NHS
Norfolk and Norwich
University Hospitals
NHS Foundation Trust

Annual Report and Accounts 2018-19

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

I have been Chairman for the last six years and will step down just after the end of my second term in June 2019. The new chairman David White is very experienced having been chairman of East Suffolk and North Essex NHS Foundation Trust and a former CEO of Norfolk County Council. This makes me confident that I am leaving our hospitals with an experienced chairman who can build on our achievements.

The last six years have been eventful as the NHS has been under growing pressure during this time from an increasing population and an ageing one, nowhere is this trend more marked than in Norfolk.

During my time as Chairman cancer referrals have increased by two thirds, representing an increase of over 10% each year. Emergency ambulance arrivals have increased by a similar amount.

The vital ingredient in keeping pace with these trends has been our outstanding staff who ensure we deliver safe and appropriate care to our patients. Their commitment in the face of service pressures and the fantastic support they give to our patients is second to none. We are a major employer in Norfolk and have seen our workforce grow from about 6,000 when I joined the Trust to over 8,000 now.

We are also exceptionally fortunate to be supported by over 800 volunteers, incredibly hard working Governors, fantastic charities, committed partners and of course our strong local community.

We have always been rated highly as a caring institution and our patients have reinforced this position with consistently high scores on the friends and family test which measures patient satisfaction. I am pleased to say that our CQC rating has been uplifted to '*requires improvement'* thanks to an organisation-wide quality improvement plan, led by the chief nurse and medical director, which has helped us to make improvements across the board and reinforce a culture of constant improvement.

The footprint of the N&N hospital has increased dramatically over six years and there has been an ongoing programme of training and developing staff and investment to upgrade and expand our facilities. Having cranes and construction work on site is the sign of a thriving and growing organisation which is certainly true of our hospitals. Over the last few years, we have seen the Bob Champion Research and Education Building opened as a joint venture with UEA. It houses researchers finding new treatments for diseases affecting ageing populations and a unique bio-bank facility to store DNA and tissue samples, as well as undergraduate and postgraduate education.

The Quadram Institute (QI) opened in 2018 in which we run one of the largest endoscopy units in Europe and the Clinical Research Facility. We are one of four partners in the QI, a world class research centre bringing together food science, gut biology, human health and disease and capitalising on the world-class bioscience cluster based at the Norwich Research Park. I am very proud to have been a part of this development which will have a major impact on research in the future.

We continue to put a lot of focus on research and one of the big steps in establishing ourselves in this area was to be appointed as one of just 15 NHS Trusts in England to run a regional branch of the National Institute for Health Research (NIHR) Clinical Research Networks.

NIHR is the clinical research delivery arm of the NHS, and every year it is responsible for helping thousands of patients take part in research studies that contribute towards improving treatments for the future.

In terms of capacity, our Emergency Department has expanded its footprint significantly in recent years as demand has grown from 60,000 attendances per year when the hospital opened in 2001 to over 130,000 attendances during 2018/19. In winter 2018, we added a temporary building to give us extra capacity for our ambulance arrivals for our Rapid Assessment and Treatment service. The previous year, we tripled the size of the paediatric emergency department and opened the UK's first Older People's Emergency Department offering specialist care for older people. Despite all this investment we are still experiencing an increase in ambulance arrivals and this trend looks set to continue.

Part of our winter preparations for 2018/19 included the addition of a new discharge suite in a modular building to give us more capacity and smooth the pathway for discharging patients.

Cromer Hospital is the jewel in our crown and I am delighted to say that we have formed a partnership with Macmillan Cancer Support to develop a new cancer centre on the site benefitting the population of North Norfolk.

More recently, we have started work on plans to expand our interventional radiology and cardiology services with an extension on top of the east wing of the N&N Hospital. The new unit will quadruple the number of interventional suites, placing NNUH among the biggest centres in the UK for interventional radiology. The project will also double the cardiology procedure rooms at the hospital. The development will help meet increasing demand on services, reduce waiting times for patients and enable NNUH staff to offer new services in the future such as stroke thrombectomy where blood clots are directly mechanically removed from the brain following a stroke.

In February 2019, we were delighted to welcome Matt Hancock, Secretary of State for Health and Social Care to the Trust where he met with a cross section of staff. Mr Hancock was able to see the state-of-the-art Quadram Building and the expanded Weybourne chemotherapy day unit. Our discussions included the need for a massive digital upgrade.

I am pleased that our Digital Strategy was agreed by the Board and having launched the Electronic Document Management Solution (EDMS) project which will see patients' paper records going digital, this work is now underway. I have talked extensively about the expansion of our services and nearly every service in the hospital has grown during my time as chairman. We can never stand still and it is becoming clear that we still have to go further to meet the demand we are facing.

I reserve a special thank you to our Chief Executive Mark Davies and the executive team who have supported me so well. The skill, dedication and compassion of our outstanding staff has helped to make this a wonderful hospital and I will have proud memories of the difference we have made to the local community and it has been a hugely enjoyable to meet and spend time with our staff and see first-hand the excellent and compassionate care they give our patients every day.

John Fry
Chairman

Chief Executive's Statement

I have been hugely impressed by the commitment of our staff to improve the care we deliver for patients. The Improvement Programme which launched in September 2018 has been led by the Chief Nurse and Medical Director and is producing excellent results and ensuring that our staff are fully involved in developing and improving their own services. The effort and attention to detail is impressive and makes me proud of the care our teams deliver.

We know that in many respects our clinical outcomes are extremely good, but there is a need for greater consistency and a more robust framework around this. We have seen a very substantial increase in the number of patients coming to hospital on an emergency basis – especially by ambulance and this has placed extreme pressure on the NNUH hospital and its staff. The response of our staff has been tremendous and we remain focussed on patient safety especially when particularly busy.

We continue to operate in an environment where demand is rising driven by an increasing population and an ageing one. The latest statistics show that 23.9% of people in Norfolk are over the age of 65 compared with 17.9% nationally. Some older people are living very well but others live with increasing frailty. This is widely defined as either significantly reduced muscle mass and strength, or a disproportionate step down in function resulting from an innocuous medical event. In fact, 5-10% of all people attending ED and 30% of patients in our Acute Medical Unit are older people with frailty.

CQC report

The Trust implemented a robust Quality Improvement Programme and action plan following the "Inadequate" rating and placement into special measures by the CQC in June 2018. These plans addressed all issues raised by both the CQC and the King's Fund "Organisational Diagnostic Review".

Following a further inspection in January 2019 the CQC published its report in May 2019 which saw a significant improvement as our rating rose from *'inadequate'* to '*requires improvement'*.

We welcomed the CQC's most recent report which recognised the significant improvements we have made in many areas across the Trust.

I would like to thank every one of our amazing staff who have been working so hard to deliver the Trust's clear, comprehensive improvement programme. It is their dedication, commitment and hard work mainly through the winter months which has helped to improve our ratings in such a short period of time. We are now well on our way on our five year journey to outstanding.

The CQC recognised a number of examples of outstanding practice here at the trust including leading the way in the East of England in the use of robotic surgery, improving the safety culture through human factors training and the plans we have to increase capacity at the NNUH particularly in interventional radiology and endoscopy in the newly opened Quadram Institute.

It is also recognised that the hospital has some of the lowest infection and mortality rates in the country.

I am very proud of the staff and they should feel very proud of the immense contribution they are making to patient care for the people of Norfolk and beyond.

Capacity and investment

I have been clear in speaking to staff, MPs and the media that we cannot do this on our own. We need to fix the capacity issues across the county with how we work with our colleagues at other hospitals.

From the system, what we need is investment. That would include new IT infrastructure and around 200 more beds. The equipment at NNUH was mostly purchased when the N&N opened in 2001 and much of it needs to be replaced and updated.

In addition to the capital backlog, we also struggle with paying the annual £20m private finance initiative (PFI) payments. The combination of the capital bill and the PFI is significant. We are not in a position to borrow any more money and we don't have the savings in the bank.

We have seen an ongoing demand for our services in recent years with the number of patients arriving at A&E increasing by 10 per cent every year whilst the numbers attending the Norwich Walk-in Centre have declined. In terms of the four hour target, we know that we are not providing patients with the speed of service we would want. We are doing everything we can to bring about improvements.

Lack of capacity and sustained high levels of demand continue to put our services under extreme pressure as the STP confirmed in the report commissioned with the Boston Consulting Group review of demand and capacity reported to the STP – see page 15.

With our neighbouring hospitals, the James Paget University Hospital and the Queen Elizabeth Hospital at King's Lynn, we are working together more closely exploring the opportunities to join up the cardiology, vascular, urology, haematology, oncology, and ear, nose and throat services, and this is going well.

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 2020. At Cromer & District Hospital with have partnered with Macmillan Cancer Support to create some exciting plans for a new medical and cancer unit in one of the older buildings on the site.

The Quadram Institute opened in the autumn of 2018 with the Clinical Research Trials Unit moving into the building in September and our new endoscopy suite becoming operational in November 2018.

This is providing a massive capacity boost for our endoscopy service and will double our capacity from 20,000 procedures a year to 40,000. It provides state of the art facilities for patient care, juxtaposed with world leading research facilities.

Change of culture

The CQC inspectors found improvements to both the culture and leadership.

As part of our journey to outstanding, we have joined the national culture change programme with NHS Improvement.

In 2018, we implemented the King's Fund recommendations, following on from the staff survey, and established the Leading and Communicating with PRIDE programme attended by hundreds of staff in the autumn of 2018.

The culture change programme centres on creating a team of 15-20 members of staff who will form a change team that is supported and enabled to design the strategy and approach for the next stage of our improvement with leadership and culture.

We have appointed a Freedom to Speak Up Guardian who will support staff in addition to our staff governors who also play a role in enabling staff to voice any concerns.

In October, I started my Chat with the Chief sessions where I spend an hour talking informally to any member of staff who would like to drop in. These sessions are held in a public area of the hospital, rather than my office, and it is both fascinating and a pleasure to talk with the members of staff and to help them to take issues forward.

These meetings are in addition to my monthly Viewpoint briefings, about performance, strategy, finance and workforce issues, which are open to all staff in the lecture theatre.

Research and Innovation
There are currently more than 300 research projects at NNUH covering many areas of medicine and more than 3,500 patients took part in clinical trials at the Trust last year. Many of the research projects at the hospital involve partners from the University of East Anglia, Norwich Research Park and the National Institute for Health Research. There is a strong commitment and serious ambition for research at NNUH and we are enhancing research capability and support at the hospital.

Finance
The whole Trust has been working hard to make savings and achieve our Cost Improvement Programme and this has been crucial to achieving a planned deficit of £60.6m.
We are also working on our Medium Term Financial Strategy looking five years ahead and exploring how we might be able to access help with our annual PFI costs from central Government.

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 2019/20.

Digital Agenda
Our digital strategy has been launched and the Electronic Document Management Solution (EDMS) project will see patients' paper records going digital. The records will be electronically converted and stored in a massive Trust-wide project managed by the hospital's own Digital Health (formerly known as IT) team in partnership with Health Records, clinical and operational teams, with a view to completion within two years.

We are also looking at the introduction of a full Electronic Patient Record (EPR) which would replace the existing Patient Administration System and many of our standalone clinical IT systems at the Trust.

I have decided to leave the NNUH in the autumn. As you might imagine this has been a really difficult decision. I love working here and I believe the Trust has some of the most amazing people I have ever worked with – every day providing great care. After 40 years in the NHS and 30 years as a CEO it's time for me to develop other professional pursuits and, as I won't be leaving the NHS completely, I would like to thank everyone for their continued dedication and commitment to our patients and wish NNUH all the best in the future.

Mark Davies
Chief Executive

Overview of Performance

Welcome to our 2018/19 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 8,000 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 700 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 nearly one million. 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 stronger relationships with both of these hospitals over recent years, including the Eastern Pathology Alliance (EPA), and numerous clinical networks. We are currently looking at development joint clinical strategies across a number of specialties.

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 Norfolk and Waveney Sustainability and Transformation Partnership (STP).

Key Issues and Risks

We continue to see an increase in demand for emergency care, cancer referrals, 18 week wait referrals and ambulance arrivals at the Emergency Department. Demand is increasing across the Trust and this position was confirmed by the STP which commissioned the Boston Consulting Group to review demand and capacity in December 2018. It concluded that the STP has key challenges, being:

- A growing and ageing population
- Primary care working to capacity, with a shrinking GP workforce;
- Acute inpatient bed capacity cannot meet demand;
- Community services cannot meet demand from acutes;
- Social care DToCs are high and there is a lack of home care capacity;
- The system has significant financial challenges.

The review highlighted that

- Demand and capacity is mismatched and could result in a 500 bed deficit by 2023 in a 'do nothing' scenario.
- Current system issues cannot be addressed by any single provider. Collective interventions across the system could create a sustainable position.
- Even given the potential solutions within the review it is estimated that there will be a shortfall of 140 beds so further capacity / new models of care will be required.
- Representatives from the three acutes plus STP are meeting regularly to develop next steps in taking forward the recommendations from the review.

Strategy

Our strategy agreed in 2016 remains in place to guide developments at the Trust and address the level of demand from the local population. In summary there are four 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, innovation 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 facility known as Diagnostic Assessment Centre (DAC)
- Develop our digital capability and capacity
- Develop services at Cromer Hospital
- 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 2018/19 includes:

- Construction of the new Interventional Radiology and Cardiology services
- Agreement with Macmillan Cancer Support to develop a new hospital at Cromer & District Hospital
- Development of new models for Urology, Cardiology and Radiology across Norfolk
- Commencement of a masterplan for future investment in estates
- Refinement of DAC to focus primarily on a diagnostic centre for cancer referrals
- Further investment in the infrastructure of the Emergency Department
- Successful work in reducing acute admissions
- Agreement for NNUH to lead the East of England Radiotherapy Network
- Construction of a dedicated discharge suite and medical day unit (Alysham Suite).

Research at NNUH

There are currently about 380 research projects at NNUH; however this figure often exceeds 400. Of these, there are up to 60 active Commercial studies. Across the Trust Rheumatology, Gastroenterology and Oncology are currently the most commercially active.

The total recruitment of participants into research for 2018 was 4,856. 91% of the participants were recruited into the Clinical Research Network (CRN) Portfolio and 96% of the total participants were recruited into non-commercial trials.

Many of the research projects at the hospital involve partners from the University of East Anglia, Norwich Research Park and the National Institute for Health Research.

The NNUH focuses particularly on research excellence in chronic diseases around oncology, gastroenterology, diabetes and muscular skeletal conditions, paediatrics, older peoples' medicine and platform technologies relating to radiology and advanced imaging, and microbiology.

Almost a quarter of all research projects at NNUH are dedicated to helping cancer patients and nearly 10 per cent are looking into the healthcare of babies, children and young people.

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 2018 The Trust was fully compliant.

Going Concern Statement

The Board is required under IAS 1 Presentation of Financial Statements to undertake an assessment of the Trust's ability to continue as a going concern. Due to the materiality of the financial deficit, the Board has carefully considered the advice in the Department of Health and Social Care Group Accounting Manual 2018/19 that "The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern." These accounts have been prepared on a going concern basis and the factors taken into consideration in making this assessment are set out below.

The Trust is forecasting a deficit of £20.7m for 2019/20 following a reported deficit of £61.8m in 2018/19 and a deficit of £19.6m in 2017/18. The forecast deficit for 2019/20 is based on a number of assumptions including the delivery of cost savings of £26.6m. The Trust forecast cash position as at 31 March 2020 is a total revenue support borrowing of £140.4m. This assumes that the deficit support required in 2019/20 of £29.3m will be made available. However no agreement for this has been received to date. As with any Trust placing reliance on the DHSC for financial support, the directors acknowledge that there can be no certainty that this support will continue although, at the date of approval of these financial statements, they have no reason to believe that it will not do so. 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 £20.7m for 2019/20 and it is recognised that the plan contains demanding cost improvement targets. The revenue support funds required of £29.3m 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 2019/20 have been signed with the Trust's main Commissioners.

Based on these indications the directors believe that it remains appropriate to prepare the accounts on a going concern basis. However, the matters referred to above represent a material uncertainty that may cast significant doubt on the Trust's ability to continue as a going concern and, therefore, to continue realising its assets and discharging its liabilities in the normal course of business. The financial statements do not include any adjustments that would result from the basis of preparation being inappropriate.

NNUH scoops national award

NNUH scooped a national award for being one of the best performing Trusts in the UK.

The hospital was shortlisted for a healthcare efficiency award at the CHKS Top Hospitals programme awards 2018.

The Trust received a Top Hospitals Award after judges analysed performance data of every hospital in England, Wales and Northern Ireland.

The NNUH scored highly for its performance in clinical effectiveness, health outcomes, efficiency, patient experience and quality of care.

Mark Davies, Chief Executive, said: “I’m thrilled that we have been named as one of the top performing hospitals in the UK and we were in the top five for healthcare efficiency.

“I’d like to congratulate our dedicated staff who work hard every day and deliver an excellent standard of care to our patients.”

CHKS, part of Capita Healthcare Decisions, analysed hospital data over the last year. The annual Top Hospitals awards celebrate the success of healthcare providers across the UK and are awarded to healthcare organisations for their achievements in healthcare quality and improvement.

