce medication errors focussing on insulin

Why is this a priority for 2018/19?

Concern in relation to harm and potential harm from errors of insulin prescriptions remains high

How progress will be achieved, monitored and measured

Number of insulin errors reported on DATIX– NPSA category Moderate harm or above as last year and reported via the Trusts Integrated Performance Report

Patient Safety – Change: Prompt recognition and treatment of deteriorating patient

Why is this a priority for 2018/19?

Redefined from focusing solely on sepsis to reflect outcomes of Root Cause Analysis investigations and themes arising out of mortality review

How will progress be achieved, monitored and measured

- Sepsis CQUIN metrics
- Number of avoidable cardiac arrests
- Number of Serious Incidents/ Mortality reviews where failure to recognise and respond is identified
- Number of inpatients developing AKI (from renal registry).
- Early Warning Score audits

Patient Safety – New Priority: Increase safety through improved teamwork and better communication

Why is this a priority for 2018/19?

To reflect priority for improving safe practice through the learning from Never Event (NE) investigations particularly in relation to culture change, teamwork and communication.

How will progress be achieved, monitored and measured?

Human Factors are the non-technical knowledge and skills that support safer ways of working. These include teamwork, situational awareness, communication and leadership. There is overwhelming evidence that the integration of Human Factors into clinical care is an important aspect of improving patient safety. By helping clinical teams to work together safely and effectively by training them about leadership, communication, situational awareness, problem solving and decision-making it will help to reduce medical error and its consequences.

- Number of staff trained in Human Factors against plan (Risk stratified roll out – priority areas where NE have occurred)
    - Q1 – devise plan and training content
    - Q2 - 4 deliver training plan
- Number of staff trained as trainers

Patient Safety – New Priority: Improvement in frailty provision and care

Why is this a priority for 2018/19?

To reflect increased emphasis on older persons care and changes instituted in NNUH for older peoples medicine.

How will progress be achieved, monitored and measured?

Please refer to page 68 for detail on the frailty pathway development work that has been undertaken in 2017/18

The measure will be the number of comprehensive Geriatric assessments undertaken on admission.

Metrics will form part of the Trusts Quality Care Indicators for Emergency Medicine.

Clinical Effectiveness – No change: Improve quality of care through research

Why is this a priority for 2018/19?
Evidence shows that research active hospitals have good quality and safety records

How will progress be achieved, monitored and measured?
No change to measures used last year which are detailed later in this report

Clinical Effectiveness – Change: 7 day services

Why is this a priority for 2018/19?
The Trust continues to participate in the national 7 Day Services Assessment Audit and has contributed data again in March and September of 2017/18. As a result of the last audit, a robust action plan is being put in place which includes the forming of Quarterly Steering Committee services, with exec board and CCG membership, to provide additional focus on implementing the priority clinical standards for seven day hospital services.

How progress will be achieved, monitored and measured
Externally, The Trust submits data and assurance bi-annually to NHS England through the national 7 Day service audit process against the 4 priority clinical standards, which need to be embedded by 2020. The Trust also provides assurance through regular meetings with NHS England that the required progress is being made on the other 6 standards ensuring patients receive the same standards of care in hospitals, seven days a week.

Internally the Trust will report regular project progress to the Management board, Divisional leads and Commissioners through the newly created project Steering Committee which will meet quarterly. The Steering committee will also report into the Trusts improvement process.

Clinical Effectiveness – Change: Keeping patients safe from infection

Why is this a priority for 2018/19?

1. Gram-negative blood stream infections
   NHS Improvement (NHSI) contacted all Trusts and CCGs in June 2017 sharing the ambition across the whole health sector to reduce healthcare-associated Gram-negative blood stream infections (BSI) by 50% by March 2021. The initial focus to reduce *Escherichia coli (E. coli)* was launched as a joint initiative by NHSI to promote working together.

   E.coli BSI figures have been published by Public Health England (PHE) since 2011. In 2017 it also became mandatory for Trusts to collect Klebsiella spp. and Pseudomonas aeruginosa BSI surveillance data for PHE.

   How progress will be achieved, monitored and measured
   The NNUH will collect and review surveillance data for all Gram-negative BSI with enhanced mandatory surveillance completed for any healthcare-associated Gram-negative BSI.

NHS Improvement has recognised that approximately three-quarters of *E. coli* BSIs occur before people are admitted to hospital but the sample will be taken by the hospital. Therefore the CCG IP&C lead and the Infection Prevention and Control (IPC) team at NNUH have worked together to develop a joint improvement plan. Review and evaluation of the healthcare-associated Gram-negative BSI will determine common themes that could help prioritise areas for action. Progress to achieve these priorities will be monitored and measured jointly with the CCG.

Trust Gram-negative bacteraemia figures are published monthly by PHE. NNUH Gram-negative bacteraemia figures will be reported to the Board via the Integrated Performance Report (IPR).

2. Carbapenemase-producing Enterobacteriaceae (CPE)
PHE published an acute trust toolkit for the early detection, management and control of carbapenemase-producing Enterobacteriaceae (CPE) in 2013. This provides practical advice for the management of colonisation or infection and provides risk assessment tools. In February 2014 PHE requested that this should be embedded into clinical practice within Trusts. In 2016 PHE published details of the enhanced surveillance system for CPE.

How progress will be achieved, monitored and measured
The NNUH will collect and review surveillance data for CPE positive cases and complete enhanced surveillance for any new cases of CPE identified.
A risk assessment tool is in place to be undertaken at patient admission. This identifies patients previously colonised or infected with CPE, those who have been a contact of a person with CPE, or have been admitted to a hospital abroad or in UK hospital with known high prevalence of CPE within the last 12 months. Those identified as “at risk” are screened and cared for in accordance with PHE guidance. The NNUH will continue to embed the risk assessment process into clinical practice.

There are currently no objectives for CPE. The enhanced surveillance form for any new cases of CPE identified will get completed and the data for England is published by PHE it is not Trust specific. CPE figures will be reported to the Board via the Integrated Performance Report (IPR).

Care and Patient Experience – No change: Improved continuity of care and experience through reduced ward moves and reduced numbers of outliers

Why is this a priority for 2018/19?
Important to retain focus on this priority in the light of continuing high bed occupancy and flow challenges

How progress will be achieved, monitored and measured

- Number of ward moves tracked by PAS (same measures as last year)
- Clinical Utilisation Review

Care and Patient Experience – Change: Improved discharge processes and communication

Why is this a priority for 2018/19?

Timely and accurate communication of discharge and out-patient letters is a specifically contracted requirement and an important duty of professionals.

How progress will be achieved, monitored and measured

Increased Trust communication to emphasise Electronic Discharge Letters as at present but updated to include Outpatient letters according to required electronic format.

Care and Patient Experience – New Priority: To improve our care to those at the end of their life

Why is this a priority for 2018/19?

Recent inspections and external scrutiny have rightly focused upon Mental Capacity Assessment particularly in relation to DNA CPR decisions. End of Life care is a specific CQC inspection field. NNUH has invested in end of life care with increased provision in the last 4 months.

How progress will be achieved, monitored and measured

- DNACPR compliance
- Number of Individualised care plans in place
- Specialist palliative care coding rates
- Quarterly Local End of Life (EoL) care audit
- National EoL care audit

Care and Patient Experience – New Priority: To improve the assessment and quality of care for patients in Mental Health crisis

Why is this a priority for 2018/19?

Increased national and local focus on mental health and during recent CQC inspection in ED and the expansion of the core 24 liaison service from NFST should mean that measuring the quality of this provision is a priority

How progress will be achieved, monitored and measured

- Number of referrals to Psychiatric liaison from:
  - ED/ assessment areas (where)
  - Wards (and where).
  - Waiting time from referral to assessment
  - standard 1hr ED, 4hrs
  - assessment areas including EAUS
  - 24hrs response for wards
- Staff training – numbers trained in year and outcome of training, confidence and competence of staff measured by outcome tool to capture baseline knowledge and confidence post training perception and focussed follow up questionnaire 6mths post training.

Progress against our 2017/18 priorities

Table 2 describes the Trusts high level assessment of achievement against the 2017/18 priorities set within the 2016/17 Quality Report. Following this there is a more in depth review of each category.

	Priority	Measure	Goal	Rating
Patient Safety	Reduction in medication errors	Number of insulin errors causing National Patient Safety Agency (NPSA) category moderate harm or above	Zero errors with harm	
	Prompt recognition / treatment of sepsis	% of patients screened, and % of patients treated for sepsis	CQUIN criteria	
	Keeping patients safe from hospital acquired thrombosis	Percentage compliance with TRA assessment as evidenced on EPMA.	95%	
	Incident reporting and management	Position in relation to all acute trusts for incident reporting on NLRS. Percentage compliance with Duty of Candour	Top quartile for incident reporting. 100% compliance Duty of Candour.	
Clinical Effectiveness	Keeping patients safe from infection	No. of hospital attributable C Diff cases Number of hospital acquired MRSA bacteraemias	Below trajectory target for C Diff. Zero MRSA bacteraemia	
	Improve quality of care through research	Numbers of patients recruited into NIHR studies	3,300 recruitment into NIHR studies	
	Timely medical review of all patients	SAFER criteria for patient review: **Senior review** - every patient should be reviewed by a doctor every day. All new and unstable patients and all patients for potential discharge should be reviewed by an ST3 or above. **Review** – there will be a weekly systematic review of patients with extended lengths of stay (>14days) to identify the actions required to facilitate discharge.	100% patients have recorded senior review daily on board round Less than 200 patients with length of stay over 14 days	
Patient Experience	Patients are happy with the experience they receive during their care and treatment	Percentage of patients in all areas report through FFT that they extremely likely or likely to recommend our services to their friends and family	95% or more	

	Priority	Measure	Goal	Rating
	Improved continuity of care and experience through reduced ward moves and reduced numbers of outliers	Number of patients recorded on WardView as boarders. Monthly average report	No more than 20	
	Improved discharge processes	Estimated Date of Discharge (EDD) recorded within 24 hours of admission on WardView – SAFER criteria EDL to be completed within 24 hours of discharge	100% compliance 95% compliance	

Rating Key

Red – Quality priority not achieved

Amber – Quality priority partially / mostly achieved or significant improvement achieved

Green – Quality priority achieved

Patient Safety – Reduction in Medication Errors

What was our aim?

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

How did we measure our performance?

Review of all reported incidents involving insulin every month undertaken by the medication incident group with a subsequent report to the Clinical Safety Sub Board, governance Leads and Dr Jeremey Turner Service Director for Endocrinology.

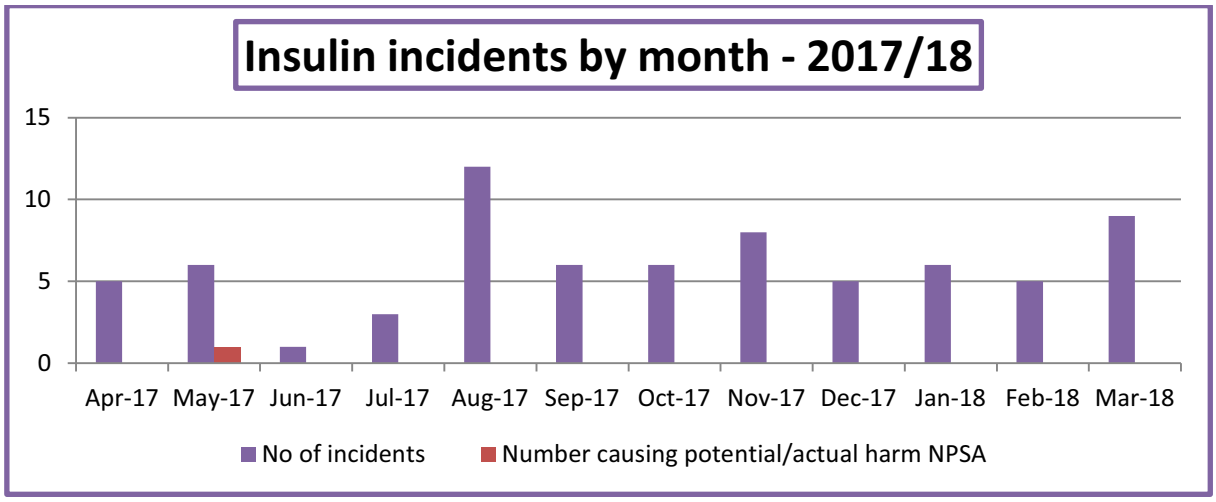
How did we do?

At the end of 2017/18 there had been one insulin error (moderate harm) in these NSPA categories (1 incident of moderate harm in 2016/17). The learning from the case review was the need to identify from the Electronic Prescribing and Medicines Administration system EPMA those patients prescribed high doses of insulin as soon as possible, with rapid verification of the prescription by a pharmacist. This has been achieved by commissioning a specific report from the EPMA system highlighting patients on high dose insulin to ward pharmacists on a daily basis, ensuring that all prescriptions are verified, or discontinued if a prescribing error has occurred within 24 hours.

Other initiatives aimed at the reduction of incidents involving insulin include:

- An audit of insulin prescribing assessing local performance against known local and national incidents.
- Foundation Year 1 and 2 doctor insulin prescribing session delivered as part of the prescribing education series.
- A focus group for foundation year 1 and 2 doctors to understand the barriers and issues surrounding the prescribing of insulin effectively.
- A business case approved for increased staff resources to better support in-patients who are prescribed insulin.
- A variable rate intravenous insulin quick reference guide written for the management of surgical patients, which will be an additional educational resource available to all Trust staff. This is currently being progressed through the Trust approval processes.

Figure 1 - Insulin incidents by month



Source: NNUH data, national definition used

Patient Safety - Prompt recognition and treatment of sepsis

What was our aim?

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

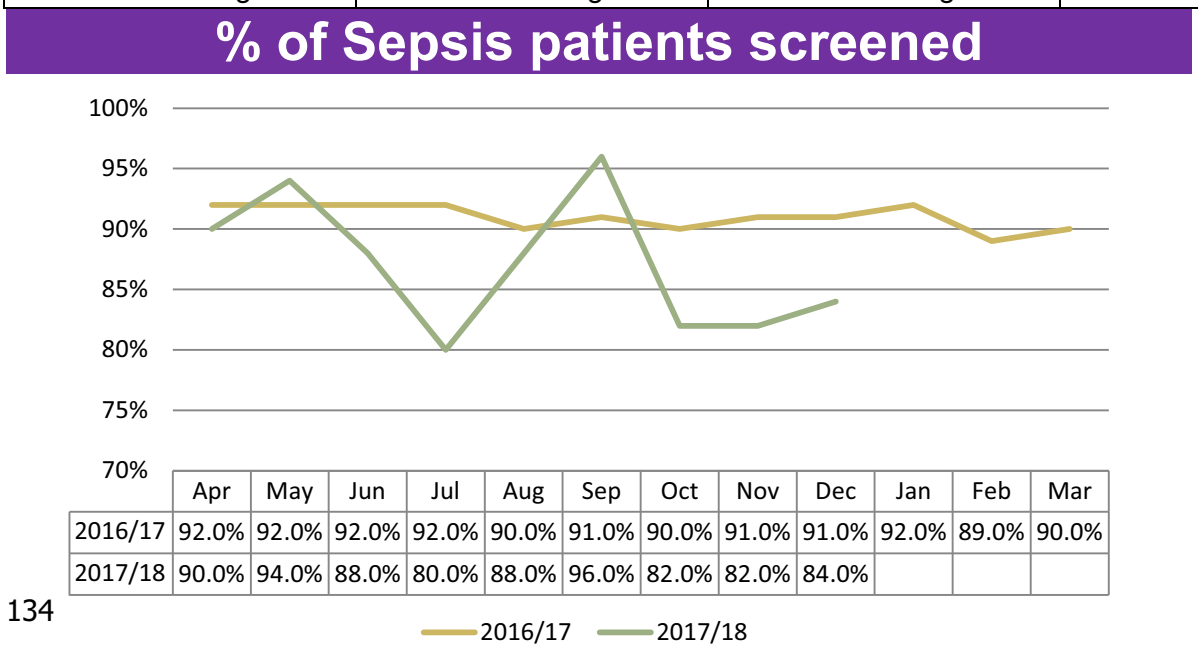
How did we measure our performance?

Trust performance during 2017-18 was measured using national Commissioning for Quality and Innovation (CQUIN) stipulated Key Performance Indicator (KPI) criteria

How did we do?

The percentage of patients who met the criteria for sepsis screening and were screened for sepsis. This indicator applies to adults and child patients arriving in hospital as emergency admissions and to all patients on acute in-patient wards. The threshold for top compliance (payment) within the CQUIN is 90% average per quarter.

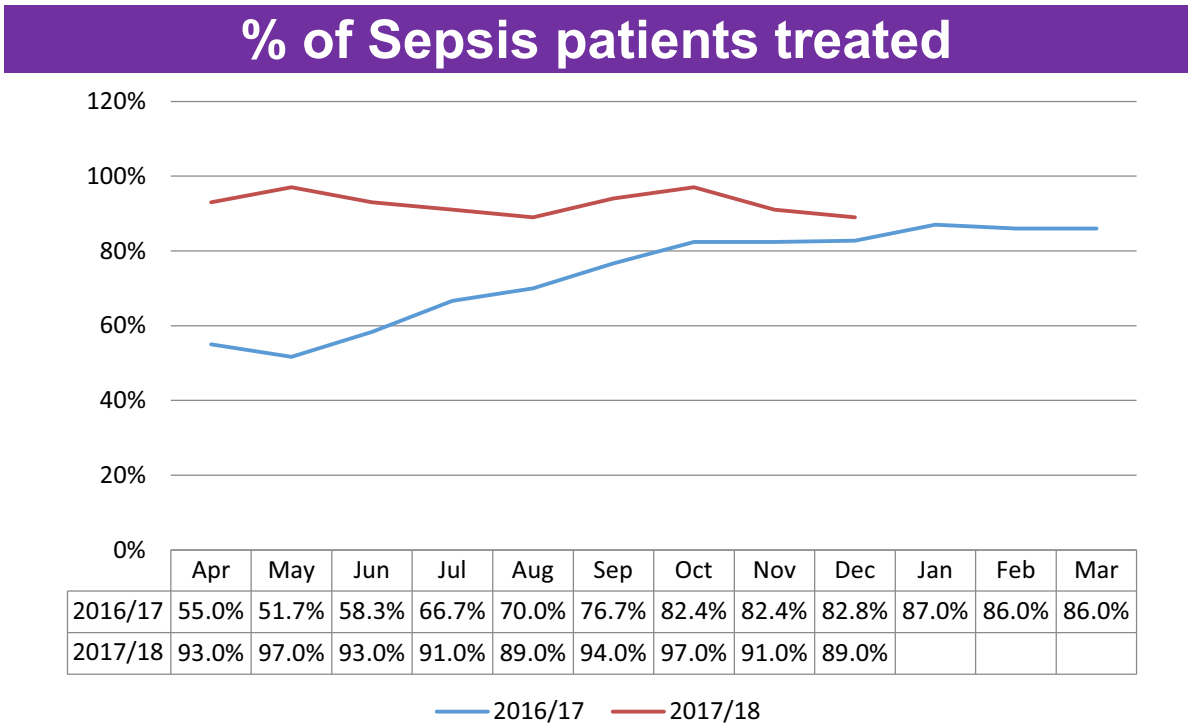
Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
90%	94%	88%	90%	94%	88%	82%	82%	84%	Data not yet available		
91% Average			91% Average			83% Average					



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	92.0%	92.0%	92.0%	92.0%	90.0%	91.0%	90.0%	91.0%	91.0%	92.0%	89.0%	90.0%
2017/18	90.0%	94.0%	88.0%	80.0%	88.0%	96.0%	82.0%	82.0%	84.0%			

The percentage of patients who were found to have sepsis and received IV antibiotics within 1 hour of diagnosis. The indicator applies to adults and child patients arriving in hospital as emergency admissions and to all patients on acute in-patient wards. The threshold for top compliance (payment) within the CQUIN is 90% average per quarter.

Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
93%	97%	93%	93%	97%	93%	97%	91%	88%	Data not yet available		
94% Average			94% Average			92% Average					



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	55.0%	51.7%	58.3%	66.7%	70.0%	76.7%	82.4%	82.4%	82.8%	87.0%	86.0%	86.0%
2017/18	93.0%	97.0%	93.0%	91.0%	89.0%	94.0%	97.0%	91.0%	89.0%			

The percentage of antibiotic prescriptions documented and reviewed by a competent clinician (E.g. Infection control senior doctor; Infection control pharmacist; or a senior member of the clinical team) within 72 hours. The threshold for top compliance (payment) within the CQUIN is 90% average per quarter.

Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
77%	83%	90%	77%	83%	90%	93%	97%	87%	Data not yet available		
83% Average			83% Average			92% Average					

Some of the actions that have helped us to achieve performance:

- The Sepsis lead consultant has worked with the Symphony Emergency Department IT system administrator to develop an electronic sepsis screening tool that will be automatically triggered when a patient attends with an elevated Early Warning Score. This process went live in July 2017 and has improved Emergency Admissions Sepsis Screening through the Emergency Department to near 100%. It has also reduced the auditing burden significantly from a by hand paper based search to an electronic report that can be generated much more rapidly.
- The Sepsis Lead consultant has delivered Sepsis Training Sessions to new medical staff and on the local FY1 and FY2 teaching program to further improve the awareness and utilisation of the '2222 Inpatient Emergency Sepsis Pathway'.
- The Critical Care Outreach Team (CCOT) and Hospital at Night team (H@N) are working with the Sepsis Lead to improve utilisation of the Inpatient Sepsis

Screening Tool by requesting the inpatient ward nursing staff to use the tool as a necessary component of a referral to both the CCOT and H&N teams.

- A new obstetric sepsis screening pathway unified with the other sepsis pathways across the Trust has been introduced in July.
- A Sepsis Lead Nurse has been seconded to help develop sepsis care, improve pathways and deliver ward level sepsis education.
- The Sepsis Lead consultant has delivered Sepsis Training Sessions to Emergency Department medical staff from the eastern region, presented a sepsis update at the Eastern Region Anaesthesia Conference and has attended the inaugural Regional Sepsis meeting where the Sepsis Leads from most Trusts in the Eastern region have met to discuss practice and disseminate learning from across the area. This group have agreed to meet quarterly with an aim to standardise some sepsis pathways and processes across hospitals in the region.
- The Sepsis Lead clinician has visited Nottingham University Hospitals NHS Foundation Trust with the E-Observations Working Group (which he leads) to evaluate the Nerve-Centre E-Obs system. This system incorporates Automated Sepsis Screening and Alerting and has the potential to revolutionise the care of sick and deteriorating patients across the NNUH. A business case is being prepared to support the introduction of an E-observation system at the NNUH.
- Reliable Inpatient screening for sepsis has remained a challenge as sepsis is much less common on inpatient wards compared with admission areas and reducing the variation in practice across over 25 wards has proven difficult. The Sepsis Lead Nurse and Lead Consultant are developing a revised inpatient sepsis screening pathway whereby the sepsis screening tool is incorporated into the standard ward observation chart rather than on a separate sticker. It is intended that this will remind ward nursing staff of the sepsis screening pathway whenever they take a set of observations and the screening tool for sepsis will be on the patient observation charts making it easier for them to be completed.

Patient Safety - Keeping patients safe from hospital acquired thrombosis

What was our aim?

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

How did we measure our performance?

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

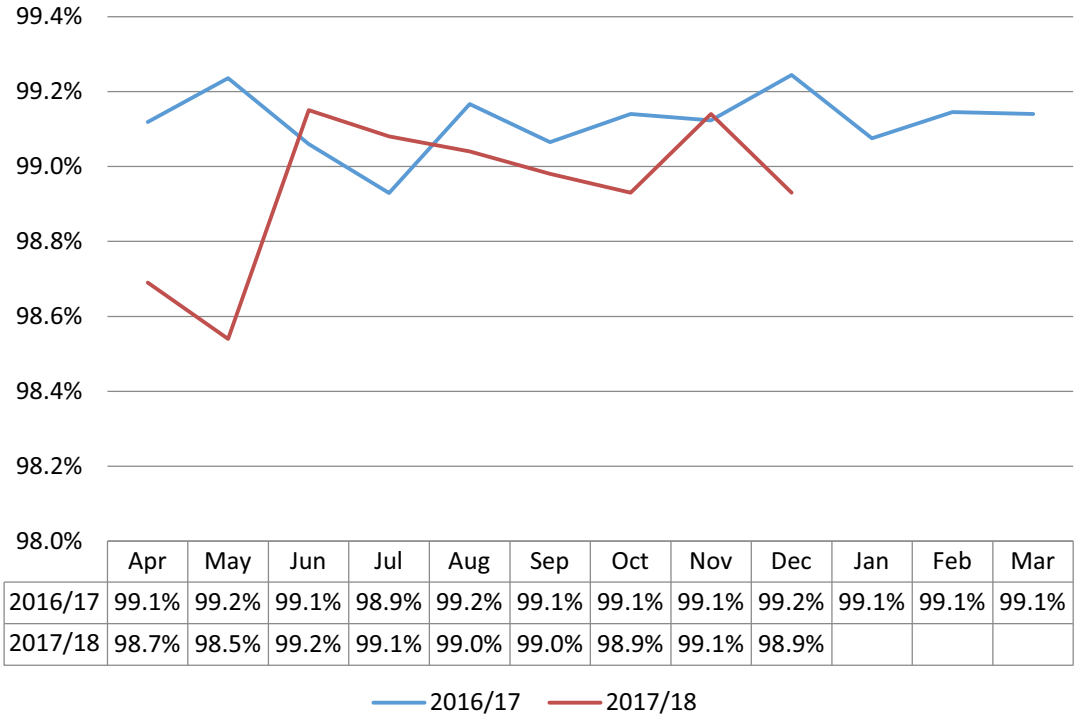
RCAs are carried out by the VTE Team on all Hospital Acquired Thrombosis (HATs) that are reported on Datix. The HATS are all initially classified as ‘moderate’ on Datix and then downgraded if appropriate following the RCA. The RCA target for HATs is 100%.

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

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

How did we do?

% compliance with TRA assessment as evidenced on EPMA



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	99.1%	99.2%	99.1%	98.9%	99.2%	99.1%	99.1%	99.1%	99.2%	99.1%	99.1%	99.1%
2017/18	98.7%	98.5%	99.2%	99.1%	99.0%	99.0%	98.9%	99.1%	98.9%			

Ward-level VTE Screening Compliance
TRA compliance report for 2017/18

Division	Total Not Complete	Total Eligible	Compliance
Women & Children Division	736	14401	94.89%
Surgical Division	902	35377	97.45%
Not recorded	29	21397	99.86%
Medical Division	3	112215	100.0%
Clinical Support Services Division	0	35	100.0%

Year	Month	Screening Not Complete	Total Eligible Population	Compliance
2017	April	131	15167	99.136%
	May	126	16792	99.250%
	June	141	16547	99.148%
	July	149	16393	99.091%
	August	158	16474	99.041%
	September	165	16144	98.978%
	October	177	16501	98.927%
	November	143	16689	99.143%
	December	169	15723	98.925%
2018	January	156	16505	99.055%
	February	174	14689	98.815%
	March	13	5801	99.776%

Patient Safety - Incident reporting and management

What was our aim?

To remain within the top quartile of acute trusts for incident reporting on NRLS and to achieve 100% Duty of Candour compliance.

How did we measure our performance?

All patient incidents, regardless of their severity, are recorded on DATIX and are submitted quarterly to the National Reporting and Learning System (NRLS).

The Risk and Patient Safety Team maintain a Duty of Candour Compliance database which tracks compliance regarding Duty of Candour across the Trust. Duty of Candour is a Health and Social Care Act (2008) regulation that ensures that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

All Moderate Harm or above severity incidents which are reported an Datix are verified with the Consultant / clinical lead and a Duty of Candour 'Compliance Statement' is completed to confirm that all actions have been taken and documented in the patient notes. In addition, the team requests confirmation that a letter has been provided confirming the details of the Duty of Candour conversation, and that a copy of this letter is kept within the patient's medical records.

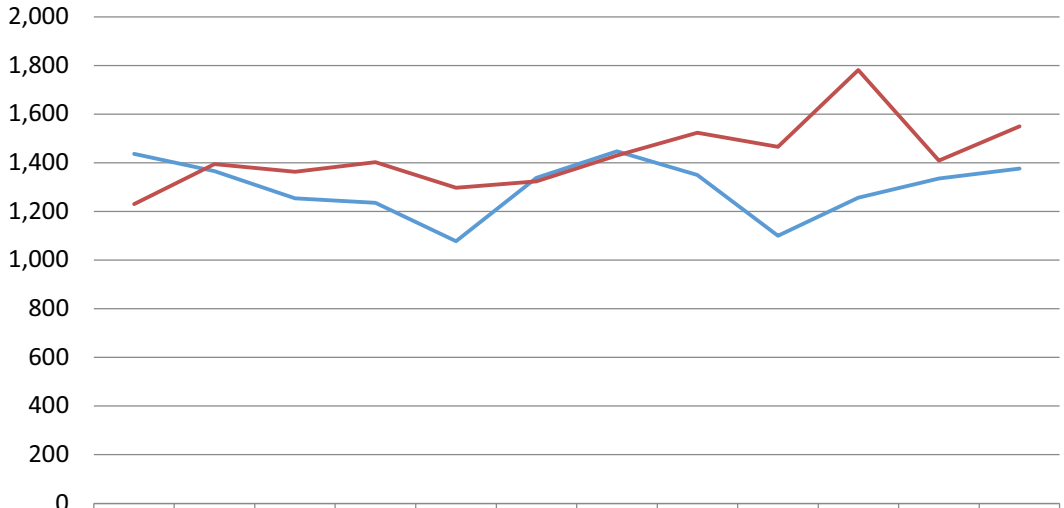
Compliance with the Duty of Candour process is audited and reported on the IPR and in the Clinical Safety & Effectiveness Sub-Board Report every month. Any predicted breaches (these may be on compassionate grounds) in meeting Duty of Candour are reported to the CCG by the Medical Director. From April 2017 to the date of this report there were five such occasions that were reported.

How did we do?