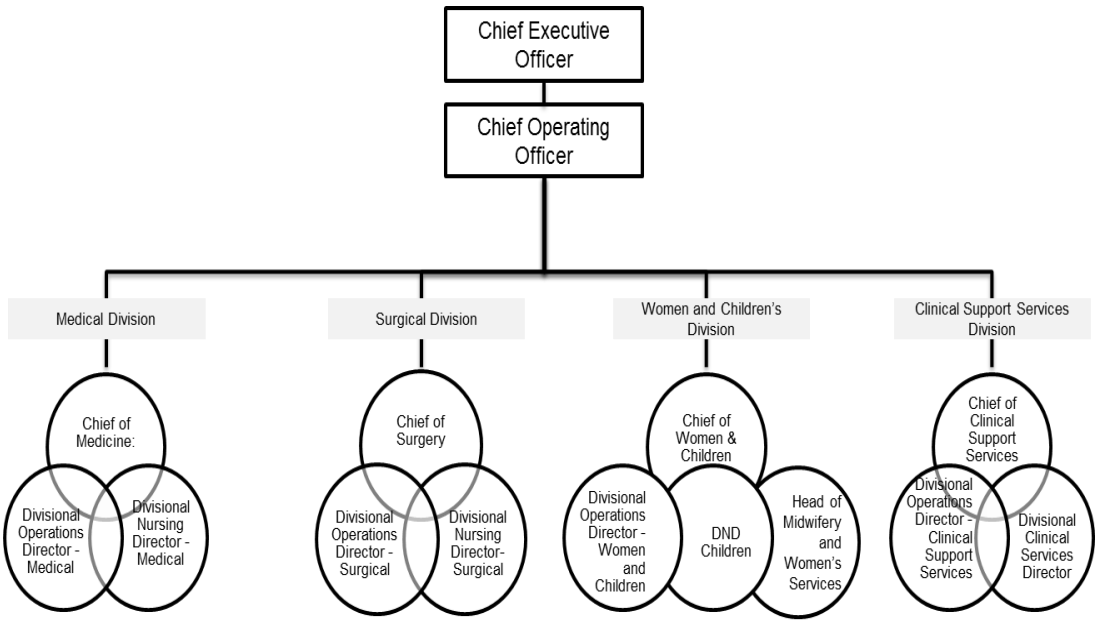
May 2018

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:

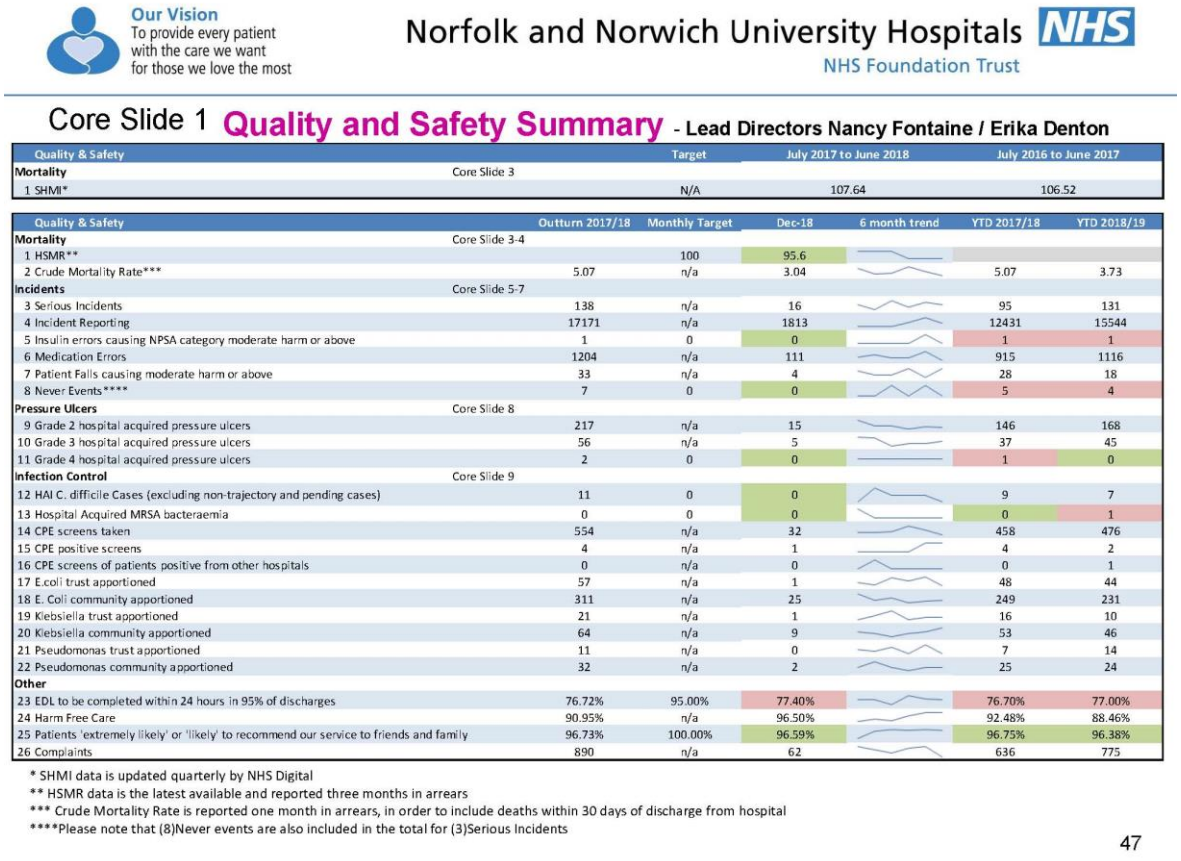


Integrated Performance Analysis

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 1 **Quality and Safety Summary** - **Lead Directors Nancy Fontaine / Erika Denton**

Quality & Safety		Target	July 2017 to June 2018	July 2016 to June 2017
Mortality	Core Slide 3			
1 SHMI*		N/A	107.64	106.52

Quality & Safety		Outturn 2017/18	Monthly Target	Dec-18	6 month trend	YTD 2017/18	YTD 2018/19
Mortality	Core Slide 3-4						
1 HSMR**			100	95.6			
2 Crude Mortality Rate***		5.07	n/a	3.04		5.07	3.73
Incidents	Core Slide 5-7						
3 Serious Incidents		138	n/a	16		95	131
4 Incident Reporting		17171	n/a	1813		12431	15544
5 Insulin errors causing NPSA category moderate harm or above		1	0	0		1	1
6 Medication Errors		1204	n/a	111		915	1116
7 Patient Falls causing moderate harm or above		33	n/a	4		28	18
8 Never Events****		7	0	0		5	4
Pressure Ulcers	Core Slide 8						
9 Grade 2 hospital acquired pressure ulcers		217	n/a	15		146	168
10 Grade 3 hospital acquired pressure ulcers		56	n/a	5		37	45
11 Grade 4 hospital acquired pressure ulcers		2	0	0		1	0
Infection Control	Core Slide 9						
12 HAI C. difficile Cases (excluding non-trajectory and pending cases)		11	0	0		9	7
13 Hospital Acquired MRSA bacteraemia		0	0	0		0	1
14 CPE screens taken		554	n/a	32		458	476
15 CPE positive screens		4	n/a	1		4	2
16 CPE screens of patients positive from other hospitals		0	n/a	0		0	1
17 E.coli trust apportioned		57	n/a	1		48	44
18 E. Coli community apportioned		311	n/a	25		249	231
19 Klebsiella trust apportioned		21	n/a	1		16	10
20 Klebsiella community apportioned		64	n/a	9		53	46
21 Pseudomonas trust apportioned		11	n/a	0		7	14
22 Pseudomonas community apportioned		32	n/a	2		25	24
Other							
23 EDL to be completed within 24 hours in 95% of discharges		76.72%	95.00%	77.40%		76.70%	77.00%
24 Harm Free Care		90.95%	n/a	96.50%		92.48%	88.46%
25 Patients 'extremely likely' or 'likely' to recommend our service to friends and family		96.73%	100.00%	96.59%		96.75%	96.38%
26 Complaints		890	n/a	62		636	775

* 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
****Please note that (8)Never events are also included in the total for (3)Serious Incidents

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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.

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.

The Chief Nurse is working with Risk Management to carry out a comprehensive review of the Trust Risk Register. Divisional governance and risk officers will be participating in this process and there will be Risk Management training to relevant staff. The Governance positions in Medicine and Surgery have now been filled, and there are now eight Governance roles across the Divisions. These Leads will play a key role in promoting a safety first culture, and disseminating and best practice learning across all staff groups.

For more information, see the Annual Governance Statement on page 106.

CQC Inspection report

On June 19 2018, the CQC published its inspection reports. During their inspection the CQC found a number of significant issues within two domains – 'Safe' and 'Well Led' - that collectively resulted in an overall rating of 'Inadequate' for the services we provide.

We were rated as 'Inadequate' for being 'Safe' and 'Well-led', and 'Requires Improvement' for being 'Effective' and 'Responsive'. We maintained our rating of 'Good' for being 'Caring'. The CQC also recommended that we be placed in 'quality special measures'; this means that we are able to access support to help deliver the required improvements.

The Trust Board accepted the CQC reports without reservation, acknowledging that we had clearly fallen short in some areas. The CQC recommendations are wide ranging, and include some things that are relatively easy to put right, such as ensuring that all of our staff have an annual performance appraisal. Many of the recommendations, though, are not 'quick fixes'. Achieving them will require a coordinated programme of sustained, transformational change.

In response to the report, we developed a Quality Improvement Plan which details how we will successfully address the 'must do' and 'should do' actions identified by the Care Quality Commission (CQC) following their recent inspection of our hospitals. This plan puts the patient at the heart of everything that we do. It embraces a 'Safety First' culture, in which safety is central to every aspect of the care we provide.

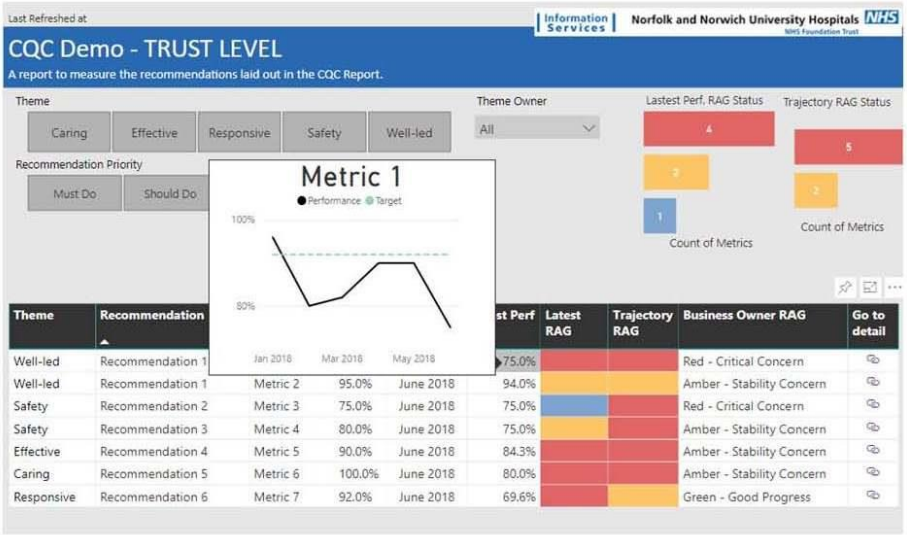
The CQC inspection reports provided the detail and focus for the immediate improvement actions, but the Trust Board ambition for our hospitals goes beyond meeting required standards and responding to the CQC reports. That is simply the first milestone on our journey. Following a further inspection in January 2019, the CQC published its findings in May 2019 and significant improvement was noted with our rating rising from inadequate to requires improvement, although the Chief Inspector of Hospitals has recommended that the Trust remain in special measures. For more information, see the Quality Report on page 122.

The governance structure includes a monthly Quality Programme Board to drive the plan forward and an Oversight and Assurance Group (OAG) which is an external stakeholder group and is part of the support in place for a Trust in special measures and it will help us to make sure that our plan and improvements are all moving forward at the right pace.

The Quality Programme Board meets monthly the week ahead of the OAG and will focus its agenda on monitoring the plan, removing blockers to success, injecting pace and momentum and managing risks to delivery.

Quality Improvement

Our Performance Dashboard is accessible to all staff members, and provides visual, dynamic management information to enable us to track our progress



We are committed to embedding a culture where all staff feel empowered to act as improvers within their own areas and work together to drive improvement across the Trust by sharing learning throughout the organisation.

Our goal is become an ‘outstanding’ Trust, recognised nationally and internationally for the exemplary care we provide.

We have already begun to establish an overarching Quality Improvement Strategy, which will set out how we will achieve our programme of sustained, longer term quality improvements and achieve an ‘Outstanding’ ranking within five years.

This strategy describes the Trust’s intent to embed a systematic and effective approach to Quality Improvement and create a culture of continuous improvement and learning which is both patient centred and safety focused.

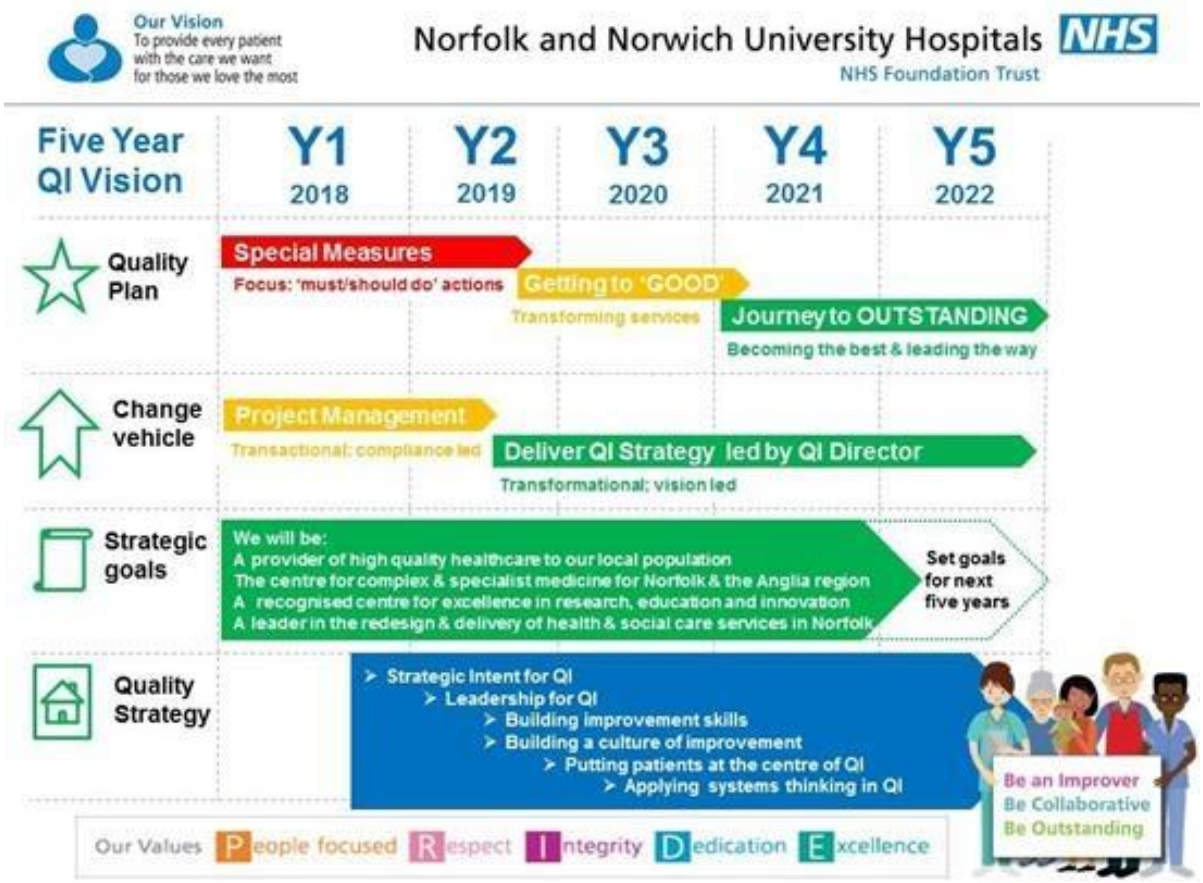
We will achieve this by addressing the following elements depicted below.

- Strategic intent for QI.
- Putting patients at the centre of QI.
- Leadership for QI.
- Building improvement skills at all levels.
- Building a culture of improvement.
- Applying systems thinking in QI activity.

This QIP maps stage one of our journey - the stage that takes us from ‘inadequate’ to ‘good’. We anticipate that we will complete that stage within eighteen months of entering special measures.

On completion of stage one we will refresh this plan, and map out stage two of our journey, the stage that takes us from ‘good’ to ‘outstanding’.

Our aim is to complete our ‘Journey to Outstanding’ by April 2023, which is within five years of entering special measures.



Safety Matters

We have launched a ‘Safety Matters’ campaign, which aims to create a social movement among our staff to improve all aspects of patient safety. A Serious Incident Group (chaired by the Medical Director or Chief Nurse whenever possible), meets every week day lunchtime. Attendance is mandatory for all divisions. The meetings review the SIs that have caused moderate harm or above since the last meeting, or any other lower graded incidents that are a cause for concern. The group also discusses ‘great catches’ that could have led to harm had they not been noticed in time.

The meetings foster a culture of 'appreciative enquiry', which encourages staff to feel comfortable about reporting all incidents and 'great catches', because they provide an opportunity for learning and improvement.

Other initiatives include a 'Say No to Pressure Ulcers' campaign, the launch of FOAMed open access medical education in ED, and the launch of the Perfect Ward.

Reducing pressure ulcers
We have joined the national Pressure Ulcer Collaborative, where Trusts from all over the country meet to share experiences and best practice. We have also engaged staff, asking for their suggestions to reduce the number of hospital acquired pressure ulcers. A set of tools have been developed to tackle the problem. The measures taken have included:

- **Creating a pack for completion on admission**. This included checking for pressure areas on patients, Datixing any identified; a turns chart; a turns clock; undertaking a Waterlow risk assessment, and using a red sticker to highlight high risk patients.
- **Educating patients and their families**. "Keep moving, stop the pressure" posters were put up around the ward, and now patients are given leaflets on admission to help them understand the causes of pressure ulcers and how to help prevent them.
- **Prompts for nursing staff**. Prompts were placed around the ward to keep the issue of pressure ulcers front of mind, such as "think ears" signs near oxygen equipment, to remind nurses that ears are a vulnerable point for patients wearing masks.
- **Training – Ginty's Goggles.** These virtual reality training goggles were created by Sheila Ginty, Tissue Viability Sister; Caroline Linkhorn, Senior Matron; Diane Rowland, Critical Care Clinical Nurse Educator and Michelle, with Dr Jordan Tsigarides developing the goggles based on their ideas. They enable staff to conduct a virtual skin inspection and learn to recognise key indicators.

Perfect Ward
Over 75 staff have been trained to use a new app called Perfect Ward which is a system to record the quality audits carried out across the Trust in 110 outpatient areas and wards, including Cromer & District Hospital. The aim is to drive improvement by having a consistent way to capture information and track progress or compare areas.

Staff can now carry out 5 key audits on an iPad which include the daily safety checks, matron's quality rounds and QAA, the audits cover a number of themes including infection control, patient safety and patient experience. Colleagues can score questions, capture photos and write free-text comments straight into the app, so the time taken to carry out inspections is significantly reduced. Capturing the information directly in electronic format means there is no need to write up and send reports afterwards either.

For more information, see the quality report on page 122.

Changing culture
Staff from across the hospital are helping to drive improvement "from the ground up" as members of a new 27-strong Change Team.

Part of a national NHS culture change programme, it's one of the initiatives in place to ensure that NNUH is a great place to work.

The Change Team will be at the heart of many of our future improvement initiatives, giving staff a stronger voice to make a difference by collecting their views on the areas we need to take action on.

Much work is already under way to address the issues highlighted by last year's King's Fund report, the CQC and our own staff surveys, including Schwartz Rounds, the Serious Incident Group, Communicating and Leading with Pride workshops and the appointment of our lead Freedom to Speak Up Guardian.

The team, which was formed in January 2018, meets regularly and will spend around six months gathering information before defining their projects and working with colleagues from across the hospital to deliver them.

For more information on culture, see the staff report on page 84.

Long term trend analysis

Over the last ten years the NNUH has experienced significant growth in the demand for its services. Around three 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.

The Quadram Institute

The Quadram Institute opened in September 2018 and is home to the Clinical Research Facility, a partnership run by the Trust and brings together researchers and scientists from the hospital, Quadram Institute Bioscience (QIB), University of East Anglia (UEA) and across the Norwich Research Park.

The development is a major boost for the Trust's ambition to enhance research at the hospital. The CRF will be the hospital's primary facility for clinical trials that do not need to be located within the main hospital building.

The CRF is home to a host of research studies into a range of health conditions, involving patients and volunteers. Because of its close association with the NNUH Endoscopy Centre and links with QIB and UEA, the CRF is perfectly placed for research into food and nutrition. The results of these trials will lead to new strategies and treatments for improving health and preventing related disease.

The CRF will provide a mixture of outpatient clinical and laboratory space as well as a food-preparation area for diet-related studies.

The Quadram Institute will also be home to a range of NNUH services run by the Endoscopy Centre and Bowel Cancer Screening Service.

The Quadram Institute is a complex building bringing together different sets of users and under a phased occupation plan. The building is undergoing a period of further equipment installation, which will be fully tested to ensure it meets high health and safety standards as well as scientific requirements.

It has been created by four founding partners – the NNUH, UEA, QIB and Biotechnology and Biological Sciences Research Council (BBSRC) – to work across four research themes: the gut, healthy ageing, food innovation and food safety.

Gastroenterology

The Quadram is also home to the Gastroenterology department at the Trust which moved some of its services to the state-of-the-art Quadram Institute and welcomed its first patients in December 2018.

The multi-million pound facility on Norwich Research Park will be home to a range of endoscopy and bowel cancer screening services.

The NNUH Gastroenterology department at Quadram Institute will be conducting at least 40,000 procedures a year in the facility, making it one of the largest endoscopy centres in Europe, as part of its expansion of services.

The Trust's Emergency Department has also been expanded during 2018/19 and a new Discharge suite and elective day unit have been opened. See page 34 for more details.

Aylsham Day Unit and Discharge Suite
A new day unit was opened at the end of December 2018 to improve patient experience and ease pressure on beds during the winter.

There are two main clinical areas in the new modular building: a medical day unit and a discharge suite.

Medical Day Unit
The teams moved from their old home on Gunthorpe ward into the new Aylsham Medical Day Unit just before Christmas. This has freed up extra beds for people needing to be admitted at one of the hospital's busiest times of the year.

The medical day unit includes the endocrinology clinical investigation unit (CIU) which was the first day unit the hospital opened to prevent hospital admissions back in 1981. The day unit has grown enormously since those early days and is now open to all specialties. The new move brings more change – co-locating the day team with the discharge team in the Aylsham Suite, working together to help people be discharged from the hospital more quickly and to prevent many people needing to be admitted at all.

According to new figures, 90 bed days were saved at the hospital in January and 72 patients avoided an admission to hospital, thanks to the new facility.

The day unit enables patients to come up for the day to receive treatments that traditionally needed a hospital admission. This helps to maintain elective work at NNUH during the busy winter period and patients who require procedures such as intravenous therapies, blood transfusions, biopsies, lumbar punctures, liver ablations and iron transfusions are being cared for on the day unit.

Discharge Suite
One of the major steps towards extra capacity for winter has been the installation of a Discharge Suite. This provides an improved service to patients by providing a better experience when they leave hospital with a dedicated Discharge Suite with its own staffing, refreshments and comfortable facilities.

Installing the new unit is part of our winter preparations to boost our capacity and improve patient flow which will enable us to transfer patients from the Emergency Department to the wards in a timely way.

The Discharge Suite operates seven days a week and can accommodate up to 28 patients at a time as they get ready to leave hospital. There is a comfortable seating area, plus eight beds for patients who may need a bed to support their ongoing recovery. Patients will move to the new unit on the day of discharge, providing an enhanced environment whilst they wait for medication to take away, transport and any other last minute arrangements which may be required before going home.

NNUH at Home service
We are working in partnership with HomeLink Healthcare to set up and deliver this service, which will benefit patients by supporting them to leave hospital as soon as they are clinically stable. The service is under development with a clinical lead appointed in March 2019.

The service will aim to accommodate up to 30 clinically selected patients who will be able to go home to recover for the last few days of their acute episode of care. These patients will remain under the care of the hospital and will be supported at home with bespoke care services such as therapy, nursing care, personal care, wound care and dressings, and IV antibiotics.

Patients will be able to complete the remainder of their care in the comfort of their own homes, with the full support of their medical consultant and the NNUH and HomeLink teams.

The NNUH at Home team will comprise of nurses, physiotherapists, occupational therapists and Healthcare Support Workers.

Patients transferred to the NNUH at Home service will remain under the care of their hospital consultant until they are formally discharged by the hospital to their GP at the end of their agreed length of stay.

NNUH at Home will complement existing NHS community services.

The following developments are also taking place:

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. A formal partnership has been announced with Macmillan Cancer Support for the £4m proposal. Planning permission will be sought later in 2019.

Digital strategy
We have launched the Electronic Document Management Solution (EDMS) project which will see patients' paper records going digital.

The records will be electronically converted and stored in a massive Trust-wide project managed by the hospital's own Digital Health team in partnership with Health Records, clinical and operational teams, with a view to completion within two years.

The digitisation of Paper Medical Records through EDMS allows scanned, digitised Medical Records to be made available immediately to staff without the need to store and manage paper. This releases space, time and resources whilst also having a significant impact on the quality of working lives and the ability to make informed clinical decisions.

It is a key part of our strategy to transform to digital care at NNUH. It will eventually make paper records a thing of the past, it will be easier for staff to access and read a patient's health records, and will be a quantum leap in improving quality and reduce costs for the NHS.

The deployment is expected to take approximately two years with the Trust reaching a Fully Digitised state by January 2021. At this point no new medical records will be created or added to with any residual paper still being generated incorporated into the electronic document management solution record after care is completed.

The Trust is also looking at the introduction of a full Electronic Patient Record (EPR) which would replace the existing Patient Administration System and many of our standalone clinical IT systems at the Trust.

The introduction of an EPR will reduce and look to stop the amount of new paper being generated, as clinical information is captured electronically, whilst also improving the flow of information across the various care pathways. It is envisaged that the EPR and EDMS will work side by side to progressively move towards a state where no paper is generated but access is always easy and in context to the historical records.

Community joins together to knit lap blankets for NNUH patients

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In alignment with the NNUH Dementia Information Fayre 2018, the Trust has been asking the community to offer their creative skills to support our patients who are living with dementia.

NNUH has been inundated with decorative knitted, crocheted and even woven lap blankets which have been given to patients, who are living with dementia, in our Older People's Medicine Wards, in outpatient areas and in our Emergency Department.

This project, which has been organised by the NNUH Dementia Support team, has been a chance to bring the local community together, support patients during their stay in hospital and help spread dementia awareness.

Claudia Rumford, Dementia Support Worker said: "Last year, our bunting project was a big success, and this year we wanted to plan something similar in alignment with the event. The lap blankets provide many benefits for our patients who are living with dementia and who are staying in hospital."

Benefits of the lap blankets include providing comfort and calm to patients, being a familiar object in an unfamiliar environment, added warmth, visually stimulating and a lovely gift for the patient to keep.

Jenny Woolgrove, Dementia Support Nurse added: "We'd like to thank all those who have taken part in the project for their time, generosity and their help in spreading dementia awareness."

April 2018

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.

Mental Health Developments

We appointed a Mental Health Matron in November 2018. This post is in addition to our Matron for MCA/DoLs (Mental Capacity Act and Deprivation of Liberty safeguards). We also have two Mental Health Boards working at a strategic and tactical level to improve mental health care for our acute patients.

The Mental Health Matron is a new role, working with all wards, departments and teams, including out-patients, to support them with the risk assessment and risk management of patients who have an identified mental health need.

This role is to help to implement new systems and processes as part of embedding a 'culture of safety' throughout the organisation. Historically, mental and physical health have been regarded as quite separate, whereas today we look at the whole person when assessing what care they need. To give patients the best outcomes, this not only means working in a joined up way across the hospital, but also with external providers who can support our patients when they return home.

The Emergency Department is a priority because it's the front line for many people entering the hospital with such needs. A mental health assessment is now part of the triaging process, as it's vital for a patient's safety that their requirements are identified as early as possible. A quiet room has been built in Children's ED, an interview room and a new trolley bay have been adapted in Majors, and all these areas provide a more suitable environment to care for individuals with an identified mental health need

Another key focus is supporting frequent attenders to hospital, identifying their underlying needs so we can put the right interventions in place in the community once they leave hospital to promote their continued wellbeing.

Two Deputy Mental Health Matrons also joined NNUH in April 2019 as Deputy Mental Health Matrons, new roles for the hospital reporting to the Mental Health Matron.

One post will focus on our in-patient wards while the other will work with the Emergency Department, Acute Medical Unit, Emergency Assessment Unit (Surgical) and Children's ED.

Development and Performance

Treating sepsis

We have developed an electronic sepsis screening tool in the Emergency Department, which has helped staff detect the condition when carrying out observations on patients, and a project is being worked on to expand electronic screening across the whole hospital.

Time is of the essence when a patient is confirmed to have sepsis, which is why we launched sepsis emergency kits two years ago to speed up the treatment.

Performance figures show over 92.6% patients receiving antibiotics within an hour of diagnosis. This is testament to the good awareness across the Trust, embedded pathways for the prompt delivery of antibiotics in sepsis and a continuous educational programme for medical staff across the NNUH about the importance of timely sepsis management.

Paediatric orthopaedics

The Paediatric Orthopaedic Emergency Service was introduced to provide specialist emergency orthopaedic care to patients aged 0-12 across Norfolk and Suffolk, 24 hours a day, seven days a week.

Specialist Paediatric orthopaedics has been a service that the NNUH has offered for more than 30 years, and in recent years has grown from a single consultant to 4 consultants, making it the biggest children's orthopaedic unit in the East of England. This expansion has allowed the introduction of this new round-the-clock service which means that these specialist consultants have been able to see younger patients suffering from infection in the bones and joints, complex fractures and orthopaedic conditions from across Norfolk and Suffolk at any time of day or night. Prior to the launch of this service, younger patients would have needed to travel as far as London or Birmingham to receive this level of specialist out-of-hours care.

New cancer treatment

New state-of-the-art equipment, called the Varian Bravos afterloader system, is being used to treat some gynaecological and prostate cancers with a form of radiotherapy called brachytherapy at the hospital's Colney Centre.

The new system, made by Varian, can potentially reduce the amount of treatments patients need by directly targeting tumours with high dose rate (HDR) radiotherapy.

Standard radiotherapy uses radiation directed at the tumour from outside the body. Brachytherapy places radioactive sources inside or near a tumour to reduce long-term side effects and reduces the risk of damaging healthy tissue.

The service is available to patients in Norfolk and the wider area as the only other centres that offer brachytherapy in the region are in Cambridge and Colchester. Patients can have the treatment as a day case.

Reducing length of stay

In March 2018, we began are the introduction of weekly reviews of patients with length of stay greater than 14 days to improve the experience of long-stay patients. This was an initiative introduced and facilitated last December by ECIST (The emergency care intensive support team which is a clinically led national team) to help prevent delayed discharge by embedding the "Home First" and "Why not home? Why not today?" principles into our processes.

In June 2018, NHS Improvement produced a document called “Guide to reducing long hospital stays”. Part of this document relates specifically to long-stay patient reviews – patients that have been in hospital for more than 21 days and this forms the basis of the process along with an aim to provide shared learning across our teams.

NHSE has set the Trust a trajectory of reducing patients with long length of stay greater than 21 days by 25% .

The review involves a visiting team attending wards weekly. The visiting team to the ward includes a senior decision maker. The ward sister/charge nurse or a ward representative is invited to attend to give details/information about the patients. Other members of the multi-disciplinary team are also asked to attend where possible.

Ending PJ paralysis campaign

In summer 2018, we joined the National 70 Day Challenge which aims for one million patient days of people up, dressed and moving in their own clothes rather than hospital gowns and pyjamas.

The campaign is based on research which shows that older patients can quickly decondition if they remain in a hospital bed for long periods of time. The aims was for our patients to maintain their mobility and strength whilst they are in hospital as this makes it easier for them to return home and get back to their normal lives. Where ever possible we want patients to be able to get up, get dressed and get moving in line with the campaign aims.

Winter preparations and patient flow

As part of our preparations for winter, we recruited a senior doctor, nurse and manager to become our Winter Room directors.

The winter team has been leading the preparations for and the delivery of the Trust’s operational approach to the 2018/19 winter period and beyond, working in partnership with our system-wide partners. They are responsible for patient flow through the hospital and support the Emergency Department.

The team has a wealth of clinical and management experience at NNUH and has been working with all the divisions and teams across the hospital.

Emergency Department performance

We experienced a very busy year in the Emergency Department with attendances rising by more than 10,000 compared to last year. 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 86.69% for the year. Our performance has improved since a number of improvements were made in hand over procedures in March 2019.

Our position has been greatly affected by a growth in emergency demand. 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 in addition to opening the new Rapid Assessment and Treatment unit in December 2018. Over the last year we have trebled the size of the children’s ED, introduced the UK’s first Older People’s Emergency Department (OPED) and increased staffing for patients with mental health needs in crisis. In addition we have increased ED staffing by 38% over the last two years.

In early March 2019, the ED team introduced a number of initiatives to improve performance which led to the most improved ambulance handover times for 12 years. There were no 60-minute ambulance handover delays for eight consecutive days and, in addition, the majority of ambulances were handed over within 15 minutes.

CQC inspection of ED

The CQC came and visited us in a planned visit in January 2019 and an unannounced visit in February 2019. We received a letter from them relating to urgent and emergency care services across the Trust. The CQC said that the quality of healthcare at our Trust required significant improvement.

We recognise the validity of the issues raised by the CQC and we have been making considerable headway in improving our urgent and emergency care services, both within the ED and across the hospital as a whole. Our ED team are dedicated and enthusiastic and the entire Trust is collaborating well to improve patient flow. We are confident that, by continuing to work as an entire Trust-wide team, we will address all issues raised."

The CQC identified five areas of significant concern which covered ineffective risk and escalation procedures, long waits for patients to be seen by a clinician to decide on their treatment pathway, the new quiet rooms in the ED, specifically for patients with mental health needs, were not being used appropriately for this purpose, a lack of qualified staff and in Paediatric ED there were too few qualified nurses to provide two registered children's nurses on each shift (in line with national guidance).

An action plan was submitted on 1 April 2019 and substantial improvements are planning to the service by 30 May 2019.

A multi-disciplinary working group has been set up to look at our Rapid Assessment and Treatment area which aims to agree and embed effective procedures and pathways to improve immediate patient care.

We have created an Emergency and Urgent Care Board to strengthen our governance of urgent and emergency care throughout the Trust. This Board is well represented internally by our hospital staff and it also includes our external partners such as the local CCG, EEAST and NHSI. Everyone is working together and keen to engage and facilitate improvements across our ED.

Rapid Assessment and Treatment Unit for Emergency Department

As part of our winter preparations, a new modular building was installed adjacent to the Emergency Department to help to increase our capacity and speed up the handover of patients arriving by ambulance. Over the course of the past five years the number of assessment and treatment spaces in our ED has risen from 22 to 84. To meet growing demand, eight additional Rapid Assessment and Treatment (RAT) cubicles are located in the new building. This was part of a package of improvements in our Emergency Department to improve patient care.