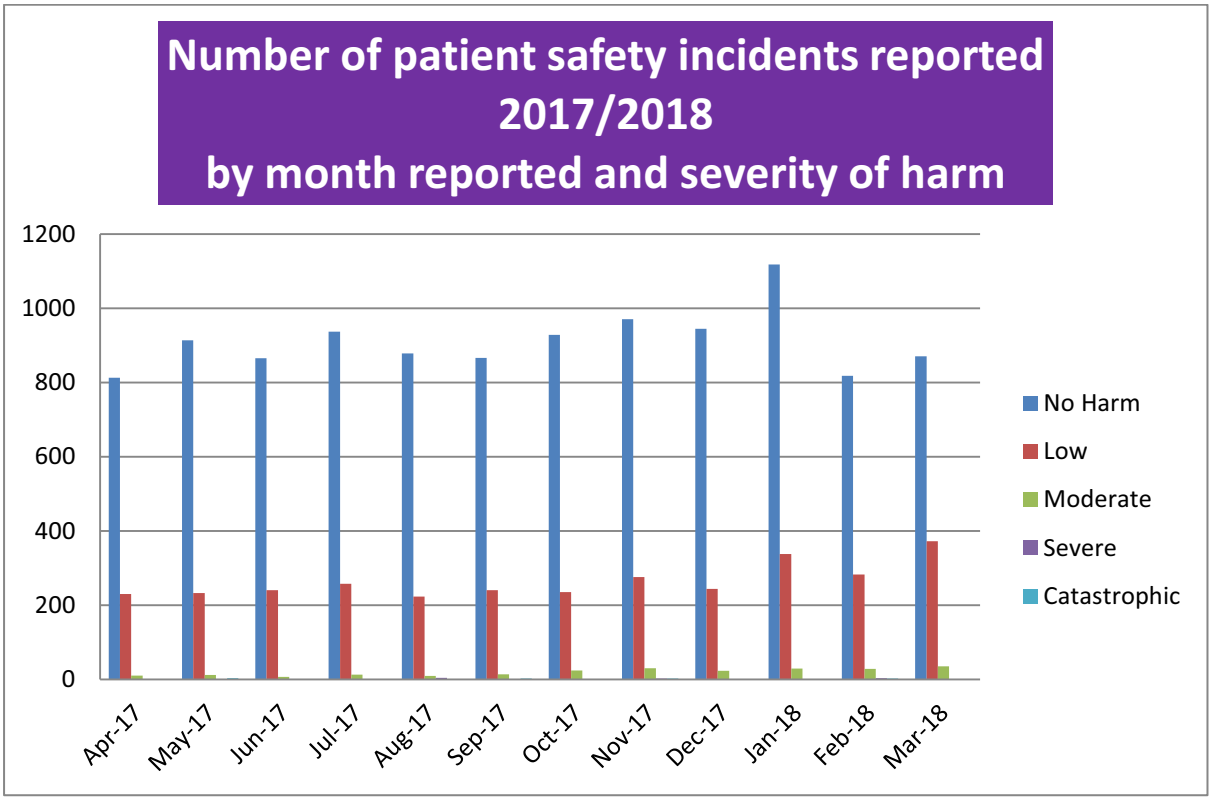
In the twelve months ending 31st March 2018, **14,356 incidents** were recorded on DATIX. Of these, **14,096 (98.19%)** caused either no harm or low harm to patients. In 2016/17 there were 14,469 reported incidents, of which 14,309 (98.89%) caused no harm or low harm. This indicates that the percentage of no/low harm events is reasonably static, although overall the number of reported incidents has marginally reduced during 2017/18.

Our most recently published incident reporting rate is 42.14 incidents per 1,000 bed days (for incidents reported to NRLS between 1st October 2016 and 31st March 2017). When comparing this figure against 136 other Acute (non- specialist) organisations within our cluster, the median reporting rate for the cluster is 40.14 incidents per 1,000 bed days and the NNUH is ranked at 57th out of 136.

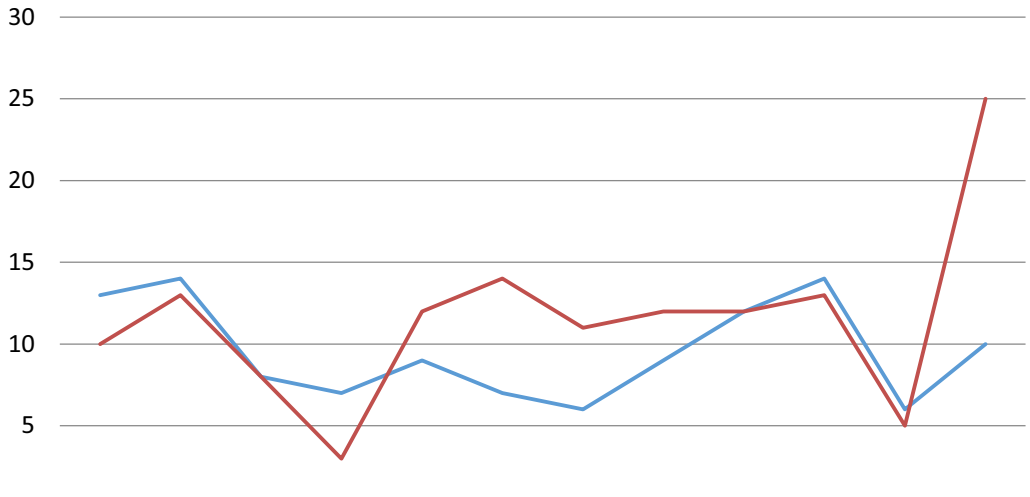
Incident Reporting



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	1437	1366	1254	1235	1077	1338	1447	1350	1100	1256	1336	1376
2017/18	1230	1395	1363	1403	1297	1324	1430	1523	1466	1781	1409	1550



Serious Incidents



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	13	14	8	7	9	7	6	9	12	14	6	10
2017/18	10	13	8	3	12	14	11	12	12	13	5	25

All incidents reported provide an opportunity for learning and continuous improvement in care delivery. As such the Trust supports a culture of reporting and in Quarter 4 of 2017/18 governance structures within Divisions were strengthened providing greater oversight of incidents. This is reflected in the number of incidents declared in March, although it should be noted that four of these occurred in February but were unable to be recorded in the National reporting system as it was being transferred to another platform.

As in previous years, pressure ulcers *(PUs)* and falls have together accounted for the majority of the recorded *Serious Incidents* (SI) during the period covered by this report. In respect of *PUs,* the figure only includes hospital-acquired tissue damage that following specialist peer review is concluded as avoidable harm. Hospital-acquired *PUs* are monitored closely to identify trends by ward and department and to highlight opportunities for improvements in clinical care. Full *RCA* is carried out on all Grade 2 and 3 hospital-acquired PU cases, with the learning outcomes shared with the clinical teams. SI figures are reported monthly to the Trust Board via the Clinical Safety and Effectiveness Sub-Board, and learning points are disseminated.

Clinical Effectiveness - Keeping patients safe from infection

What was our aim?

Clostridium difficile within trajectory target, 0 cases of Hospital Acquired MRSA bacteraemia

How did we measure our performance?

It has been mandatory for NHS acute Trusts to report all cases of *Methicillin-resistant Staphylococcus aureus* (MRSA) bacteraemia since April 2004. Surveillance of *Clostridium difficile* (*C. difficile*) infection (CDI) was originally introduced in 2004 for patients aged 65 years and over. From April 2007 this was then extended to include all cases in patients aged 2 years and over.

Public Health England uses the surveillance data to produce spreadsheets and graphs that we used to measure our performance against other acute Trusts.

Internally the Infection Prevention and Control (IP&C) monthly report continued to be distributed with surveillance and alert organism graphs and tables data updated monthly. Local *C. difficile* and MRSA data by ward is available to staff on the IP&C dashboard as part of on-going surveillance.

The clinical teams from the hospital and an IP&C nurse from the clinical Commissioning Group (CCG) jointly review every case of hospital-acquired case *C. difficile*. The post-infection review process establishes whether there have been any lapses in care that can be learnt from. Learning was shared throughout the Trust via the monthly IP&C organisational wide learning [OWL].

How did we do?

Our 2017-18 *C. difficile* objective remained the same as the previous year to stay below 49 hospital acquired cases. The objective was achieved and there was an improvement on the 2016/17 figures with a total of **35** *C. difficile* cases deemed to be hospital acquired. We successfully appealed **24** cases resulting in a final total for the year of **11**.

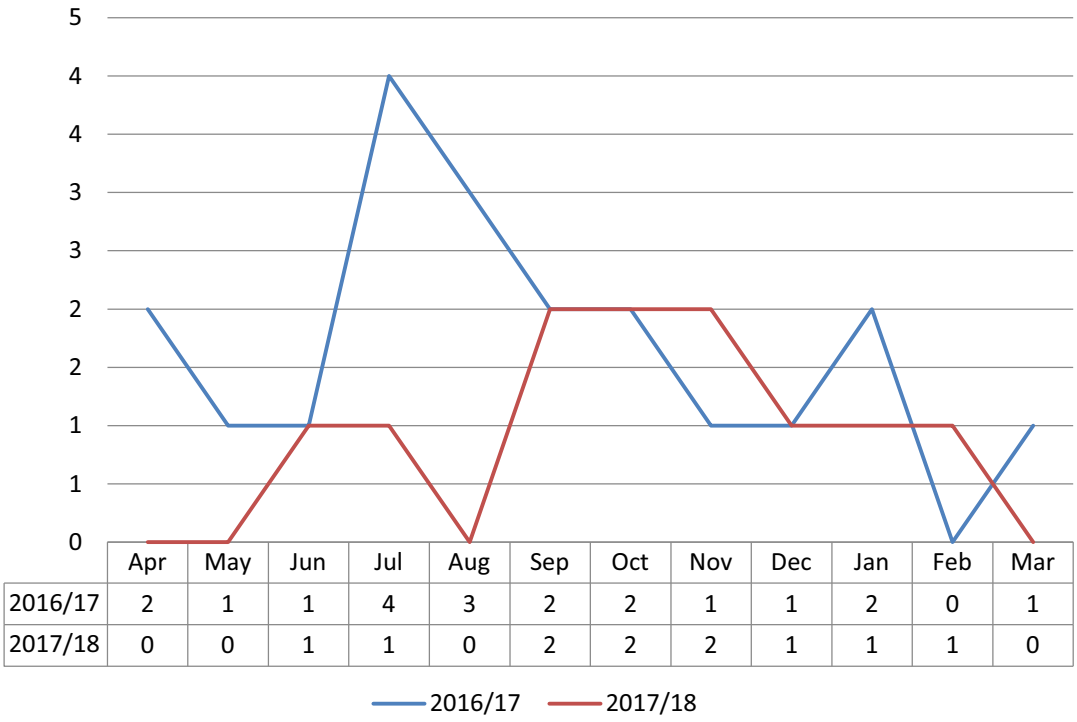
C. difficile Performance

Summary Table		Non-Trajectory	Trajectory	Pending	Total
Quarter	4	5	2	0	7
	3	5	5	0	10
	2	6	3	0	9
	1	8	1	0	9
April 17 to March 18		24	11	0	35
April 16 to March 17		*22*	*20*	*0*	*42*

Source: NNUH data, national definition used

The Trust 2017-18 MRSA bacteraemia (blood stream infections) objective was zero hospital acquired cases and again the objective was achieved with 0 hospital attributable MRSA blood stream infections.

HAI C. difficile Cases (excluding non-trajectory and pending cases)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	2	1	1	4	3	2	2	1	1	2	0	1
2017/18	0	0	1	1	0	2	2	2	1	1	1	0

NNUH is first hospital in region to offer new option for pain relief in labour

The Norfolk and Norwich University Hospital will be the first in the region to offer a new choice of pain relief for women in labour.

Remifentanil is a potent, very short-acting drug which can be used as an alternative to Pethidine. With Remifentanil Patient Controlled Analgesia (PCA) women in labour can control when and how much pain relief they receive, by pressing a button. The button is connected to a specifically designed pump which will deliver a small dose of pain relief. Unlike Pethidine, Remifentanil does not accumulate in mother or baby and breastfeeding is not affected.

Remifentanil PCA will be available to women giving birth within the hospital's Delivery Suite.

The hospital took part in the national RESPITE trial between December 2014 and September 2016, recruiting 16 patients to participate. The trial sought to investigate the proportion of women, who having had either Remifentanil PCA or Pethidine during their labour, went on to require an epidural.

This research was published last month and showed that 50% less people who have Remifentanil go on to have an epidural than those who have had Pethidine. There was also a significant reduction in the number of women who needed an instrumental delivery (Forceps or Ventouse). Research has shown that pain scores are lower and maternal satisfaction is higher with Remifentanil when compared with Pethidine.

Clinical Effectiveness - Improve quality of care through research

What was our aim?

Year on year increase in patients recruited into research studies. Aim to achieve 3300 recruitment into NIHR studies in 2017-18.

How did we measure our performance?

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

How did we do?

During 2017/18, our total recruitment was 3,228 compared against 2016/17 recruitment of 5,438.

Figure 9 shows that at the end of February we are close to achieving our stated goal of recruiting 3300 participants into NIHR studies in 2017/18.

Figure 9: Recruitment into research studies

Recruitment for 17/18	Number	Percent
Portfolio recruitment target	3300	
Total Recruitment	3228	
NIHR Portfolio	3137	97%
Non Portfolio	91	3%
Commercial Studies	165	5%
Non Commercial Studies	3063	95%

Source: NNUH data, national definition used

Participation in clinical research demonstrates our commitment to both improving the quality of care we offer to our patients and to contributing to wider health improvement. Involvement in research enables our clinicians to remain in the vanguard of the latest available treatment options, and there is strong evidence that active participation in research leads to improved patient outcomes. We have an active programme to engage health professionals and other staff in research through our research seminars and email updates on relevant research issues.

The Norfolk and Norwich University Hospitals NHS Foundation Trust was involved in conducting 335 clinical research studies (369 in 2016/17) in a wide range of medical specialities during 2017/18. 104 new studies were opened in 2017/2018 (130 in 2016/17). There were around 150 clinical staff (consultants) participating in research approved by a research ethics committee during 2017/18; supported by approximately 150 research nurses, research administrators/managers and research specialists in our support departments (e.g. Pharmacy, Radiology, Pathology).

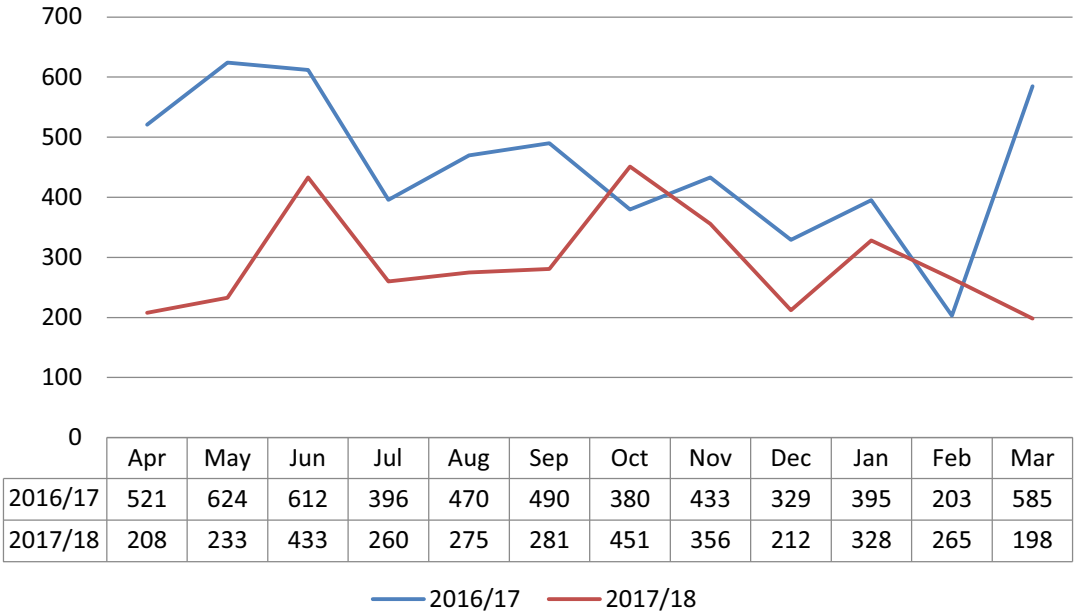
To facilitate consistent local research management, and to greatly improve performance, we participate in the National institute of Health Research (NIHR) Research Support services. We have publicly available Standard Operating Procedures (SOPs) for research.

Readers wishing to learn more about the participation of acute Trusts in clinical research and development can access the library of reports on the website of the National Institute for Health Research, at the following address: http://www.nihr.ac.uk/Pages/default.aspx and the Trust website http://www.nnuh.nhs.uk/research-and-innovation/research-outcomes-patient-benefits/

Overview of research activities

During 2017/18 building work has continued on the Quadram Institute (QI) and is due for completion later this year. QI will house a Clinical Research Facility (CRF) which is committed to becoming the leading facility for undertaking human health and nutrition research trials in the UK. The CRF will host both academic and commercial studies undertaken by researchers from across the Norwich Research Park (NRP) and beyond. There are several dedicated NHS clinical trial facilities throughout the UK, but the CRF will become the only purpose-built trials facility in Norfolk. The co-location of the CRF, endoscopy suites and research labs within QI will resolve geographical issues associated with the coordination of clinical and academic expertise and availability of human tissue. The unique stability and demographics of the Norfolk population provide additional advantages for the recruitment of study participants for long-term studies.

Patients recruited into research studies



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	521	624	612	396	470	490	380	433	329	395	203	585
2017/18	208	233	433	260	275	281	451	356	212	328	265	198

Clinical Effectiveness - Timely medical review of all patients

What was our aim?

The SAFER patient flow bundle blends five elements of best practice. It's important to implement all five together for cumulative benefits. SAFER stands for **S**enior review, **A**ll patients, **F**low, **E**arly discharge, and **R**eview; the criteria for patient review are:

Senior review - every patient should be reviewed by a doctor every day. All new and unstable patients and all patients for potential discharge should be reviewed by an ST3 (senior medical trainee) or above.

Review – there will be a weekly systematic review of patients with extended lengths of stay (>14days) to identify the actions required to facilitate discharge.

How did we measure our performance?

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

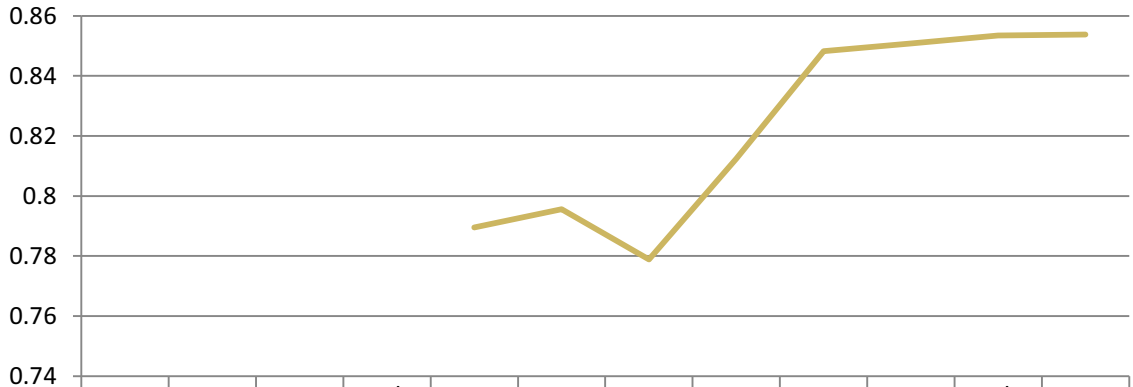
- A review by a senior decision maker (ST3 or above)
- A multidisciplinary team review (MDT) which included a senior decision maker
- A note from a junior doctor that they discussed the patient with a senior decision maker (e.g. plan d/w Dr Doe CON)
- A ward round or board round which included a senior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

How did we do?

Senior Review

Since the 2016/17 report, the Trust now has a mechanism in place to electronically record whether each patient has had a senior review every day. A report has been designed within Information Services to pull this data weekly and distribute to all Ward managers, Matrons, Divisional Nursing Directors. Red to Green and SAFER are led by a named Matron within the Improvement Team who is currently re-launching on each ward to embed process and improve compliance.

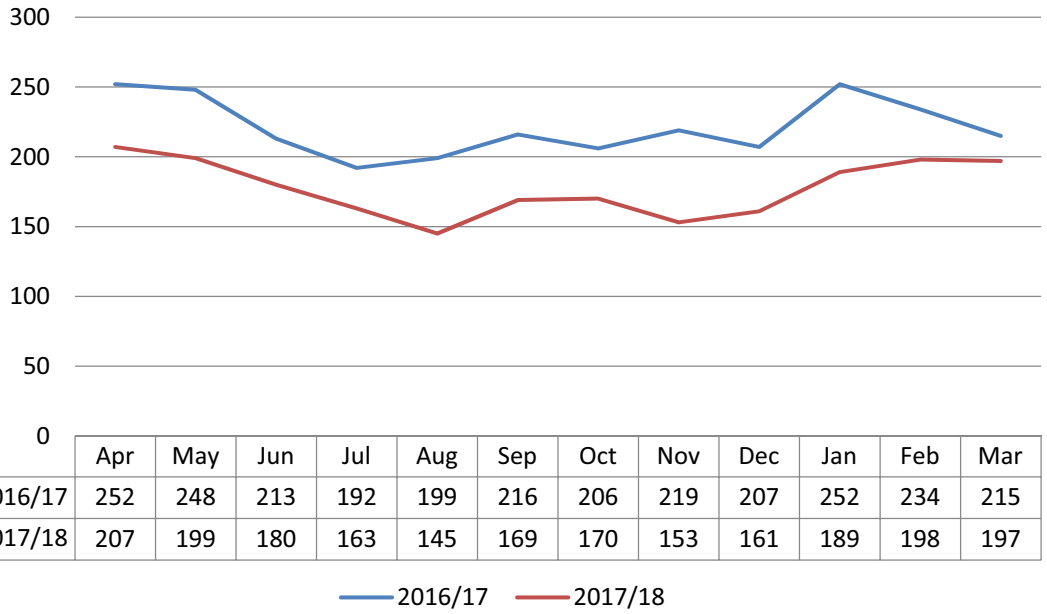
% Senior Review Complete



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18					78.9%	79.6%	77.9%	81.2%	84.8%	85.1%	85.3%	85.4%

Patients staying in Excess of 14 days

Average number of patients with LoS >14 days



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	252	248	213	192	199	216	206	219	207	252	234	215
2017/18	207	199	180	163	145	169	170	153	161	189	198	197

Patient Experience - Patients are happy with the experience they receive during their care and treatment

What was our aim?

95% or more of patients in all areas report through the Friends and Family Test that they are extremely likely or likely to recommend our services to their friends and family

How did we measure our performance?

Performance is monitored by ward through monthly performance meetings between the Director of Nursing and her senior team and the measure is reported through the Trust Integrated Performance Report. Any negative free-text comments made during the collection of Friends and Family feedback is themed, reviewed and actioned at Directorate level.

How did we do?

At the time of writing the snapshot view of February 2018 was that 2137 responses were received. January responses totalled 3392 once all final submissions were included. The overall Trust wide score remains high in February at 97%. Individually A & E - (96%), In-patients (97%), Maternity (98%) and Day Patients (97%) continue to be amongst those receiving strong positive scores. Patients were asked additional questions to assist us with the monitoring of the care on our wards. Of the 683 patients who responded when asked if they had been involved in their care, 98% responded they had been. 98.6% of patients felt they had been treated with dignity and respect. In terms of the overall year a total of 38,380 responses were recorded with 96.52% of participants saying that they would recommend the Trust, 1.46% stating that they would not, and the remaining 3.48% stating that they would neither be likely or unlikely or do not know whether they would recommend the Trust.

NNUH team carries out the first robotic colorectal cancer surgery in East Anglia

A team at the Norfolk and Norwich University Hospital (NNUH) has become the first in East Anglia to carry out robotic colorectal cancer surgery.

Last month, Consultant colorectal surgeon Irshad Shaikh led the team on the first surgery of its kind at the Trust.

The surgery was carried out in collaboration with Colorectal Surgeon Professor Amjad Parvaiz, one of the country's leading robotic surgeons.

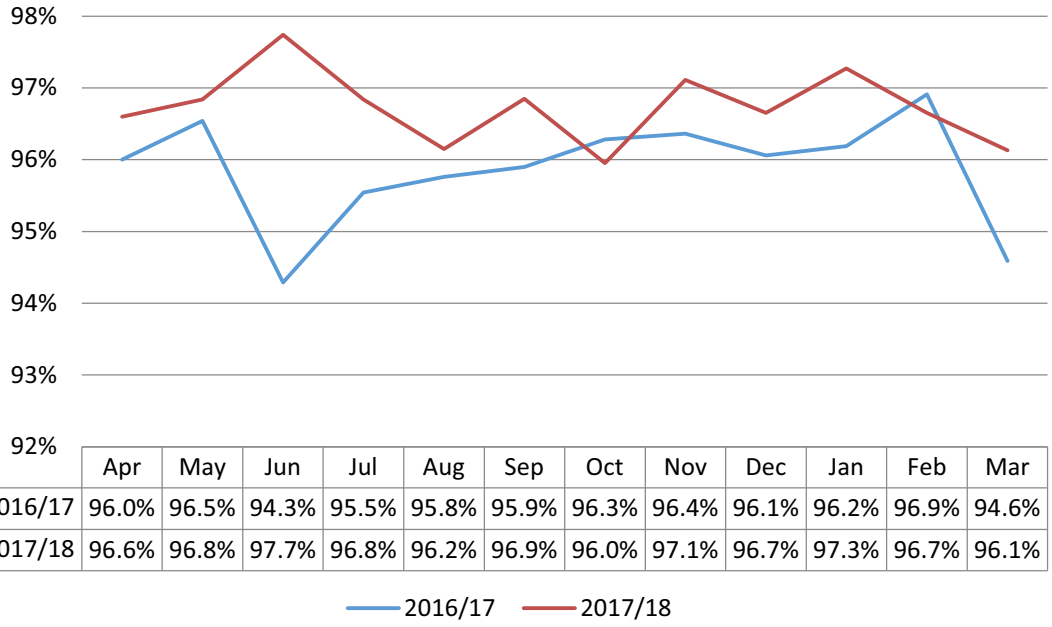
The team has carried out more than 1,100 colorectal operations over the past five years – among the highest of any Trust in the country.

Mr Shaikh said robotic surgery offered a minimal invasive approach and dissection was more precise because the method offered a three-dimensional view and full freedom of movement.

He said: "The robot was first used by the urology team at NNUH and, building on their excellent work, we now have the option of using it for colorectal cancer removal."

Surgery for such cancer removal can be carried out via a number of ways: open, where the surgeon makes a cut in the abdomen, keyhole (laparoscopic) surgery or robotic surgery which may improve functional outcomes for patients as it allows better dissection around pelvic nerves needed for bowel, bladder and sexual function.

%FFT Trust Scores



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	96.0%	96.5%	94.3%	95.5%	95.8%	95.9%	96.3%	96.4%	96.1%	96.2%	96.9%	94.6%
2017/18	96.6%	96.8%	97.7%	96.8%	96.2%	96.9%	96.0%	97.1%	96.7%	97.3%	96.7%	96.1%

Patient Experience - Improved continuity of care and experience

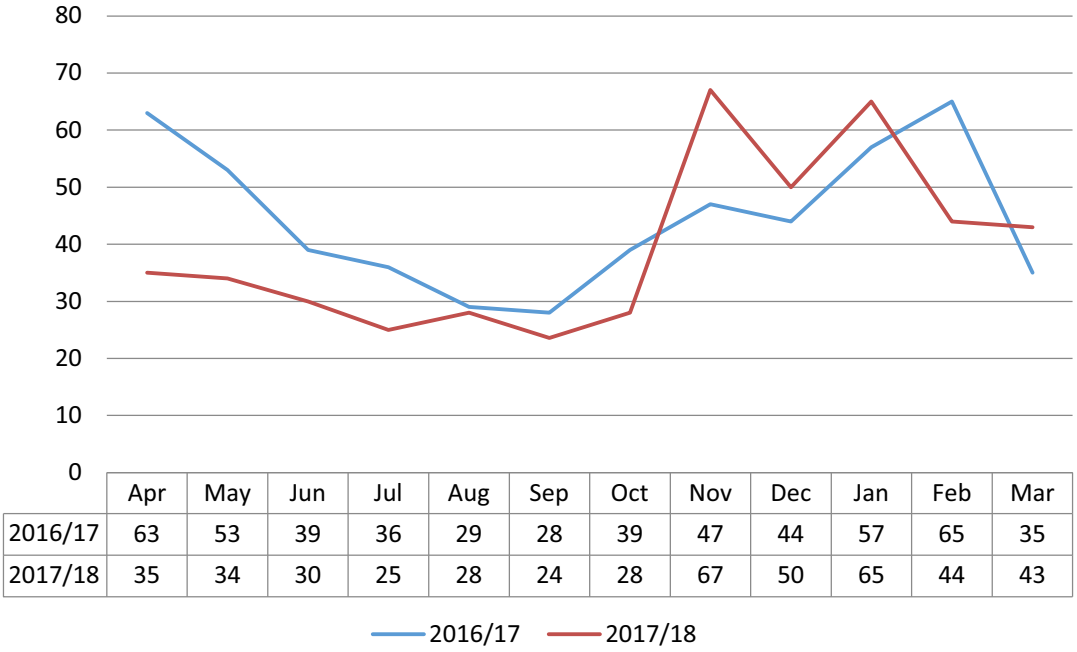
What was our aim?

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

How did we measure our performance?

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

Monthly average boarders



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	63	53	39	36	29	28	39	47	44	57	65	35
2017/18	35	34	30	25	28	24	28	67	50	65	44	43

Patient Experience - Improved discharge processes

What was our aim?

100% of Estimated Date of Discharges (EDD) recorded within 24 hours of admission on WardView – SAFER criteria;

95% Electronic Discharge Letters (EDL) to be completed within 24 hours of discharge

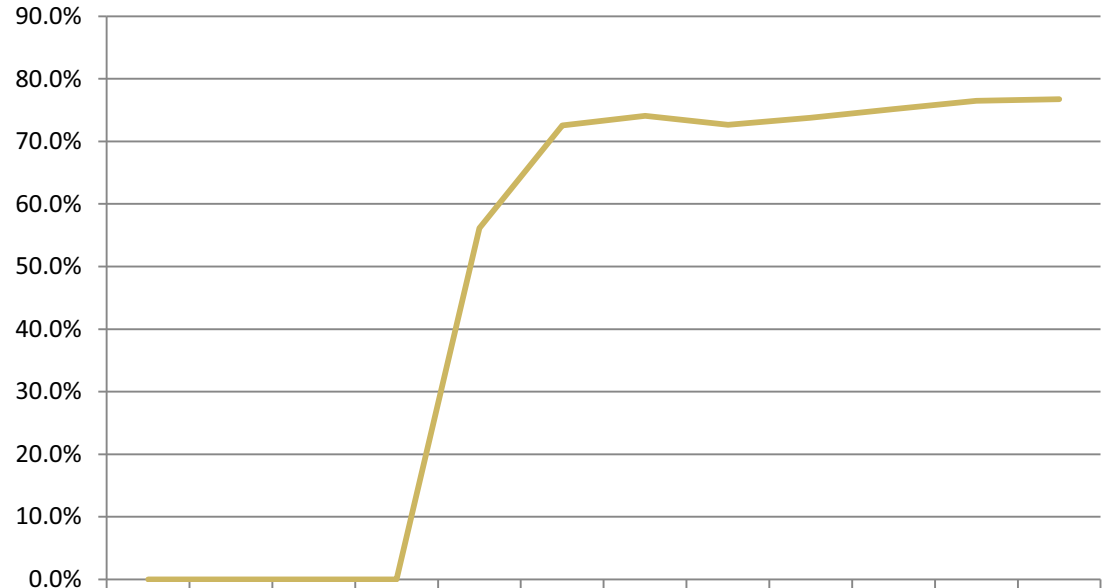
How did we measure our performance?

With regards to EDD, WardView no longer exists and has been replaced by the National Medworxx Clinical Utilisation Review (CUR) system. EDD continues to be documented on the Trusts Patient Administration Service which is then data mined by Medworxx CUR. Wards are required to record EDD's and this is enforced via Board Rounds. Reports can be pulled from CUR to demonstrate compliance of completion of EDD.

Within CUR there is also a PDD (planned date of discharge) to further improve discharge planning processes which is completed following an informed decision agreed at ward or board rounds.