Older People's Emergency Department

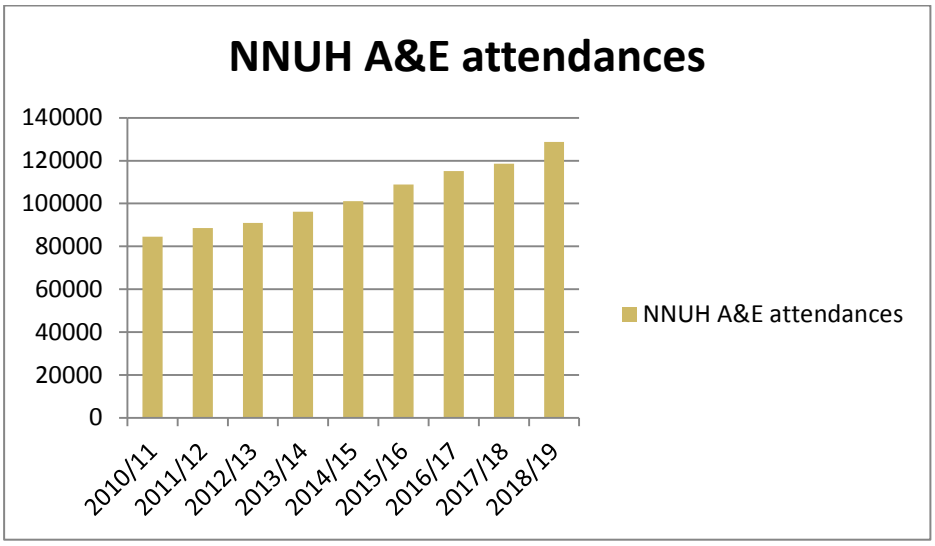
Our Older People's Emergency Department was the first unit of its kind in the UK and we celebrated its first anniversary in December 2018. The dedicated department for patients over the age of 80 has brought specialists in older people's medicine to the front doors of the hospital. The department, which has received interest from across the country since its inception, has improved care by providing patients with immediate access to a geriatrician and has helped reduce the average length of stay in hospital for patients. The OPED unit also expanded its opening hours as part of our preparations for winter 2018/19.

The service, which is a multi-disciplinary team consisting of Emergency Department Consultants, Consultant Geriatricians and Emergency and Older People's Medicine Nurses, sees on average 20 to 25 patients a day who receive a specialist review and comprehensive geriatric assessment.

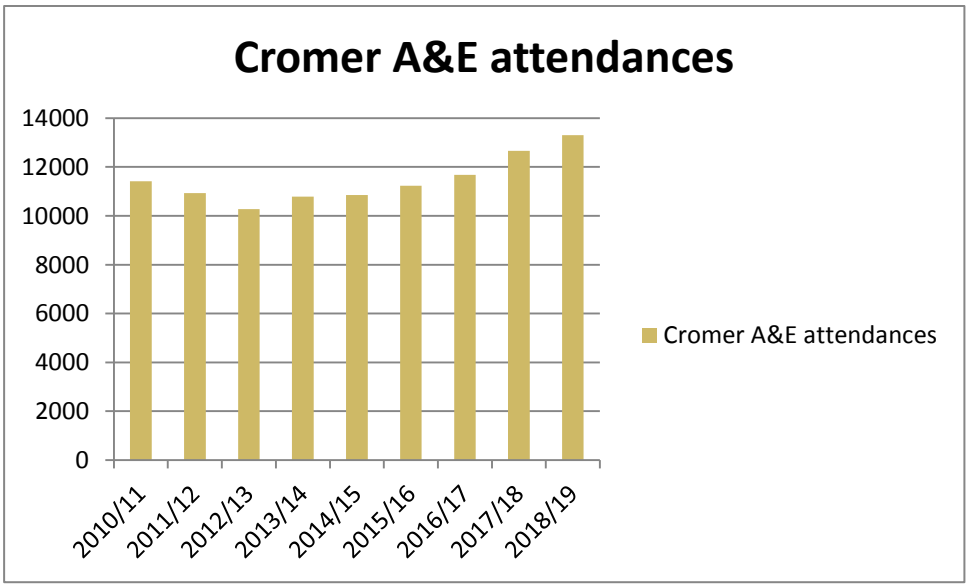
The unit was developed in response to a growing older population in Norfolk and to improve patient care and experience. There has been some great feedback from patients and families since the unit opened as the space is tailor-made for them and feels quieter than the main part of the Emergency Department. More than 800 patients over the age of 80 are admitted to the hospital every month. However, earlier access to a geriatrician has reduced the average length of stay in hospital by 1.2 days since the introduction of the service and revised pathways.

Performance against key health targets

Emergency Department Performance



There were 128,671 attendances at the NNUH Emergency Department in 2018/19, compared to 118,583 the previous year, a rise of 10,088 attendances.



At the Cromer Hospital Minor Injuries Unit, there were 13,295 attendances in 2018/19 compared to 12,655 in 2017/18, a rise of 640 attendances.

Cancer

The landscape of Cancer Services has experienced significant change during 2018-19, which has brought with it both challenge and opportunity in equal measure. The start of the year was characterised by a significant and sharp increase in two week wait referral demand, with a 20% across the board increase and a 28% increase in referrals for suspected Urological cancer.

The largest increases were seen in referrals for Prostate Cancer – high profile celebrity cases leading to increased public awareness and presentation being the key driver. Such a rapid and sustained increase has caused difficulty in delivering the 85% standard of 62 days from Referral to Treatment, a task made more difficult by increasingly complex and resource intensive diagnostic and treatment pathways that do however deliver better outcomes and patient experience. Although our 62 day performance for the year of 71.2% was a decrease on 2017-18, it is a situation shared by many neighbouring hospitals and large Cancer Centres similar to NNUH. In November 2018 the Board of NNUH undertook a "deep dive" analysis of the issues preventing a return to achievement of the 62 day standard, and as a result we have a clear plan of recovery for 2019-20.

Our 31 day diagnosis to treatment target has been met with good performance of 96.2%, as has our 31 day subsequent chemotherapy treatment performance 99.6% and 31 day subsequent radiotherapy treatment performance 97.7%. However, meeting the 31 day subsequent surgery treatment standard has proved challenging, with performance at 85.6%, due mainly to repeated surges in demand for Skin and Urology cancer procedures. We have recently undertaken a robust demand analysis for our most common cancer procedures and are now working with operational and clinical teams to increase capacity.

Significant increases in referral demand have also impacted our delivery of the 2WW standard across 2018-19, with overall performance of 80.8%. The most significant driver of underperformance in the early months of the year was an earlier and larger increase than usual in demand for suspected Skin Cancers, however a rapid and committed response from the team in Dermatology saw a complete return to the 93% standard for them by December.

The autumn and winter months have seen a repeated series of significant spikes in demand for suspected Breast Cancer, in the context of 75% increase in demand over the past 10 years. The Breast team are in the process of utilising additional space to accommodate this additional demand and return 2WW performance to achievement, and in October 2018 NNUH launched the Boudicca Appeal to raise £800,000 to fully refurbish this space into a state of the art Breast Cancer Diagnostic Centre.

So that the NHS in the East of England and Norfolk & Waveney can respond to not only the challenges of increased demand but also earlier diagnosis, improved survival and better support for people living with and beyond cancer, NNUH has been part of an exciting and ambitious regional transformation programme starting in 2018. This will see an investment of almost £4million in Cancer Services in Norfolk & Waveney to deliver improvements to pathways such as nurse-led referral triage, targeted template Prostate biopsy and a new, more accurate diagnostic technique for suspected Colorectal cancer. These improvements all have the key overarching aims of faster diagnosis and treatment, and reducing variation.

NNUH is now almost two years into its own five year Strategy to become a Centre of Excellence for Cancer Services, and to date has a programme of over 90 projects already

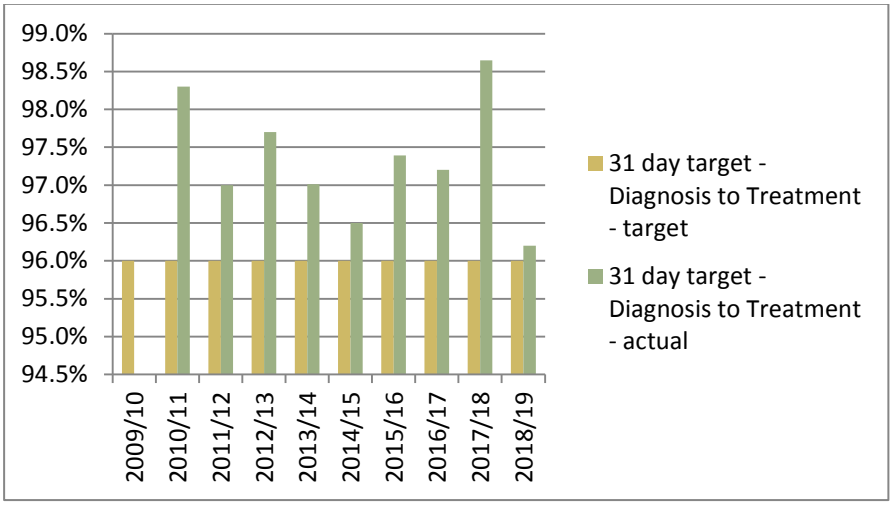
complete or well in progress. Many of the objectives of this build on areas where NNUH is already a global pioneer: for example in 2019 we celebrated completing over 750 robotic surgery procedures since 2016, making us one of the country's largest robotic surgery centres, and in 2018 we were the first site in the world to go live with the Varian Bravos system for treating Prostate Cancer with Brachytherapy.

We are also working in partnership with Macmillan Cancer Support on proposals for a £4.15 million state-of-the-art cancer care and support centre at Cromer and District Hospital. it will provide capacity to treat up to 36 chemotherapy patients a day and an additional 10,000 outpatient appointments annually.

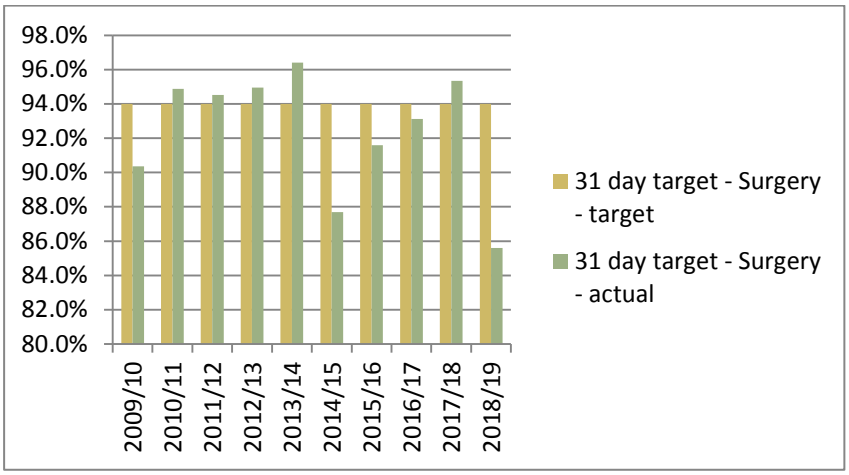
In 2018, we saw our best ever results published in the National Cancer Patient Experience Survey, our fifth year of continuous improvement that placed us in the top 20 per cent of Trusts in the country in eight of the subject areas

For the two week wait target, we achieved 80.8% against a target of 93%.

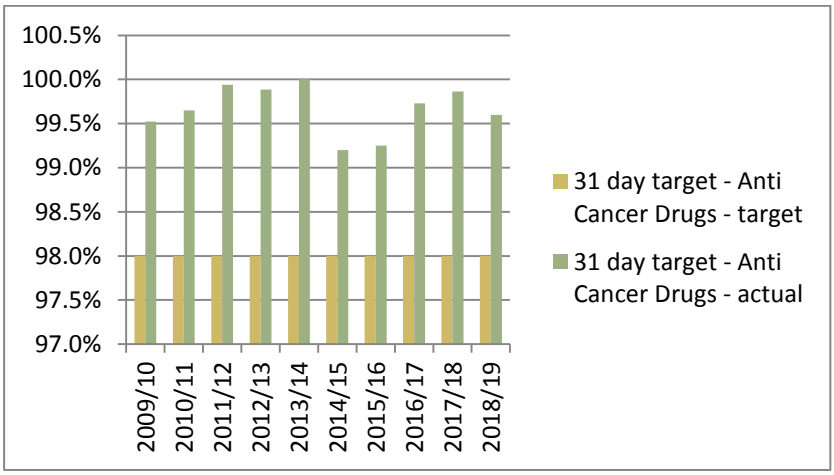
For the 31 day target for diagnosis to treatment, we achieved 96.2% which is above the target of 96%.



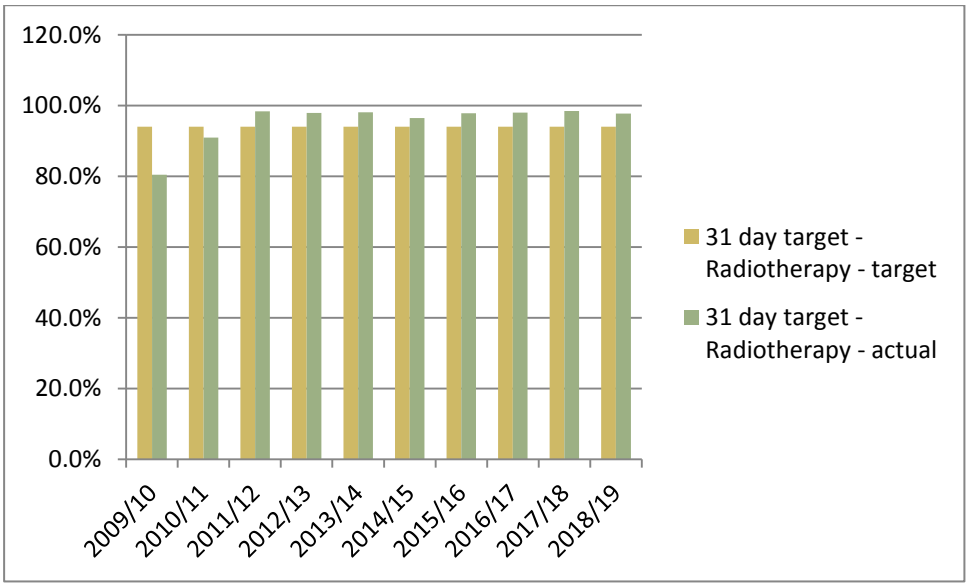
For 2018/19, we achieved 85.6% which is below the target of 94% for the 31 day target for surgery.



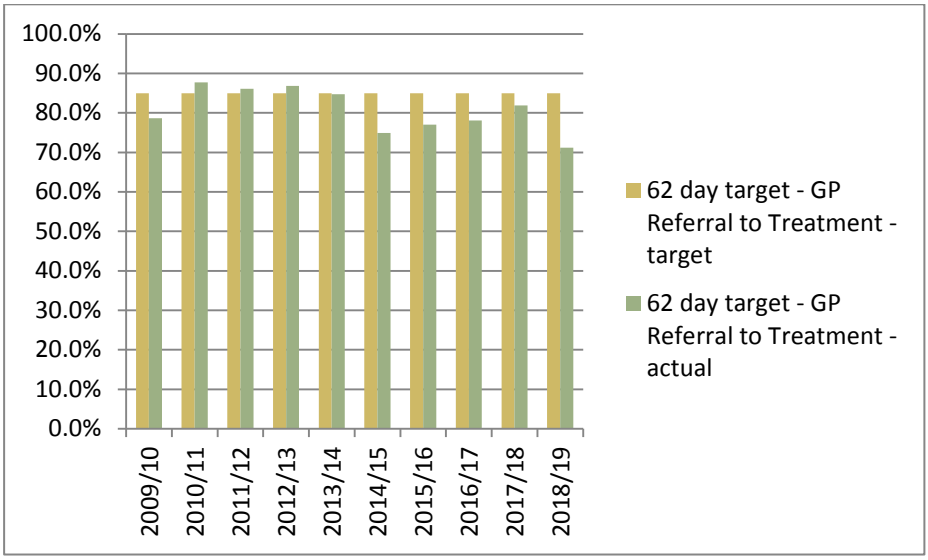
For the 31 day target for anti-cancer drugs, we performed well with 99.6% achieved against a target of 99%.



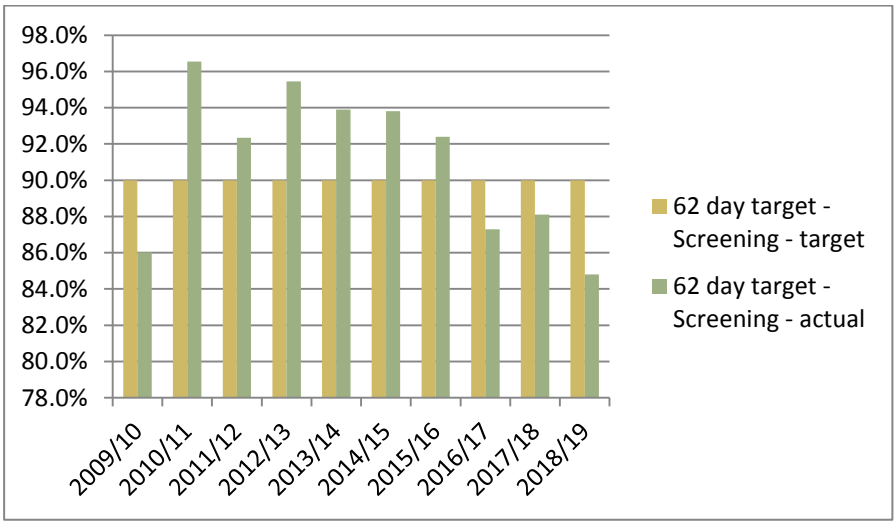
For the 31 day target for radiotherapy, we achieved 97.7% exceeding the target of 94%.



The 62 day target for GP referral to treatment was not achieved with 71.2% achieved against the target of 85%. In terms of the 62 day target - Reallocated GP Referral to Treatment – we achieved 73.3% against a target of 85%.



The 62 day target for consultant screening was not achieved with 84.8% against a target of 90%.



For more information about cancer performance, see page 35.

NNUH staff praised by cancer patients in latest survey

NNUH staff have been praised for their care and dedication after the Trust received its best ever patient satisfaction scores in a national survey.

Almost 1,200 patients under the care of the Norfolk and Norwich University Hospital (NNUH) took part in the National Cancer Patient Experience Survey 2017. Nine out of 10 respondents rated the care they received as very good.

The survey results, which were published this week, places the Trust above the national average for how patients rated the care and treatment they received.

Cancer patients at NNUH were asked 59 questions between April, May and June 2017 with 70% responding to the survey. The Trust received responses to eight questions which were better than the expected range nationally.

Matt Keeling, Cancer Manager at NNUH, said: “These results are fantastic and we are seeing continuous improvement every year. The results are testament to the hard work and amazing care that our staff provide every day at NNUH, which is a major cancer treatment centre.”

Receiving a diagnosis of cancer can sometimes be devastating and we are very grateful to our patients who respond in such large numbers to this survey every year. We receive one of the best response rates in the country.”

October 2018

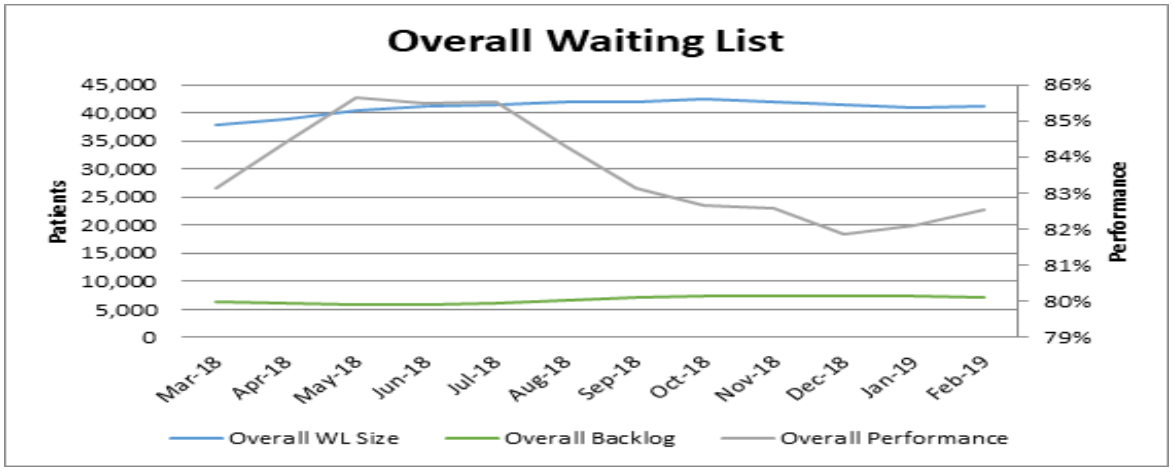
Referral to Treatment waiting times

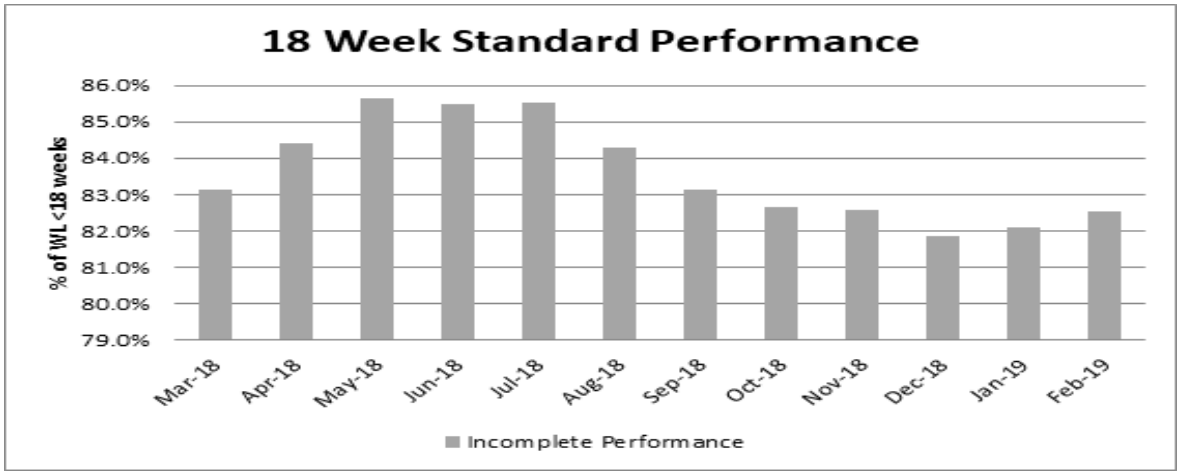
The Trust has seen an ongoing demand for its services in recent years. The compound annual growth rate over the last five years has seen two week wait referrals for cancer rise 8.57% year-on-year, with RTT demand rising by 1.85% and emergency attendances up 5.86% during this period. This has placed the Trust's capacity under continuing pressure and means we have not achieved the RTT incomplete standard of seeing and treating 92% of patients within 18 weeks.

During the course of the last 12 months a significant amount of work has been undertaken within the Trust and with commissioners and the wider healthcare system to utilise capacity more efficiently and manage the demand coming into the hospital.

In RTT terms what this means is that the overall waiting list has grown due to the increasing demand for cancer, but owing to the urgent nature of managing cancer referrals, 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.



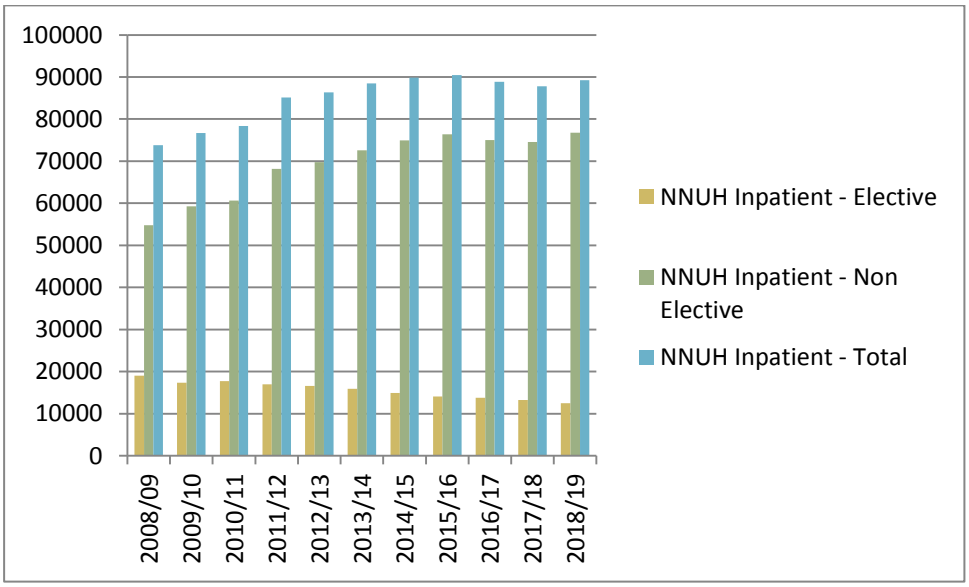


Incomplete pathways represent those patients who have been referred on to consultant-led referral to treatment (RTT) pathways, but whose treatment had not yet started at the end of the reporting period. The volume of incomplete pathways is often referred to as the size of the RTT waiting list. These 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 not achieved the RTT standard and some patients have experienced longer waits for treatment.

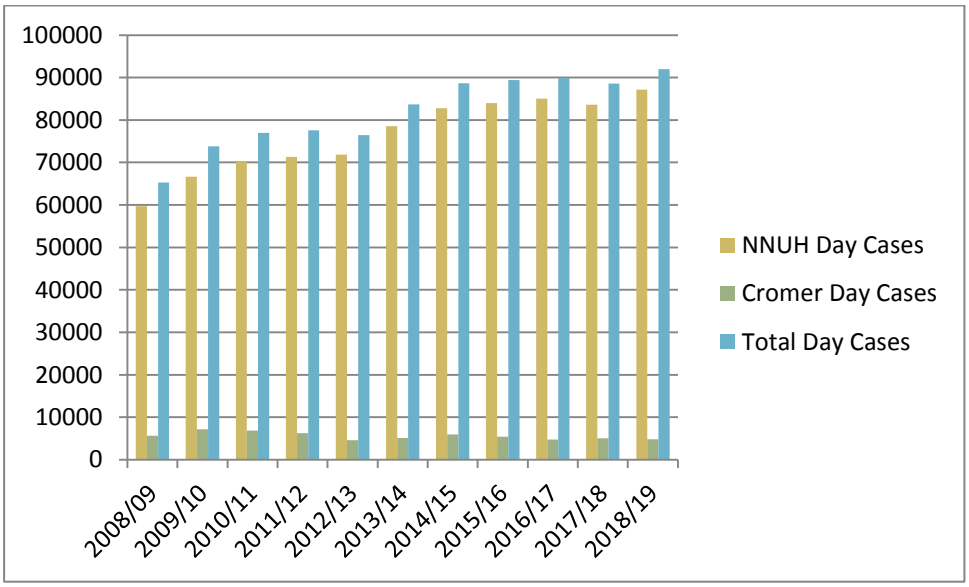
Inpatient cases

The number of elective inpatient cases fell from 13,241 in 2017/18 to 12,479 in 2018/19 whilst the number of non-elective inpatient cases (emergency admissions) was increased from 74,555 in 2017/18 to 76,755 in 2018/19.

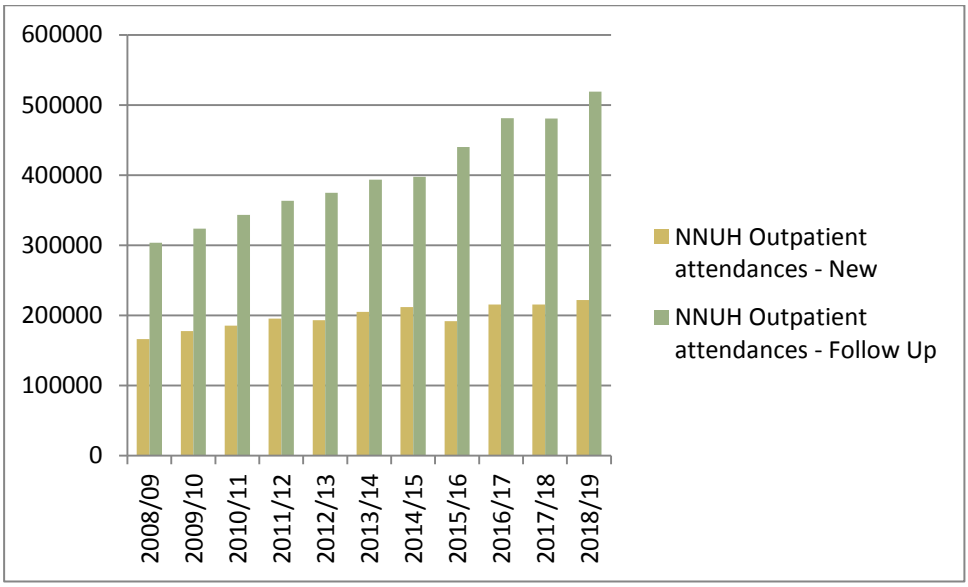


Day Cases

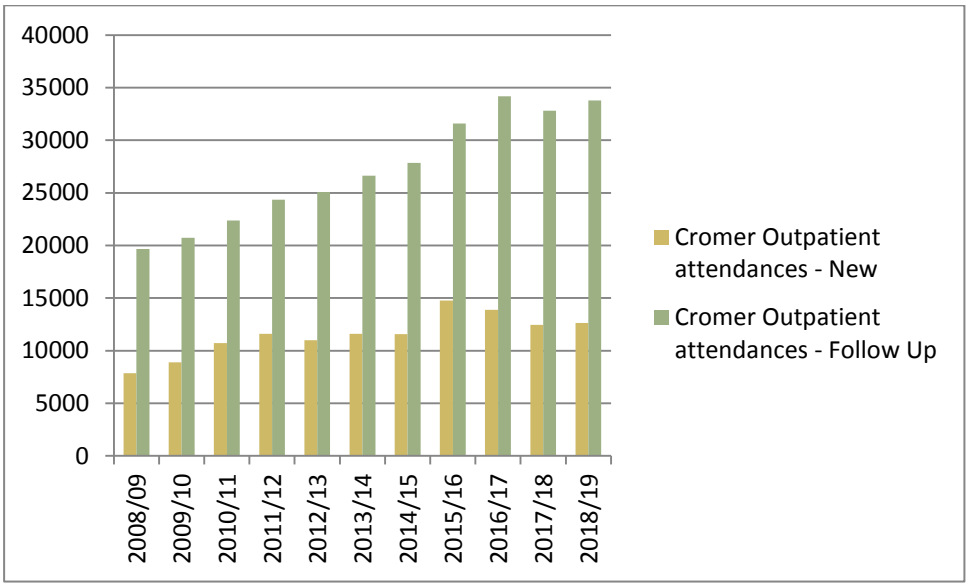
In 2018/19, there were 87,128 day cases at NNUH, 4,862 at Cromer Hospital with a total of 91,990, compared to 88,597 in 2018/19.



Outpatient Services



At the N&N hospital there were 221, 783 new outpatient attendances in 2018/19, compared to 215,662 in 2017/18, with 519,068 follow ups in 2018/19 compared to 480,772 in 2017/18.

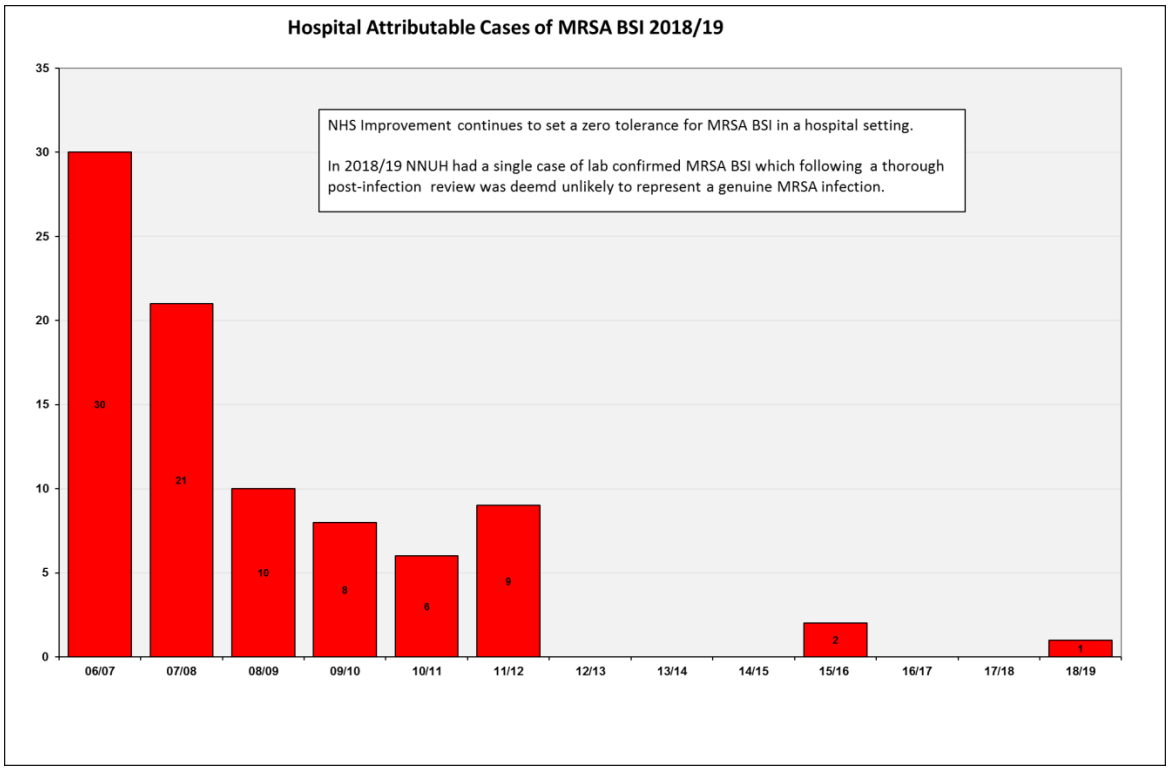


At Cromer Hospital we saw 12,631 new outpatients in 2018/19 compared to 12,439 in 2017/187 and 33,781 follow up appointments in 2018/19 compared to 32,813 in 2016/17.