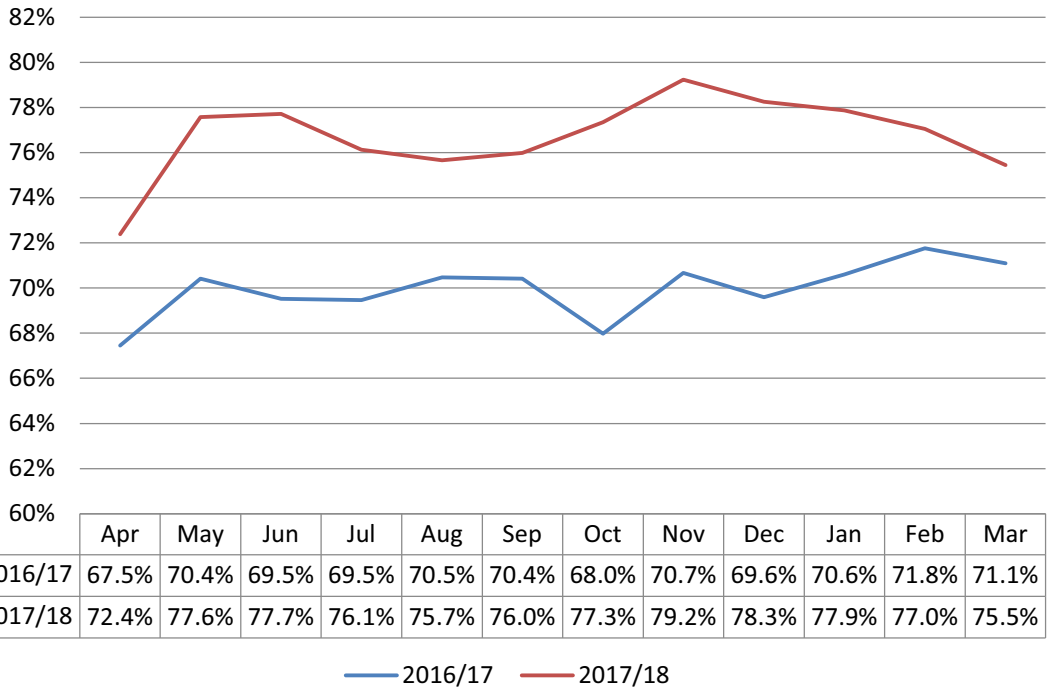
Electronic discharge summaries (EDL) must be sent by either secure email or direct electronic transmission. This generates a time stamped record from which performance is recorded and monitored via the relevant hospital Divisional management process.

% EDD Reviewed



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	0.0%	0.0%	0.0%	0.0%	56.1%	72.6%	74.1%	72.6%	73.8%	75.2%	76.5%	76.7%

% EDL to be completed within 24 hours in 95% of discharges



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	67.5%	70.4%	69.5%	69.5%	70.5%	70.4%	68.0%	70.7%	69.6%	70.6%	71.8%	71.1%
2017/18	72.4%	77.6%	77.7%	76.1%	75.7%	76.0%	77.3%	79.2%	78.3%	77.9%	77.0%	75.5%

Expansion plan announced for Cromer Hospital

Cromer & District Hospital is due to be expanded as part of the future plans by the Norfolk and Norwich University Hospitals NHS Foundation Trust which runs the hospital. NNUH has agreed to redevelop one of the original buildings on the Cromer & District Hospital site and bring it up to modern standards.

Part of this building has been modernised already and contains the renal dialysis unit. An existing building on the hospital site will be redeveloped to create the new medical unit which will provide services such as chemotherapy, blood transfusion and rheumatology treatments. It will also free up space in the main Cromer Hospital building to deliver surgical treatments in dermatology, urology, vascular surgery and pain management.

Due to the previous generosity of local individuals and the community we are able to use our existing charitable funds to fund much of the scheme. The NHS pays for the staffing and running costs of Cromer & District Hospital and this will include the new unit. A new fundraising campaign will be launched later in the year to help achieve the full amount required for the building and the equipment.

An exhibition event for the public is being held on Wednesday 25th October, from 4pm to 8pm, at Cromer & District Hospital, where people will be able to find out more about the plans and get involved.

Simon Hackwell, Director of Strategy at NNUH, said: “We will be redeveloping one of the original buildings on the site, bringing it up to modern standards and using it for medical treatments. This will benefit local people who can be treated without travelling to Norwich”.

Iain Young, Operational Manager for Cromer & District Hospital, said: “We are delighted to be in a position to offer more services to patients in North Norfolk and further afield. Cromer & District Hospital offers a high quality service in a modern setting.”

Board Assurance Statements

Review of services

During 2017/18 the Norfolk and Norwich University Hospitals NHS Foundation Trust provided and/or sub-contracted 79 relevant health services.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 79 of these relevant health services.

The income generated by the relevant health services reviewed in 2017/18 represents 83.8% of the total income generated from the provision of relevant health services by the Norfolk and Norwich University Hospitals NHS Foundation Trust for 2017/18.

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

During 2017/18 49 national clinical audits and 4 national confidential enquiries covered relevant health services that the Norfolk and Norwich University Hospitals NHS Foundation Trust provides.

During that period Norfolk and Norwich University Hospitals NHS Foundation Trust participated in 100% national clinical audits and 100% 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 the Norfolk and Norwich University Hospitals NHS Foundation Trust was eligible to participate in during 2017/18 are as follows:

Key		
National Clinical Audit	National Confidential Enquiry	Not applicable to NNUH

National Clinical Audit (alphabetical order)	Eligible y/n	Took part y/n	Participation Rate Cases Submitted	Completed/ In-progress/ Ongoing
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Y	Y	849/948 (89%)	Ongoing
Adult Cardiac Surgery	N	N/A		
Adult Community Acquired Pneumonia	Y	N/A	Audit listed in Quality Accounts but did not take place in 2017/18	n/a
BAUS Urology Audits: Cystectomy	Y	Y	Figures not available until June 2018	Ongoing
BAUS Urology Audits: Nephrectomy	Y	Y	Figures not available until June 2018	Ongoing

BAUS Urology Audits: Percutaneous nephrolithotomy	Y	Y	Figures for 17/18 not available but will be 100%	Ongoing
BAUS Urology Audits: Radical prostatectomy	Y	Y	Figures for 17/18 not available but will be 100%	Ongoing
BAUS Urology Audits: Urethroplasty	Y	Y	Figures for 17/18 not yet available	Ongoing
BAUS Urology Audits: Female stress urinary incontinence	Y	Y	Figures for 17/18 not yet available	Ongoing
Bowel Cancer (NBOCAP)	Y	Y	533/533 (100%)	Ongoing
Cardiac Rhythm Management (CRM)	Y	Y	Electrophysiology (EP) 164/164 (100%) Pacemakers 1073/1073 (100%)	Ongoing
Case Mix Programme (CMP)	Y	Y	445 (01/04/2017-01/06/2017) No further figures or percentage available from Clinicians	Ongoing
Child Health Clinical Outcome Review Programme	Y	Y	Young People's Mental Health, Clinical Forms 1/5 (20%) Clinical Notes 5/5 (100%) Chronic Neurodisability, Lead Clinician forms 6/6 (100%) Admission Clinical Form 6/9 (66%) Clinical Notes 15/15 (100%)	Ongoing
Congenital Heart Disease (CHD)	N	N/A		
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Y	Y	1569/1645 (95.4%)	Ongoing

Diabetes (Paediatrics) (NPDA)	Y	Y	302/302 (100%)	Completed
Elective Surgery (National PROMs Programme)	Y	Y	Hip 736/658 (89%) Knee 665/607 (91%) Hernia 551/417 (76%) Varicose Veins 122/104 (85%)	Ongoing
Endocrine and Thyroid National Audit	Y	Y	Throidectomy 38/38 (100%) Parathryoidectom y 10/10 (100%)	Ongoing
Falls and Fragility Fractures Audit Programme (FFFAP)	Y	Y	30/30 (100%)	Completed
National Hip Fracture Database	Y	Y	696/696 (100%)	Ongoing
Fractured Neck of Femur	Y	Y	50/50 (100%)	Completed
Head and Neck Cancer Audit (HANA) (TBC)	Y	Y	Data collected on 740 patients will be submitted April 2018. Will be 100%	Ongoing
Inflammatory Bowel Disease (IBD) Programme	Y	Y	7/7 (100%)	Ongoing
Learning Disability Mortality Review Programme (LeDeR Programme)	Y	Y	9/9 (100%)	Ongoing
Major Trauma Audit	Y	Y	584/683 (86%)	Ongoing

Maternal, Newborn and Infant Clinical Outcome Review Programme	Y	Y	Maternal 1/1 (100%) Late Fetal Loss 2/2 (100%) Terminations 2/2 (100%) Stillbirths 29/29 (100%) Early Neonatal Deaths 6/6 (100%) Late Neonatal Deaths 2/2 (100%)	Ongoing
Medical and Surgical Clinical Outcome Review Programme	Y	Y	Acute Heart Failure Clinician Forms 6/6 (100%) Clinical Notes 6/6 (100%) Perioperative Management of Diabetes Clinician Forms 9/12 (75%) Clinical Notes 6/6 (100%)	Ongoing
Mental Health Clinical Outcome Review Programme	N	N/A		
National Audit of Anxiety and Depression	N	N/A		
National Audit of Breast Cancer in Older Patients (NABCOP)	Y	Y	Submission numbers are unavailable until report published	Ongoing
National Audit of Dementia	Y	Y	20/20 (100%)	Completed
National Audit of Intermediate Care (NAIC)	N	N/A		
National Audit of Psychosis	N	N/A		

National Audit of Rheumatoid and Early Inflammatory Arthritis	Y	N/A	Does not start until March 2018	Ongoing
National Audit of Seizures and Epilepsies in Children and Young People	Y	Y	1/1 Only requirement this year was for an organisational data set. Clinical data collection will not commence until April 2018	Ongoing
National Bariatric Surgery Registry (NBSR)	N	N/A		
National Cardiac Arrest Audit (NCAA)	Y	Y	April 2017-June 2017 22/22 (100%) No further figures available from clinicians	Ongoing
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme	Y	Y	530/530 (100%)	Ongoing
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	N	N/A		
National Comparative Audit of Blood Transfusion Programme	Y	Y	57/80 72%	Completed
National Diabetes Audit - Adults	Y	Y	National Diabetes audit 2177/2177 (100%) National Diabetes Inpatient Audit 132/132 (100%) National Diabetes Foot care Audit 242/242 (100%)	Completed
National Emergency Laparotomy Audit (NELA)	Y	Y	227/227 (100%)	Ongoing
National End of Life Care Audit	Y	N/A	Did not run 2017/18 Data collection to commence Autumn 2018	Ongoing

National Heart Failure Audit	Y	Y	192/886 (22%)	Ongoing
National Joint registry (NJR)	Y	Y	1089 (100%)	Ongoing
National Lung Cancer Audit (NLCA)	Y	Y	Invasive Lung 288/288 (100%) Mesothelioma 15/15 (100%)	Ongoing
National Maternity and Perinatal Audit	Y	Y	5803/5803 (100%) April 17 to March 2018	Ongoing
National Neonatal Audit Programme (NNAP) (Neonatal Intensive and Special Care)	Y	Y	1208/1208 (100%)	Ongoing
National Ophthalmology Audit	Y	Y	4409/4409 (100%)	Completed
National Vascular Registry	Y	Y	Clinicians did not give data	Ongoing
Neurosurgical National Audit Programme	N	N/A		
Non-Invasive Ventilation - Adults	Y	N/A	Audit listed in Quality Accounts but did not take place in 2017/18	n/a
Oesophago-gastric cancer (NAOGC)	Y	Y	238/238 (100%)	Ongoing
Paediatric Asthma	Y	N/A	Audit listed in Quality Accounts but did not take place in 2017/18	n/a
Paediatric Intensive Care (PICANet)	N	N/A		
Paediatric Pneumonia	Y	N/A	Audit listed in Quality Accounts but did not take place in 2017/18	n/a
Pain in Children	Y	Y	50/50 (100%)	Completed
Pleural Procedures	Y	N/A	Audit listed in Quality Accounts but did not take place in 2017/18	n/a
Prescribing Observatory for Mental Health(POMH-UK)				
Procedural Sedation in Adults (care in emergency departments)	Y	Y	50/50 (100%)	Completed

Prostate Cancer	Y	Y	Figures for 17/18 not available but will be 100%	Ongoing
Sentinel Stroke National Audit Programme (SSNAP)	Y	Y	April-June2017: 346/346 (100%) Aug –Nov 2017: 387/387 (100%)	Ongoing
Serious Hazards of Transfusion (SHOT): UK National haemovigilance scheme	Y	Y	11/11 (100%)	Ongoing
Smoking Cessation	Y	N/A	Audit listed in Quality Accounts but did not take place in 2017/18	n/a
UK Parkinson's Audit	Y	Y	40/40 (100%)	Y

The reports of 14 national clinical audits were reviewed by the provider in 2017/18 and the Norfolk and Norwich University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided

Audit and Survey Title	Results/Actions Taken / Planned
Acute Coronary Syndrome or Acute Myocardial Infarction National Audit Project (MINAP)	The Myocardial Ischaemia National Audit Project (MINAP) is a national clinical audit of the management of heart attack. MINAP provides comparative data to help clinicians and managers to monitor and improve the quality and outcomes of their local services. MINAP published its annual report in June 2017 and it was discussed at the July 2017 Governance meeting. The report demonstrated that Norfolk and Norwich University Hospital (NNUH) data is consistent with national data. NNUH performance is at or above national averages with no evidence of significant variance.
Coronary Angioplasty/ National Audit of Percutaneous Coronary Interventions (PCI)	The aim of this national audit is to describe the quality and patterns of care, the process of care and outcomes for patients receiving a percutaneous coronary intervention (PCI). The annual report for January to December 2015 was published in September 2017. The report demonstrated that the Cardiology Department practice pattern is consistent with national data. This is the only hospital with high rates of using drug coated balloons rather than drug-eluting stents with emerging evidence that they give a similar or better outcome.
National Heart Failure Audit	The aim of this national audit is to improve the quality of heart failure services and achieve better outcomes for patients. The National Heart Failure annual report for 2014-15 was published in August 2017. The report demonstrated that the Norfolk and Norwich University (NNUH) care is at or above national average. A new Heart Failure Nurse was appointed earlier this year to help improve outcomes further.
United Kingdom Renal Registry (UKRR) Audit	The results of the United Kingdom Renal Registry (UKRR) Audit were published 29th September 2017. The report was reviewed at the Renal Governance meeting in November 2017. The Renal Department is examining in greater detail any patients who are being prepared for renal transplant and the management of anaemia in patients.

Audit of Potential Organ Donation	An audit report is published every six months detailing the performance of each Trust in relation to organ donation. This includes the rate of referral, approach rate, approaches with Specialist Nurse for Organ Donation (SN-OD) presence, consent rate and number of proceeding donors. NNUHFT is one of the busiest Trusts in the whole of the eastern region in relation to its donation activity. The Trust currently performs above that of the national average. Since April 2017, 29 families out of 36 approached have said 'yes' to donation. 20 of those patients have gone on to be actual organ donors - saving the lives of 59 others. Each case of missed opportunity is scrutinised by the SN-OD team, discussed with the Trust's clinical lead for organ donation and further discussed with all members of the Multi-Disciplinary Team directly involved. Outcomes of the investigations are then shared throughout various channels and specific related objectives then added to any local/regional educational programmes whilst feedback may also be constructively given to those colleagues involved.
National Audit of Breast Cancer in Older Patients (NABCOP)	The aim of this national audit was to evaluate quality of care provided to women aged 70 years or older by Breast Cancer Services in England and Wales. The annual report was published in July 2017. This audit found regional variations in the way women were treated. The Breast Surgery Department reviewed the report and follows all the recommendations, no further action was required.
National Audit of Oesophago-Gastric Cancer (NAOGC)	The aim of this National Oesophago-Gastric Cancer Audit (NOGCA) is to examine the overall care received by patients from the time they are diagnosed with cancer or high-grade dysplasia to the end of their primary treatment. The NOGCA annual report covering April 2014 to March 2016 was published in December 2017. The Norfolk and Norwich University Hospital (NNUH) continues to be rated as top in the country for its Oesophago-Gastric Cancer Centre. Nationally the centre has the shortest length of stay at 7 days and the lowest mortality at 0.7%. This is down to continuous team effort and the successful implementation of Minimally Invasive oesophagectomy, and enhanced recovery program at NNUH over the last 8 years.
National Vascular Registry	The 2017 Annual Report for the National Vascular Registry (NVR) was published in November 2017. This national audit is undertaken to support improvement in vascular services by comparing units on outcomes for the major vascular interventions. This audit found that the NNUH undertook the 2nd highest number ruptured acute abdominal aneurysm repairs in the United Kingdom with a mortality rate well below national average. The recommendations made by NVR in the report were thoroughly reviewed some areas for improvement were identified as well as areas where the Trust is doing exceptionally well.
National Joint Registry	The National Joint Registry (NJR) collects data on all hip, knee, ankle, elbow and shoulder replacement operations and monitors performance of joint replacement implants. The NJR published their 14th annual report in September 2017. This report outlined outcomes and activity up to December 2016. The audit found that the hip replacement and shoulder replacement revision rates at the Norfolk and Norwich University Hospital (NNUH) were below national average and that the knee replacement revision rate at NNUH was in line with national averages. The NJR 13-year results do suggest that whilst the cemented cup used at NNUH has excellent (10A*) results, there may be a comparable cup with slightly superior survival. In response to this audit the Orthopaedic Department is reviewing a possible change to hip replacement constructs in line with evidence presented in the national report.

National Hip Fracture Audit	The aim of this national audit is to improve the care and secondary prevention of hip fracture. The National Hip Fracture Database (NFHD) published their annual report in September 2017. The report covered patients presenting in 2016. The report identified several areas of improvement for the Trust. Over the past 12 months the Orthopaedic, Anaesthetic and Older Persons Medicine (OPM) Departments have been involved in a number of initiatives to improve the management of hip fracture patients. These include the prioritisation of hip fracture patients on trauma lists to ensure more are operated on within the 36 hour target, introduction of anaesthetic standard operating procedure to help with mobilisation, and the appointment of another Ortho-Geriatric Consultant.
Major Trauma Audit - Trauma Audit and Research Network (TARN)	The Trauma Audit and Research Network (TARN) is a national database of trauma care. The audit was undertaken to benchmark national survival figures and trauma care against nationally accepted standards. Submissions to the audit are continuous. The National Clinical Report for the Trauma Audit and Research Network (TARN) was published on 24th November 2017. Findings were discussed at the Trauma Committee and actions to improve practice are actively discussed and implemented.
Medical and Surgical Clinical Outcome Review Programme: National confidential enquiry into patient outcome and death (NCEPOD)	The National Confidential Enquiry of Patient Outcomes and Death (NCEPOD) aims to improve standards of clinical and medical practice by reviewing the management of patients, by undertaking confidential surveys and research, and by maintaining and improving the quality of patient care by publishing and generally making available the results of these activities. During this year NCEPOD published a report on Non-Invasive Ventilation (NIV) in July 2017. A gap analysis was carried out against NCEPOD recommendations and an action plan put in place. These included ensuring Acute NIV beds are protected to allow quick patient transfer and a database of all staff who are trained to prescribe or make changes to NIV treatment. The report on 'Each and Every Need' a review of the care received by patients aged 0-25 with a cerebral palsy on 8th March 2018. This is currently under review by the Trust and a gap analysis and action plan will be undertaken in relation to the recommendations.
Elective Surgery National Patient Reported Outcome Measures (PROMS) Programme Audit	This audit was undertaken to gain information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves. The results are made available via NHS Digital and are disseminated via the Clinical Safety and Effectiveness Sub-Board monthly. The results are discussed and any actions required to improve the effectiveness of patient's are undertaken. PROMS scores are used to improve care for our patients.
7 Day Services Assessment Audit	The Trust contributed data in March and September 2017. As a result of the last audit, a robust action plan is being put in place. This includes the formation of a quarterly Steering Committee, with Executive Board and Clinical Commissioning Group membership. This will provide additional focus on implementing the priority clinical standards for seven day hospital service.

The reports of 85 local clinical audits were reviewed by the provider in 2017/18 and the Norfolk and Norwich University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided

Audit and Survey Title	Results/Actions Taken / Planned
Laboratory Service User - Feedback Audit	This audit was undertaken to ensure user satisfaction with the Laboratory Service for both Hospital and General Practitioner Users within the Eastern Pathology Alliance (EPA). The results highlighted some areas for improvement and as a result, an action plan was formulated to improve information sharing between all of the EPA sites.
Audit of Point of Care Testing (POCT)	This audit was undertaken to ensure that the results documented in the notes are accurate with those recorded using glucose meters. The results of the audit showed positive levels of compliance with how the Glucose results were recorded in the Patient notes and as a, it was felt that no immediate actions are required.
Audit of percutaneous transabdominal superior hypogastric plexus block prior to uterine artery embolization (new therapy)	This audit was undertaken as part of the process to introduce a New Therapy into the Trust for percutaneous transabdominal superior hypogastric plexus block prior to uterine artery embolization. The results demonstrated that the treatment did not raise any concerns and was signed off for use within the Trust.
Audit of Non-Medical Led Peripherally Inserted Central Catheter (PICC) Service. Using BARD Sherlock 3CG system provided at the bedside	This audit was undertaken as part of the process to introduce a New Therapy into the Trust for Non-Medical Led Peripherally Inserted Central Catheter (PICC) Service using BARD Sherlock 3CG system provided at the bedside. The results demonstrated that the treatment did not raise any concerns and was signed off for use within the Trust.
Audit of Weight Management Psychology Service	This audit was undertaken to ensure patient satisfaction with the Weight Management Psychology Service. The audit demonstrated that most patients attending the service found it worthwhile. Following the audit a drive to develop service provision was actioned. This included increasing the group capacity, development of psychoeducational groups and improving the sharing of information.
Audit of Trust Carers Passport	This audit was undertaken to assess the impact of the introduction of the Trust Carers Passport. The results demonstrated that the passport has had a very positive impact for carer experience. The audit did highlight some awareness issues by staff but these have since been addressed.
Audit of the Use of Second Troponins after an Initial Negative Troponin in Accident & Emergency (A&E) and Acute Medical Unit (AMU)	This audit was undertaken to assess practice around the Trust policy for troponins. The results identified that samples were not always repeated at the appropriate time interval. As a result of this audit, posters/ flow charts have been introduced to highlight current guidelines in Acute Medical Units (AMU) with further education for junior medical staff being undertaken.

Audit to British Society of Gastroenterolgy (BSG) quality and safety indicators for endoscopic retrograde cholangio-pancreatography (ERCP)	This audit was undertaken to determine if the endoscopic retrograde cholangio-pancreatography (ERCP) service and provision at Norfolk and Norwich University Hospital (NNUH) reaches the standards set out in the British Society of Gastroenterology's document 'ERCP – The way forward, a standards framework'. The audit found that the service met all the standards set out in the framework. A re-audit will be carried out once the Gastroenterology Department has relocated to the new Quadram.
Older People's Medicine (OPM) Regional Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) Audit	The audit was undertaken to determine if resuscitation was being appropriately discussed in patients admitted under Older People's Medicine and that resuscitation decisions were being communicated to patients' General Practitioners (GPs). The audit found if patients had potentially life limiting illnesses then appropriate decisions would take place. Since the audit, changes have been made to the electronic discharge letter template to aid the documentation of DNACPR decisions and communicating the decisions to GPs.
Do Not Attempt Cardiopulmonary Resuscitation Electronic Discharge Letter Documentation Audit	The audit was undertaken to identify if all resuscitation decisions were documented on electronic discharge letters (EDLs). The audit demonstrated an improvement from previous results, with 90% of patients having their resuscitation decisions documented. Following the audit it was agreed to send the 'Gold Standard EDL' lesson of the week at the start of every junior doctor rotation and to re-audit on an annual basis.
Haemodialysis vascular access audit	This audit was undertaken to ensure that new end-stage kidney disease patients planning to start haemodialysis and patients on long-term dialysis are given the type of vascular access as recommended by the United Kingdom Renal Association. The audit also counted the number of 'line infection days'. Data was collected on all suitable patients and reported at quarterly Vascular Access Meetings. Over the year the Trust was very close to national target of 80% long-term patients on correct vascular access. However the Trust fell short of the 60% target for new patients getting dialysis via a functioning arteriovenous fistula or arteriovenous graft. A Service Improvement Programme is in place in the Renal Department which should address the issues found in this audit.
Adequacy of Haemodialysis Audit	This audit was undertaken to ensure that all patients have an adequate level of haemodialysis. This audit found a small number of patients were not having enough dialysis. Following this audit individual plans were created for each patient.
Audit of adherence to national protocols; clinical reviews of staff in Newborn Hearing Screening Programme (NHSP)	This audit was undertaken to assess the clinical practice by Newborn Hearing Screeners and to ensure adherence to national and local protocols. The results found all screens were conducted according to protocols and in line with national guidelines and as a result of the audit no actions were required.
Documentation audit of adult hearing aid reassessment service	This audit was undertaken to ensure documentation had been completed for patients attending the hearing aid reassessment service. The results found a good adherence, with 84% of medical questions being completed. The ear conditions question was left blank and as a result of this audit the history form has been adapted to include prompts.

Audit of Periorbital Cellulitis	The aim of this audit was to ensure that children presenting with Periorbital Cellulitis were managed according to the current guidelines. The results of the audit found that there was a good compliance against the current guidelines and a re-audit will be undertaken to ensure continued compliance.
Audit of robotic assisted colorectal resection using Da Vinci	This audit was undertaken to examine outcomes of using the new procedure, the Da Vinci Robot Assisted Bowel Resection. The audit collected outcome data from the first eight patients who underwent this procedure. The outcomes were reviewed by the Clinical Standards Group. The treatment did not raise any concerns and was signed off for use within the Trust.
Delay to discharge post major limb amputation Audit	The aim of this audit was to determine whether the pathway for patients with lower limb amputations followed recommendations by the Vascular Society. The audit found some areas for improvement. Following the audit a proforma has been produced to improve documentation. The pain team are involved on day one post operation, and antibiotic education is given to staff.
Re-audit of Infant Feeding	This audit was undertaken to ensure minimum standards in infant feeding and relationship building practices were achieved to protect maternal and infant physical and emotional health. The results found that of the 34 United Nations Children's Fund (UNICEF) Baby Friendly Initiative standards which were assessed, 26 were met. As a result of the audit, the Maternity Team at the Norfolk and Norwich University Hospital were re-accredited.
Audit of management of infants at risk of Hepatitis B	This audit was undertaken to evaluate if all babies at risk of Hepatitis B virus (HBV) were given the first vaccination dose as per Trust guidance. The findings demonstrated that all standards were complied with.
Audit of adherence to guidelines of postnatal management of antenatally detected hydronephrosis	This audit was undertaken to evaluate compliance to the Trust guideline on post-natal management of antenatal hydronephrosis (ANH). The findings confirmed the majority of babies were managed appropriately, however for babies born outside of the Trust data was limited so full assessment could not be made. As a result the guideline has been updated and a database of ANH will be instigated and maintained.
Audit of compliance to NICE Policy	This re-audit of compliance to the Trust Implementation of National Institute of Health and Care Excellence Policy reviewed a random selection of the central evidence folders and the central NICE Spread sheet. The audit found that limited evidence was available from Divisional Boards when formal risk assessments relating to NICE were presented. The implementation of the new clinically led divisional structure and appointment of Governance Managers for each Division is anticipated to improve compliance. A re-audit will be undertaken in 18/19.
Audit of compliance to Audit Policy	This re-audit of compliance to the Trust Clinical Audit Policy reviewed a random selection of 25 audit evidence folders from the 16/17 Trust Audit Plan. The audit demonstrated a high level of compliance and no changes to the current policy were recommended. A re-audit will be undertaken in 18/19.

Head and Neck Cancer - Multidisciplinary Team Audit	This audit aimed to ensure good clinical practice and documentation around the treatment of Head and Neck patients. The results of this audit supported the development of an integrated care plan which was introduced into practice.
Audit of the Adherence to the Mental Capacity Act 2005 when working with People with Learning Disabilities And Audit of Reasonable Adjustments and Use of Learning Disability Resources	Results from these monthly audits were presented to the Caring and Patient Experience (CaPE) Sub-Board, as a part of the Learning Disability and Autism report. The frequency of audit enabled dynamic assessment of results and quick response to areas of change. Changes were made to both the strategic direction and operational processes of the Learning Disability Liaison Team as a result of the dynamic identification of trends
Audit of Patient Satisfaction in Adult Rehabilitation	The aim of this audit was to determine if service users were satisfied with the Adult Rehabilitation Service. The results demonstrated a high level of satisfaction with 100% of patients being very satisfied. No actions were required but a re-audit will be undertaken to ensure that patients remain satisfied with the service provided.
Audit of Patient Satisfaction in Paediatric Audiology	The aim of this audit was to determine if service users are satisfied with the Paediatric Audiology Service. The results demonstrated a high level of satisfaction. No actions were required but a re-audit will be undertaken in 12 months.
Audit of Patient Satisfaction in Vestibular Service	The aim of this audit was to determine if service users are satisfied with the Vestibular Service. The results of the audit demonstrated that 100% of patients were very satisfied with the overall service and as a result no actions were required.
Audit of Patient satisfaction in Bone Conduction Hearing Systems Service	The audit was undertaken to evaluate patient experience and satisfaction with the bone conduction hearing systems service. The results found that over 95% of patients were very satisfied with the service. A re-audit is planned for the following year to continue surveillance of the service.
Audit of Patient satisfaction of Vascular Access Practitioners-led Peripherally Inserted Central Catheter (PICC) line insertion	This audit was undertaken to ensure patient satisfaction when undergoing Peripherally Inserted Central Catheter (PICC) line insertion. The feedback was of a very high standard with 100% satisfaction throughout.

Audit of Chaplaincy Provision for Patients in an In-Patient setting from Staff Perspective	This audit was undertaken to evaluate staff understanding of the role of the chaplains. The audit demonstrated that staff members felt very positive about the Chaplaincy Service and understood the role which it plays throughout the Trust. An action plan was put into place to maintain and enhance this understanding.
Audit of Patient Experience of Psychology Treatment within the Pain Centre	This audit was undertaken to ensure patient satisfaction with the Pain Management Psychology Service. The feedback was generally positive. As a result of the audit, patient information was improved with amendments being made to the clinical psychology leaflets in the clinic. Psychology expansion within the Pain Clinic is now also being explored.
Audit of Patient Feedback in Nuclear Medicine	The aim of this audit was to assess the patient experience of the Nuclear Medicine Department. The feedback was very positive with 97% of answers given rating each element of practice as either good or very good. It was felt that patient information could be improved so a review of information letters was undertaken to improve patient experience.
Audit of Patient Satisfaction of Speech and Language Therapy (SLT) Surgical Voice Restoration Service	The aim of this audit was to assess patient experience of the Specialist Voice Prosthesis Clinic, provided by the Specialist Head and Neck Speech and Language Therapy Team. The results were positive with high levels of satisfaction demonstrated. An action plan was formulated which included an investigation of outpatient parking facilities
Audit of Gastroenterology Unit Patient Experience 2017	This audit of patient experience was undertaken as part of the requirements of the Global Rating Scale for Endoscopy. The findings demonstrated the service was in accordance with recommendations although keeping patients informed of delays was not always achieved. Patient views were very positive. The survey has led to the Unit Coordinator checklist being amended to include regular feedback of delays to patients. Chairs and coat hooks have been placed in changing areas.
Dementia Person Centred Care Audit	The audit was undertaken to establish the use of the 'This is Me' tool and dementia approved identifications for patients with dementia across the Trust. The audit demonstrated largely improved results compared to 2016/17. As a result of the audit, an Associate Physician in training is completing a service improvement project to assist improved use of the identification flower wristband and This is me. A Dementia Support Nurse is also now in post and applying extra vigilance of these elements.
Audit of satisfaction with the Big C centre information day	This audit was undertaken to evaluate patient and relative/carer satisfaction with the November 2017 Big C Centre information day. The findings from the evaluation suggest the day continues to be well received. The majority of visitors find the day useful and said it helped them understand and manage issues around cancer more effectively. 98% would recommend the day to others, which supports the continuation of the events.