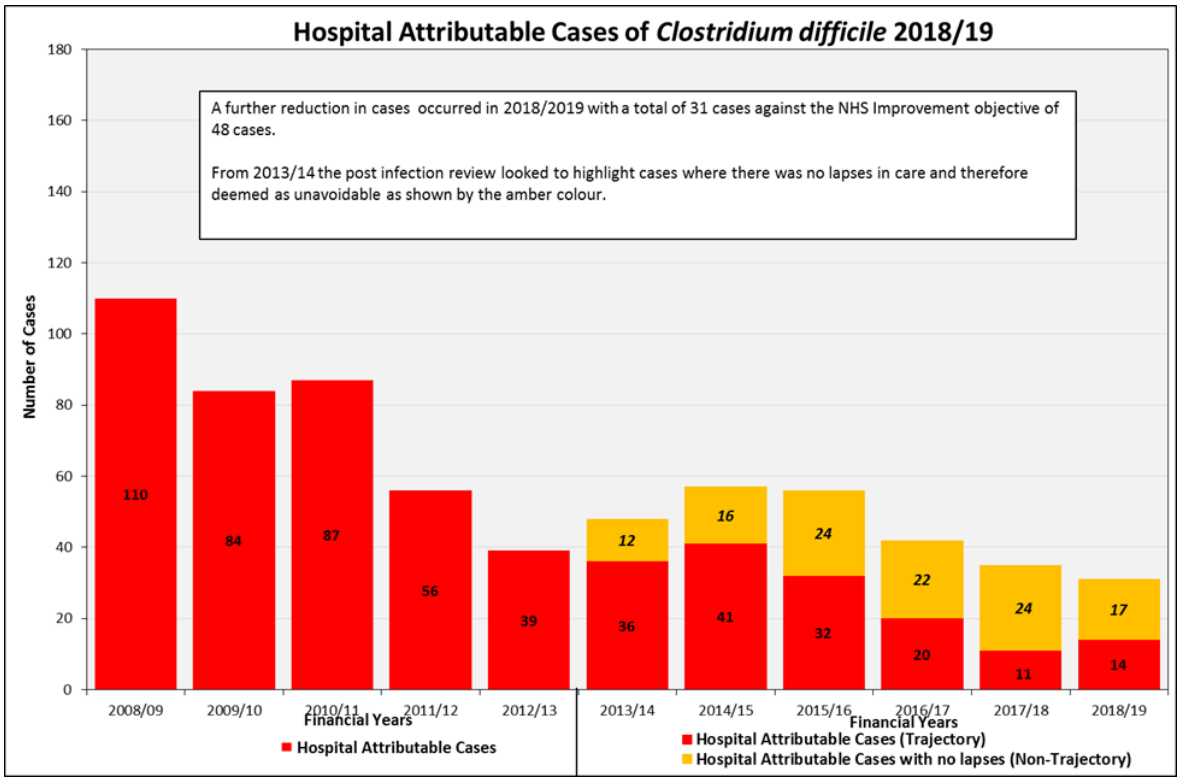
Overall, there were 787,263 outpatient appointments in 2018/19 compared to 741,499 in 2017/18.

Healthcare Acquired Infections
For more information on how we manage infection prevention and control, see the quality report.

MRSA bacteraemia: The DH ceiling set for the hospital was zero. The trust had one single confirmed case of MRSA bacteraemia in 2018/19.



Clostridium difficile:



Our Financial Performance

The financial plan in support of the operational plan for 2018/19 was a deficit of £55m. It was based on activity and demand assumptions having regard to current experience, outline savings plans and costs. The control total we were given by our regulator was a deficit of £8m, which was clearly not achievable. Accordingly we did not accept the control total and as a result were not eligible for 'provider sustainability funding' of £18.7m associated with that control total.

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 2018/19 were not as originally planned. Our final reported actual position was a deficit of £60.6m.

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. 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.

Financial Improvement

Our financial improvement plan required us to deliver £30.0m of savings, representing 5% of turnover – a challenging target. We were successful in delivering savings of £27.8m, of which £19.3m was recurrent. There has been a focus on productivity and associated efficiency improvements, along with continuing challenge to reduce premium pay costs. 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 revenue borrowing was £111.7m; an increase of £59.3m in year. Our closing cash was £7.5m.

Capital Expenditure

We invested £9.8m in new and replacement capital assets during the year (2017/18: £9.4m).

To support this investment we bid for, and received, £3.5m Public Dividend Capital (PDC) funding to purchase a linear accelerator (£1.7m), creation of a rapid assessment treatment system [RATS] (£1.2m), and cancer funding (£0.6m).

In addition to the PDC funded purchases, the most notable investments were for the Quadram Institute (£1.5m as part of a total investment project of £8.58m), creation of a discharge suite (£1.3m), and an investment in cyber security (£0.4m).

Overseas operations

We do not have any overseas operations.

Charitable Funding

We are fortunate to be supported by the Norfolk and Norwich Hospitals Charity, The Friends of Norfolk and Norwich University Hospital Charity and The Cromer Community and Hospital Friends Charity. In addition we are again fortunate to receive support from many external charities and organisations. In 2018/19 we benefited from £1.2m of donated assets (2017/18: £1.7m).

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. 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.

The specific risks facing us for 2019/20 include:

- Providing the required capacity to deliver patient care to the required standards and activity levels
- Achieving the required efficiency savings for 2019/20
- Delivering our control total and securing the associated Provider Sustainability Funding

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

Financial Accounts 2018/19

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.

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

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 Engagement and Experience Governance Sub Board meeting, 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%.

Over 75 staff have been trained to use a new app called Perfect Ward which is a system to record the quality audits carried out across the Trust in 110 outpatient areas and wards, including Cromer & District Hospital. The aim is to drive improvement by having a consistent way to capture information and track progress or compare areas.

Staff can now carry out 5 key audits on an iPad which include the daily safety checks, matron's quality rounds and QAA, the audits cover a number of themes including infection control, patient safety and patient experience. Colleagues can score questions, capture photos and write free-text comments straight into the app, so the time taken to carry out inspections is significantly reduced. Capturing the information directly in electronic format means there is no need to write up and send reports afterwards either.

A new role has been created to lead Patient Engagement and Experience, reinforcing our shared vision to provide every patient with the care we want for those we love the most.

Ideas and feedback from patients are absolutely central to delivering outstanding care and this appointment marks a step change in the way we involve them in how we shape our services. We are aiming to create and outstanding patient experience, working with patients, families and carers as partners to ensure continuous improvement.

One of the new developments under this post will be a Patients' Panel. The panel will comprise 15-20 current or former patients, representing the spectrum of people who use the hospital.

The panel will enable the thoughts and ideas of patients to be heard and taken into account at the board and senior management level, to help NNUH instil a patient-centred approach when developing and improving services, ensuring we are work in partnership with patients.

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:

End of Life Butterfly Volunteers

We are very proud to have launched our partnership with the Anne Robson Trust, to bring 'Butterfly Volunteers' to the Norfolk and Norwich Hospital. The role of the Butterfly

volunteer is to provide compassionate care at end of life for patients across the hospital. The volunteer's role is to provide support to patients and their loved ones who have been recognised as being in the last days and hours of their life. The Butterfly volunteer shifts may include sitting with the patient and providing companionship, offering gentle hand massage and supporting the families of patients.

Volunteer Patient Transport Home Service
On the 25th February we went live with a 3 month trial for volunteer drivers transporting suitable patients home after discharge. The volunteers have access to 2 wheelchair accessible vehicles and one multi person vehicle that have been supplied by Serco and transport patients home that are being discharged through the Aylsham Discharge Suite. We currently have 4 volunteers that have been trained and assessed by a ROSPA approved assessor and the project is backed by Serco lease hire agreement ensuring the vehicles are fit for purpose.

In the first 6 weeks we have taken 64 patients home that would have normally waited for ERS transport, or paid for a taxi home. This has enabled the patient to be home earlier and in comfort. The service has also on 4 separate occasions delivered equipment to patients homes enabling them to be discharged earlier. The volunteers cover the whole of Norfolk and Waveney and are available Monday to Friday. 100% of patients surveyed felt this service enabled them to get home quicker and would fully recommend the service to others if required.

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.

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 three 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.

Membership scheme

As an NHS Foundation Trust, we have a membership scheme with over 17,000 public members. Members receive a copy of our magazine The Pulse and they are invited to talks on health topics and events such as our open day and fete. Members also give their views on health priorities and other issues. More information about membership is given in the Council of Governors’ section of the Director’s report on page 72.

Health Overview and Scrutiny Committee

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

Healthwatch

Healthwatch England is the national consumer champion in health and care. It has significant statutory powers to ensure the voice of the patient is strengthened and heard by those who commission, deliver and regulate health and social care services. Healthwatch Norfolk members have been part of our quality assurance audit process and have also assisted in gathering feedback from patients.

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 hospital governors are invited to review newly-developed patient information leaflets prior to their approval, to report on the clarity of the information presented.

The Norfolk and Norwich Hospitals Charity

Norfolk & Norwich 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. It 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 the charity gave grants for the benefit of the Trust in the amount of £2,232k, 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:

- £1096k on life saving equipment and new technology
- £490k for enhancing the patient environment
- £132k on research
- £514k investment in staff welfare and amenities

Impact of Charity Funding

The charity funds a whole range of projects across the hospitals here are just a few stories of how the charity has made a difference over this last year.

Palliative Care Support

Each month a number of patients come to hospital at the end of life. Families and close friends (those important to the patient) often wish to stay with the patient both day and night to be able to be there for them.

When a family member stays with the patient under these circumstances is can be for an indeterminate number of days and nights: we like to be able to do everything possible to ensure the family member is as well supported as possible. This includes emotional support, support from our chaplaincy team as well as physical support – offering food and drink, bathroom facilities, toiletries, free car parking and a bed for the night, in the same room as the patient so they can be together at this difficult time. It is these seemingly little things and gestures of consideration that have a big impact on families.

In the past few years we have put forward a proposal to buy beds, which the Trust has approved, or relatives and have been lucky enough to secure funding for 12 beds so far through charitable support. Every single bed is in use every day and is greatly appreciated by the patients and their families. Although sleep may be interrupted having a bed does allow the family member the opportunity to get some rest, whereas otherwise this would not happen. When there is more than one member of the family staying with the patient they often sit with the patient in shifts – so one person rests and the other person sleeps in the chair.

The beds we have to purchase are costly they meet a very strict criteria so our safest to use in a hospital environment. They can be folded away when not needed, easily cleaned and comfortable to rest on.

Being able to offer the use of a bed makes a huge difference to many families. The family members are very grateful and often comment on this after their loved one has died. The comments are always positive.

We would like to thank everyone who has made this possible on behalf of the palliative care team, our patients and those important to the patients.

Support for Antenatal

'The antenatal ultrasound department were extremely grateful to receive two new ultrasound machines to replace two old machines from charitable funds. The machines are used by sonographers, student sonographers and student midwife sonographers. These machines are part of five machines that are used to screen for fetal abnormalities in pregnant women and monitor the fetal growth, along with gynaecology ultrasound examinations. The image quality on the new machines is considerably better which is essential of the diagnosing fetal abnormalities. The sonographers get a clearer view of the anatomy which has increased the number of abnormalities that have been diagnosed. The functions provided on the new machines allows the sonographer to achieve cleared, more diagnosis images on women with high BMI. This results in fewer women having to be recalled at a later stage to complete the essential checks.

As well as an improved patient experience, the ergonomics of the new machines allows sonographers to adjust their scanning position and the design of the transducers helps to reduce the risk of RSI which is a common complaint in sonographers.'

Artwork in Ultrasound Room 1

We currently run three dedicated Paediatric lists in Ultrasound a week. These lists can have anything between 10 – 16 [sometimes more] children each time and includes both in-patients and out-patients.

Many of the children we see are very scared and anxious about coming into hospital. The environment is very clinical and unusual for a child, particularly when it may be their first experience of hospital.

They walk into a room and are confronted by strange machines and people they haven't met before. The idea of installing some artwork was to create an environment that was friendly and welcoming, and to attempt to minimise their fear and anxiety. Since the installation in November 2018, the artwork has had a very positive impact on our younger patients. It has reduced the ''clinical'' feel of the room and gives the child something to focus on when they walk into the room. Parents have also commented very positively – often likening the pictures to seaside holidays on the Norfolk coast.

We have also been able to use the artwork as a distraction tool for children when having their scans. We ask the children about the different animals they can see, which is their favourite animal, how many donkeys they can see on the beach. We talk about the different colours and it encourages discussion about their own trips to the seaside. We cannot underestimate the impact this has on the children in making the whole experience so much more positive and even enjoyable! Parents also appreciate the effort that has been made to welcome their child and like to become involved in the discussions we have about the pictures.

We feel that this artwork has been a very positive step-forward in the provision for Paediatric patients in Radiology and I have seen first-hand the difference it has made to the children and parents."

Parents' comments (recorded in a comments book within the room):

- "How wonderful, much nicer than a boring plain wall"
- "Love the artwork – lots to look at. Good distraction"
- "Amazing, great idea to distract the children"
- "Love it! Very Colourful"
- "Love the range of animals"

Christmas Dinner for Staff

Julie and I both volunteered to work Christmas Day supporting both the Surgery and Women's & Children's Divisions (I guess I shouldn't give away that I was Father Christmas!) working with the Ward teams. All our colleagues work incredibly hard throughout the year, none more so than at Christmas when they really do go the extra mile for patients, relatives and each other. There's a really special feel to the hospital on Christmas Day, including at lunch time, when teams take the opportunity to head down to the Restaurant for Christmas Dinner. It was great to see staff enjoying themselves, in good company and with good food to a backdrop of Christmas Carols – some even brought their families along! It was the highlight of a really special day – being our first Christmas as a married couple.

Matthew and Julie Keeling

Large Calendar Wall Clocks

Patients in many areas of the hospital have benefitted from these clocks through charitable donations. Knowing what time it is can be especially important when you are away from home and perhaps waiting for an out-patient appointment or for a relative to visit you on a ward. These clocks are large and clear, so can be read from a distance – very helpful if you can't move around easily or if your eyesight is limited. It is no surprise that we see these clocks as being 'dementia friendly' and they help us to create a far better environment for our patients.

They even have the added benefit of displaying the date too! We are grateful for these donations in helping our patients maintain their independence and dignity whilst providing a sense of security.

For more information about our charity please visit www.nnuhcharity.org.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 on page 122.

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.

Approval of the Performance Report

I confirm my approval of the Performance Report:

Mark Davies
Chief Executive

Date: 29/05/2019

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 Anglia Innovation Partnership LLP and the Quadram Institute Partners.

Chief Operating Officer
Chris Cobb was appointed as Acting Chief Operating Officer in January 2019 and as Chief Operating Officer (COO) in April 2019. As COO, Chris is responsible for the operational performance of the Trust and chairs our Divisional Performance Committee. Prior to taking-up post as COO, Chris was Divisional Operations Director for the Division of Medicine.

Medical Director
As Medical Director, Professor Erika Denton is responsible for providing professional strategic medical advice to the Board and leadership on clinical quality and safety and clinical research. Erika has been a consultant radiologist for 20 years at the Trust since 1999. Erika was appointed to the role of Associate Medical Director at NNUH in 2016 and Medical Director in July 2018. Erika chairs our Clinical Safety and Effectiveness Governance Sub-board, Mental Health Board and Research Oversight Board.

Chief Nurse
Professor Nancy Fontaine was appointed as Chief Nurse in August 2018 and is responsible for professional leadership of nurses, midwives, AHPs, Pharmacists and Bio-Scientists across the Trust. As Director for Infection Prevention and Control and Executive lead for Quality, Safety, Patient Experience and Engagement, the Chief Nurse is responsible for providing professional clinical guidance to the Board and is responsible for leading non-medical research and education. Nancy chairs our Patient Experience and Engagement Governance Sub-board and our Emergency and Urgent Care Board. Nancy holds professorial roles at the University of Essex and Anglia Ruskin University.

Chief Finance Officer
John Hennessey was appointed to the Board as our Chief Finance Officer in August 2018 having been interim CFO since February 2018. 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. John chairs our Procurement Board and Financial Improvement and Productivity Board.

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

Non-Executive Directors

Chairman
John Fry was appointed Chairman of the Trust in May 2013. John, was chief executive of regional media group Johnston Press from 2009 to 2012, and before that was chief executive of Archant, 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 Council of Governors and of the Nominations & Remuneration Committee. He is also a member of the Finance & Investments Committee and Quality Programme Board.

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 chairs the Finance & Investments Committee and is a member of the Nominations and Remuneration Committee, People and Culture Committee and Charitable Funds Committee. Tim is also the Senior Independent Director for the Trust.

Mark Jeffries is a solicitor, formerly senior partner and consultant at the national law firm Mills & Reeve LLP. Mark is Non-Executive Director of R G Carter Holdings Ltd and N W Brown Group Ltd. Mark was first appointed as a Non-Executive Director in November 2011, reappointed from November 2014, November 2017 and again from November 2018 to November 2019. 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 Chair of the Quality and Safety Committee, and a member of the Audit Committee and Nominations and Remuneration Committee.

Professor David Richardson is Pro-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 Anglia Innovation Partners LLP. He is also a member of the Health Education East of England Board. David is Chair of our People and Culture Committee and is a member of the 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 first appointed as a Non-Executive Director for a three year term in November 2011, reappointed by the Council of Governors from November 2014, November 2017 and again in November 2018 to November 2019. 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 was Chair of our Quality and Safety Committee and a member of the Nominations and Remuneration Committee. Sally's tenure as Non-Executive Director finished in December 2018 and we are currently recruiting to this post.

Changes during the Year

In addition to those noted above, there were a number of changes to the membership of the Board during the year:

- Frances Bolger was Acting Chief Nurse between February and August 2018
- Peter Chapman stood down as Medical Director in June 2018
- Richard Parker stood down as Chief Operating Officer in December 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 seven committees of the Board – Audit, Quality and Safety, Finance and Investments, Quality Programme Board, Charitable Funds, People and Culture and Nominations and Remuneration. Terms of Reference allocate specific assurance responsibilities between the committees.

Two of these Committees (People and Culture Committee and Quality Programme Board) were established by the Board during 2018/19 as part of the Trust's response to the CQC report (June 2018) and an organisational review of leadership and culture commissioned from the Kings Fund (April 2018).

Audit Committee:

The Committee membership consists of Non-Executive Directors only. The Committee is chaired by Angela Robson with Mark Jeffries and Geraldine O'Sullivan also as members. The external and internal auditors are normally in attendance at Committee meetings and 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 2018/19 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 Hospitals Charity of which the NNUH Foundation Trust Board of Directors is the Corporate Trustee. The fees in respect of this engagement in 2018/19 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 where necessary.

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 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 is based on the principles of the UK Corporate Governance Code issued in 2012. The UK Corporate Governance Code was revised during 2018 and it is anticipated that in due course, this revised code will be reflected in the FT Code of Governance. In the meantime, the Audit Committee has reviewed the Trust's position against the revised UK Corporate Governance Code to identify any obvious areas for further action. No need for specific new action was identified beyond the ongoing initiatives in the Trust to further strengthen our governance arrangements.

Main Activities of the Audit Committee during the Year Ended 31 March 2019

The Audit Committee met on 4 occasions during the year ended 31 March 2019. The focus of the Committee was on:

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

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 2018/19 included audits relating to Data Quality, Operating Theatre Utilisation, Facilities Management, Procurement, Clinical Research, Payroll and processes for evidencing quality improvement.

The Committee received regular reports from the Local Counter Fraud Service including reviews with regard to processes in place to identify and manage risks associated with 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.

The financial performance of the Trust for 2017/18 was reviewed by the Auditors during April and May 2018 and presented to the Committee in May 2018. In accordance with this established annual cycle, financial performance for 2018/19 is subject to external audit review during April and May 2019, for review of the Accounts by the Committee in May 2019.

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, 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 no less than twice a year. During 2018/19 the Committee has met on six occasions. In accordance with its Terms of Reference, the Committee has reviewed the size, structure and composition of the Board of Directors and made recommendations to the Council of Governors with regard to the recruitment of Non-Executive Directors.

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 Chief Financial Officer, Professor Denton as Medical Director, Professor Fontaine as Chief Nurse, and Mr Cobb as Chief Operating Officer. In each case these appointments were achieved with the assistance of recruitment agents, following a national recruitment search and following an open and competitive recruitment process.

The Committee has also approved the process for recruitment of both Chief Executive and Director of Workforce, as vacancies in these posts will arise during the course of 2019/20.

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 2018/19, 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 relevant appointment decisions during 2018/19 and those vacancies that are expected to arise during 2019/20.

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 5 Board members, including at least two Non-Executive Directors, Chief Executive, Chief Nurse and Medical Director. The Committee met on 6 occasions during 2018/19.

Matters considered by the Committee during 2018/19 have included the operation of the Trust's clinical governance systems and processes, including our procedures for learning from incidents and driving a reduction in mortality rates.

A significant area of focus of the Committee has also been on quality and safety related issues arising from operational pressure, particularly in our Emergency Department and at times of very high patient demand. The Committee has also scrutinised quality and safety related risks identified through our risk management process and Board Assurance Framework, notably those relating to aging equipment in the context of very limited financial capital.

The Committee has also received regular updates concerning the Clinical Quality Impact Assessment (QIA) process which is used in the Trust to protect quality and safety whilst making financial savings and productivity improvements.

The Committee has discussed arrangements for enhancing the feedback from patients and families in the continuous improvement in the Trust's services. In liaison with the newly established Quality Programme Board, the Committee has also received reports regarding the response of the Trust to recommendations and feedback from the CQC. Each of these areas is scheduled for the ongoing attention of the Committee during 2019/20.

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 2018/19 such visits have included:

- the Day Procedure Unit (DPU) and General Medical Day Unit (GMDU) (in the context of reviewing the operation of the Escalation Policy);
- Radiology Department and Emergency Department (in the context of concerns raised by the CQC);
- Mental Health suite (in the context of reviewing work undertaken in response to a Warning Notice from the CQC);
- Hospital Operations Centre (to inform discussion with regard to Winter planning and management of periods of very high demand).

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 the Trust's financial position, capital schemes and delivery of contractual standards. The Committee has a membership including three Non-Executive Directors, Chief Executive, Chief Operating Officer, Chief Finance Officer and Director of Strategy.

Matters considered by the Committee during 2018/19 have included review of the Trust's financial plans for the forthcoming year, 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.

2018/19 was another very challenging year for the Trust from a financial perspective. The Committee oversaw the process of re-forecasting for the full year to reflect, not least, the financial impact of very high levels of emergency patient demand over the Winter, which has disrupted the Trust's elective surgical programme.

The Committee has also provided scrutiny on behalf of the Board in relation to the development of a number of capital schemes aimed at improving our facilities for patients, including a discharge lounge, a new Interventional Radiology Unit and refurbishing the Davison Unit at Cromer Hospital. The Committee has also played a key role in developing our financial plans for 2019/20, ensuring that assumptions around clinical activity, income and cost control are balanced between being appropriately challenging, realistic and promoting quality improvement.

Quality Programme Board

The Quality Programme Board of the Board was established in July 2018 to obtain assurance on behalf of the Board of Directors with regard to implementation of the Quality Improvement Plan (QIP) in response to recommendations from the CQC and as part of the Trust's response to Quality Special Measures. The membership of the Quality Programme Board comprises Non-Executive Directors and members of the Management Board.

Matters considered by the Quality Programme Board during 2018/19 have included ongoing monitoring of actions in response to the CQC report, highlight reports from executive and service areas, reports from the Evidence Group (which scrutinises progress made in relation to specific actions), consideration of our draft Quality Improvement Strategy, the Risk Register and deep dive' planning.

People and Culture Committee

The People and Culture Committee of the Board was established in October 2018 to obtain assurance on behalf of the Board that the Trust has appropriate and effective strategies and plans relating to workforce, education, organisational development and culture. The Membership of the Committee includes two Non–Executive Directors, Chief Executive, Director of Workforce, Chief Operating Officer, Chief Nurse, Medical Director and the four Chiefs of Division.

Matters considered by the People and Culture Committee during 2018/19 have included the Workforce & Education Strategy, Corporate Risk Register, relevant extracts of the Board Assurance Framework, Staff Survey Results, cultural improvement and Equality, Diversity & Inclusion.

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 on 11 occasions. Attendance at meetings of the Board and its Committees was as shown below:

	April 2018	May 2018	June 2018	July 2018	Sept 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
Mr John Fry	✓	✓	✓	✓	✓	✓	✓	✓	✓	X	✓
Ms Francis Bolger	✓	✓	✓	✓							
Mr Peter Chapman	✓	✓									
Mr Chris Cobb									✓	✓	✓
Mr Mark Davies	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Prof Erika Denton			✓	✓	✓	✓	✓	✓	X	✓	✓
Prof Nancy Fontaine					✓	✓	✓	✓	✓	✓	✓
Mr John Hennessey	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr Tim How	✓	✓	✓	X	✓	✓	✓	✓	X	✓	✓
Mr Mark Jeffries	✓	X	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Geraldine O'Sullivan	✓	✓	✓	✓	✓	✓	✓	X	✓	✓	✓
Mr Jeremy Over	✓	✓	✓	✓	✓	✓	✓	✓	X	✓	✓
Mr Richard Parker	✓	✓	✓	✓	✓	✓	✓	✓			

	April 2018	May 2018	June 2018	July 2018	Sept 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
Prof David Richardson	✓	✓	✓	✓	✓	✓	X	✓	✓	X	✓
Mrs Angela Robson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Miss Sally Smith QC	✓	✓	✓	✓	✓	✓	✓	✓			

[1] Ms Bolger was Acting Chief Nurse until 31 July 2018.
[2] Mr Chapman stood down as Medical Director in June 2018.
[3] Mr Cobb became Acting Chief Operating Officer in January 2019.
[4] Professor Denton was appointed as Medical Director in July 2018.
[5] Professor Fontaine became Chief Nurse in August 2018.
[6] Mr Hennessey was appointed as Chief Finance Officer in August 2018.
[7] Mr Parker stood down as Chief Operating Officer in December 2018.
[8] Miss Smith stood down as Non-Executive Director in December 2018.

Attendance at meetings of the Audit Committee

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

	25 May 2018	12 Sept 2018	12 Dec 2018	13 Mar 2019
Mrs Angela Robson (Chair of Committee)	✓	✓	✓	✓
Mr Mark Jeffries (Non-Executive Director)	X	✓	✓	X
Dr Geraldine O'Sullivan (Non-Executive Director)	✓	✓	✓	✓

Nominations & Remuneration Committee

The Nominations and Remuneration Committee meets routinely twice a year and otherwise as required. The Committee met on 6 occasions during the year.

	25 May 2018	29 Jun 2018	28 Sept 2018	30 Nov 2018	22 Feb 2019	29 March 2019
Mr John Fry (Chairman and Chair of Committee)	✓	✓	✓	✓	X	✓
Mr Mark Davies (Chief Executive)	✓	✓	✓	✓	✓	✓
Mr Tim How (Non-Executive Director)	✓	✓	✓	✓	✓	✓
Mr Mark Jeffries (Non-Executive Director)	X	✓	✓	✓	✓	✓
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 at least five times per year and it met on 6 occasions during 2018/19.

	5 Apr 2018	21 Jun 2018	14 Sept 2018	29 Nov 2018	16 Jan 2109	12 Mar 2019
Miss S Smith QC (Non-Executive Director & Chair of Committee (up to 14 September)	✓	✓	✓	✓		
Dr Geraldine O'Sullivan (Non-Executive Director & Chair of Committee (from 29 November)	✓	✓	✓	✓	✓	✓
Mr Mark Jeffries (Non-Executive Director)	✓	✓	✓	✓	✓	✓
Mr Peter Chapman (Medical Director)	✓	X				
Mr Mark Davies (Chief Executive)	✓	✓	✓	✓	✓	✓
Ms Frances Bolger (Acting Director of Nursing)	✓	✓				
Mr Richard Parker (Chief Operating Officer)	✓	✓	✓	X		
Prof Nancy Fontaine (Chief Nurse)			X	✓	✓	✓
Prof Erika Denton (Medical Director)			✓	✓	✓	✓

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

	25 Apr 2018	25 Jun 2018	17 Sept 2018	26 Nov 2018	19 Dec 2018	21 Jan 2019	11 Feb 2019	20 Mar 2019
Mr Tim How (Chair of Committee and Non-Executive Director)	✓	✓	✓	✓	✓	X	✓	✓
Mr Mark Davies (Chief Executive)	✓	✓	✓	✓	✓	✓	✓	✓
Mr John Fry (Chairman)	✓	✓	✓	✓	✓	✓	✓	X
Mr John Hennessey (Chief Finance Officer)	✓	✓	✓	✓	✓	✓	✓	✓
Mr Richard Parker (Chief Operating Officer)	✓	✓	✓	X	✓			
Professor David Richardson (Non-Executive Director)	X	✓	X	X	✓	X	X	✓
Mr Chris Cobb (Acting Chief Operating Officer)						✓	✓	✓
Mr Jeremy Over (Director of Workforce)						X	X	X
Mr Simon Hackwell (Director of Strategy)						✓	✓	✓

People and Culture Committee – meeting and attendance

The People and Culture Committee routinely meets quarterly and otherwise as required. The Committee held its first meeting on 19 December and met twice during 2018/19. Attendance was as follows:

	19 Dec 2018	12 Feb 2019
David Richardson (Chair and Non-Executive Director)	✓	✓
Ms Frances Bolger (CoD - Women and Children)	X	X
Chris Cobb (Acting Chief Operating Officer)	✓	X
Mark Davies (Chief Executive)	X	✓
Erika Denton (Medical Director)	X	X
Nancy Fontaine (Chief Nurse)	✓	✓
Dr Richard Goodwin (CoD - Clinical Support Services)	✓	✓
Tim How (Non-Executive Director)	✓	✓
Dr Tim Leary (CoD - Surgery)	✓	✓
Jeremy Over (Director of Workforce)	✓	✓
Dr Frankie Swords (CoD - Medicine and Emergency Services)	✓	X

Quality Programme Board – meeting and attendance

The Quality Programme Board routinely meets monthly. The Quality Programme Board met on 8 occasions during the year as follows:

	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019	Mar 2019
Chief Executive (Chair)	✓	✓	X	X	✓	✓	✓	✓
Independent Non-Executive Director(s)	✓	✓	✓	✓	✓	✓	✓	✓
Chief Operating Officer	✓	✓	✓	X	X	✓	X	✓
Chief Nurse	✓	✓	✓	✓	✓	✓	✓	✓
Medical Director	✓	✓	✓	✓	✓	✓	X	✓
Director of Workforce	X	X	✓	X	✓	✓	✓	X
Chief Information Officer		✓	✓	✓	✓	✓	✓	X
Director of Communications	✓	✓	✓	X	X	✓	✓	✓
Chief of Division - Medicine	X	✓	✓	✓	✓	✓	X	✓
Chief of Division - Surgery	✓	✓	✓	X	✓	✓	✓	✓
Chief of Division - Women & Children	✓	✓	✓	X	✓	✓	✓	X
Chief of Division - DCSS	✓	✓	✓	✓	✓	✓	✓	✓
Chief of Service: Winter Team							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 2018/19 additional posts were established to strengthen our clinical governance, quality improvement and risk management teams as part of the Trust's response to Quality Special Measures and feedback from the CQC.

In accordance with its established practice, the Board carried out a review of its performance and that of its Committees and Chairman. Following this 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.

During 2018/19, the Board established two additional Committees (People and Culture Committee and Quality Programme Board) as part of the Trust's response to the CQC report (June 2018) and an organisational review of leadership and culture commissioned from the Kings Fund (April 2018). The Board also commissioned an independent review by PWC of the Board's Capacity, Capability and Effectiveness (November 2018). This review was commissioned to inform future recruitment to the Board and the Board Development Plan.

This was followed by publication of the CQC assessment (May 2019) which found that "*Overall the Trust had improved from inadequate to requires improvement for well led. The Trust had taken appropriate action in response to many of our concerns raised in our previous report, published June 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;
- re-appointed Sally Smith, Angela Robson and Mark Jeffries 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. Elections are held on an annual basis to fill any vacancies on the Council. These elections are administered on our behalf by an independent organisation (Mi-Voice) and in accordance with the election rules set out in our Constitution. We promote elections through mailings to members, media coverage and through the Trust's social media channels. The Trust receives a good level of interest from the local community and staff in filling these vacancies and they are usually contested. As at March 2019 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
• Jackie Hammond	Broadland
• Janet King	Broadland
• Mary Pandya	Rest of England
• Trevor Plunkett	Broadland
• John Rees	Broadland
• Matthew Roe	North Norfolk
• Jane Scarfe	South Norfolk
• Joy Stanley	Breckland
• Penny Sutton	King's Lynn and West Norfolk

Staff Governors

- Rob Boyce — Clinical Support
- Sue Burt — Nursing and Midwifery
- Terry Davies — Contractors and Volunteers
- Sheila Ginty — Nursing and Midwifery
- John Nolan — Medical and Dental
- Vacant — Admin and Clerical

Partner Governors

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

Changes during the year:

The following Governors stood down from the Council in 2018/19:

- **Rosalynd Jowett — Norwich**
- **Vikki Worman — Admin and Clerical**
- **Janet King — Broadland**

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

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

- the development of our strategic plans, including the Digital Health Strategy and the Quality Improvement Strategy;
- our performance against national standards;
- the Staff Survey and Action Plan;
- the opening of the Quadram Institute and the new Discharge Lounge (Aylsham Suite);
- preparations for the CQC inspection.

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 2018/19. Attendance at Council meetings was as set out below:

	25 April 2018	26 July 2018	24 October 2018	23 January 2019
Ms Erica Betts	✓	✓	✓	✓
Mr Rob Boyce	X	X	X	✓
Mr Nick Brighouse	✓	✓	✓	✓
Ms Sue Burt	X	✓	✓	✓
Mr Terry Davies	✓	X	✓	✓
Prof Diane DeBell	X	✓	✓	✓
Dr Anoop Dhesi	X	X	X	X

	25 April 2018	26 July 2018	24 October 2018	23 January 2019
Ms Nina Duddleston	✓	✓	✓	✓
Ms Carol Edwards	✓	✓	✓	X
Ms Sarah Ellis	✓	✓	✓	✓
Miss Sheila Ginty	X	✓	✓	✓
Mrs Ines Grote	✓	X	✓	X
Cllr Shelagh Gurney	X	✓	✓	X
Mrs Jackie Hammond				✓
Prof Rosalynd Jowett	X	✓	X	
Ms Janet King	✓	✓	✓	
Mr John Nolan	✓	X	✓	✓
Ms Mary Pandya	X	✓	✓	✓
Mr Trevor Plunkett	✓	X	✓	X
Dr John Rees	✓	✓	✓	✓
Mr Matthew Roe				✓
Ms Jane Scarfe	✓	✓	✓	✓
Mrs Joy Stanley	✓	X	✓	✓
Miss Penny Sutton	✓	✓	✓	✓
Ms Vikki Worman	✓	✓	X	

Lead Governor

In accordance with the Foundation Trust Code of Governance, the Council of Governors has nominated one of its members to act as Lead Governor with particular responsibility for providing a channel of communication between the Council and NHSI in appropriate circumstances. Public Governor Jane Scarfe was appointed as Lead Governor in October 2018 with Terry Davies, Staff Governor, as Deputy Lead Governor.

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 have been elected to this role.

The work of the Committee is supported by the Board Secretary. As at April 2019, 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 recommended the reappointment of Sally Smith, Angela Robson and Mark Jeffries as a Non-Executive Directors. The Committee has also undertaken work in preparation for further appointments to maintain the ongoing re-refreshing of Board membership during 2019/20.

The Committee is also responsible for overseeing the remuneration of our non-executive directors and making any recommendations for change to the Council. In 2018/19 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 our partner University (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 target minimum set by the Council of Governors. By the end of March 2019 we had 17,143 Public Members.

We have a Membership Strategy for which the objectives in 2018/19 were to:

- continue the communication and involvement programme with members;
- hold elections in the following constituencies: Breckland, Broadland, and the admin and clerical constituencies:
- develop strong and representative public membership reflecting the diversity of the population.