End of Life Care Audit	The audit was undertaken to assess the care of patients who were identified as dying, with regard to the appropriate and accurate prescribing of anticipatory medication and the use of the Palliative Care Rounding. The audit found there was a need to continue end of life education for all clinical staff, including communication skills training pertaining to end of life situations to support complex discussions. Specialist Palliative Care (SPC) Educators will continue supporting end of life care on wards and referrals to the SPC team will be promoted throughout the Trust alongside individualised patient care plans.
Audit of use of Cystic Fibrosis Identification Wristbands	This audit was undertaken to identify the opinion of service users with cystic fibrosis in regard to wearing coloured identification wristbands to aid the prevention of cross infection when in public areas. The results demonstrated that patients were keen on the idea. The department have purchased the wristbands and put them into use.
Stroke Carer's Audit	The aim of this audit was to determine if carers had all the information they needed to care for stroke patients when stroke patients were discharged from hospital. The results of the audit found that overall the carer's feedback was excellent. All stroke carers would have recommended the Early Supported Discharge (ESD) Team to friends and family. A re-audit will be undertaken to ensure standards are being maintained.
Audit of Nurse-led Breast Screening Patient Experience	The aim of this audit was to collect information about patient experiences following attendance at the Breast Screening Assessment Clinic at the Norfolk and Norwich University Hospital. The response rate was high at 65%. The survey had very positive feedback from the patients about the Breast Care Nurses, valuing the time they spent with the nurses when being given the results of their investigations and the support they provided. Some patients commented that they felt unprepared for further investigations such as biopsy. All assessment patients are now sent a more detailed biopsy leaflet before their appointment.
Grove Road Patient Experience Audit	This audit was undertaken to review patient satisfaction with regards to their experience of attending the Central Norwich Eye Clinic at Grove Road. The feedback demonstrated high levels of patient satisfaction. An action plan was put in place to improve the signage and the parking at the clinic.
Diabetes Eye Screening - Patient Satisfaction Audit	This audit was undertaken to review patient satisfaction with regards to their experience of attending Diabetes Eye Screening. The results were positive and demonstrated a high level of patient satisfaction and therefore no immediate actions were required.
Colposcopy Clinic Re-audit	This audit was undertaken in response the Colposcopy Quality Assurance Team Visit on the 28th September 2016, which recommended yearly audit. The audit reviewed the quality of the colposcopy service and patients' level of satisfaction with the clinic. Results highlighted that overall satisfaction was high although provision of verbal and written communication could be improved. As a result the NNUH Colposcopy Booklet is sent with every new colposcopy appointment and written information is available in the clinic for colposcopists to give following any discussions with patients.

Audit of Out of Hours Discharges	The Out of Hours Discharge Audit reviewed the discharges of all patients discharged between the hours of 2300 and 0559 from 1st April 2017 to 31st May 2017 to their usual place of residence. 18 sets of notes were reviewed for in depth analysis. The results were reported to the Caring and Patient Experience Sub-Board. As result of the audit it will be ensured that Ensure that PAS is updated in 'real time' and accurately reflects the time the patient discharged from the ward and a review of the inclusion/exclusion for the audit amended. This audit will be part of the on-going audit programme in the future.
Audit of Patient Advice and Liaison Service Activities and Trends	This audit is undertaken to determine activity and trends of patient requests to the Patient Advice and Liaison Service. The audit reviews all requests received by the Patient Advice and Liaison Service. The results are reported monthly to the Caring and Patient Experience Sub-Board for discussion and any actions recommended implemented
Quality Assurance Audits of Care Quality Commission Fundamental Standards	These audits were undertaken to evidence that the Trust is achieving the Care Quality Commission Fundamental Standards. Results have demonstrated that overall the percentage of 'Good' or 'Outstanding' standards remains high across the Trust at 90.2%. Local action plans have been put in place to address the few standards rated as requiring improvement. The audit programme will continue for 2018/19
Audit of Red to Green Days	The aim of the audit was to demonstrate as part of the Red2Green initiative that the patient experience was enhanced due to an increased understanding of the identified four questions. The audit ran for one cycle which did demonstrate an increase in the patients understanding of the four questions compared to baseline data. All medical and surgical inpatients wards are now supporting the Red2Green initiative which will enable more sites for data to be collected in the future. An audit will now completed every three months and the results will be shared with the Patient Flow and Site Operations Group and appropriate actions implemented.
Audit of Patient Advice and Liaison Service - Patient Feedback	This audit was undertaken to monitor whether PALS was providing a good service to its clients and is meeting clients' needs. This audit relates to Key Lines of Enquiry relating to Caring and Patient Experiences and Responsiveness. The audit demonstrated that patients were very positive about the service received. The results were reported to the Caring and Patient Experience Sub-Board for discussion and any actions recommended implemented.
Cardiology Local Safety Standards for Invasive Procedures (LocSSIPs) Audit	This audit was undertaken to determine if that all components of the Cardiology Local Safety Standards for Invasive Procedure (LocSSIP) and handover signatures are completed for patients undergoing a procedure in the Cardiology Catheter Laboratories. The audit found that not all checklists were fully completed. The results were fed back to staff in emails and posters. Spot checks of documents and a re- audit are planned.
Audit of compliance to LocSSIP (Local Safety Standards for Invasive Procedures) for Botulinum Toxin injections	This audit was undertaken to evaluate compliance to the completion of the local safety standard for botulinum injections. A pilot audit was undertaken which revealed the form was not in routine use. This has now been addressed and all clinicians have started to use the form. A re-audit will be undertaken in 2018/19.

Medical Documentation Audit - Older People's Medicine	The audit was undertaken to ensure basic standards as set out in the Health Records Keeping Policy were being met. The audit found that improvements could be made. As a result a lesson of the week was sent and DNACPR decisions have become part of 'Red-to-Green' discussions.
Urology Documentation Audit	This audit reviewed several touch points on the patient journey including transfers between care areas. The majority of overall compliance for audited documentation was greater than 60% and key metrics within sections were greater than 80% compliant. The audit findings were presented at the Clinical Governance Meeting and circulated to clinicians to enable improvement. A re-audit will be undertaken in the future.
Audit of Ongoing Surveillance of Modified Early Obstetric Warning Score (MEOWS)	This audit was undertaken to evaluate compliance to recording and acting on the modified early obstetric warning score (MEOWS). The findings demonstrated compliance on completion and accuracy was stable but had dipped below 90% in quarter 3. Actions taken in response include revision of the MEOWS observation chart to include sepsis prompts and the introduction of sepsis stickers. "Champions" have been identified in each area to promote the use of MEOWS and collect the data. Education continues and a report has been submitted to the Clinical Safety and Effectiveness Sub Board. This is an ongoing audit.
Audit on children's early warning scores (CEWS)	This audit was undertaken to evaluate compliance to recording and acting on children's early warning scores (CEWS). The results demonstrated consistently good compliance to completeness and accuracy of CEWS, some areas for improvement were identified. Early warning scoring systems for children are complex and results have been discussed in Operational Meetings and the adoption of new national guidance to improve compliance is being discussed.
Audit of Electronic Discharge Letters of Patients who had C-Diff	This audit was undertaken to demonstrate whether a patient with confirmed C. *difficile* infection has this on their Electronic Discharge Letter (EDL) / death notification. The audit found that 5.2% did not have an EDL and 5.2% of EDLs did not mention C. *difficile* of these 3.4% were death notifications. A letter is sent to the consultant in charge of the patient asking for the EDL to be updated where required following the audit checks. The audit will continue.
Audit of Manual Handling	A total of 278 Nursing and Patient Care Records were audited in June 2017. The audit demonstrated 88% of manual handling risk assessments were documented on admission. The results were disseminated to all relevant leads and clinical staff for review and action in their areas if required. The Health and Safety Lead Advisor and Manual Handling Co-ordinator will be to continue to impress upon staff at Induction and update training the importance of completing this documentation for compliance and safety reasons. A re-audit will be undertaken in 2018/19.
Audit of Compliance to Discharge Policy	An audit of compliance with the completion of the Home Circumstances and Discharge documentation was undertaken in July 2017.The audit identified that our acute Trust processes to support discharges to long term environments could be improved. As a result, key actions have been identified and implemented. A re-audit again in 2018/19.

Falls Documentation Audit	This audit was undertaken to ensure good clinical practice with regards to the completion of paperwork for patients at risk of falling as part of the Falls Steering Group review of the Falls Policy. An action plan was formulated which included changes to the Falls Policy.
Audit of Resus Equipment	The audit was undertaken to determine the process for checking emergency resuscitation equipment and to review the compliance of checks. The results found that there has been an overall improvement across all aspects. Annual audits will continue to be undertaken to review and ensure compliance.
Audit of Oxygen and Suction Equipment	The audit was undertaken to determine the process for checking emergency oxygen and suction equipment and to review the compliance of checks. The results found that there has been an overall improvement across all aspects. Annual audits will continue to be undertaken to review and ensure compliance.
Audit of Hypo Box Equipment	The audit was undertaken to determine the process for checking emergency glucose monitoring equipment and to review the compliance of checks. The results found that there has been an overall improvement across all aspects. Annual audits will continue to be undertaken to review and ensure compliance.
Audit of Compliance to Consent Policy	This audit was undertaken to establish the level of compliance with the completion of the consent forms and to ascertain the types of information being recorded. Newer versions of the consent forms are being used across the Trust. Compliance of completion had improved but the audit identified improvement was still required for some specific elements of the documentation .An action plan was introduced which included a clinically-led review of the current Consent Policy. A re-audit will be undertaken.
Early Warning Score Observation Documentation, and Early Warning Score Response Audit	Quarterly audits of a small sample of triggering episodes were undertaken by the Clinical Care Outreach Team (CCOT), to review the response to Early Warning Score (EWS) triggers ≥4, by adult wards. Real time feedback was given to ward staff by the CCOT when undertaking these audits to ensure any omissions were reviewed by senior nursing staff. The results are reported to the Recognise and Respond Committee, Clinical Safety and Effectiveness Sub-Board and the Matrons dashboard for discussion and any actions recommended are implemented. An amendment to the current auditing process is being undertaken.
Handover of Care Audit	This audit was undertaken to ensure that patients being transferred in to Radiology have appropriate documentation and assessments completed. The audit highlighted that compliance with these could improve. An action plan included improving awareness of requirements amongst staff and the introduction of incident reporting for cases not meeting the criteria. A re-audit will be undertaken on a monthly basis in the 2018/19 cycle. A larger annual audit will also be completed.

Audit of Sepsis Commissioning for Quality and Innovation (CQUIN) element	This audit is undertaken to determine compliance with the National Sepsis CQUIN. On-going actions undertaken to continue to improve compliance include; the implementation of an electronic sepsis screening tool that will be automatically triggered when a patient in the Emergency Department with a high Early Warning Score presents. This process went live at the beginning of Quarter 2 and has improved Emergency Admissions Sepsis Screening through the ED to near 100%. The Sepsis Lead Consultant has delivered Sepsis Training Sessions to new medical staff and on both the FY1 and FY2 education program in August and September 2017. The Critical Care Outreach Team (CCOT) and Hospital @ Night (H&N) team are continuing to work with the Sepsis Lead to improve utilisation of the Inpatient Sepsis Screening Tool by requesting the inpatient ward nursing staff to use the tool as a necessary component of a referral to both the CCOT and H&N teams. The NNUH sepsis processes are now routinely covered during the NNUH ALERT (Acute Life-Threatening Event Recognition and Treatment) courses which run for NNUH staff and medical students throughout the year. A business case has been approved for a 'Sepsis Audit and Improvement Officer to assist the Sepsis Lead with regular ward level audit and early feedback, ward level sepsis education and sepsis pathway development. The Inpatient Sepsis Emergency 2222 Pathway has seen increased reflecting improved awareness of sepsis at ward level. The Sepsis Lead clinician has established a working group to evaluate current electronic patient observation systems with an aim to gain approval for procurement and implementation across all inpatient areas at the NNUH during 2018. The audit will continue.
Re-audit of unplanned admissions from Day Procedure Unit	This audit was undertaken to identify unplanned patient admission rates following day surgery. The results found that the unplanned admission rate during this re-audit period improved to 1.1% (from 1.5% in 2012) This remains within expected Royal College of Anaesthetists (RCoA) standard. As a result of the audit no improvements were required. The audit will be repeated in a year's time to continue to monitor unplanned admission rate from day surgery.
Audit of stress ulcer prophylaxis in adult critically ill patient	This audit was undertaken to determine if the Trust Guideline for Stress Ulcer Prophylaxis in Critically Ill Patients was followed. The results found that 100% of patients on intermittent positive pressure ventilation (IPPV), without established enteral feed, received stress ulcer prophylaxis. 95% of patients with specific indications received stress ulcer prophylaxis. The results were presented at the Critical Care Complex (CCC) Clinical Governance meeting. As a result of the audit the guidelines have been amended and dual antiplatelet as an indication for stress ulcer prophylaxis has been added.
Audit of the quality of the undertaking of World Health Organisation checklist within theatres	This audit is undertaken to assess the level of compliance and involvement in carrying out the World Health Organisations surgical safety checklist in theatres. The audit collects information on teams' involvement with each stage of the checklist process. Reports of the audit are distributed to Senior Theatre Staff for action on a monthly basis.
Re-audit of child safeguarding training	This audit was undertaken to identify if safeguarding children training increases participants knowledge in recognising and appropriately acting upon safeguarding issues. All course participants rated their knowledge on specific criteria pre and post workshop. The results demonstrated participants felt their knowledge and understanding post workshop had increased. The majority of participants scored 8-10 for most categories (a score of equal to or greater than 8 is considered ideal for confirming the workshop's positive impact). The mean score for usefulness of the workshop was 9.1 out of 10. No improvements to the training programme were recommended. A re-audit will be undertaken.

Audit Monitoring of Compliance to Trust Hand Hygiene Standards	This audit was undertaken to demonstrate compliance with parts of the hand hygiene policy. The audit found an average of 97% compliance. The nurse average was 97%, HCA 97%, doctors 95% and others 97%. Following the audits, results were fed back monthly and the importance of good hand hygiene was emphasised throughout all training. If results are below 95% a follow up is sent to the sister/charge nurse to action learning outcomes, requesting return of the completed plan to Infection Prevention and Control. Results are also published on the Nursing Dashboard. Audits will continue.
Audit and Surveillance of compliance to High Impact Interventions	This audit was undertaken to demonstrate compliance with the High Impact Intervention care bundles for Peripheral Cannulas, Urinary Catheters, Central Venous Catheters, prevention of Ventilator Associated Pneumonia, Renal Dialysis catheters and prevention of Surgical Site Infection using the electronic audit system. Average results for this period for Peripheral Cannulas 86%, Urinary Catheters 91%, Central Venous Catheters 92%, prevention of Ventilator Associated Pneumonia 99%, Renal Dialysis catheters 100% and prevention of Surgical Site Infection 79%. Audit results were fed back monthly. Action plans were sent to sisters/ charge nurses in areas with scores below 80%, to action learning outcomes and return the completed plan to IP&C. Work is ongoing to encourage ownership and make changes in practice particularly in relation to consistent documentation. These audits will continue in the 2018/19 audit cycle.
Audit Surveillance of Central Lines Infection Rate	This surveillance was undertaken to determine the blood stream and exit site infection rates for adults with central lines in place for 48 hours or more (excluding the Critical Care Complex). In quarter 1 the rate was 0.41 per 1000 line days and in quarter 2 it was 0.19 per 1000 line days, well below the Matching Michigan bench mark of 1.4 per 1000 line days. Results are fed back quarterly on the IP&C monthly report and at training sessions as part of a session for trained nurses that aims to prevent complications with central venous catheters. These audits will continue in the 2018/19 audit cycle.
Surveillance Audit of Surgical Site Infection (SSI)	This surveillance was undertaken utilising Public Health England (PHE) protocol for Surveillance of Surgical Site Infection (SSI) 2013 to provide a surveillance programme designed for the NNUH. These surveillance programmes provide quarterly reports of infection rates to the departments involved. This programme aims to promote good practice and reduce SSI rates. Vascular SSI rates were 7.1% in quarter 1 2017/18 and 10.8% in quarter 2. SSI rates following C section have decreased from 5.5% in quarter 1 to 2.4% over this period. These audits will continue in the 2018/19 audit cycle.
Audit of meticillin-resistant staphylococcus aureus (MRSA) (hospital acquired) infections and screening for MRSA	This audit was undertaken to demonstrate the timely identification of patients found to be MRSA positive. It also aims to determine the number of hospital acquired cases of MRSA and the number of patients screened correctly. It is in line with the Trust guideline for MRSA screening. The audit demonstrates that the elective screening average is 93% and the emergency screening average is 97% for the Trust. These audits will continue in the 2018/19 audit cycle.
Audit of Compliance to Trust Isolation Policy	This annual audit was undertaken to determine whether patients are isolated in accordance with the isolation policy. It also provides information on the reasons for side room use. It demonstrated that 34% of the side rooms were used for Infection Prevention and Control reasons. A priority table for isolation is available in the Isolation policy. A re-audit will be undertaken in the 2018/19 audit cycle.

Audit of Trust Commodes	This audit was undertaken to demonstrate that all surfaces of the commode are visibly clean with no blood or body substances, dust, dirt, debris, adhesive tape or spillages. It also monitors evidence of cleaning with time, date and signature in line with the Trust guideline for Cleaning and Disinfection in the hospital. The audit found an average of 95% compliance. Following the audit, results are fed back and ward sisters/charge nurses are asked to action learning outcomes. Training is provided if required. Results are reported on the Nursing Dashboard. These audits will continue in the 2018/19 audit cycle.
Pressure Ulcers Audit	This on-going surveillance audit reviews all pressure ulcers in the Trust. Various methods are utilised for the audit including: review of Datix Incident Reports, review of ward documentation during Quality Assurance Audits and ward staff reviews of their documentation during matron's rounds. A weekly pressure ulcer report which includes all community acquired pressure ulcers and hospital acquired grade 2 and above is circulated to Senior Staff. A Route Cause Analysis (RCA) is undertaken by ward staff and the Divisional Matron for any reported Grade 2 or above pressure ulcer. A weekly meeting is held to discuss the grade 2 pressure ulcers that have occurred in hospital. It is attended by the ward staff concerned in the pressure ulcer, Lead Tissue Viability Specialist and Senior Matron. The grade 3 pressure ulcer, Root Cause Analysis are discussed at ward level with the ward teams, Divisional Matron, Matron of the area and Lead Tissue Viability Specialist. An action plan is formulated following each RCA and learning is disseminated within the Divisions to determine learning is shared across the organisation.
Audit of Clinical Incidents, Complaints and Claims	Clinical incidents, complaints and claims have been reviewed alongside each other throughout the year in order to identify themes. Information resulting from these reviews has been disseminated to staff via a specific Organisation-Wide Learning publication and within reports to the Clinical Safety and Effectiveness Sub-Board. Opportunities to improve communication with our patients have been a consistent theme from reviews of complaints. There have been no significant themes between clinical incidents, complaints and claims identified.
Audit of Duty of Candour	This audit is undertaken to assess Trust compliance with Duty of Candour (DoC) statutory obligations. A monthly report is submitted to the Clinical Safety and Effectiveness Sub-Board. The audit found that specialities were not routinely following up conversations held with patients in writing. As a result of the audit clinicians are requested to add all Duty of Candour letters to the electronic template, if a copy is not to be filed in the patient notes. The electronic template is a formal repository for patient notes and should be seen as an additional resource when clinical notes are reviewed.
Audit of Trust Quality Priorities	Our Quality Priorities and the work streams underpinning them have been monitored via our governance committees and reported monthly via the Integrated Performance Reports to the Trust Board. Sepsis screening is among our safety priorities where improvement is demonstrated, whilst some patient experience elements have proved challenging due to a combination of the on-going operational pressures and consequently data collection for some elements has been incomplete. Some extremely aspirational targets have also not been achieved. Quality Priorities for 2018-19 will be set in line with some of our challenges and will be reviewed and agreed through consultation with Governors and the Trust Board.

Health Records Management	This audit was undertaken to demonstrate users' compliance with tracking plus timely and appropriate handling of case notes. The audit found a significant high proportion of users not complying with this standard, particularly when receipting case notes on PAS. For the ward bed state audits, compliance was much improved. Often the delay in receipting case notes to the ward seemed to occur on overnights and weekends when ward clerk cover is limited. Health Records are investigating the possibility for all newly trained PAS users to visit the Health Records Library and thereby understand the issues arising from poorly tracked case notes.
Audit of external safety alerts, recalls, inquiries, investigations or reviews	A monthly report is submitted to the Clinical Safety and Effectiveness Sub-Board, to provide assurance on the assessment of and action taken in respect of safety alerts and recall notices received via the Department of Health's Central Alert System. Through these monthly reports, the Trust has been assured that all appropriate action is taken where the alert is assessed as being relevant to the organisation
Audit of Transfer Guidelines and Clinical Handover of Care	The process for auditing clinical handover within the Trust was changed from an annual audit to a more focused 3 monthly review of incident reports for issues related to transfers. This is themed to allow for targeted further actions and auditing if required. Datix incidents were reviewed on a quarterly basis and were then reported quarterly to the Clinical Safety and Effectiveness Sub-Board for discussion and any actions recommended implemented.
Audit of Stress	This audit was undertaken to demonstrate how workplace stressors are identified within the organisation. The audit found that these are being identified in line with the stress at work policy. Trends are reported monthly to the Workforce Sub Board and quarterly to Health and Safety Committee. It has been noted that the reasons for work related stress have broadened this year. There have continued to be concerns from staff surrounding the relationship elements although this has seen an increase in colleague to colleague relationships rather than line manager to colleague issues. Concerns regarding the demands of people's roles have been raised in this last year as concerning and a trend identified within the specialist nurse role. As far as peoples role is concerned, a new area of concern is the impact on staff dealing with a 'difficult shift' has been cited, continued concerns regarding change, future changes to role or the impact of ward closures. The Trust has supported the Health and Wellbeing Department in the recruitment of some preventative resource. A Health and Well Being Assistant Practitioner commenced in post in January 2018 and this individual will be working with departments and training staff in preventative mental health initiatives.

Participation in research and development

The number of patients receiving relevant health services provided or sub-contracted by the Norfolk and Norwich University Hospitals NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee was 3,228 (5,438 in 2016/17).

Commissioning for Quality and Innovation (CQUIN)

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

The agreed measures for the Trust are as follows:

1. Improving staff health and wellbeing
2. Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)
3. Improving services for people with mental health needs who present to A&E
4. Offering advice and guidance
5. NHS e-Referrals (2017/18 only)
6. Preventing ill health by risky behaviours – alcohol and tobacco (2018/19 only)
7. Supporting proactive and safe discharge
8. Reinforcing the critical role Providers have in developing and implementing local STPs
9. Clinical Utilisation Review (NHS England Commissioning)
10. Hospital Pharmacy Transformation and Medicines Optimisation (NHS England Commissioning)
11. Nationally standardised Dose banding for Adult Intravenous Anticancer Therapy (SACT) (NHS England Commissioning)

Further details of the agreed goals for 2017/18 and for the following 12-month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/.

The monetary value of CQUIN available to the Norfolk and Norwich University Hospitals NHS Foundation Trust in 2017/18 is £9.581 million conditional on achieving goals.

The monetary value of CQUIN available to the Norfolk and Norwich University Hospitals NHS Foundation Trust in 2016/17 was c£9.2 million as reported in the 2016/17 Quality Report

Care Quality Commission (CQC) reviews

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

Norfolk and Norwich University Hospitals NHS Foundation Trust has no conditions on registration. The Care Quality Commission has not taken enforcement action against Norfolk and Norwich University Hospitals NHS Foundation Trust during 2017/18.

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

NNUH Oesophago-gastric Cancer Unit named as one of the best in UK in recent national audit

The Oesophago-gastric Cancer Centre at the Norfolk and Norwich University Hospital is celebrating results from the recent National Oesophago-gastric Cancer Audit (NOGCA), which show the Trust to have maintained an 'excellent profile' for their services offered to patients.

Most notably, NNUH reported a 30 day mortality percentage of 0% and the shortest length of stay for patients after major complex operations for cancer of the oesophagus compared with every major cancer centre in the country. This means we have one of the quickest recovery rates following this type of surgery for our patients in the country.

In addition, the Trust continues to perform the highest percentage of Minimally Invasive Oesophagectomy (MIO) in the UK, a procedure to remove part of the oesophagus (gullet). The national average for minimally invasive approaches to oesophagectomies is 38%. NNUH performs at around 95%.

Mr Edward Cheong, Upper GI Cancer Lead and Consultant Oesophago-Gastric Surgeon said: "The results from this recent audit reflect the enormous dedication and commitment from the entire Oesophago-gastric Cancer team at the hospital. We are extremely proud of the work we do and it is fantastic to be independently recognised for the quality of our service."

NNUH is rated as one of the top units in the country for treating Oesophago-Gastric Cancer and one of the few units in Europe to perform totally minimally invasive oesophagectomy whereby the entire operation is done by keyhole surgery (laparoscopic and thoracoscopic oesophagectomy). The keyhole or laparoscopic surgery is less traumatic to the body allowing the patient to recover significantly faster.

Data Quality

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

Information Governance Toolkit Attainment Levels

The Norfolk and Norwich University Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2017/18 was 76% and was graded Red – Not satisfactory.

Clinical Coding error rate

The Norfolk and Norwich University Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2017/18 by the Audit Commission.

Improving Data Quality

The Norfolk and Norwich University Hospitals NHS Foundation Trust will be taking the following actions to improve data quality 2017/18

18 Weeks Referral to Treatment

As part of the Trust's internal data quality spot check audit programme the Data Quality team will undertake a rolling programme of 18 week RTT Spot Checks. The audit will include all specialities with a view to ensure data is accurate, valid, reliable, timely, relevant and complete on the Patient Administration System (PAS). The audit's main focus will be on the data accuracy of those patients on an 18 Week Referral to Treatment (RTT) pathway in compliance with the Trust's, Patient Access Policy, Information Governance & National Guidance for 18wk RTT Rule Suite.

The 18 week RTT pathway is about improving patient's experience of the NHS – ensuring all patients receive high quality elective care without any *unnecessary* delay. Managing a patient through their pathway involves accurate data capture at each step along the way thus providing: the clinicians with an accurate 18 week status for their patients and administrative staff with potential evidence of any bottlenecks in the pathway which may be due to process delay.

18 Week Audit Programme 2017/18 results

- 26 Audits were completed
- 17 Specialties improved on 2016/17 results
- 4 Specialities achieved the Trust target of 90%
- 2 Specialties achieved the same results as 2016/17
- 6 Specialties decreased in performance

The Trust reviewed the results and patterns of errors from the 2017/18 audit programme and has used the information to plan coaching and robust communication over the next 12 months.

The Trusts holds monthly Referral to Treatment Operational meetings (RTTOMG) attended by Admin Leads. At this forum best practice is shared and issues raised throughout the previous month are discussed, audit results are shared to date and advice and guidance is provided as required on multiple subject matters.

The 18 week eLearning forms part of core competency for staff who manage 18 week patient pathways, noncompliance is flagged via a report. This process ensures we keep ourselves updated and informed.

Secondary Uses Service (SUS) Dashboard
SUS is the single, comprehensive repository for healthcare data in England which enables a range of reporting and analyses to support the ***NHS*** in the delivery of healthcare services.
The SUS+ Data Quality Dashboards (DQDs) monitor and drive improvements in the quality and completeness of SUS+ data. They allow organisations to assess their own data in SUS+ to ensure that it is comprehensive and compliant with data standards. They also show a comparison to National and Region level data.
The NNUH reviews the data and will work collaboratively to enhance performance in multiple areas – please see example below of on-going work to ensure NHS numbers are recorded and used on PAS and Key Systems.

NHS Number
The NNUH works collaboratively to ensure the patients NHS number is recorded on PAS and other Key Systems used within the Trust.
The General Principles as summarised on NHD Digital are:
Find it, Use it, Share it
The NNUH has its own NHS Number Policy to assist staff with the robust management of NHS numbers.
The SUS Dashboard is used as a bench marking tool.
We use some of the data items included within the SUS Dashboard to form part of the Key System Audit criteria and again we can work together to enhance performance.
The NNUH's performance is above the national average for Admitted Patient Care, Outpatient Care and A&E (the only exception is Data Item – Patient pathway ID on APC & OPC)

Learning From Deaths

In support of this section the Trust draws the reader's attention to the our public Corporate and Clinical Governance web page, which details the Trust's Responding to Patient Deaths Policy and supporting information: http://www.nnuh.nhs.uk/about-us/healthcare-and-governance/

During 2017/18 3177 of Norfolk and Norwich University Hospitals NHS Foundation Trust patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 933 in the first quarter; 995 in the second quarter; 1189 in the third quarter; 1188 in the fourth quarter.

By 1st April 2018 1545 case record reviews and 13 investigations have been carried out in relation to 4365 of the deaths included above.

In 13 cases 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:

532 in the first quarter; 479 in the second quarter; 358 in the third quarter; 176 in the fourth quarter. For Q4 and to a lesser extent for Q3 there will be more reviews coming through as the teams catch up in April, May and June. These latter two quarter figures therefore are not complete.

13 representing 0.41% 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: 5 representing 0.5% for the first quarter; 5 representing 0.5% for the second quarter; 2 representing 0.17% for the third quarter; 1 representing 0.08% for the fourth quarter.

These numbers have been estimated using the Trust Potentially Preventable death review process. The Structured Judgment Review Method as recommended by the National Mortality Case Record Review programme is currently being implemented as the methodology for this process.

Learning from case record reviews has highlighted appropriate response to acute deterioration or to clinically significant results; Early Warning Score monitoring; Fluid balance and electrolytes management; lack of senior review; resuscitation status documentation and inappropriate resuscitation team calls; and medication issues – anticoagulants.

As a consequence of the learning gained from record reviews and investigations, the Trust has made the following actions: Clinical Governance focus on Early Warning Score and response on Sepsis 6; Acute Kidney Injury (AKI) group formed with an associated business case for AKI services in development; focus on senior review through SAFER and the 7 day survey; a business case is being developed for emergency observation services; the overall redesign of the Quality and Safety team to increase family liaison; a Medical Examiner business case is being developed; Neck of Femur Fracture Excellence Together working group

With respect to the impact these actions are having, regarding the Neck of Femur Fracture Excellence Together working group, from Nov 16- April 17 the average time to theatre for neck of femur (NOF) patients was 32 hours, this has progressively decreased every month to 28 hours for Feb 2018 (National Hip Fracture database data)

Overall from February to July 2017, 30 day mortality averaged 9%, significantly above the national average of 7% which led to the NNUH being identified as a national outlier. This has now decreased to 5.9 % for the month of Feb 2018.

364 case record reviews and 9 investigations completed after 1st of April 2017 which related to deaths which took place before the start of the reporting period.

9 representing 0.2% of the patient deaths before the reporting period, 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 Potentially Preventable death review as per local Trust process. The Structured Judgment Review Method as recommended by the National Mortality Case Record Review programme is currently being implemented as the methodology for this process.

22 representing 0.5% 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.

Reporting against core indicators

Please note that the guidance 'Detailed requirements for quality reports 2017/18' published by NHS Improvement instructs that 'since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the trust by NHS Digital' (p15). Currently no such data is available to Trusts through NHS Digital for the year 2017/18. However, so as to offer as detailed and transparent a picture of Trust performance as possible, what follows is the best information available at the time of writing. Please note that previous reporting years, 2016/17 and 2015/16, are as published by NHS Digital.

SHMI value and banding						
Indicator	2017/18 NHS Digital not available				NNUH 16/17	NNUH 15/16
	NNUHFT (Self-reported Oct 2016-Sept 2017)	National Average	Best performer	Worst performer		
SHMI value and banding	1.066 Band 2	No data yet published	No data yet published	No data yet published	1.065 Band 2	1.056 Band 2
No data published for 2017/18 Location: https://indicators.hscic.gov.uk/webview/ > SHMI indicator > Download September 2017 publication > SHMI data at trust level, select from value and banding columns **Current version uploaded: Mar-18 (contains only data for Oct16 – Sep17). // Next version due: Jun-18**						
% of patient deaths with palliative care						
Indicator	2017/18 NHS Digital not available				NNUH 16/17	NNUH 15/16
	NNUHFT (Self-reported July 2016-June2017)	National Average	Best performer	Worst performer		
% of patient deaths with palliative care coded at either diagnosis or specialty level for the reporting period	22.3%	No data yet published	No data yet published	No data yet published	22.1%	19.5%
No data published for 2017/18 Location: https://indicators.hscic.gov.uk/webview/ > SHMI indicator > Download September 2017 publication > SHMI contextual indicators > Palliative care coding > Percentage of deaths with palliative care coding **Current version uploaded: Mar-18 (contains only data for Oct16 – Sep17). // Next version due: Jun-18** The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The data sets are nationally mandated and internal data validation processes are in place prior to submission. The Norfolk and Norwich University Hospitals NHS Foundation Trust intends to take the following actions to improve the indicator and percentage in (a) and (b), and so the quality of its services. By increasing the amount of analysis on the factors underpinning SHMI, the Trust is confident that it will be able to improve its performance.						
PROMS						
Indicator	2017/18 NHS Digital not available				NNUH 16/17	NNUH 15/16
	NNUHFT	National Average	Best performer	Worst performer		
Patient reported outcome scores for groin hernia surgery	No Trust data yet published	No Trust data yet published	No Trust data yet published	No Trust data yet published	0.099	0.095 (Apr-Sep)
Patient reported	No Trust	No Trust	No Trust	No Trust	0.099	0.088

outcome scores for varicose vein surgery	data yet published	data yet published	data yet published	data yet published		(Apr-Sep)
Patient reported outcome scores for hip replacement surgery	No Trust data yet published	No Trust data yet published	No Trust data yet published	No Trust data yet published	0.495	0.421 (Apr-Sep)
Patient reported outcome scores for knee replacement surgery	No Trust data yet published	No Trust data yet published	No Trust data yet published	No Trust data yet published	0.259	0.293 (Apr-Sep)

Data is only available at CCG level and last reporting period is 2014/15 as of 6/04/2017
Location: 3.3 Patient reported outcome measures (PROMs) for elective procedures
Current version uploaded: Sep-17 // Next version due: Sep-18

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

28 day readmission rates

Indicator	2017/18 (NNUH reported based on the NHS Outcomes Framework Specification)				NNUH 16/17 (NNUH Reported)
	NNUHFT	National Average	Best performer	Worst performer	
28 day readmission rates for patients aged 0-15	12.43	No data published	No data published	No data published	12.58
28 day readmission rates for patients aged 16 or over		No data published	No data published	No data published	

Please note that this indicator was last updated in December 2013 and future releases have been temporarily suspended pending a methodology review.
There is no data published for 2012/13, 2013/14, 2014/15 and 2015/16 as of 6/04/2017.
Current version uploaded: Dec-13 // Next version due: TBC

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

Trust responsiveness

Indicator	2016/17 NHS Digital				NNUH 16/17	NNUH 15/16
	NNUHFT	National Average	Best performer	Worst performer		
Trust's responsiveness to the personal needs of its patients during the reporting period.	68.2	68.1	85.2	60	68.2	68.7

Location: https://indicators.hscic.gov.uk/webview/ > 4.5 Responsiveness to Inpatients' personal needs > CCG OIS - Indicator 4.5
Current version uploaded: Sep-17 // Next version due: Sep-18

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: The data source is produced by the Care Quality Commission.
The Norfolk and Norwich University Hospitals NHS Foundation Trust has taken the following actions to improve this data, and so the quality of its services: By increasing the amount of

feedback we gather from patients in real time through the Friends and Family test and our inpatient feedback project, we are able to identify emergent issues very quickly and to swiftly take any appropriate corrective action to address the cause of the problem.

% Staff employed who would recommend the trust

Indicator	2017 NHS Staff Survey Results				NNUH 16/17	NNUH 15/16
	NNUHFT	National Average	Best performer	Worst performer		
Percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.	76%	70%	86%	47%	76%	71.5%

No data found in the portal

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

% of patients assessed for VTE

Indicator	2017/18 (Trust Reported)				NNUH 16/17	NNUH 15/16
	NNUHFT	National Average	Best performer	Worst performer		
Percentage of patients who were admitted to the hospital and who were risk assessed for VTE during the reporting period	98.94	No data yet published	No data yet published	No data yet published	99.31 (Oct-Mar)	91.2% (Apr-Dec)

No data available in NHS indicator portal

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

C difficile

Indicator	2016/17 NHS Digital				NNUH 16/17	NNUH 15/16
	NNUHFT	National Average	Highest	Lowest		
Rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period	11.97	13.19	82.72	1.17	11.97	16.11

Rates found for financial years of 2015/16 and 2016/17. No data for 2017/18
Location: https://indicators.hscic.gov.uk/webview/ > NHS Outcomes Framework - Indicator **5.2.ii**
Current version uploaded: Aug-17 // Next version due: Aug-18

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this rate is as described for the following reasons: The data have been sourced from the Health & Social Care Information Centre, compared to internal Trust data and data hosted by the Health Protection Agency

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

Patient Safety Incidents per 100 admissions

Indicator	2016/17 NHS Digital				NNUH 16/17	NNUH 15/16
	NNUHFT	National Average	Highest	Lowest		
Number and rate of patient safety incidents per 100 admissions	41.6	40.95	70.4	22.1	Q1/2 Rate 41.1 (n7276) Q3/4 Rate 42.1 (7076)	21.3 rate No:7,297 (Apr-Sept)
Number and percentage of patient safety incidents per 1000 admissions resulting in severe harm or death	0.065	0.16	0.565	0.01	Q1/2 Rate 0.07 (n12) Q3/4 Rate 0.06 (n10)	0.12 No: 9 (Apr-Sept)

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

Current version uploaded: Nov-17 // Next version due – May-18

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

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

Other Information

Patient Safety – Serious Incidents (SIs)

Please refer to pages 138 -141

Patient Safety – Never events

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

In our hospitals there were six never events during the period covered by this Quality Report (four in 2016/17).

- Insertion of wrong implant – stent
- Retained Swab post surgery
- Retained Swab post delivery
- Wrong site surgery
- Transfusion of incompatible blood product (Declared in March 2018. Still under investigation)
- Insertion of wrong tunnelled line

Thorough *Root Cause Analysis (RCA)* was carried out on all events, and the learning points were disseminated to the teams through Organisation Wide Learning (OWL) bulletins. These learning points included the following:

- A standardised procedure for identifying and checking correct prosthesis / implant for interventional procedures in a non-theatre setting
- Distractions during swab checks must be limited to enable the team to fully focus; a 'silent cockpit' principle should be embedded. (This was a feature in 2 cases).
- Unnecessary swabs removed from the sterile packs used in delivery
- Environment in Delivery suite modified to minimise unnecessary distractions
- Doctors' bleeps should be held by another member of the team whilst theatre cases in progress.
- Checking procedures to identify surgical site identification reviewed and strengthened
- Environment in Interventional Radiology no longer sufficient to meet demand. Business case for new unit with the most advanced level equipment in progress.

Review of IT systems within Blood Transfusion to introduce a system where it is not possible to issue ABO incompatible products.

Patient Safety – Duty of Candour

Please refer to page 138

Patient Safety – Care Quality Commission (CQC) ratings and action plan

The Care Quality Commission (CQC) last inspected our Trust in April 2017 and published their report in August 2017. The report highlighted the caring nature of the service provided by our staff. No part of our service was judged to be inadequate and the overall rating of 'requires improvement' was in line with our own self-assessment.

We continue to review and evaluate our compliance with all CQC regulations on an on-going basis and maintain an action plan developed to specifically address recommendations within our August 2017 inspection report

Warning Notice Item	Overall Task Status	Update
The Children's emergency department was not suitable for the service provided, the area was not large enough to accommodate the potential number of service users using the department at any one time, and there was no High Dependency care service outside of the department	**Completed**	• Revised footprint designed by Paediatric ED Lead Consultant and ED Paed Team. • Children's ED created in accordance with expanded specification to up to 14 cubicles and HDU facilities. • A dedicated children's HDU environment has been created within new ED environment. • Final touches of furniture and artwork being signed off W/B 12th March
The Emergency department premises were not fit for purpose; the layout was widely spread, the area was not large enough to accommodate the potential number of service users using the department at any one time, and multiple areas within the department were not being used as intended or safely	**Ongoing**	• OPED launched in December 2017 and Children's ED relocated to expanded footprint. • CDU fully operational in temporary location, with design for permanent solution signed off by ED Senior Leaders team. Construction phase provisionally planned to start April 2018. • Call Bell system installation complete, commissioning completed 8th March 2018 . New panic alarm strips in ED quiet room now all functional. • Revised SOPs have been produced, ratified and made available to all staff. • Tannoy / PA system to be installed across all ED areas end of March 2018 to improve communication and emergency response.
There was a lack of safe, and secure where necessary, environments for those living with serious mental health concerns including those that were detained under the mental health act (1983)	**Ongoing**	• Specification for works to address safety and security concerns have been agreed and completed across most areas. MH cubicle, and quiet rooms in ED and Children's ED completed Feb 2018 • Mental Health Board, chaired by Medical Director, set up and initial meetings held. • Interim Mental Health Risk Assessment completed on 01/02/2018, whilst awaiting completion of all estate works. • Works commenced on new MH spec isolation unit in old Paeds ED area due for completion 30th March 2018
The healthcare records of service users were not always accurate and complete in relation to care	**Completed**	• Reminders have been circulated to all ED staff in relation to the importance of the accuracy of patient documentation. Process for audit of documentation standards has been agreed and audits have

and treatment provided to the service user, and of decisions taken in relation to the care and treatment provided		commenced. • Bespoke training sessions have been provided by the Trust DOLS/MCA matron on completion of documentation including new mental health triage tool and capacity assessments. • Re-Audit of MH documentation to be completed 13th March after educational work and further training
Staff were not able to demonstrate a sufficient understanding of the mental capacity act (2005) nor that they were working within the requirements of this act	**Completed**	• Training has been provided by the Trust Mental Capacity Act (MCA) lead within the Emergency Department. Training ongoing with rotation of Junior ED staff into the department. Investigating mandatory training requirements of junior Drs who will rotate through ED to increase compliance. • Compliance is being measured and this is now a standing item on the ED Governance Meeting agenda (recent reduction in compliance with junior Dr changeover – most do not have have MCA/DOLS as training requirement on ESR – being investigated).
Systems & Processes were neither properly established nor operating effectively to ensure preventing and controlling the spread of infections, including those that are healthcare associated	**Completed**	• Weekly IP&C meetings set up with ED Managers and Sarah Morter to review progress against agreed plans. Standard infection control notices have been updated to specify cubicle use and have been put up within ED. • SOP for IP&C/Cleaning processes has been revised, ratified and uploaded to Trust central documentation. • Seating is constructed from intervene fabric that is waterproof, washable and anti-microbial. • Cleaning logs are being audited to ensure the regimented cleaning schedule is being adhered to. • Recent audits of compliance with transcribing IP&C PAS alerts onto ED patient documentation has demonstrated continued improvement. Audited monthly • Minor works request outstanding to replace 1 sink in ED which is not standard handwashing sink (risk assessment complete) • Minor works in place to add wall brackets for sharps bins, and increase number of alcohol gel dispensers in ED escalation corridor after recent external IP&C inspection highlighted areas for improvement.

CQC Must Do Action	Associated QIP SMART Action
The Trust must ensure that medication is stored in line with Trust policy & staff record medication refrigeration temperatures.	Review and enforce requirements and processes for the safe storage of medicines, including an options appraisal regarding technical solutions in relation to monitoring of temperatures.
The Trust must ensure that resuscitation equipment in wards, theatres and other areas is checked in accordance with Trust policy.	Review and enforce requirements and processes for resuscitation equipment checks.
The Trust must ensure that patient records are stored securely.	Review and enforce requirements and processes for the safe storage of medical records.
The provider must ensure staff complete appropriate mandatory training including safeguarding training to the required level for their job role.	Review and amalgamate existing policies regarding mandatory training, to provide explicit expectations regarding obligations for each staff group and the most effective method of achieving this.

Clinical Effectiveness – Achieving cancer referral and treatment times

	National Standard	Q1 1718	Q2 1718	Q3 1718	Q4 1718*
GP 2WW	93%	92.99%	92.27%	96.11%	95.52%
Breast Sympt 2WW	93%	97.66%	98.30%	98.27%	90.32%
31 Day First Treat	96%	97.91%	99.49%	99.19%	97.91%
31 Day Subs ACD	98%	100.00%	100.00%	100.00%	99.29%
31 Day Subs RT	94%	97.93%	98.18%	98.99%	98.00%
31 Day Subs Surgery	94%	96.29%	98.70%	96.38%	89.76%
62 Day GP	85%	76.54%	87.57%	84.25%	77.93%
Reallocated 62 Day GP	85%	76.54%	88.89%	85.36%	80.49%
62 Day Upgrade		62.93%	61.29%	65.04%	53.95%
62 Day Screening	90%	86.11%	88.62%	86.82%	90.51%
62 Day Breast Sympt	85%	100.00%	100.00%	100.00%	50.00%

Source: NNUH data, national definitions used

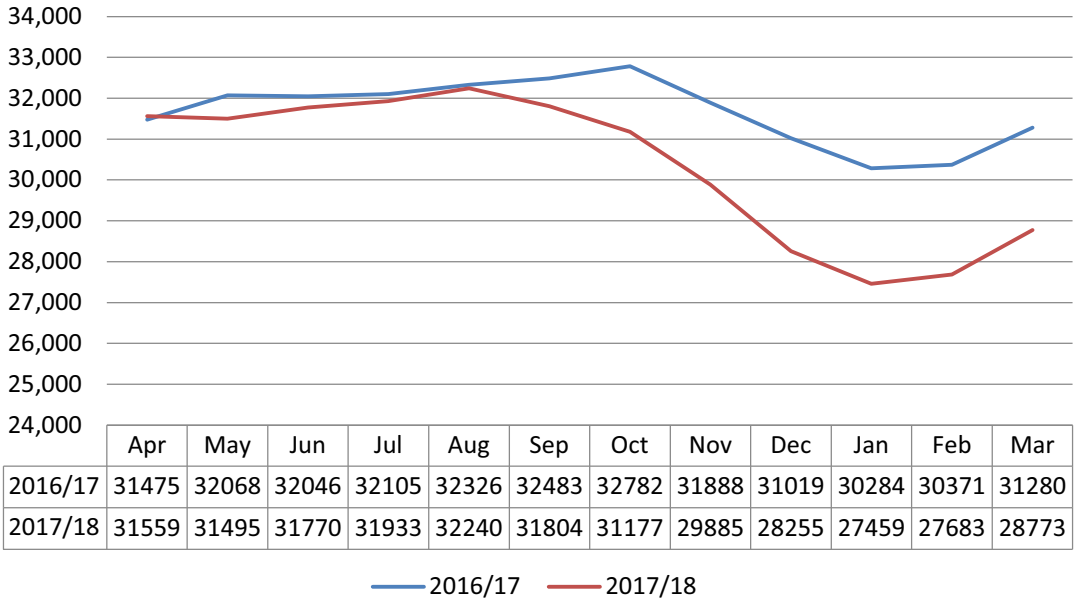
**Quarter 4 2017/18 data is currently provisional*
Please note that reallocations have been applied in line with the East of England Cancer Alliance policy, and are only available from August 2017 onwards

Clinical Effectiveness – 18 week RTT waiting times

In line with National reporting, 2017/18 has seen congestion from increased non elective admissions, particularly over the severe Winter period and complexity of presentation and conversion rates have increased. There has been a significant acuity and rise in admissions for Respiratory and attendees in the age group 70-79.

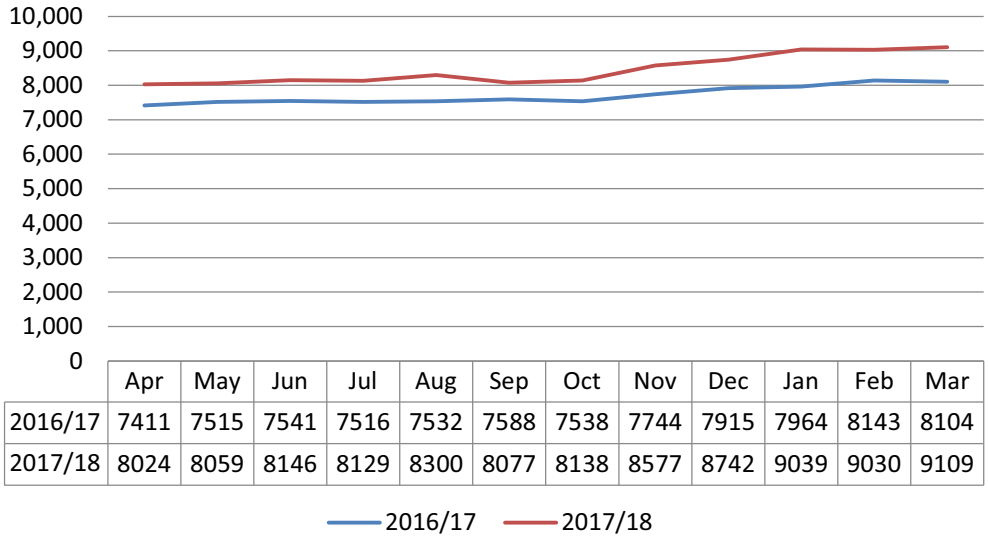
These factors have impacted on the Trusts 18 week referral to treatment performance, however recovery trajectories have been remodelled to take into account revised operational plan and impact of outpatient/daycase/inpatient procedures cancelled during adverse weather.

Non-Admitted Waiting List



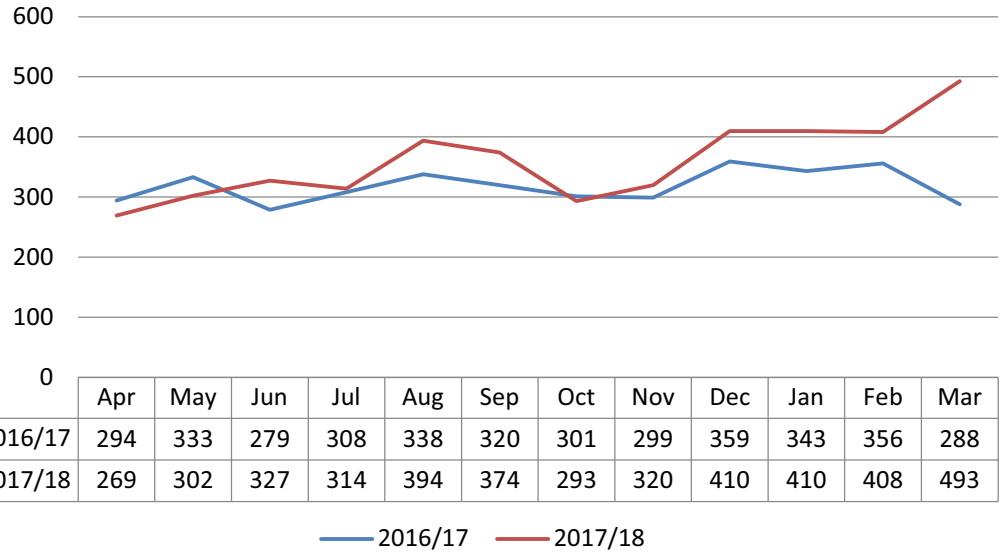
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	31475	32068	32046	32105	32326	32483	32782	31888	31019	30284	30371	31280
2017/18	31559	31495	31770	31933	32240	31804	31177	29885	28255	27459	27683	28773

Admitted Waiting List



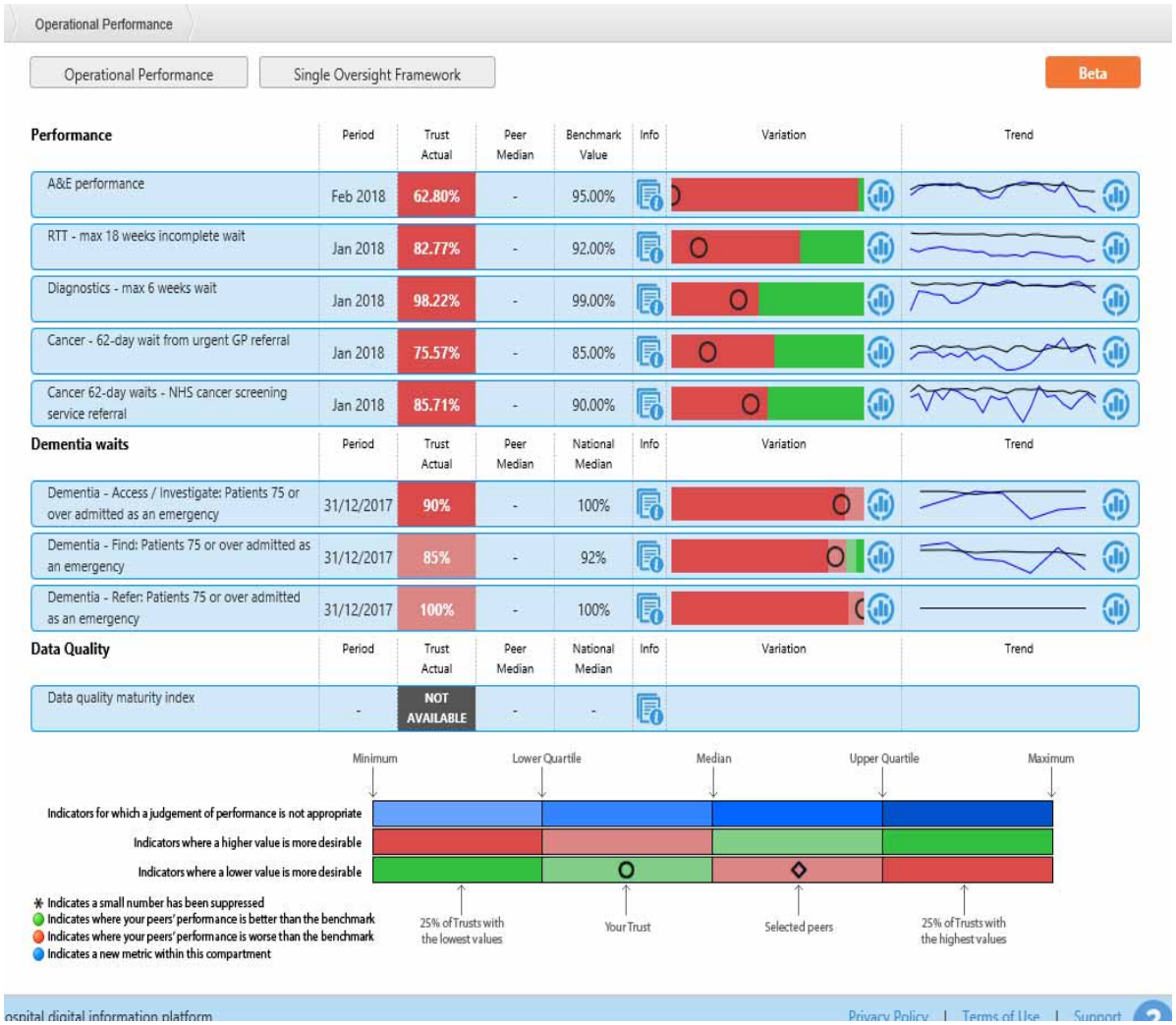
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	7411	7515	7541	7516	7532	7588	7538	7744	7915	7964	8143	8104
2017/18	8024	8059	8146	8129	8300	8077	8138	8577	8742	9039	9030	9109

Long Waiters - 40+



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016/17	294	333	279	308	338	320	301	299	359	343	356	288
2017/18	269	302	327	314	394	374	293	320	410	410	408	493

Clinical Effectiveness - NHSi's Compliance Framework (limited to those metrics that were included in both RAF and SOF for 2017/18)



Clinical Effectiveness – Clinical research and development

Please refer to page 139.

Staff Experience – NHS Staff Survey

All hospitals' staff survey reports are published online at www.nhsstaffsurveys.com

Over 3,500 of Trust Staff returned the survey form. The report shows that 18 of the 32 categories demonstrated significant improvement over the last 2 years, and none of the key findings worsened in the rankings.

There were 10 key findings in the bottom category compared with all trusts in the country (reduced from 20 last year) and this shows us where we need to focus our attention to improve things for you and colleagues.

Results are shared within clinical divisions and corporate departments, and through other groups like the council of governors, joint committee with trade union reps and the staff experience working group, in order to plan actions for continuing further improvements.

Patient Experience – Encouraging Patient Flow

Please refer to page 141.

Patient Experience – Frailty Strategy

During 2017/18 the Trust has delivered a range of inpatient and outpatient service developments to improve provision and care for frail patients.
The ultimate aim of these developments is to ensure that all patients receive the "gold standard" of care as quickly as possible. Identifying potentially Frail patients and completing a Comprehensive Geriatric Assessment (CGA) of their medical conditions, cognitive state, level of independence and social circumstances, is accepted as the most effective way in which to ensure that older people avoid unnecessary hospital stays while having their care needs met, maintaining their independence for as long as possible and spending no longer in hospital than is absolutely necessary.

OPAS (Older People's Assessment Service)
The Trust has made significant improvements to the way in which the outpatient service functions, by reducing the wait for an appointment and moving to an ambulatory approach to care which supports patient independence and admission avoidance. This service provides a rapid assessment of needs including all appropriate elements of a Comprehensive Geriatric Assessment.
GPs fill in an electronic referral and access the service via a confidential email account. Once the referral is received, the patient is contacted and invited for assessment. Results of the assessment and changes / recommendations for future care and management are made available to GPs via the same email system, usually on the same day.
The service has seen a reduction in patients requiring a follow-up appointment and long waits for an assessment significantly reduced from an average of 6 weeks to 2 days.

OPAC (Older People's Ambulatory Care)
OPAC provides care for patients arriving from the Emergency Department (ED). OPAC is a more conducive environment for older patients who may require further investigations, a period of recovery and a Comprehensive Geriatric Assessment. The aim of OPAC is to safely discharge the patient to their usual place of residence within a day.

OPED (Older People's Emergency Department)

OPED is the UK's first Emergency Department that is entirely dedicated to older patients. The department opened in December 2017. It has a designated Older People's team consisting of Emergency Department Consultants and a senior geriatrician, junior medical staff and advanced Nurse Practitioners who work in conjugation with the Early Intervention team identifying and assessing potentially frail older patients. OPEDs working hours are 9-5pm Monday to Friday with the ambition to extend these hours to 8pm Monday to Friday and eventually 7 days a week.

There are already fast track pathways in existence for patients with stroke, fractured neck of femur and heart attack. OPED is for those patients that do not fit the established pathways already in place. When a patient of 80 years or over arrives at the emergency department (ED), they are triaged and if suitable go straight to OPED. Patients who require admission will be admitted directly to one of the specialist older people's wards or to another specialty ward if appropriate.

Working closely with clinical teams in the Emergency Department to identify and pull these patients through to OPED has resulted in a continued reduction in the Emergency Department's conversion rate and better outcomes as regards length of stay if admitted.

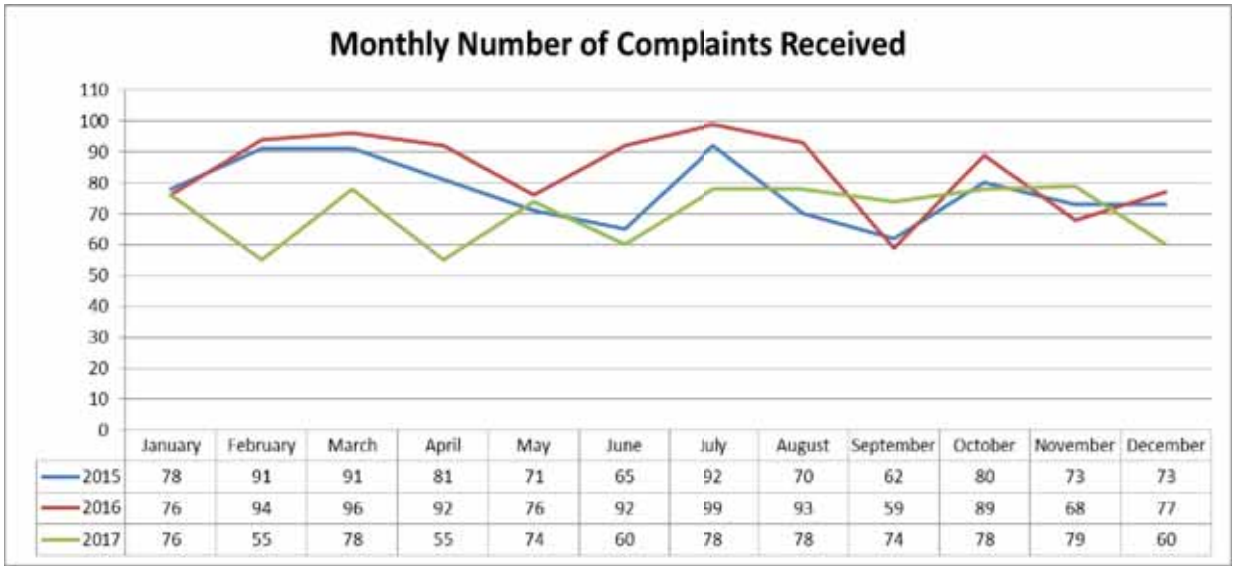
Feedback from patients, relatives and GPs has been positive so far. Patients find the environment quieter than the main ED. Families find it helpful to talk to an expert doctor or nurse on the day of admission very helpful. It also gives our staff the opportunity to gain very useful information to help with planning for discharge and / on-going care needs

Patient Experience – Complaints

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

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

Complaints received by month



	January	February	March	April	May	June	July	August	September	October	November	December
2015	78	91	91	81	71	65	92	70	62	80	73	73
2016	76	94	96	92	76	92	99	93	59	89	68	77
2017	76	55	78	55	74	60	78	78	74	78	79	60

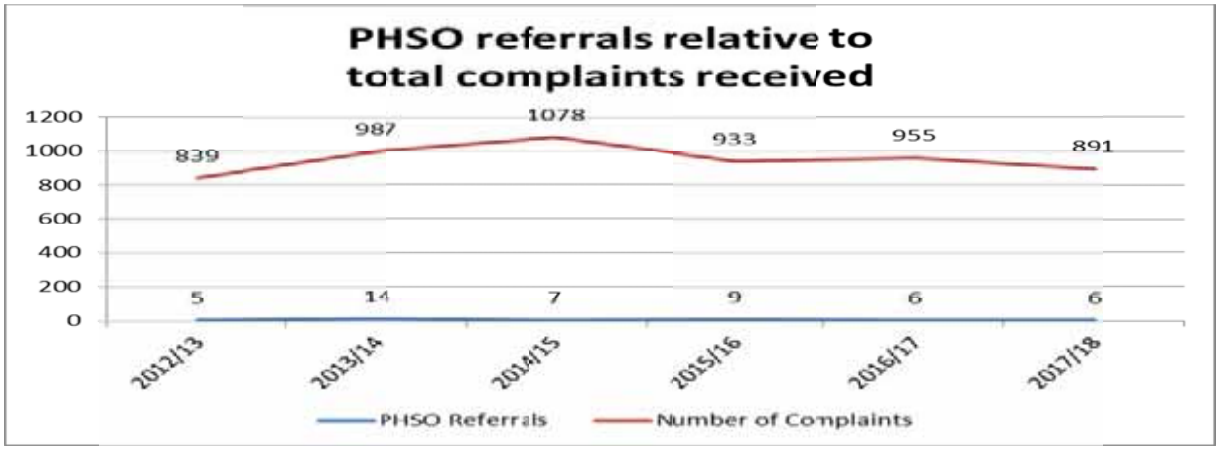
Source: NNUH data, local definition

To ensure that our complaints processes are 'fit for purpose' and are being followed, they are regularly reviewed by our Internal Audit service. They were last reviewed in 2015 and no recommendations for change were made.

A periodic review of complaints files is also conducted by the Healthwatch Norfolk Team, which has been consistently complimentary of our approach to managing complaints. We are grateful to Healthwatch for their work with us to provide an additional means of independent assurance with regards to our approach to complaints. We have been pleased to implement a number of recommendations made by the Healthwatch team.

During the period covered by this report, an analysis of complaints 'appealed' to the Parliamentary and Health Service Ombudsman (PHSO) was carried out as below:

PHSO referrals



Source: NNUH data, local definition

The PHSO has the power to investigate a complaint once local resolution has been completed. The number of appeals to the PHSO represents 0.5-2% of complaints. The number of referrals from this Trust is low relative to other Trusts, indicating relative success in resolving matters at the first stage.

The annual Clinical Audit Plan now includes reference to those areas that are being audited in response to changes resulting from complaints. This ensures that there is clear follow-up of the implementation of actions agreed.

NNUH receives recognition for fantastic Friends and Family Test rate

“The trust is a real example to others, demonstrating how to ensure that patients get the care that they deserve” said Jeremy Hunt Secretary of State for Health in a letter to the Norfolk and Norwich University Hospital in regards to the trust’s Friends and Family Test recent recommendation rate.

NNUH achieved 97% in the Friend and Family Test recommendation rate in June this year following feedback from outpatients. The test allows patients who have visited one of our outpatient departments to provide their comments on the care they have received.

Mr Hunt added: “From visiting organisations throughout the country, I know that the immense amount of work that will have been behind this outcome cannot be underestimated. This is a testament to the hard work and dedication of the trust’s staff.”

The feedback taken from the survey allows the Trust to look at how and where improvements can be made to enhance patient experience at NNUH.

Annex 1 - Statements from Clinical Commissioning Boards, Local Healthwatch organisations and Overview and Scrutinty Committees

Statement from NHS North Norfolk CCG

NHS North Norfolk Clinical Commissioning Group (NNCCG), as the coordinating commissioner for Norfolk and Norwich University Hospital (NNUH FT) for the Norfolk and Waveney CCG's (Norwich, North Norfolk, South Norfolk, West Norfolk and Great Yarmouth & Waveney), supports the Trust in its publication of the 2017/18 Quality Account.

Having reviewed the mandatory detail of the report, the CCG's are satisfied that the Quality Account incorporates the mandated elements that are required. The CCG recognises that NNUH have undertaken to develop and deliver a significant number of quality improvement initiatives including a significant reduction in your mortality rate. The success in delivery of key metrics associated with infection prevention and control in 2017/8 is also recognised.

The CCG's recognise the challenges experienced by the Trust and the impact that this has had on the organisation as a whole not least its frontline staff. NNUH is currently awaiting feedback from the Section 29a letter submitted to the CQC in January 2018 and the outcome of the CQC Inspection undertaken in March 2018.

The Trust continues to work collaboratively with a range of stakeholders and has received external support from both NHS I and NHS E during the year. The CCG has and will continue to support the Trust through Clinical Quality Review Meetings (CQRM).

Quality Priorities 2017/18

1) Reduction in medication errors: zero insulin errors causing moderate harm or above.

   The CCG's confirms that NNUH only had one incident of moderate harm at the end of 2017/8 however overall the number of incidents did not decline and we welcome the continued inclusion unchanged in the priorities for 2018/9.

2) To improve screening and compliance with the 'Sepsis 6' Care bundle, of which the single most important aspect is the administration of antibiotics within an hour of diagnosis.

   The CCG's recognise that progress was made across the domains however there is still further work to be done. The CCG welcomes the proposal to continue to focus on sepsis as part of the redefined priority for 2018/9. Data remains incomplete for the year.

3) To ensure that 95% compliance with thromboprophylaxis risk assessment (TRA), as evidenced on the Electronic Prescribing and Medicines Administration system (EPMA).

   NNCCG note that this measure has been consistently achieved throughout the year.

4) To remain within the top quartile of acute trusts for incident reporting on NRLS and to achieve 100% Duty of Candour compliance.

   NNUH have consistently delivered its ambition to achieve 100% Duty of Candour compliance.

The Trust has also achieved its ambition to be in the top quartile of acute trusts for incident reporting on NRLS. NNUH is a good reporter of incidents generally NNCCG would however recommend that further work is required to ensure the Trust maintains and improves on this ambition. The CCG welcomes the addition of a new priority focusing on human factors and improving teamwork and communication. The CCG also noted that in March this year there were 25 SIs reported which was a marked increase on the monthly incidents previously reported. The CCG requests that NNUH also continue to focus on decreasing potential SI's notably those that cause moderate harm or above and the improving the quality of the investigations. NNUH should also ensure that the lessons learnt are fully embedded and that this is demonstrable.

5) Clostridium difficile within trajectory target, 0 cases of Hospital Acquired MRSA bacteraemia.

   NNUH have achieved this ambition and improved on the previous year's position.

6) Year on year increase in patients recruited into research studies. Aim to achieve 3300 recruitment into NIHR studies in 2017-18.

   The CCG whilst recognising there are pockets of excellence note that NNUH continue to experience problems recruiting patients to take part in research and as such recommend that this remain a priority for 2018/9. The CCG would like to better understand where the challenges have been and what actions are being taken to improve this.

7) Timely medical review of all patients - every patient should be reviewed by a doctor every day. All new and unstable patients and all patients for potential discharge should be reviewed by an ST3 (senior medical trainee) or above.

   Compliance against this ambition has not been achieved and data is only reported for part of the year. A number of SI's during the year have also indicated that timely review of patients has not always been achieved and has in part contributed to delays in treatment. The CCG's welcome the implementation of a new reporting tool and will continue to monitor this at CQRG. NNCCG recommend that this remains a Quality Priority for 2018/9.

8) 95% or more of patients in all areas report through the Friends and Family Test that they are extremely likely or likely to recommend our services to their friends and family.

   The CCG's recognise that NNUH have consistently achieved this ambition with 96.52% of participants saying that they would recommend the Trust. This is an excellent reflection of the value patients place on the care received at NNUH. Whilst not distracting from this achievement it is important to note that overall numbers of responses is low in some areas and NNUH should explore new ways to improve on this.

9) Improved continuity of care and experience through reduced ward moves and reduced numbers of outliers.

   During the year NNUH has experienced unprecedented demand for beds this has subsequently had an impact on the ability to deliver this priority. It is important that NNUH do not lose sight of this ambition due to the impact on patient care and outcomes. Likewise NNUH need to ensure that escalation policies reflect the need to repatriate patients back to the appropriate clinical area as soon as possible.

10) Improved discharge process 100% of Estimated Date of Discharges (EDD) recorded within 24 hours of admission on WardView – SAFER criteria (now Medworxx).

    95% Electronic Discharge Letters (EDL) to be completed within 24 hours of discharge.

NNUH have failed to achieve this ambition and this continues to be discussed on a regular basis at CQRG and SPRG. The CCG have requested an action plan to provide assurance that this ambition is being addressed across the Trust. The CCG recommends that this remains a Quality Priority for 2018/9.

Quality Priorities 2018/19

The CCG's are in support the key quality priorities for 2018/19. The CCG's do however recommend that the Trust ensures that those Quality Priorities that were not realised in 2017/8 are continued. NNUH should ensure that there are SMART Action plans put in place against all priorities so that assurance can be provided to Regulators and Commissioners that the level of ambition can be realistically achieved. NNUH should also ensure that improvements are measureable and demonstrable by designing comprehensive measures and patient outcomes against each quality priority identified for 2018/19.

The CCG's will continue to work with the Trust to monitor and review progress on the areas identified and have made the following additional recommendations on specific priorities:

Patient Safety

- Prompt recognition and treatment of deteriorating patient – the CCG welcomes this as a priority and the links to investigations and the mortality review process. Further understanding is required as to what the key lessons and recommendations that have resulted from investigations are and how these will inform the actions that demonstrate how this priority will be achieved.
- Improvement in frailty provision and care – the CCG's would like to understand in more detail what this priority will achieve. Similarly more detail would be welcomed as to the actions that will be undertaken to deliver this ambition and how success will be demonstrated. The document suggests further detail is provided later specifically at page 68. This could not be found. The CCG recommends that NNUH include a focus on falls prevention, reducing urinary tract infections and reducing the number of Grade Two and Grade Three Pressure Ulcers.

Clinical Effectiveness

- Seven day services – the CCG welcomes this ambition however more assurance is required about delivery including detail of the action plan that is referred to, key performance measures and improved quality outcomes to demonstrate how it will be realised.
- Keeping Patients Free form Infection - we fully support the step change included within the 'Keeping patients safe from infection priority' which now includes Gram–negative blood stream infections and Carbapenemase-producing Enterobacteriaceae (CPE) which are aligned with the national agenda.

Patient Experience

- Improved discharge processes and communication' – The CCG notes that contractual requirement regarding timely and accurate discharge communication and outpatient letters are not included in the key outcome measures. The CCG would like assurance that these will be monitored and that any trends and themes identified result in embedded learning and action plans.

- Care and Patient Experience – To improve our care to those at the end of their life -
  The CCG's welcome and support the inclusion of improving care to those at the end of their life and would suggest this could be strengthened by including the review of all audit results and the development of actions according to

recommendations from each. The CCG would also recommend that particular attention is paid to advanced care planning for patients with dementia.

- Care and Patient Experience – To improve the assessment and quality of care for patients in Mental Health crisis – the CCG's are pleased to see this as a priority area for 2018/9. NNCCG as coordinating commissioner would recommend that NNUH consider how the organisation will gather the views and experience of patients in mental health crisis in the delivery of this ambition, for example could patient stories be used?

  Additional quality measures that demonstrate how outcomes for patients are improved should be included as should measures that demonstrate engagement and co-production with service users and NSFT who will need to work in partnership with NNUH in the delivery of this ambition.

Overall we recognise that the Trust is using a range of national and local audits, national and local key performance indicators (KPIs), surveys and other forms of feedback such as the Friends and Family Test (FFT) to gain feedback from service users and their families and to improve services. Whilst outcomes from some of these measures (for example, FFT response rates) are positive there is further work to be done to increase the number of responses. The Trust should continue to explore different ways of increasing and improving feedback and patient engagement. The CCGs' also note that only four specialities achieved the Trust target of 90% for the 18 week audit programme (ref p57) and would like to understand how this will be improved upon in 2018/9.

The CCG's welcome the detailed quantitative analysis related to the learning from deaths but are mindful that this could be difficult for the reader to interpret and as such a narrative to support the analysis would further enhance the findings.

Finally the CCG's recognise, that while the recent staff survey has shown some improvement there are areas that continue to be of concern. NNUH should therefore be working hard to improve staff satisfaction through a robust Workforce and Organisational Plan where it is clear there is more to do.

The CCG looks forward to continuing to working in a positive and collaborative manner with the Trust to continue improvements in patient care during the coming year.

Alison Leather
Chief Quality Officer (SNCCG & NNCCG)

Statement from Norfolk Health Overview and Scrutiny Committee

The Norfolk Health Overview and Scrutiny Committee has decided not to comment on any of the Norfolk provider Trusts' Quality Accounts and would like to stress that this should in no way be taken as a negative comment. The Committee has taken the view that it is appropriate for Healthwatch Norfolk to consider the Quality Accounts and comment accordingly.

Statement from Healthwatch Suffolk

No return at the time of publications

Statement from Healthwatch Norfolk

Healthwatch Norfolk Statement –NNUH Quality Account

Healthwatch Norfolk appreciates the opportunity to make comments on the NNUH Quality Account for 2017/18.

In terms of the format of the document we were not able to locate any details about how to obtain the document in large print, Braille or another language. However we presume this will be added in Part 1 “Information about this report”. There is currently no glossary, which would be very helpful to the lay reader. At the time of writing this statement we note that there is significant data to be added to the draft report prior to publication and we assume that the wording attached to the graphs and tables will be amended appropriately once all data is included.

The introduction from the Chief Executive is very good in the way it summarises a range of mainly positive information, particularly improved infection prevention and control, better performance on cancer targets and an all time low on mortality rate. The development of critical care facilities at the N & N, a new medical and cancer unit at Cromer hospital, and the new Quadram Institute are all very welcome developments.

In general , the report presents very detailed Quality information, some of which is not easy for members of the public to understand. This could perhaps be addressed by providing an Executive Summary in plain English – or this could be done by expanding the statement from the Chief Executive.

Healthwatch Norfolk is aware that the NHS is under pressure for many reasons, increased numbers attending hospitals, especially older people, an expanding number of opportunities for intervention and treatment, and a reduction in budgets. All this places a strain on health and social care staff, and makes the achievement of targets harder and harder. In this context it is good that 95% of patients are happy with their experience of care and treatment at the NNUH.

The priorities for improvement appear to be more systematic and show greater improvements, when compared to last year.

It is perhaps worthy of note that patient safety incidents were highest in January 2018 and there was a significantly higher number of serious incidents in March 2018, more than double the average for the rest of the year.

The report gives considerable detail on national clinical audits (49) and national confidential enquiries (4), and 3228 patients have participated in research (down from the 5438 figure of 2016/17).

Key Targets

From the information provided in the report it would appear that whilst 17 out of 26 specialties improved their performance on the 18 week referral to treatment pathway, only 4 achieved the Trust target of 90%.

Although the Chief Executive recorded improved performance on cancer treatment, there some significant shortfalls in the 4th quarter, notably 62 day GP (77.9%) and 62 day breast symptoms. (50%).

CQC Report

The most recent CQC report was published in August 2017, with a rating of requires improvement. There does seem to have been a detailed and rapid response to the most significant warnings; notably hat the Children's emergency department was not suitable for the service provided, that the area was not large enough and there was no high dependency care outside the department. Similarly that the Emergency department premises were deemed not fit for purpose. There were 4 other warning notices and 4 must do actions, all of which have been addressed. It will be interesting to see whether the CQC are happy on their next visit.

Staff Survey

It is well worth reading the 2017 national NHS staff survey for the Norfolk and Norwich hospital in detail at www.nhsstaffsurveys.com For example, the following two questions:

	2017	2016
I would recommend my organisation as a place to work:	61%	56%
If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation	76%	71%

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

May 2017

Statements from Governors

Comments after reading the extremely detailed and informative report.
Noted that the use of Acronyms is necessary and most are explained when used in the report for the first time, but I feel it would be very useful to have a glossary to refer back to when advancing through the document.

Nina Duddleston
Public Governor (Breckland)

My statement for inclusion in the Quality Report 17/18:

Despite the adverse environment in which the NHS is currently operating, this report demonstrates that the NNUH staff are striving, with determination, to deliver a safe & clinically effective experience for each and every patient that they care for, whilst delivering ground breaking innovation that will continue to improve the quality of the region's health services.

Rob Boyce
Clinical Support Staff Governor

I have read the Quality Report for 2017/18 and commend those responsible for completing this huge piece of work. This year's version seems to be clearer and easier to understand.

It would be interesting to know why 2000 fewer patients were involved in research trials in 2017/18? Also while Pressure Ulcers and Falls account for the majority of serious incidents, there seem to be far more protocols for PUs than falls. The Falls & Fragility Fractures Audit was completed and the Falls Policy has been reviewed and changes recommended but no results have been shared in the report to show what exactly is being recommended and done to try to reduce falls.

It is good to see improvements in many areas such as the mortality rate, increased space in ED for Paediatrics plus the addition of an Older Persons ED, which makes so much sense in a county like Norfolk with a high population of older people. The introduction of an E-observation system to detect sepsis seems an excellent idea to help catch cases as early as possible. It is also good that there is a new priority to improve care to patients at the end of their life.

Erica Betts
Public Governor (Breckland)

Annex 2 - Statement of Directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.
In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS foundation trust annual reporting manual 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 25/05/2018
    - papers relating to quality reported to the board cover the period April 2017 to 25/05/2018
    - feedback from commissioners dated 23/05/2018
    - feedback from governors dated May 2018
    - feedback from local Healthwatch organisations dated 21/05/2018
    - feedback from Overview and Scrutiny Committee dated 01/05/2018
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 03/05/2018
    - the 2016 national patient survey
    - the 2017 national staff survey
    - the Head of Internal Audit's annual opinion of the trust's control environment dated 25/05/2018
    - CQC inspection report dated 10/08/2017
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported in the Quality Report is reliable and accurate
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- the Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.
By order of the board:

John Fry
Chairman

25th May 2018

Mark Davies
Chief Executive

25th May 2018

Annex 3 – Independent Auditor Report

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF NORFOLK & NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Norfolk & Norwich University Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Norfolk & Norwich 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 following two national priority indicators (the indicators):

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period;
- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 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 the six dimensions of data quality set out in the *Detailed Requirements for external assurance for 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 consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes and papers for the period April 2017 to 25 May 2018;
- papers relating to quality reported to the board over the period April 2017 to 25 May 2018;
- feedback from commissioners, dated 23 May 2018;
- feedback from governors, dated May 2018;
- feedback from local Healthwatch organisations, dated 21 May 2018
- feedback from Overview and Scrutiny Committee, dated 1 May 2018;

- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 3 May 2018;
- the 2016 national inpatient survey;
- the 2017 national staff survey;
- Care Quality Commission Inspection report, dated 10 August 2017;
- the Head of Internal Audit's annual opinion over the trust's control environment, dated 25 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 Norfolk & Norwich University Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 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 Norfolk & Norwich University Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Norfolk & Norwich University Hospitals NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 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
Chartered Accountants
Botanic House, 100 Hills Road, Cambridge, CB2 1AR

25 May 2018

Annex 4 - Mandatory performance indicator definitions

The following indicator definitions are based on Department of Health guidance, including the 'NHS Outcomes Framework 2016/17 Technical Appendix' (https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/385751/NHS_Outcomes_Tech_Appendix.pdf)

Where the HSCIC Indicator Portal does not provide a detailed definition of the indicator this document continues to use older sources of indicator definitions.

Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways

Source of indicator definition and detailed guidance
The indicator is defined in the technical definitions that accompany Everyone counts: planning for patients 2014/15-2018/19 at www.england.nhs.uk/wpcontent/uploads/2014/01/ec-tech-def-1415-1819.pdf

Detailed rules and guidance for measuring referral to treatment (RTT) standards are at www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/

Detailed descriptor
EB3: The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period

Numerator
The number of patients on an incomplete pathway at the end of the reporting period who have been waiting no more than 18 weeks

Denominator
The total number of patients on an incomplete pathway at the end of the reporting period

Accountability Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at: www.england.nhs.uk/wpcontent/uploads/2013/12/5yr-strat-plann-guid-wa.pdf (see Annex B: NHS Constitution Measures).

Indicator format
Reported as a percentage

Source of indicator definition and detailed guidance

Source of indicator definition and detailed guidance
The indicator is defined in the technical definitions that accompany Everyone counts: planning for patients 2014/15 - 2018/19 at www.england.nhs.uk/wpcontent/uploads/2014/01/ec-tech-def-1415-1819.pdf

Detailed rules and guidance for measuring A&E attendances and emergency admissions are at www.england.nhs.uk/statistics/wpcontent/uploads/sites/2/2013/03/AE-Attendances-Emergency-Definitions-v2.0- Final.pdf

Additional information
Paragraph 6.8 of the NHS England guidance referred to above gives further guidance on inclusion of a type 3 unit in reported performance.

Numerator
The total number of patients who have a total time in A&E of four hours or less from arrival to admission, transfer or discharge.

Calculated as: (Total number of unplanned A&E attendances) – (Total number of patients who have a total time in A&E over 4 hours from arrival to admission, transfer or discharge)

Denominator
The total number of unplanned A&E attendances

Accountability
Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at:
www.england.nhs.uk/wpcontent/uploads/2013/12/5yr-strat-plann-guid-wa.pdf
(see Annex B: NHS Constitution Measures).

Indicator format
Reported as a percentage

Referral to Treatment Pathways

Source of indicator definition and detailed guidance
The indicator is defined within the document 'Technical Definitions for Commissioners' https://www.england.nhs.uk/wp-content/uploads/2015/02/6-tech-defi-comms-0215.pdf.

Detailed Descriptor:
The percentage of Referral to Treatment (RTT) pathways within 18 weeks for completed admitted pathways, completed non-admitted pathways and incomplete pathways.

Lines Within Indicator (Units):
E.B.1: The percentage of admitted pathways within 18 weeks for admitted patients whose clocks stopped during the period, on an adjusted basis.
E.B.2: The percentage of non-admitted pathways within 18 weeks for non-admitted patients whose clocks stopped during the period.
E.B.3: The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period.

Data Definition:
A calculation of the percentage within 18 weeks for completed adjusted admitted RTT pathways, completed non-admitted RTT pathways and incomplete RTT pathways based on referral to treatment data provided by NHS and independent sector organisations and signed off by NHS commissioners.
The definitions that apply for RTT waiting times are set out in the RTT Clock Rules Suite found here: https://www.gov.uk/government/publications/right-to-start-consultant-led-treatment-within-18-weeks.
Guidance on recording and reporting RTT data can be found here: http://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/

Monitoring Frequency: Monthly

Monitoring Data Source: Consultant-led RTT Waiting Times data collection (National Statistics)

What success looks like, Direction, Milestones:
Performance will be judged against the following waiting time standards:-
☐Admitted operational standard of 90% – the percentage of admitted pathways (on an adjusted basis) within 18 weeks should equal or exceed 90%
☐ Non-admitted operational standard of 95% – the percentage of non-admitted pathways within 18 weeks should equal or exceed 95%
☐Incomplete operational standard of 92% – the percentage of incomplete pathways within 18 weeks should equal or exceed 92%

Timeframe/Baseline: Ongoing

Rationale:
The operational standards that:
- 90% of admitted patients and 95% of non-admitted patients should start treatment within a maximum of 18 weeks from referral; and,
- 92% of patients on incomplete pathways should have been waiting no more than 18 weeks from referral.

These RTT waiting time standards leave an operational tolerance to allow for patients who wait longer than 18 weeks to start their treatment because of choice or clinical exception. These circumstances can be categorised as:
- Patient choice - patients choose not to accept earliest offered reasonable appointments along their pathway or choose to delay treatments for personal or social reasons
- Co-operation - patients who do not attend appointments that they have agreed along their pathways
- Clinical exceptions - where it is not clinically appropriate to start a patient's treatment within 18 weeks

Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

Detailed descriptor[1]
PHQ03: Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer

Data definition
All cancer two-month urgent referral to treatment wait

Numerator
Number of patients receiving first definitive treatment for cancer within 62 days following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05)

Denominator
Total number of patients receiving first definitive treatment for cancer following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05)

Accountability
Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at:
www.england.nhs.uk/wpcontent/uploads/2013/12/5yr-strat-plann-guid-wa.pdf
(see Annex B: NHS Constitution Measures).

1 Cancer referral to treatment period start date is the date the acute provider receives an urgent (twoweek wait priority) referral for suspected cancer from a GP and treatment start date is the date first definitive treatment starts if the patient is subsequently diagnosed. For further detail refer to technical guidance at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131 880

Emergency re-admissions within 28 days of discharge from hospital[2]

Indicator description
Emergency re-admissions within 28 days of discharge from hospital

Indicator construction
Percentage of emergency admissions to a hospital that forms part of the trust occurring within 28 days of the last, previous discharge from a hospital that forms part of the trust

Numerator
The number of finished and unfinished continuous inpatient spells that are emergency admissions within 0 to 27 days (inclusive) of the last, previous discharge from hospital (see denominator), including those where the patient dies, but excluding the following: those with a main speciality upon re-admission coded under obstetric; and those where the re-admitting spell has a diagnosis of cancer (other than benign or in situ) or chemotherapy for cancer coded anywhere in the spell.

Denominator
The number of finished continuous inpatient spells within selected medical and surgical specialities, with a discharge date up to 31 March within the year of analysis. Day cases, spells with a discharge coded as death, maternity spells (based on specialty, episode type, diagnosis), and those with mention of a diagnosis of cancer or chemotherapy for cancer anywhere in the spell are excluded. Patients with mention of a diagnosis of cancer or chemotherapy for cancer anywhere in the 365 days before admission are excluded.

Indicator format
Standard percentage

More information
Further information and data can be found as part of the HSCIC indicator portal.

2 This definition is adapted from the definition for the 30 days re-admissions indicator in the NHS Outcomes Framework 2013/14: Technical Appendix. We require trusts to report 28-day emergency re-admissions rather than 30 days to be consistent with the mandated indicator requirements of the NHS (Quality Accounts) Amendment Regulations 2012 (S.I. 2012/3081).

Minimising delayed transfer of care

Detailed descriptor
The number of delayed transfers of care per 100,000 population (all adults, aged 18 plus).

Data definition
Commissioner numerator_01: Number of Delayed Transfers of Care of acute and non-acute adult patients (aged 18+ years)
Commissioner denominator _02: Current Office for National Statistics resident population projection for the relevant year, aged 18 years or more
Provider numerator_03: Number of patients (acute and non-acute, aged 18 and over) whose transfer of care was delayed, averaged over the quarter. The average of the three monthly SitRep figures is used as the numerator.
Provider denominator_04: Average number of occupied beds[3]

Details of the indicator
A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed.
A patient is ready for transfer when:
[a] a clinical decision has been made that the patient is ready for transfer AND
[b] a multidisciplinary team decision has been made that the patient is ready for transfer AND
[c] the patient is safe to discharge/transfer.
To be effective, the measure must apply to acute beds, and to non-acute and mental health beds. If one category of beds is excluded, the risk is that patients will be relocated to one of the 'excluded' beds rather than be discharged.

Accountability
The ambition is to maintain the lowest possible rate of delayed transfers of care.
Good performance is demonstrated by a consistently low rate over time, and/or by a decreasing rate. Poor performance is characterised by a high rate, and/or by an increase in rate.

Detailed guidance and data
Further guidance and the reported SitRep data on the monthly delayed transfers of care can be found on the NHS England website.[4]

3 In the quarter open overnight.
4 /www.england.nhs.uk/statistics/statistical-work-areas/delayed-transfers-of-care/

C. difficile[5]

Detailed descriptor
Number of Clostridium difficile (C. difficile) infections, as defined below, for patients aged two or over on the date the specimen was taken.

Data definition
A C. difficile infection is defined as a case where the patient shows clinical symptoms of C. difficile infection, and using the local trust C. difficile infections diagnostic algorithm (in line with Department of Health guidance), is assessed as a positive case. Positive diagnosis on the same patient more than 28 days apart should be reported as separate infections, irrespective of the number of specimens taken in the intervening period, or where they were taken. In constructing the C. difficile objectives, use was made of rates based both on population sizes and numbers of occupied bed days. Sources and definitions used are:
For acute trusts: The sum of episode durations for episodes finishing in 2010/11 where the patient was aged two or over at the end of the episode from Hospital Episode Statistics (HES).

Basis for accountability
Acute provider trusts are accountable for all C. difficile infection cases for which the trust is deemed responsible. This is defined as a case where the sample was taken on the fourth day or later of an admission to that trust (where the day of admission is day one). To illustrate:
• admission day; • admission day + 1; • admission day + 2; and
• admission day + 3 – specimens taken on this day or later are trust apportioned.

Accountability
The approach used to calculate the C. difficile objectives requires organisations with higher baseline rates (acute trusts and primary care organisations) to make the greatest improvements in order to reduce variation in performance between organisations. It also seeks to maintain standards in the best performing organisations. Appropriate objective figures have been calculated centrally for each primary care organisation and each acute trust based on a formula which, if the objectives are met, will collectively result in a further national reduction in cases of 26% for acute trusts and 18% for primary care organisations, whilst also reducing the variation in population and bed day rates between organisations.

Timeframe/baseline
The baseline period is the 12 months, from October 2010 to September 2011. This means that objectives have been set according to performance in this period.

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5 The QA Regulations requires the C. difficile indicator to be expressed as a rate per 100,000 bed days. If C. difficile is selected as one of the mandated indicators to be subject to a limited assurance report, the NHS foundation trust must also disclose the number of cases in the quality report, as it is only this element of the indicator that we intend auditors to subject to testing.

Percentage of patient safety incidents resulting in severe harm or death[6]

Indicator description
Patient safety incidents (PSIs) reported to the *National Reporting and Learning Service (NRLS),* where degree of harm is recorded as 'severe harm' or 'death', as a percentage of all patient safety incidents reported.

Indicator construction
Numerator: The number of patient safety incidents recorded as causing severe harm /death as described above.
The 'degree of harm' for PSIs is defined as follows;
'severe' – the patient has been permanently harmed as a result of the PSI, and
'death' – the PSI has resulted in the death of the patient.

Denominator: The number of patient safety incidents reported to the *National Reporting and Learning Service (NRLS).*

Indicator format:
Standard percentage.

6 This definition is adapted from the definition for the 30days readmissions indicator in the NHS Outcomes Framework 2012/13: Technical Appendix

Financial Statements

FINANCIAL STATEMENTS
FOR THE YEAR ENDED 31 MARCH 2018

Contents

KPMG

Independent auditor's report

to the Council of Governors of Norfolk and Norwich 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 Norfolk and Norwich University Hospitals NHS Foundation Trust ("the Trust") for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion:

- the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and Trust's income and expenditure for the year then ended; and
- the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2017/18 and the Department of Health Group Accounting Manual 2017/18.

2. Material uncertainty on going concern

We draw attention to note 1 to the financial statements which indicates that the Trust has incurred a significant deficit of £19.6 million for the year ended 31 March 2018. In addition, the Trust has submitted a 2018/19 financial plan to NHS Improvement with a planned deficit of £55 million. Based on the plan, the Trust will also need a significant injection of loan support of £68 million (£20 million capital and £48 million revenue) over the course of 2018/19 in order to meet its liabilities and continue to provide healthcare services. The extent and nature of the financial support from the Department of Health, including whether the support will be forthcoming and sufficient, is currently uncertain, as are any terms and conditions associated with the funding.

These events and conditions, along with the other matters explained in note 1 constitute a material uncertainty that may cast significant doubt on the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Overview	
Materiality: Trust financial statements as a whole	£11.5m (2016/17: £11.3m) 2% (2016/17: 2%) of total operating income

Risks of material misstatement		vs 2016-17
Recurring risks	Valuation of land and buildings	◄►
	Accuracy and valuation of trade receivables	◄►

3. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In arriving at our audit opinion above, the key audit matters, in decreasing order of audit significance, were as follows (unchanged from 2016/17):

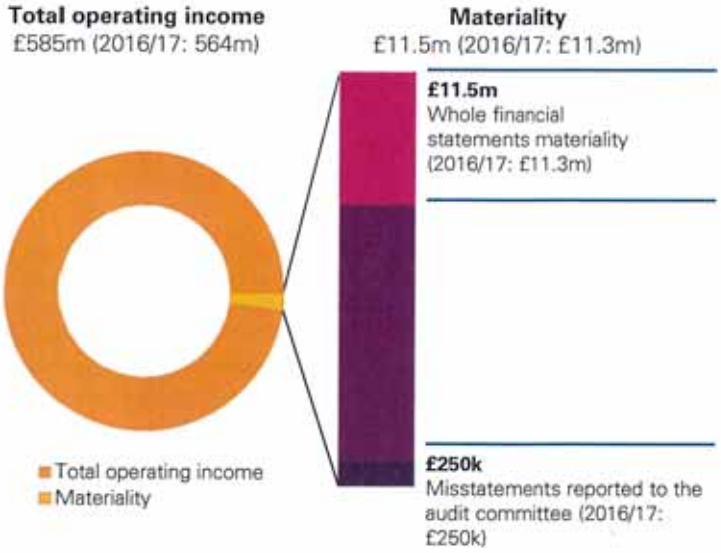
All of these key audit matters relate to the Trust.

	The risk	Our response
Valuation of land and buildings £210 million (2016/17: £214 million) *Refer to pages 15 to 17 (accounting policy) and page 32 (financial disclosures).*	**Subjective valuation:** Land and buildings are required to be held at fair value. The Trust's main land and buildings relate to a hospital built under the Private Finance Initiative (PFI) at Colney Lane, Norwich. As hospital buildings are specialised assets they are valued at depreciated replacement cost of a modern equivalent asset that has the same service potential of the existing property. The valuation of land and buildings relies on the expertise of the valuer and the appropriateness of the assumptions adopted. There is a risk that land and buildings values are materially misstated.	Our procedures included: — **Assessing valuer's credentials:** critically assessing the scope, qualifications, experience and independence of the Trust's external valuer. — **Benchmarking assumptions:** comparing the valuer's assumptions to externally derived data in relation to the indices used and the market conditions cited. — **Test of detail:** inspecting 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.
Accuracy and valuation of trade receivables £23 million (2016/17: £18 million) *Refer to page 20 (accounting policy) and page 35 and 36 (financial disclosures).*	**Subjective estimate** The Trust had £23 million in NHS and non-NHS receivables at year end. The risk presented by NHS receivables is different to that of non-NHS receivables. NHS receivables are subject to an 'agreement of balances' exercise which is undertaken between all NHS bodies to agree the value of receivables at year end. 'Mismatch' reports are available setting out discrepancies between the submitted balances. There is a risk that the Trust has material mismatches with other NHS bodies for which it cannot provide sufficient evidence to support the validity of its recognised receivable. These mismatches can arise at year end due to disagreements regarding activity levels and contract performance. Non-NHS receivables are not subject to an agreement of balances exercise. There is a risk that the Trust has recognised receivables to which it is not entitled. There is also a risk that the Trust's non-NHS receivables are not recoverable.	Our procedures included: — **Test of detail:** obtaining the outcome of the agreement of balances exercise with other NHS bodies. Where relevant we sought explanations and supporting evidence to verify the Trust's entitlement to the receivable; — **Test of detail:** obtaining copies of the signed contracts in place for the Trust's most significant commissioners by value. We reconciled the income per the contract to the actual income recognised in the year and agreed variances to source documentation or suitable explanation; — **Test of detail:** testing a sample of transactions before and after year end to supporting documentation to agree the items were correctly recorded at year end; — **Test of detail:** assessing the Trust's assumptions behind the provision against available data on historic payment performance of counterparties and our own knowledge of the Trust and recent bad debts affecting the NHS sector.

4. Our application of materiality and an overview of the scope of our audit

Materiality for the Trust financial statements as a whole was set at £11.5 million (2016/17: £11.3 million), determined with reference to a benchmark of total operating income (of which it represents approximately 2% (2016/17: 2%)). We consider total operating income to be more stable than a surplus- or deficit-related benchmark.

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £250k (2016/17: £250k), in addition to other identified misstatements that warranted reporting on qualitative grounds.



5. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

Corporate governance disclosures

We are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy; or
- the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or
- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

KPMG

6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 105, the Accounting Officer is responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention

to dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.
- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

Our conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources is qualified

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

Qualified conclusion

As a result of the matters outlined in the basis for adverse conclusion paragraph below, we are unable to satisfy ourselves that, in all significant respects Norfolk and Norwich University Hospitals NHS Foundation Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2018.

Basis for adverse conclusion

The Trust's outturn position for 2017/18 is a deficit of £19.6 million. The £19.6 million deficit represents a £23.2 million deterioration against its budget of £4.5 million surplus. The Trust has received cash support of £36 million from the Department of Health and Social Care to support working capital and fund capital injection payments. The Trust has £52 million of interim revenue support facility borrowings from the Department of Health and Social Care at year end.

The Trust's plans for 2018/19 forecast a £55 million deficit excluding donated asset income. The Trust does not currently have agreed plans in place to return to breakeven in the medium term.

The trust received an enforcement notice in year relating to financial performance and breaches in A&E, Cancer and RTT targets. The CQC rating for the Trust remains as requires improvement.

As a result of these matters, we are unable to satisfy ourselves that Norfolk and Norwich University Hospitals NHS Foundation Trust made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the whole year ended 31 March 2018.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements to secure economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

The significant risks identified during our risk assessment are set out below together with the findings from the work we carried out on each area.

Significant Risk	Description	Work carried out and judgements
Financial sustainability	The NAO Code of Audit Practice requires us to consider 'sustainable resource deployment'. The ongoing financial position and its reliance on support from regulators exposes the Trust to operational and financial challenges in terms of financial sustainability.	Our work included: • Reviewing 2017/18 financial outturn against budget and achievement of cost improvement schemes against plan; • Review of the 2018/19 financial plan. **Our findings on this risk area:** • The Trust has incurred a deficit of £19.6 million against an initial budget of £4.5 million surplus; • The Trust has prepared a budget for 2018/19 which forecasts a £55 million deficit before donated asset income. Achieving this forecast will depend on the delivery of significant income generating and cost saving initiatives. An improvement to breakeven is not forecast in the short term; • The trust is reliant on further cash support from NHS Improvement in order to meet its liabilities and continue to provide healthcare services; • The CQC rating for the Trust remains as "requires improvement".

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 Norfolk and Norwich University Hospitals NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

SBeavis

Stephanie Beavis
for and on behalf of KPMG LLP (Statutory Auditor)

Chartered Accountants
Botanic House
100 Hills Road
Cambridge
CB2 1AR

25 May 2018

KPMG

Foreword to the Accounts

These accounts, for the year ended 31 March 2018, have been prepared by the Norfolk and Norwich University Hospitals NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed.....

Mark Davies
Chief Executive

Date: 25 May 2018

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2018

STATEMENT OF COMPREHENSIVE INCOME	Note	Year ended 31 March 2018 £'000	Year ended 31 March 2017 £'000
Operating income	3	491,180	483,257
Other operating income	4	95,489	80,829
Operating expenses	6	(575,861)	(558,911)
OPERATING SURPLUS		**10,808**	**5,175**
FINANCE INCOME AND EXPENSES			
Finance income	12	58	60
Finance expense - financial liabilities, including unwinding of discount on provisions	14	(30,421)	(28,625)
PDC Dividends payable	28	0	(1,470)
NET FINANCE COSTS		**(30,363)**	**(30,035)**
(DEFICIT) FOR THE YEAR		**(19,555)**	**(24,860)**
Other comprehensive income			
Revaluations	15	0	(49,655)
TOTAL COMPREHENSIVE (EXPENSE) FOR THE YEAR		**(19,555)**	**(74,515)**

The accompanying notes form an integral part of the Financial Statements

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2018

STATEMENT OF FINANCIAL POSITION	Note	31 March 2018 £'000	31 March 2017 £'000
Non-current assets			
Property, plant and equipment	15	234,750	234,212
Trade and other receivables	18	71,245	64,502
Total non-current assets		**305,995**	**298,714**
Current assets			
Inventories	17	9,369	8,404
Trade and other receivables	18	28,544	21,901
Cash and cash equivalents	19	5,733	15,510
Total current assets		**43,646**	**45,815**
Current liabilities			
Trade and other payables	20	(58,164)	(62,469)
Other liabilities	22	(5,138)	(14,942)
Borrowings	21	(2,847)	(3,149)
Provisions	25	(307)	(328)
Total current liabilities		**(66,456)**	**(80,888)**
Total assets less current liabilities		**283,185**	**263,641**
Non-current liabilities			
Trade and other payables	20	0	(331)
Other liabilities	22	(4,606)	(1,328)
Borrowings	21	(246,249)	(212,704)
Provisions	25	(2,159)	(2,842)
Total non-current liabilities		**(253,014)**	**(217,205)**
Total assets employed		**30,171**	**46,436**
Financed by (taxpayers' equity)			
Public dividend capital		28,408	25,117
Revaluation reserve		15,003	15,025
Income and expenditure reserve		(13,239)	6,294
Total taxpayers' equity		**30,171**	**46,436**

The financial statements on pages 8 to 45 were approved by the Board on 25th May 2018 and signed on its behalf by:

Signed: .....(Chief Executive) Date: 25 May 2018

The accompanying notes form an integral part of the Financial Statements

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2018

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total Taxpayers' Equity
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017	**25,117**	**15,025**	**6,294**	**46,436**
Deficit for the year	0	0	(19,555)	**(19,555)**
Other transfers between reserves	0	(22)	22	**0**
Revaluations	0	0	0	**0**
Public dividend capital received	3,291	0	0	**3,291**
Taxpayers' equity at 31 March 2018	**28,408**	**15,003**	**(13,239)**	**30,171**

The accompanying notes form an integral part of the Financial Statements

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2017

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total Taxpayers' Equity
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2016	**25,105**	**65,621**	**30,213**	**120,939**
Deficit for the year	0	0	(24,860)	**(24,860)**
Other transfers between reserves	0	(941)	941	**0**
Revaluations	0	(49,655)	0	**(49,655)**
Public dividend capital received	12	0	0	**12**
Taxpayers' equity at 31 March 2017	**25,117**	**15,025**	**6,294**	**46,436**

The accompanying notes form an integral part of the Financial Statements

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2018

	Note	Year ended 31 March 2018 £'000	Year ended 31 March 2017 £'000
Cash flows from operating activities			
Operating surplus		10,808	5,175
Operating surplus		**10,808**	**5,175**
Non-cash income and expense:			
Depreciation	6	10,604	12,161
Loss on disposal of non-current assets		1	26
Income recognised in respect of capital donations (cash and non-cash)		(1,731)	(170)
Decrease/(Increase) in trade and other receivables		(7,321)	2,647
Decrease/(Increase) in inventories		(965)	30
(Decrease) in trade and other payables		(12,327)	(3,830)
(Decrease) in provisions		(707)	(550)
Net cash generated from operations		**(1,638)**	**15,489**
Cash flows from investing activities			
Interest received	12	53	60
Purchase of property, plant, equipment and investment property		(15,001)	(13,372)
Sales of property, plant, equipment and investment property		12	56
Net cash used in investing activities		**(14,936)**	**(13,256)**
Cash flows from financing activities			
Public dividend capital received		3,291	12
Movement on loans from the Department of Health		36,393	16,000
Capital element of finance lease rental payments		(168)	(162)
Capital element of PFI, LIFT and other service concession payments		(2,981)	(3,360)
Interest paid on finance lease liabilities		(21)	(27)
Interest paid on PFI, LIFT and other service concession obligations		(29,524)	(28,562)
Other interest paid		(778)	0
PDC dividend paid		585	(2,118)
Net cash used in financing activities		**6,797**	**(18,217)**
(Decrease) in cash and cash equivalents	19	(9,777)	(15,984)
Cash and Cash equivalents at start of the year	19	15,510	31,494
Cash and Cash equivalents at 31 March	19	**5,733**	**15,510**

The accompanying notes form an integral part of the Financial Statements

NOTES TO THE ACCOUNTS

1. Accounting Policies

Basis of Preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Going Concern

The Trust is forecasting a deficit of £55m for 2018/19 following a reported deficit of £19.6m in 2017/18 and a deficit of £24.9m in 2016/17. The forecast deficit for 2018/19 is based on a number of assumptions including the delivery of cost savings of £30.0m. The Trust forecast cash position as at 31 March 2019 is a total revenue support borrowing of £100.4m. This assumes that the deficit support required in 2018/19 of £48m will be made available. However no agreement for this has been received to date. As a consequence there is material uncertainty that may cast significant doubt about the Trust's ability to continue as a going concern.

As part of reviewing the financial sustainability of the organisation, we have considered the scale of the financial challenges facing the Trust over the next 12 month period, in particular the revenue cash support required. Our operational plan forecasts a deficit of £55m for 2018/19 and it is recognised that the plan contains demanding cost improvement targets. The revenue support funds required of @£48m are subject to agreement by the Department of Health and Social Care, for which no agreement has been received to date. However our experience of Department of Health and Social Care practice is that they approve funding requirements on a monthly basis – not in advance. The Directors have considered the associated risks and material uncertainty over the revenue support required and based on past experience and the vital role that the hospital plays we expect that the revenue support needed will be made available.

Our expectation is also informed by the anticipated continuation of the provision of service in the future, as evidenced by inclusion of financial provision for that service in published documents. Contracts for Service, being the NHS Standard Contract 2018/19 have been signed with the Trust's main Commissioners.

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

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

1.1.1 Subsidiaries

Subsidiary entities are those over which the Trust has the power to exercise control or a dominant influence so as to gain economic or other benefits.

1.1.2 Consolidation

The NHS foundation trust is the corporate trustee to Norfolk and Norwich University Hospitals NHS Foundation Trust Charitable Fund. The foundation trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the foundation trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

Prior to 2013/14, the FT ARM permitted the NHS foundation trust not to consolidate the charitable fund. Since 2013/14 the Trust has chosen not to consolidate the charitable fund on the basis it is not material.

1.2 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.2.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the accounts.

1. Accounting Policies (Continued)

1.2.1 Critical judgements in applying accounting policies (continued)

An assessment of the Trust's PFI schemes was made as part of the IFRS transition in the 2009/10 accounts, and it was determined that the PFI scheme in respect of the main Hospital building should be accounted for as an on statement of position asset under IFRIC 12. This required judgements to be made in order to determine the required accounting treatment. The key judgements were to initially value the hospital at the cost of construction, to attribute an asset life of 70 years and to identify the components of the hospital subject to lifecycle maintenance, that should be accounted for separately. The annual contribution to lifecycle maintenance is treated as a non current prepayment until it is capitalised consistent with the operators schedule for replacement.

An interim valuation of the PFI hospital was performed by David Boshier as at 31 March 2017. Prior to this the last full market valuation of land and building assets was carried out by David Boshier (MRICS) of Boshier & Company Chartered Surveyors RICS and was applied on 31 March 2015 . The Trust has considered updated indices to provide assurance that the carrying value for its specialised buildings remains reasonable as at 31 March 2018.

1.2.2 Key sources of estimation uncertainty

No key assumptions concerning the future have had to be made and there are no key sources of estimation uncertainty at the end of the reporting period. Therefore there is no significant risk of a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

Estimations as to the recoverability of receivables and the valuation of inventories have been made in determining carrying amounts of those assets. Variation is not expected to be significant.

Judgement has also been used to determine the carrying value of provisions, deferral of income and accruals.

An estimate has also been used to determine total future obligations under PFI contracts as disclosed in note 24.2, in relation to future rates of inflation. This estimate does not affect the carrying value of liabilities in the Statement of Financial Position at 31 March 2018 or 31 March 2017, or the amounts charged through the Statement of Comprehensive Income.

Valuation of property has been made using BCIS indices and is updated regularly. Plant and equipment are valued at depreciated cost as described in notes 1.6 and 1.7. using esimated useful economic lives.

1.3 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services. Income relating to patient care spells that are part-completed at the year end is apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay. Application of performance related fines by commissioners are accounted for in the period to which the fine relates.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pensions Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.4 Employee Benefits

1.4.1 Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the accounts to the extent that employees are permitted to carry-forward leave into the following period.

1.4.2 Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

1. Accounting Policies (Continued)

1.4.2 Retirement benefit costs (Continued)

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

1.5 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.6 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:
- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has a cost of at least £5k; or
- Collectively, a number of items have a cost of at least £5k and individually have a cost of more than £0.25k, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

1.6.1 Valuation

All property, plant and equipment assets are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land, buildings and dwellings used for the Trust's services or for administrative purposes are reported in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings and dwellings– market value for existing use
- Specialised buildings – depreciated replacement cost using the modern equivalent asset method

The Trust commissioned a revaluation of its estate as at 31 March 2015 and it was conducted by Mr David Boshier MRICS, of Boshier & Company Chartered Surveyors RICS. The revaluation basis for specialised building was for a Modern Equivalent Asset (MEA) on an existing site basis. Specialised buildings are valued on a Depreciated Replacement Cost basis.
Since then an interim valuation of the PFI Hospital Building was commissioned as at 31 March 2017 and conducted by Mr David Boshier MRICS. The basis of valuation was the same, however the valuation of the PFI asset was excluding VAT, to better reflect the cost of when the asset would be replaced by a PFI operator.
In between revaluations, consideration is given to market trends, supported by a review of the impact of applying nationally published and recognised indices, to assess whether an interim revaluation is required. The BCIS indices were considered for this purpose in 2017/18 for all of the land and property estate.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Prior to 31 March 2008, plant and machinery, transport equipment, information technology and furniture and fittings were valued at replacement cost, as assessed by indexation and depreciation of historic cost. This ceased at 1 April 2008 when the nationally published indices were withdrawn. The carrying value of existing assets at that date are being written off over their remaining useful lives and new assets are carried at depreciated historic cost as this is not considered to be materially different from fair value.

1. Accounting Policies (Continued)

1.6.2 Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

1.6.3 Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

1.7 Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

1.8 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.
The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

1.9 De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:
• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;

• the sale must be highly probable i.e.:

- management are committed to a plan to sell the asset;
- an active programme has begun to find a buyer and complete the sale;
- the asset is being actively marketed at a reasonable price;
- the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

1. Accounting Policies (Continued)

1.9 De-recognition (Continued)

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.10 Leases

1.10.1 Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

1.10.2 Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

1.10.3 The Trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate of interest on the remaining balance of the liability. Finance charges are recognised in calculating the Trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated. Leased land is treated as an operating lease. Leased buildings are assessed as to whether they are operating or finance leases.

1.10.4 The Trust as lessor

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1. Accounting Policies (Continued)

1.11 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as "on-Statement of Financial Position" by the trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment at their fair value, together with an equivalent PFI finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to 'Finance Costs' in the Statement of Comprehensive Income.

1.11.1 PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and is expensed in the Statement of Comprehensive Income. It is detailed in note 14 as a contingent finance cost.

1.11.2 Lifecycle replacement

Components of the asset scheduled to be replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. This charge is used to establish a prepayment to fund future replacement.

1.11.3 Assets contributed by the Trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trust's Statement of Financial Position.

1.11.4 Other assets contributed by the Trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the Trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.12 Off Statement of Financial Position PFI transactions

Where a PFI scheme fails to meet the requirements of IFRIC 12, it is accounted for off Statement of Financial Position as an operating lease.

1. Accounting Policies (Continued)

1.13 Inventories

Inventories are valued at the lower of cost and net realisable value using a first in first out basis. This is considered to be a reasonable approximation to fair value due to the high turnover of inventories. Provision is made, for slow moving, obsolete and defective inventories.

1.14 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

1.16 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 25 but is not recognised in the Trust's accounts.

1.17 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHSLA and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.18 Contingencies

Contingent liabilities are not recognised, but are disclosed in note 32, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 32 where an inflow of economic benefits is probable.

1.19 Financial instruments and financial liabilities

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described above.

1. Accounting Policies (Continued)

1.19.1 De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.
Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.19.2 Classification and measurement

Financial assets are categorised as loans and receivables, whilst financial liabilities are classified as 'other financial liabilities'.

1.19.3 Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

The Trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS receivables, accrued income and 'other receivables'.

1.19.4 Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

A provision is made when there is uncertainty around the recoverability of a financial asset. At the point that it is determined that the amounts are unlikely to be recovered, the impairment is charged directly to the asset.

1.20 Financial liabilities

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

1.20.1 Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

1. Accounting Policies (Continued)

1.21 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.22 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary assets and liabilities denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the Trust's income or expense in the period in which they arise.

1.23 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM. See note 30 to the accounts.

1.24 Public Dividend Capital (PDC) and PDC dividend

Public Dividend Capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.25 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on a cash basis with the exception of provisions for future losses.

1. Accounting Policies (Continued)

1.26 Accounting standards that have been issued but have not yet been adopted

IFRS 9 - ***Financial Instruments*** IFRS 9 reduced the number of classification categories and provided a clearer rationale for measuring financial assets. It also applied a single impairment method to all financial assets not measure at fair value and aligned the measurement attributes of financial assets with the way the entity manages its financial assets and their contractual cash flow characteristics. There is also guidance included for when part of a financial asset could be considered for derecognition. The derecognition principles should be applied to a part of a financial asset only if that part contained no risk or reward relating to the part not being considered for derecognition.	Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FRem: early adoption is not therefore permitted.
IFRS 14 - ***Regulatory Deferral Accounts*** IFRS 14 Regulatory Deferral Accounts specifies the reporting requirements for regulatory deferral account balances that arise when an entity provides goods or services to customers at a price or rate that is subject to rate regulation.	Not yet EU-Endorsed* Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DH group Bodies
IFRS 15 - ***Revenue from Contracts with Customers*** IFRS 15 establishes principles for reporting useful information to users of financial statements about the nature, amount, timing and uncertainty of revenue and cash flows arising from an entity's contracts with customers. It is anticipated that additional disclosures around contracts will need to be made including performance related income contracts with the commissioners. However, no significant impact upon actual revenue recognition is expected. Depending on the type of arrangements entered into the future, assets and/or impairment losses may be recognised and disclosed	Application required for account periods beginning on or after 1 January 2018, but not yet adopted by the Frem: early adoption is not therefore permitted.
IFRS 16 - ***Leases*** IFRS 16 sets out the principles for the recognition, measurement, presentation and disclosure of leases for both parties to a contract, ie the customer ('lessee') and the supplier ('lessor').	Application required for account periods beginning on or after 1 January 2019, but not yet adopted by the Frem: early adoption is not therefore permitted.
IFRS 17 - ***Insurance Contracts*** IFRS 17 requires a company that issues insurance contracts to report them on the balance sheet.	Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRIC 22 - ***Foreign Currency Transactions and Advance Consideration*** IFRIC 22 clarifies the accounting for transactions that include the receipt or payment of advance consideration in a foreign currency.	Application required for accounting periods beginning on or after 1 January 2018.
IFRIC 23 - ***Uncertainty over Income Tax Treatments*** IFRIC 23 clarifies the accounting for uncertainties in income taxes.	Application required for accounting periods beginning on or after 1 January 2019.

* The European Financial Reporting Advisory Group recommended in October 2015 that the standard should not be endorsed as it is unlikely to be adopted by many EU countries.

1. Accounting Policies (Continued)

1.27 Accounting standards that have been early-adopted

No new accounting standards or revisions to existing standards have been early-adopted in 2017/18.

1.28 Research and development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Operating Expenses on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.29 Corporation Tax

The Trust does not fall within the scope of Corporation Tax for the year ended 31 March 2018, neither did it for the year ended 31 March 2017.

1.30 Charitable Funds

The Trust is Corporate Trustee to Norfolk and Norwich University Hospitals NHS Foundation Trust Charitable Fund, a Charity registered with the Charities Commission (Charity No 1048170).

The main purpose of the charitable funds held on trust is to apply income for any charitable purposes relating to the National Health Service wholly or mainly for the services provided by the Norfolk and Norwich University Hospitals NHS Foundation Trust.

At the 31st March 2018, the Charitable funds reserves stood at £10,408k (2016/17: £11,552k) and it had a surplus of income after expenditure in the year of £1,144k (2016/17: £1,477k).

1.31 Interests in Joint Operations

The Trust has a 58% interest in a joint operation for the provision of pathology services in Norfolk known as the Eastern Pathology Alliance EPA. The arrangement has been effective from 1st November 2013, and has not involved the establishment of a separate entity.

Accordingly, the Trust's share of operating income and expenditure is included in these accounts.

2. Operating segments

Segmental reporting is required to reflect the content and form of information that is supplied to the Chief Operating Decision Maker. In the case of the Trust, this has been determined to be the Executive Directors.

The Executive Directors receive segmental information for expenditure. Segments are defined as the Trust's divisions, as identified in the following table which also describes the service that each provides. The Services division deals with areas such as the commissioning of catering, portering and cleaning, as well as support functions. During the year there was a restructure of the Trust's divisions and as a result, the comparatives have been realigned without change in overall total.

Income and assets are not reported by division, so are not analysed in the data below. Details of income by source is provided in note 3.1. The Trust's main source of income is from within the UK for the provision of healthcare services.

2017/18:

	Medicine	Clinical Support	Surgery and Cromer	Women, Children and Sexual Health	Emergency	Services	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Pay	68,846	59,730	98,679	36,732	37,374	23,553	**324,914**
Non Pay	81,055	30,955	37,865	7,473	3,843	57,303	**218,494**
Total	**149,901**	**90,685**	**136,544**	**44,205**	**41,217**	**80,856**	**543,408**

2016/17 :

	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Pay	66,015	57,312	94,942	34,654	38,961	22,024	**313,908**
Non Pay	77,128	30,618	38,895	7,203	4,208	52,050	**210,102**
Total	**143,143**	**87,930**	**133,837**	**41,857**	**43,169**	**74,074**	**524,010**

Reconciliation - Pay

	2017/18	2016/17
	£'000	£'000
Employee Expenses - Executive directors (note 6)	1,572	1,156
Employee Expenses - Non-executive directors (note 6)	139	134
Employee Expenses - Staff (note 6)	323,142	312,618
VSS & Redundancy (note 6)	61	0
Total	**324,914**	**313,908**

Reconciliation - Non Pay

	£'000	£'000
Operating Expenses (note 6)	575,861	558,911
Less: Pay (see above)	(324,914)	(313,908)
Less: Depreciation (note 6)	(10,604)	(12,161)
Less: Consortium payments (note 6)	(16,321)	(16,764)
Less: Loss on disposal (note 6)	(1)	(26)
Less: Research and development (note 6)	(5,526)	(5,950)
Total	**218,495**	**210,102**

3. Operating income

3.1 Income from activities

	Year ended 31 March 2018 £'000	Year ended 31 March 2017 £'000
NHS Foundation Trusts	0	14
NHS Trusts	66	82
CCGs and NHS England	487,461	479,707
Local Authorities	0	(5)
NHS Other	97	72
Non-NHS: Private patients	1,381	1,631
Non-NHS: Overseas patients (non-reciprocal)	311	229
NHS injury scheme (formerly RTA)	1,314	1,047
Non-NHS: Other	550	480
Total income from activities	**491,180**	**483,257**

Substantially all income from activities comes from mandatory services.
NHS injury scheme income is subject to a provision for impairment of receivables of 22.84% (2016/17: 22.94%) to reflect expected rates of collection.
Overseas patients (non-reciprocal) income is amounts received by the Trust, where the overseas patient is liable for the cost. This occurs when there is not a national reciprocal arrangement with the country that the patient is a national of.

Substantially all income arises in the UK. There are four main customers of the Trust who each account for over 19% of its income from activities. They are NHS England (22.1%) and NHS South Norfolk CCG (22.8%, NHS Norwich CCG (24.6%) and NHS North Norfolk CCG (20.6%).

3.2 Income from activities by category

	Year ended 31 March 2018 £'000	Year ended 31 March 2017 £'000
Elective income	89,779	90,477
Non elective income	138,285	123,138
Outpatient income	68,663	81,477
A & E income	16,020	14,274
Other NHS clinical income	175,427	170,984
Private patient income (including overseas visitors)	1,692	1,860
Other non-protected clinical income	1,314	1,047
Total income from activities	**491,180**	**483,257**

3.3 Overseas Visitors (patient charged direct by the Trust)

	Year ended 31 March 2018 £'000	Year ended 31 March 2017 £'000
Income recognised this year	311	229
Cash payments received in year (all years)	197	114
Amounts added to provision for impairment of receivables (all years)	113	(52)
Amounts written off in-year (all years)	50	125

3.4 Income from Commissioner Requested Services

Operating income includes income from Commissioner Requested Services as follows:

	Year ended 31 March 2018	Year ended 31 March 2017
Commissioner Requested Services	488,938	480,917
Non-Commissioner Requested Services	2,242	2,340
	491,180	**483,257**

4. Other operating income

	Year ended 31 March 2018 £'000	Year ended 31 March 2017 £'000
Research and development	5,379	5,907
Education and training	24,263	20,608
Donations/grants of physical assets (non-cash) - received from NHS charities	1,657	170
Donations/grants of physical assets (non-cash) - received from other bodies	74	0
Rental revenue from operating leases	256	188
Sustainability and transformation fund (STF)	8,357	0
Other		
Staff recharges	14,879	12,855
Car parking	2,886	2,576
Pharmacy sales	1,029	1,265
Staff accommodation rentals	778	748
Clinical tests	185	339
Clinical excellence awards	1,205	1,204
Grossing up consortium arrangements	16,321	16,764
Other income	18,220	18,205
Total other operating income	**95,489**	**80,829**

5. Total operating income

Income is from the supply of services.

6. Operating Expenses

	Year ended 31 March 2018 £'000	Year ended 31 March 2017 £'000
Services from NHS trusts	24	30
Employee expenses - non-executive directors	139	134
Employee expenses - staff and executive directors	324,714	313,774
Supplies and services - clinical	63,926	64,114
Supplies and services - general	13,477	8,651
Establishment	8,003	7,812
Research and development	5,526	5,950
Transport	507	541
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	21,152	20,313
Premises	16,500	16,891
Increase/(Decrease) in provision for impairment of receivables	675	469
Change in provisions discount rate(s)	21	236
Inventories written down	116	107
Inventories consumed	74,799	71,573
Rentals under operating leases	2,139	1,887
Depreciation on property, plant and equipment	10,604	12,161
Audit fees payable to the external auditor*		
audit services- statutory audit	68	68
other auditor remuneration (external auditor only)	10	10
Clinical negligence	11,668	8,335
Loss on disposal of non-current assets	1	26
Legal fees	64	30
Consultancy costs	1,536	4,672
Internal audit	77	134
Training, courses and conferences	486	690
Patient travel	1,709	1,524
Redundancy	61	0
Insurance	80	79
Other services, eg external payroll	44	1,003
Grossing up consortium arrangements	16,321	16,764
Losses, ex gratia & special payments	11	11
Other	1,403	922
Total operating expenses	**575,861**	**558,911**

* The engagement letter signed on 13th January 2017 states that the liability of KPMG LLP, its members, partners and staff (whether contract, negligence or otherwise) in respect of services provided in connection with or arising out of the audit shall in no circumstances exceed £1,000k in the aggregate in respect of all such services.

6.1 Auditor's Remuneration

	Year ended 31 March 2018 £'000	Year ended 31 March 2017 £'000
Audit Fees- statutory audit	68	68
Assurance services	10	10
TOTAL	**78**	**78**

The Trust's auditors, KPMG LLP (2016/17 KPMG LLP), also audit the associated charity (Norfolk and Norwich University Hospitals NHS Foundation Trust Charitable Fund) for a fee of £6k (2016/17 £6k).

7. Operating leases

7.1 As lessee

Payments recognised as an expense	Year ended 31 March 2018 £'000	Year ended 31 March 2017 £'000
Minimum lease payments	2,139	1,887
Total	**2,139**	**1,887**

Total future aggregate minimum lease payments	Year ended 31 March 2018 £'000	Year ended 31 March 2017 £'000
Payable:		
Not later than one year	1,640	1,426
Between one and five years	5,500	4,595
After 5 years	16,719	15,065
Total	**23,859**	**21,086**

7.2 As lessor

The Trust leases the retail units at its Colney Lane site to a third party. The contract is for a period of 30 years and was entered into in 2002.

Rentals, recognised as other operating income	Year ended 31 March 2018 £'000	Year ended 31 March 2017 £'000
Rents recognised as income in the year	87	87
Contingent rents recognised as income in the year	168	101
Total	**255**	**188**

Total future aggregate minimum lease payments	Year ended 31 March 2018 £'000	Year ended 31 March 2017 £'000
Receivable:		
Not later than one year	87	87
Between one and five years	350	350
After 5 years	787	875
Total	**1,224**	**1,312**

8. Employee costs and numbers

8.1 Employee costs

	Year ended 31 March 2018 £'000	Year ended 31 March 2017 £'000
Salaries and wages	258,743	241,371
Social security costs	24,011	22,708
Apprenticeship levy	957	-
Employer's contributions to NHS pensions	31,342	29,429
Termination benefits	61	-
Agency/contract staff	9,661	20,266
Total	**324,775**	**313,774**

Above total excludes costs of non-executive directors.
Details on the remuneration of key management personnel can be found in note 29.

8.2 Monthly average number of people employed

	Year ended 31 March 2018 Number	Year ended 31 March 2017 Number
Medical and dental	1,034	958
Administration and estates	559	481
Healthcare assistants and other support staff	2,623	2,559
Nursing, midwifery and health visiting staff	2,119	2,042
Nursing, midwifery and health visiting learners	-	11
Scientific, therapeutic and technical staff	569	481
Healthcare science staff	396	437
Total	**7,300**	**6,969**

The above numbers are based on whole-time equivalents.

8.3 Staff exit packages

Staff exit packages for the year ended 31 March 2018

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10k	-	1	1
£10k - £25k	-	2	2
£25k - £50k	-	1	1
£50k - £100k	-	1	1
£100k - £150k	-	-	-
£150k - £200k	-	-	-
	-	**5**	**5**

Staff exit packages for the year ended 31 March 2017

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10k	-	1	1
£10k - £25k	-	-	-
£25k - £50k	-	-	-
£50k - £100k	-	-	-
£100k - £150k	-	-	-
£150k - £200k	-	-	-
	0	**1**	**1**

There were no new staff exit packages in the year ended 31 March 2017.

9. Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and 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

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) has been used and replaced the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

9. Pension costs (continued)

c) Scheme provisions (continued)

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

10. Retirements due to ill-health

During 2017/18 there were 3 (2016/17: 10) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements are £170k (2016/17: £684k). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

11. Better Payment Practice Code

11.1 Better Payment Practice Code - measure of compliance	Year ended 31 March 2018		Year ended 31 March 2017	
	Number	£'000	Number	£'000
Total Non-NHS trade invoices paid in the year	156,772	277,444	147,746	263,275
Total Non-NHS trade invoices paid within target	110,233	206,800	123,529	228,918
Percentage of Non-NHS trade invoices paid within target	70%	75%	84%	87%
Total NHS trade invoices paid in the year	3,078	34,461	3,041	36,152
Total NHS trade invoices paid within target	1,345	12,630	2,240	24,538
Percentage of NHS trade invoices paid within target	44%	37%	74%	68%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

11.2 The Late Payment of Commercial Debts (Interest) Act 1998

The Trust made payments of £nil under this legislation in the year (2016/17: £nil)

12. Finance income

	Year ended 31 March 2018 £'000	Year ended 31 March 2017 £'000
Interest receivable on bank deposits	58	60
Total	**58**	**60**

13. Other gains and losses

	Year ended 31 March 2018 £'000	Year ended 31 March 2017 £'000
(Loss) on disposal of land, property, plant and equipment	1	26
Total	**1**	**26**

14. Finance expense - financial liabilities including unwinding of discount on provisions

	Year ended 31 March 2018 £'000	Year ended 31 March 2017 £'000
Interim Revenue Support Facility Cost - Dept. of Health	873	29
Finance leases	21	27
Finance Costs in PFI obligations		
- Main finance costs	17,327	17,596
- Contingent finance costs	12,197	10,966
Unwinding of discount on provisions	3	7
Total	**30,421**	**28,625**

15. Property, plant and equipment

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2017	**11,710**	**205,688**	**0**	**78,324**	**54**	**14,553**	**861**	**311,190**
Additions - purchased	0	954	4,278	2,740	24	1,431	0	**9,427**
Additions - leased	0	0	0	0	0	0	0	**0**
Additions - donated	0	587	0	1,120	0	15	9	**1,731**
Reclassifications	0	55	0	(55)	0	0	0	**0**
Revaluation	0	0	0	0	0	0	0	**0**
Disposals	0	0	0	(10,836)	0	(121)	0	**(10,957)**
Cost or valuation at 31 March 2018	**11,710**	**207,284**	**4,278**	**71,293**	**78**	**15,878**	**870**	**311,391**
Accumulated depreciation at 1 April 2017	**0**	**3,070**	**0**	**60,964**	**49**	**12,057**	**838**	**76,978**
Provided during the year	0	6,011	0	3,429	4	1,150	10	**10,604**
Reclassifications	0	8	0	(8)	0	0	0	**0**
Revaluation Eliminated	0	0	0	0	0	0	0	**0**
Disposals	0	0	0	(10,820)	0	(121)	0	**(10,941)**
Accumulated depreciation at 31 March 2018	**0**	**9,089**	**0**	**53,565**	**53**	**13,086**	**848**	**76,641**
Net book value								
NBV - Owned at 31 March 2018	11,710	29,231	4,278	13,922	25	2,749	14	**61,929**
NBV - Finance lease at 31 March 2018	0	0	0	550	0	0	0	**550**
NBV - PFI at 31 March 2018	0	158,563	0	0	0	0	0	**158,563**
NBV - Government Granted at 31 March 2018	0	0	0	0	0	0	0	**0**
NBV - Donated at 31 March 2018	0	10,401	0	3,256	0	43	8	**13,708**
NBV total at 31 March 2018	**11,710**	**198,195**	**4,278**	**17,728**	**25**	**2,792**	**22**	**234,750**
Net book value								
NBV - Owned at 31 March 2017	11,710	29,504	0	13,538	5	2,449	21	**57,227**
NBV - Finance lease at 31 March 2017	0	0	0	726	0	0	0	**726**
NBV - PFI at 31 March 2017	0	163,134	0	388	0	0	0	**163,522**
NBV - Government Granted at 31 March 2017	0	0	0	0	0	0	0	**0**
NBV - Donated at 31 March 2017	0	9,980	0	2,708	0	47	2	**12,737**
NBV total at 31 March 2017	**11,710**	**202,618**	**0**	**17,360**	**5**	**2,496**	**23**	**234,212**

Land, buildings and dwellings are all deemed to fall within the definition of protected assets.

15. Property, plant and equipment (continued)

	Land £000	Buildings excluding dwellings £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation at 1 April 2016	**11,710**	**253,432**	**77,870**	**107**	**14,278**	**884**	**358,281**
Additions - purchased	0	8,617	2,831	0	338	4	**11,790**
Additions - leased	0	0	442	0	0	0	**442**
Additions - donated	0	34	136	0	0	0	**170**
Revaluation	0	(56,395)	0	0	0	0	**(56,395)**
Disposals	0	0	(2,955)	(53)	(63)	(27)	**(3,098)**
Cost or valuation at 31 March 2017	**11,710**	**205,688**	**78,324**	**54**	**14,553**	**861**	**311,190**
Accumulated depreciation at 1 April 2016	**0**	**2,399**	**60,313**	**101**	**10,937**	**822**	**74,572**
Provided during the year	0	7,411	3,528	1	1,179	42	**12,161**
Revaluation Eliminated	0	(6,740)	0	0	0	0	**(6,740)**
Disposals	0	0	(2,877)	(53)	(59)	(26)	**(3,015)**
Accumulated depreciation at 31 March 2017	**0**	**3,070**	**60,964**	**49**	**12,057**	**838**	**76,978**
Net book value							
NBV - Owned at 31 March 2017	11,710	29,504	13,538	5	2,449	21	**57,227**
NBV - Finance lease at 31 March 2017	0	0	726	0	0	0	**726**
NBV - PFI at 31 March 2017	0	163,134	388	0	0	0	**163,522**
NBV - Government Granted at 31 March 2017	0	0	0	0	0	0	**0**
NBV - Donated at 31 March 2017	0	9,980	2,708	0	47	2	**12,737**
NBV total at 31 March 2017	**11,710**	**202,618**	**17,360**	**5**	**2,496**	**23**	**234,212**
Net book value							
NBV - Owned at 1 April 2016	11,710	32,581	12,876	6	3,271	57	**60,501**
NBV - Finance lease at 1 April 2016	0	0	437	0	0	0	**437**
NBV - PFI at 1 April 2016	0	208,195	1,165	0	0	0	**209,360**
NBV - Government Granted at 31 March 2016	0	0	0	0	0	0	**0**
NBV - Donated at 1 April 2015	0	10,257	3,079	0	70	4	**13,410**
NBV total at 1 April 2016	**11,710**	**251,033**	**17,557**	**6**	**3,341**	**61**	**283,708**

Land, buildings and dwellings are all deemed to fall within the definition of protected assets.

The revaluation loss of £49,655k on Land and Buildings has been presented in the table above in accordance with the requirements of IAS 16
The accumulated depreciation on the relevant assets has been eliminated, in the sum of £6,740k.
The cost or valuation has been adjusted to reflect the revalued amount of the assets being a reduction to buildings of £56,395k
The net impact of this presentation of the revaluation is a decrease to the net book value of land and buildings at 31.3.2017 by £49,655k.

15. Property, plant and equipment (continued)

During the year assets to the value of £1,731k (2017: £170k) were purchased using Charitable Funds donated to the Trust.

Plant and Equipment mainly consists of low value equipment with short asset lives. It is therefore considered that Depreciated Historic Cost is appropriate to be used as a proxy for Depreciated Replacement Cost and for Fair Value.

For 2016/17 and 2015/16 the Trust undertook an exercise, where it obtained the BCIS indices and applied them to its specialised buildings estate, in order to identify any change in value, with the exception of the PFI Hospital Building, which is set out below.
An interim valuation of the PFI Hospital Building was commissioned as at 31 March 2017, on the same basis as the existing valuation with the exception of VAT. The interim valuation excluded VAT to better reflect the cost of when the asset would be replaced by a PFI operator. This resulted in a reduction in value of £49,578k. This together with the impact of the change in index on the other estate assets resulted in a total revaluation of a reduction in value of £49,655k. This provided assurance to the Trust that its land and buildings, which are held for the long term, are held at fair value. For 2017/18 the Trust has taken professional valuation advice which has had regard to the movement in the BCIS index, being a slight downward movement for the 2017-2018 period and a consideration of the wider circumstances affecting the UK Construction industry. As a result, the Trust is assured that the carrying value remains reasonable.

For 2014/15 the Trust's Land and Buildings were subject to an IFRS compliant revaluation as at 31 March 2015. This was performed by David Boshier (MRICS) of Boshier & Company Chartered Surveyors RICS.

Details of the methodology and valuer used can be found in note 1.6.

The economic lives of the depreciable items of property, plant and equipment is disclosed in the table below:

	Minimum Life (years)	Maximum Life (years)
Buildings excluding dwellings	2	82
Plant and machinery	1	30
Transport equipment	5	12
Information technology	1	10
Furniture & fittings	5	15

Assets under construction are not depreciated until they are brought into use.
Land is not depreciated.

16. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these accounts:

	31 March 2018 £'000	31 March 2017 £'000
Property, Plant and Equipment	6,883	9,045
Total	**6,883**	**9,045**

17. Inventories

17.1. Inventories

	31 March 2018 £'000	31 March 2017 £'000
Drugs	2,645	2,333
Consumables	6,724	6,071
Total	**9,369**	**8,404**

17.2 Inventories recognised in expenses

	Year ended 31 March 2018 £'000	Year ended 31 March 2017 £'000
Inventories recognised as an expense in the year	133,752	121,185
Write-down of inventories (including losses)	116	107
Total	**133,868**	**121,292**

18. Trade and other receivables

18.1 Trade and other receivables

	31 March 2018		31 March 2017	
	Current £'000	Non - Current £'000	Current £'000	Non - Current £'000
Trade receivables due from NHS bodies	23,098	0	18,405	0
Provision for impaired receivables	(3,132)	0	(2,586)	0
Prepayments (non-PFI)	4,081	1,035	2,566	1,150
PFI prepayments:				
Lifecycle replacements	0	68,850	0	62,205
Accrued income	1,294	0	133	0
Interest receivable	5	0	0	0
PDC dividend receivable	295	0	880	0
VAT receivable	1,612	0	1,701	0
Other receivables	1,291	1,360	802	1,147
Total	**28,544**	**71,245**	**21,901**	**64,502**

The significant majority of trade is with Clinical Commissioning Groups, as commissioners for NHS patient care services. As Clinical Commissioning Groups are funded by government to buy NHS patient care services, no credit scoring of them is considered necessary.

18.2 Provision for impairment of receivables

	31 March 2018 £'000	31 March 2017 £'000
At 1 April as previously stated	**2,586**	**2,320**
Increase in provision	920	719
Amounts utilised	(129)	(203)
Unused amounts reversed	(245)	(250)
At 31 March	**3,132**	**2,586**

18.3 Analysis of impaired receivables

	31 March 2018	31 March 2017
Ageing of impaired receivables	**Trade & Other Receivables £000**	**Trade & Other Receivables £000**
0 - 30 days	35	0
30-60 Days	7	9
60-90 days	34	3
90- 180 days	181	67
Over 180 days	795	497
Total	**1,052**	**576**
Ageing of non-impaired receivables past their due date		
0 - 30 days	9,822	13,914
30-60 Days	1,811	2,197
60-90 days	1,010	648
90- 180 days	1,121	1,174
Over 180 days	2,767	2,218
Total	**16,531**	**20,151**

19. Cash and cash equivalents

	Year ended 31 March 2018 £'000	Year ended 31 March 2017 £'000
Balance at 1 April	15,510	31,494
Net change in year	(9,777)	(15,984)
Balance at 31 March	**5,733**	**15,510**
Comprising:		
Cash at commercial banks and in hand	275	108
Cash with the Government Banking Service	5,458	15,402
Cash and cash equivalents as in statement of financial position and statement of cash flows	**5,733**	**15,510**

20. Trade and other payables

	31 March 2018 Current £'000	31 March 2018 Non-current £'000	31 March 2017 Current £'000	31 March 2017 Non-current £'000
NHS trade payables	9,240	0	5,921	0
Amounts due to other related parties	4,376	0	4,142	0
Capital payables	1,948	0	877	0
Social security costs	6,855	0	6,277	0
Other payables	12,211	0	15,006	0
Accruals	23,534	0	30,246	331
Total	**58,164**	**0**	**62,469**	**331**

Included in Amounts due to other related parties at 31 March 2018 is £4,376k (31 March 2017: £4,142k) of outstanding pension contributions.

21. Borrowings

	31 March 2018 Current £'000	31 March 2018 Non-current £'000	31 March 2017 Current £'000	31 March 2017 Non-current £'000
Interim Revenue Support Facility - Dept. of Health	0	52,393	0	16,000
Obligations under finance leases	174	434	168	608
Obligations under Private Finance Initiative contracts	2,673	193,422	2,981	196,096
Total	**2,847**	**246,249**	**3,149**	**212,704**

Details of the PFI schemes comprising the liabilities detailed above can be found in note 24.

22. Other liabilities

	31 March 2018 Current £'000	31 March 2018 Non-current £'000	31 March 2017 Current £'000	31 March 2017 Non-current £'000
Deferred Income	5,138	4,606	14,942	1,328
Total	**5,138**	**4,606**	**14,942**	**1,328**

23. Finance lease obligations

	31 March 2018 Minimum Lease Payments £'000	31 March 2018 PV of Minimum Lease Payments £'000	31 March 2017 Minimum Lease Payments £'000	31 March 2017 PV of Minimum Lease Payments £'000
Gross lease liabilities				
of which liabilities are due				
- not later than one year;	190	190	190	190
- later than one year and not later than five years;	463	463	653	653
- later than five years.	0	0	0	0
Finance charges allocated to future periods	(45)	(45)	(67)	(67)
Net lease liabilities	**608**	**608**	**776**	**776**
Split into:				
- not later than one year;	174	174	168	168
- later than one year and not later than five years;	434	434	608	608
- later than five years.	0	0	0	0
Net lease liabilities	**608**	**608**	**776**	**776**

24. Private Finance Initiative contracts

24.1 PFI schemes on-Statement of Financial Position

(i) New Hospital

On 9 January 1998 the Trust concluded contracts under the Private Finance Initiative (PFI) with Octagon Healthcare Limited for the construction of a new 809 bed hospital and the provision of hospital related services. In addition, and as a consequence of revised patient activity projections, the Trust entered into a contract variation with Octagon Healthcare Limited to extend the new hospital by a further 144 beds. This contract variation was approved by the Department of Health and was signed on 14 July 2000.

The PFI scheme was approved by the NHS Executive and HM Treasury as being better value for money than the public sector comparator. Under IFRIC 12, the PFI scheme is deemed to be on Statement of Financial Position, meaning that the hospital is treated as an asset of the Trust, that is being acquired through a finance lease. The payments to Octagon in respect of it have therefore been analysed into finance lease charges and service charges. The accounting treatment of the PFI scheme is detailed in accounting policy 1.11.

The service element of the contract was £20,800k (2016/17: £19,600k), with contingent rent being £12,200k (2016/17: £11,000k).

The estimated value of the scheme at inception was £222,600k. Payments under the scheme commenced on 15 August 2001. In 2003/04 the Trust entered into and concluded a refinancing arrangement with Octagon Healthcare Ltd on the investment in the hospital. This resulted in an extension of the minimum term of the scheme from 30 to 35 years and a reduction in the annual charge of £3,500k per annum.

(ii) Radiotherapy

In October 2002, the Trust entered into a PFI agreement for the provision of radiotherapy services. The duration of the contract is 15 years with an estimated capital value of £7,100k. It has been assessed as being on Statement of Financial Position under IFRS, meaning that it is treated as a finance lease, with the assets being treated as assets of the Trust.

The contract includes a maintenance agreement, with the cost for 2017/18 being £300k (2016/17: £500k).

During 2013-14 a variation to this contract was agreed in order to finance an additional linear accelerator for radiotherapy services. The duration of the extension is 4.25 years with an estimated capital value of £1,200k. The extension to the contract includes a maintenance agreement, with the cost for 2017/18 being £100k (2016/17: £100k).

24.2 PFI schemes on-Statement of Financial Position (on-SoFP)

Total obligations for on-statement of financial position PFI contracts are:

	31 March 2018 £000	31 March 2017 £000
Gross PFI, LIFT or other service concession liabilities	**949,409**	**985,533**
Of which liabilities are due		
- not later than one year;	40,072	39,206
- later than one year and not later than five years;	171,315	166,521
- later than five years.	738,022	779,806
Lifecycle Maintenance expenditure	(82,592)	(89,236)
Finance charges allocated to future periods	(670,722)	(697,220)
Net PFI, liabilities	**196,095**	**199,077**
- not later than one year;	2,673	2,981
- later than one year and not later than five years;	16,753	13,728
- later than five years.	176,669	182,368
	196,095	**199,077**

Gross PFI liabilities includes £82,592k (2016/17: £89,236k) in respect of lifecycle maintenance expenditure on the hospital PFI scheme. These are payments to replace components of the hospital infrastructure throughout the course of the PFI agreement.

Finance charges include both interest payable and contingent rent payable. Contingent rent is variable dependent on the future rate of inflation using the Retail Prices Index (RPI). The Trust has assessed the future rate of RPI with regard to historical trends and current forward-looking estimates.

24.3 The Trust is committed to make the following payments for on-SoFP PFI obligations during the next year in which the commitment expires:

	31 March 2018 £'000	31 March 2017 £'000
Within one year	0	565
2nd to 5th years (inclusive)	0	0
6th to 10th years (inclusive)	0	0
11th to 15th years (inclusive)	0	0
16th to 20th years (inclusive)	40,072	38,641
Total	**40,072**	**39,206**

24.4 The Trust is committed to make the following payments in respect of the service element of the On-SoFP PFIs.

	31 March 2018 £'000	31 March 2017 £'000
Charge in respect of the service element of the PFI, LIFT or other service concession arrangement for the period	21,152	20,313
Commitments in respect of the service element of the PFI, LIFT or other service concession arrangement:		
- not later than one year;	21,847	20,670
- later than one year and not later than five years;	92,651	85,578
- later than five years.	399,139	400,312
Total	**513,637**	**506,560**

25. Provisions

	Current 31 March 2018 £'000	Non-current 31 March 2018 £'000	Current 31 March 2017 £'000	Non-current 31 March 2017 £'000
Pensions relating to other staff	204	2,159	210	2,842
Legal claims	103	0	96	0
VSS & Redundancy	0	0	22	0
Total	**307**	**2,159**	**328**	**2,842**

	Pensions relating to other staff £'000	Legal claims £'000	VSS & Redundancy £'000	Total £'000
At 1 April 2017	3,052	96	22	**3,170**
Change in the discount rate	21	0	0	**21**
Arising during the year	0	42	0	**42**
Utilised during the year	(205)	(35)	(22)	**(262)**
Reversed unused	(508)	0	0	**(508)**
Unwinding of discount	3	0	0	**3**
At 31 March 2018	**2,363**	**103**	**0**	**2,466**
Expected timing of cash flows:				
Within one year	204	103	0	**307**
Between one and five years	796	0	0	**796**
After five years	1,363	0	0	**1,363**
	2,363	**103**	**0**	**2,466**

Pensions relating to other staff covers liabilities in respect of former staff members. Due to the nature of the obligation (pension related) there is uncertainty over the expected timing of cash flows, duration and magnitude.

Legal claims include Employer's Liability and Public Liability claims. Incidents occurring after 1 April 1999 are covered by the NHS Litigation Authority Liabilities to Third Parties Scheme.

The NHS Litigation Authority holds provisions at 31 March 2018 of £170,111k (31 March 2017; £150,908k) in respect of clinical negligence liabilities of the Trust.

25. Provisions (continued)

2016/17

	Pensions relating to other staff £'000	Legal claims £'000	VSS, redundancy and other £'000	Total £'000
At 1 April 2016	3,081	80	552	**3,713**
Change in the discount rate	236	0	0	**236**
Arising during the year	60	44	0	**104**
Utilised during the year	(213)	(28)	(79)	**(320)**
Reversed unused	(119)	0	(451)	**(570)**
Unwinding of discount	7	0	0	**7**
At 31 March 2017	**3,052**	**96**	**22**	**3,170**
Expected timing of cash flows:				
Within one year	210	96	22	**328**
Between one and five years	882	0	0	**882**
After five years	1,960	0	0	**1,960**
	3,052	**96**	**22**	**3,170**

The NHS Litigation Authority holds provisions at 31 March 2017 of £150,908k (31 March 2016; £116,273k) in respect of clinical negligence liabilities of the Trust.

26. Financial Instruments

26.1 Financial assets by category	31 March 2018		31 March 2017	
	Total £'000	Loans and receivables £'000	Total £'000	Loans and receivables £'000
Assets as per SoFP				
Trade and other receivables excluding non financial assets	24,710	24,710	20,986	20,986
Cash and cash equivalents (at bank and in hand)	5,733	5,733	15,510	15,510
Total at 31 March	**30,443**	**30,443**	**36,496**	**36,496**

The net book value of the financial assets is equivalent to fair value, by virtue of the balances being deemed as current.

26.2 Financial liabilities by category	31 March 2018		31 March 2017	
	Total £'000	Other financial liabilities £'000	Total £'000	Other financial liabilities £'000
Liabilities as per SoFP				
Borrowings excluding Finance lease and PFI liabilities (at 31 March 2018)	52,393	52,393	16,000	16,000
Obligations under finance leases	608	608	776	776
Obligations under Private Finance Initiative contracts	196,095	196,095	199,077	199,077
Trade and other payables excluding non financial liabilities	58,163	58,163	62,800	62,800
Provisions under contract	2,466	2,466	3,170	3,170
Total at 31 March	**309,725**	**309,725**	**281,823**	**281,823**

The net book value of the financial liabilities is equivalent to fair value, as they are either current, relate to PFI obligations, or are already discounted using HM Treasury's discount rate of 0.10% (2016/17: 0.24%) in real terms.

26.3 Maturity of Financial Liabilities	31 March 2018 £'000	31 March 2017 £'000
In one year or less	61,318	65,947
In more than one year but not more than two years	24,528	3,178
In more than two years but not more than five years	45,848	27,489
In more than five years	178,031	185,209
Total	**309,725**	**281,823**

26.3 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trust's internal auditors.

26.3.1 Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

26.3.2 Interest rate risk

The Trust has borrowings in the form of PFI arrangements and a Finance Lease. For both types of borrowings, the interest rate is fixed, resulting in a low level of associated risk. Contingent rent does apply to the largest PFI scheme, as it is indexed through a twice yearly application of RPI. There is therefore an interest rate risk associated with that, though it is deemed to be low due to its comparative size and current market conditions.

26.3.3 Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the Trade and Other Receivables note.

The Trust's Treasury Management Policy has clear criteria, is updated regularly and advice is taken from it's investment advisers so as to ensure that there is a very low level of risk associated with cash and any deposits with financial institutions.

26.3.4 Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust is not, therefore, exposed to significant liquidity risks.

27. Events after the reporting year

There have been no events after the reporting year that have had a major impact on these accounts.

28. Capital cost absorption rate

The Trust incurs a charge on the balance of any funding received from the government. This is in the form of a PDC dividend charge that is broadly calculated as 3.5% of the Trust's average net relevant assets. In 2017/18 this equated to a £0k charge (£1,470k in 2016/17).

29. Related party transactions

The Norfolk and Norwich University Hospitals NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with the Foundation Trust.

The Department of Health is regarded as a related party. During the year the Norfolk and Norwich University Hospitals NHS Foundation Trust has had a significant number of transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These are summarised below:

Related Party Transactions	Income Year ended 31 March 2018 £'000	Expenditure Year ended 31 March 2018 £'000	Income Year ended 31 March 2017 £'000	Expenditure Year ended 31 March 2017 £'000
Value of transactions with board members	0	0	0	0
Value of transactions with key staff members	0	0	0	0
Value of transactions with other related parties				
- Charitable Funds	1,788	0	206	0
- Other	257	6,777	939	6,392

Related Party Balances	Receivables 31 March 2018 £'000	Payables 31 March 2018 £'000	Receivables 31 March 2017 £'000	Payables 31 March 2017 £'000
Value of balances (other than salary) with related parties in relation to doubtful debts	(1,860)	0	(1,756)	0
Value of balances with other related parties				
Charitable Funds	77	0	2	0
Other	1,738	10,746	1,890	10,746

Remuneration of Key Management Personnel

The following table analyses the remuneration of key management personnel (deemed to be the Board of Directors) in accordance with IAS 24.

	Year ended 31 March 2018 £'000	Year ended 31 March 2017 £'000
Short term employee benefits (pay)	1,166	1,045
Post-employment benefits (employers pension contribution)	107	116

The highest paid Director in 2017/18 received remuneration of £229k, excluding pension related benefits and exit packages, for their services as Chief Executive. In 2016/17 the highest paid Director received remuneration of £227k, not including pension related benefits, for their services as Chief Executive.

Further details on remuneration of the Board of Directors can be found in the Remuneration Report.

In addition, the Trust had a number of material transactions with other Government Departments and other central and local Government bodies. Most of these transactions were with HM Revenue & Customs in respect of the deduction and payment of PAYE and with South Norfolk Council in respect of rates.

The Trust has also received revenue and capital payments from the Norfolk and Norwich University Hospitals NHS Foundation Trust Charitable Fund, the Corporate Trustee of which is the Trust. These payments are outlined below.

29. Related party transactions (continued)

The services of the Norfolk and Norwich University Hospitals NHS Foundation Trust have benefited from payments of £40k (2016/17: £113k) from charitable funds.

During the year assets to the value of £1,731k (2016/17: £170k) were donated to the Foundation Trust, of which £1,657k (2016/17: £108k) came from the Norfolk and Norwich University Hospitals NHS Foundation Trust Charitable Fund.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has recharged the sum of £124k (2016/17: £36k) to the Norfolk and Norwich University Hospitals NHS Foundation Trust Charitable Fund for the provision of the administration and management of the charity.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has received payments of £46k (2016/17: £260k) from the Eastern Academic Health Science Network. The Chief Executive Officer is a member of the board of this network.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has made payments of £316k (2016/17: £329k) to Norwich Research Partners LLP. The Chief Executive Officer and a Non-Executive director are members of the board of this organisation.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has made payments of £3,004k (2016/17:£2,406k) to the University of East Anglia. A Non-Executive director is the Vice-Chancellor of this organisation.

30. Third Party Assets

The Trust held £4k (2016/17: £6k) cash at bank and in hand at 31 March 2018 which relates to monies held by the Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

31. Losses and Special Payments

There were 2,252 cases of losses and special payments totalling £207k paid during the year (2016/17: 2,326 cases totalling £268k).

	31 March 2018		31 March 2017	
	Number	£'000	Number	£'000
Losses				
Cash losses (including overpayments, physical losses, unvouched payments and theft)	5	1	2	1
Bad debts and claims abandoned (excluding cases between FT and other NHS bodies)	2,172	79	2,262	149
Stores losses (including damage to buildings and other properties as a result of theft, criminal damage and neglect)	3	116	3	107
Special Payments				
Ex gratia payments	72	11	59	11
	2,252	**207**	**2,326**	**268**

These amounts are recorded on an accruals basis but excludes provisions for future losses.

32. Contingent Assets and Contingent Liabilities

There are no contingent assets or contingent liabilities.

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