	Membership at 2007/08	**Membership at 2018/19**
Staff	5,000	7,500
Public	5,000	17,143
Total	10,000	24,643

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 lectures, the Annual General Meeting and participation in the Patient Choice Staff Award. During the year members have been invited to a number of events 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 on dementia took place during National Dementia Week on 14 May 2018.
- The N&N fete and Dog Show took place on 16 June 2018.
- Governors visited the new Quadram Building on 18 July 2018.
- The AGM took place on 24 September 2018.
- The governors visited the Older People's Emergency Department on 8 November 2018
- The Christmas Faye took place on 6 December 2018.
- An induction event took place for new governors on 21 January 2019.
- 'Robot Week' took place from 22-24 January 2018 to celebrate three years of robot surgery in the Trust, with the public invited to try out the robot and simulator.

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 2018/19 financial year or previous year.

Income disclosures required by Section 43(2A) of the NHS Act 2006
During 2018/19 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 £597.8m of the total income of £599.5m (2017/18 £585.0m of the total income of £586.7m).

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 31/03/2019 can be found at the back of this annual report. The statement of the responsibility of the accounting officer can be found on page 104 at the end of this document.

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

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

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

Annual Report on remuneration

Major decisions on senior managers' remuneration

Remuneration for the Trust's most senior managers (Executive Directors who are members of the Board of Directors) is determined by the Board of Director's Nominations and Remuneration Committee. The Nominations and Remuneration Committee determined that no amendments to incumbent executives' pay should be made in 2018/19, other than a flat £2,075 per annum uplift (applicable to those directors in post more than 12 months as at 01 April 2018), matching the increase applied to national non-medical contracts across the NHS.

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 2018/19, other than the uplift outlined above.

Signed by Chair of Nominations and Remuneration Committee on 29 May 2019 **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 2018/19
(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	6 Months
R Parker, Chief Operating Officer (Until 31 December 2018)	01/01/2016		n/a	6 Months
JJ Hennessey, Chief Finance Officer	26/02/2018		n/a	6 Months
JM Over, Director of Workforce	13/10/2014		n/a	6 Months
PG Chapman, Medical Director (Until 30 June 2018)	01/04/2015		n/a	6 Months
ERE Denton, Medical Director (Appointed 1 July 2018)	01/08/2018		n/a	6 Months
CM Cobb, Acting Chief Operating Officer (Appointed 1 January 2019)*	01/12/2018		n/a	6 Months
NVC Fontaine, Chief Nurse (Appointed 1 August 2018)	01/08/2018		n/a	6 Months
FL Bolger, (Until 31 July 2018)	31/01/2018		n/a	6 Months
J Fry, Chairman**	01/05/2016	09/06/2019	3 Months	6 Months
T How, Non-Executive Director	01/11/2017	31/07/2020	16 Months	3 Months
RM Jeffries, Non-Executive Director	01/11/2015	31/10/2019	7 Months	3 Months
GH O'Sullivan, Non-Executive Director	01/11/2016	31/10/2022	43 Months	3 Months
D Richardson, Non-Executive Director	01/09/2017	31/08/2020	17 Months	3 Months
A Robson, Non-Executive Director	01/11/2017	31/10/2019	7 Months	3 Months
SE Smith, Non-Executive Director (Until 31 December 2018)	01/09/2015	n/a	n/a	3 Months

**Appointed Substantive Chief Operating Officer 1 April 2019*
***David White has been appointed as Chairman with effect from 10/06/2019*

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 terms of appointment 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 three other non-executive directors. During 2018/19 the membership comprised 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 six times during 2018/19, on 25 May, 29 June, 28 September & 30 November 2018 and on 22 February & 29 March 2019. 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 2019.

Where an individual's remuneration is above the level of £150,000 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 9 Executive Directors in office during the year and 7 Non – Executive Directors, including the Chairman. In aggregate the Directors received reimbursement of expenses of £7,229 with claims from 7 directors. In 2017/18, 15 directors had been in office, being 8 executive directors and 7 non-executive directors. In aggregate they received reimbursement of expenses of £6,941 with claims from 9 directors.

No significant awards were made to past Directors during the 12 months ended 31 March 2019.

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 2018/19 and four governors claimed £693. (In 2017/18, three governors claiming expenses totalling £611.)

Remuneration – Audited

Name and title		12 months ended 31st March 2019				12 months ended 31st March 2018			
		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
J Fry, Chairman	J Fry	50 - 55	100	0	50 – 55	50 - 55	0	0	50 - 55
PM Davies, Chief Executive	PM Davies	230 - 235	400	0	230 – 235	225 - 230	400	40 - 42.5	270 - 275
CM Cobb, Acting Chief Operating Officer (Appointed 1 January 2019)	CM Cobb	30 - 35	0	45 – 47.5	75 – 80	0	0	0	0
ERE Denton, Medical Director (Appointed 1 July 2018)	ERE Denton	180 - 185	100	55 - 57.5	235 – 240	0	0	0	0
NVC Fontaine, Chief Nurse (Appointed 1 August 2018)	NVC Fontaine	90 - 95	0	152.5 - 155	245 – 250	0	0	0	0
JJ Hennessey, Chief Finance Officer*	JJ Hennessey	125 - 130	0	0	125 – 130	0	0	0	0
JM Over, Director of Workforce	JM Over	120 - 125	0	17.5 - 20	140 – 145	120 - 125	100	32.5 - 35	155 - 160
T How, Non-Executive Director	T How	10 - 15	0	0	10 – 15	10 - 15	0	0	10 - 15
RM Jeffries, Non-Executive Director	RM Jeffries	10 - 15	0	0	10 – 15	10 - 15	0	0	10 - 15
GH O'Sullivan, Non-Executive Director	GH O'Sullivan	10 - 15	0	0	10 – 15	10 - 15	0	0	10 - 15

D Richardson, Non-Executive Director	D Richardson	10 - 15	0	0	10 – 15	10 - 15	0	0	10 - 15
A Robson, Non-Executive Director	A Robson	10 - 15	0	0	10 – 15	10 - 15	0	0	10 - 15
SE Smith, Non-Executive Director (Until 31 December 2018)	SE Smith	5 - 10	0	0	5 – 10	10 - 15	0	0	10 - 15
R Parker, Chief Operating Officer (Until 31 December 2018)	R Parker	110 - 115	0	42.5 – 45	155 – 160	140 - 145	100	42.5 - 45	185 - 190
FL Bolger, Director of Nursing (Until 31 July 2018)	FL Bolger	30 - 35	0	375 - 377.5	410 – 415	15 - 20	0	0	15 - 20
PG Chapman, Medical Director (Until 30 June 2018)	PG Chapman	50 - 55	0	0	50 – 55	185 - 190	0	70 - 72.5	260 - 265
JN Norman, Chief Finance Officer (appointed 2 January 2017, until 31 January 2018)	JN Norman	0	0	0	0	240 - 245	100	0	240 - 245
EJ McKay, Director of Nursing (Until 30 January 2018)	EJ McKay	0	0	0	0	90 - 95	200	30 - 32.5	120 - 125

* John Hennessey was appointed as the Chief Financial Officer from 26 February 2018 for a period of secondment from another NHS hospital trust who continued to employ and remunerate him until his employment commenced with NNUH from 01 July 2018. A secondment agreement was in place to formally authorise his status at NNUH as an executive member of the Board of Directors for the duration of the secondment. 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 not been pro-rated / time apportioned for Directors who were appointed or resigned part way through the year.

For the Medical Director appointed during the year, the element of their remuneration relating to their non-managerial role is in the banding £195,000-200,000 (prior year N/A). For the Medical Director who left the post during the year, the element of their remuneration relating to their non-managerial role is in the banding £35,000-40,000 (prior year £210,000-215,000).

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.

	2018 - 19	**2017 - 18***
Band of Highest Paid Director's Total Remuneration (£'000)	230 - 235	225 - 230
Midpoint of band	232,500	227,500
Median Total (£)	28,615	28,268
Remuneration Ratio	8.13	8.05

The banded remuneration, of the highest paid director in the Trust in the financial year 2018/19 was £230-235k (2017/18: £225k-£230k). This was 8.13 times (2017/18 – 8.05 times) the median remuneration of the workforce which was £28,615 (2017/18 - £28,268). In 2018/19, 0 (2017/18: 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.

Total Pension Entitlement

2018/19 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 2019 (bands of £5,000) £'000	Lump Sum at age 60 related to accrued pensions at 31 March 2019 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2018 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2019 £'000
PM Davies, Chief Executive	0 - 2.5	2.5 - 5	90 - 95	270 - 275	2,039	0	0
R Parker, Chief Operating Officer (Until 31 December 2018)	0 - 2.5	-2.5 - 0	50 - 55	130 - 135	858	0	854
JM Over, Director of Workforce	0 - 2.5	-2.5 - 0	25 - 30	60 - 65	328	112	450
PG Chapman, Medical Director (Until 30 June 2018)	-5 - -2.5	25 - 27.5	45 - 50	265 - 270	1,456	0	0
ERE Denton, Medical Director (Appointed 1 July 2018)	2.5 - 5	-5 - -2.5	65 - 70	175 - 180	1,165	133	1,399
NVC Fontaine, Chief Nurse (Appointed 1 August 2018)	5 - 7.5	7.5 - 10	55 - 60	135 - 140	839	161	1,106
CM Cobb, Acting Chief Operating Officer (Appointed 1 January 2019)	0 - 2.5	0 - 2.5	20 - 25	50 - 55	328	21	421
FL Bolger, (Until 31 July 2018)	5 - 7.5	15 - 17.5	50 - 55	150 - 155	640	145	1,094

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

2017/18 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	19	635

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 2018/19, however two individuals who have held the role of Medical Director during the period 2018/19 were in receipt of clinical excellence awards as part of their remuneration packages that were determined in previous years.

Signed on behalf of the Board on 29 May 2019

Chief Executive – Mark Davies

Staff Report

Introduction

Our team is comprised of over 8,000 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 2018 to March 2019.

Average number of employees (WTE basis)	2018/19 Total	2018/19 Permanently Employed	2018/19 Other	2017/18 Total	2017/18 Permanently Employed	2016/17 Other
Medical and dental	**1108.55**	58227	526.28	1,034	466	568
Ambulance staff	**-**	-	-	-	-	-
Administration and estates	**621.64**	609.3	12.34	559	525	34
Healthcare assistants and other support staff	**2890.07**	2418.95	471.12	2,623	2,177	446
Nursing, midwifery and health visiting staff	**2320.04**	2102.81	217.23	2,119	1,871	248
Nursing, midwifery and health visiting learners	**7**	7	-	-	-	-
Scientific, therapeutic and technical staff	**606.26**	548.18	58.08	569	499	70
Healthcare science staff	**313.75**	309.55	4.2	396	361	35
Social care staff	**-**	-	-	-	-	-
Other	**0.19**	-	0.19	-	-	-
Total average numbers	**7867.5**	**6578.06**	**1289.44**	**7,300**	**5,899**	**1,324**

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

> 'Permanently employed' – staff with a permanent (UK) employment contract 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):

	2018/19			2017/18		
	Total	Permanent Staff	Other	Total	Permanent Staff	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	**280,285**	230,740	49,545	258,773	222,017	36,756
Social security costs	**28,457**	23,250	5,207	24,011	21,061	2,950
Appenticeship Levy	**1,383**	1,383	0	957	957	0
Pension cost - defined contribution plans employer's contributions to NHS pensions	**33,803**	29,617	4186	31,342	27,639	3,703
Termination benefits	**15**	14,804	0	61	61	0
Temporary staff - agency/contract staff	**12,825**		12,825	9,631		9,631
Total gross staff costs	**356,769**	**285,005**	**71,764**	**324,775**	**271,735**	**53,040**

Breakdown of male and female staff as at 31 March 2019

	Male	Female
Executive Director	6	2
Non-Executive Director	4	3
Other staff	1,691	6,569

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 2019 is 4.03%, which represents a significant reduction of 6% on the peak of September 2016 and delivers the equivalent of 20 additional staff every day. We attribute this positive picture to our Attendance policy and the *'Know Your Staff'* approach to people management.

Our people (not process) approach to attendance management is recognised nationally, including

- NHS Employers continue to cite the NNUH as an example of positive change through a people-centric ethos
- More than 50 Trusts from across the country have sought our advice
- Sharing our approach at the NHS Confederation annual conference and at a learning event hosted by NHS Improvement
- Sharing our experiences at national conferences targeted at the wider public sector

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

The Trust has been 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.

Equality and Diversity

Equality Act 2010

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.

Equality, Diversity and Inclusion Objectives

As part of our commitment to providing equal opportunity to all our employees whilst recognising we each have our own diverse needs the Trust have developed the following equality, diversity and inclusion objectives:-

- To build an inclusive environment for our staff. We will continue to work with staff to develop a positive culture and good relations where our staff feel engaged, valued, empowered and proud to work at the NNUH.

- We will improve the capture of equality information in respect of our workforce. We will analyse the data in order to have a sound evidence base and inform appropriate responses and priorities.

- We will maintain compliance with NHS requirements, including:
  - Equality Delivery System (EDS2)
  - Workforce Race Equality Scheme (WRES)
  - Workforce Disability Equality Scheme (WDES)

- We will ensure compliance with the requirements of the Gender Pay Gap Regulations and publish information in respect of:
  - Gender pay gap (mean and median averages)
  - Gender bonus gap (mean and median averages)
  - Proportion of men and women receiving bonuses
  - Proportion of men and women in each quartile of the organisation's pay structure

Trade Union

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.

NNUH has 32 trade union representatives providing 28.54 FTE. The following table outlines the percentage of working hours these officials spent on facility time.

Percentage of working hours spent on facility time	No of Representatives
0%	5
1 – 50%	25
51 – 99%	2
100%	0

The total spend on paying employees who were relevant union officials for facility time during the relevant period was £104,688 which represented 0.03% of NNUH's total pay bill.

The total hours spent on paid TU activities facility time totalled 5,482 which represented 2.63% of total paid facility time. In addition there were 144 hours spent on paid trade union activities.

Communications and consultation

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 2018.

Other communication mechanisms

Staff engagement is supported by a comprehensive internal communications programme which includes daily and weekly e-newsletters, intranet, magazine, and events such as Chat with the Chief where staff can drop in and speak directly to the chief executive. Monthly Viewpoint meeting sessions, which are open to all staff are also provided by the Chief Executive Officer 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.

NHS Staff Survey 2018

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 format for reporting and analyzing the data have changed for this year with 32 key findings presented as 10 high level themes benchmarked against other hospital trusts. The survey provides graphical analysis showing the best and worst Trusts, England average and own organization. There is also a five year trend analysis which is helpful when we review the data.

Themes	2018/19		2017/18		2016/17	
	Trust	Benchmark-ing Group	Trust	Benchmark-ing Group	Trust	Benchmark-ing Group
Response Rate	46%	44%	47%	44%	46%	43%
Equality, diversity & inclusion	9.1	9.1	9.1	9.1	9.2	9.2
Health & wellbeing	9.1	9.1	9.1	9.1	9.2	9.2
Immediate managers	6.0	5.9	6.2	6.0	6.1	6.1
Morale*	6.5	6.7	6.5	6.7	6.5	6.7
Quality of appraisals	6.0	6.1	n/a	n/a	n/a	n/a
Quality of care	5.4	5.4	5.3	5.3	4.9	5.3
Safe Environment - Bullying & harassment	7.1	7.4	7.3	7.5	7.2	7.6
Safe Environment - Violence	7.7	7.9	7.8	8.0	7.6	8.0
Safety culture	9.5	9.4	9.5	9.4	9.4	9.4
Staff engagement	6.4	6.6	6.5	6.6	6.4	6.6
	6.8	**7.0**	**6.9**	**7.0**	**6.8**	**7.0**

* Morale is a new theme so no comparable data for previous survey's available.

The top three questions demonstrating improvement for the Trust together with progress made over a four year period are as follow:-

- Care of patients is my organisation's top priority - +5%
- I would recommend my organisation as a place to work - +5%
- If a friend or relative needed treatment I would be happy with the Standard of Care provided by this organisation - +7%

Four areas for improvement for the Trust include the following:-

- Views on quality of care
  - 4% reduction in staff feeling satisfied with the quality of care they feel able to give
  - 2% reduction in staff feeling that their role makes a difference to patients.
  - 1% reduction in staff feeling they are able to deliver the care they aspire to

- Contributing to Improvement
  - 4% reduction in staff feeling able to make suggestions for improvement of their team
  - 5% reduction in staff feeling able to make improvements happen in their area of work

- Bullying, harassment and abuse
    - 3% increase from colleagues (although reductions of 3% from managers and 4% from patients).

Taking action on the staff survey

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.

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.

Leading with Pride

An independent review of staff views was commissioned with The King's Fund and the report they provided detailed a key deliverable as providing support for our leaders at all levels.

To take this forward, workshops were held in August 2018 to co-create an approach to bullying and poor behaviour and this informed our Leading with PRIDE events.
700 leaders at all levels attended Leading with PRIDE masterclasses in September 2018 with positive engagement and feedback. These sessions are continuing on a monthly basis.

At these masterclasses managers are reminded of the importance of having effective engagement with their staff and our expectation of managers to use the 'know your staff' principles of:

- Have an outcome focus.
- Think about the person before the process.
- Have no surprises.
- Apply discretion appropriately.
- Provide clarity, have ownership and be accountable.
- Adopt an ethos of leading through:
    - Trust, with positive
    - Relationships and
    - Engagement, knowing that you are
    - Empowered to take appropriate decisions

Managers are also provided with tools for:

- giving constructive feedback and tackling issues
- building on individual team members' strengths;
- modelling PRIDE values as leaders

In addition a new Communicating with PRIDE (Dignity at Work Framework) replaced the Dignity at Work Policy in October 2018.

Communicating with Pride

The Communicating with Pride approach was based on feedback obtained at the workshop events held in August 2018. The basis of this is to provide help and support for all – whether staff had experienced, witnessed, had to manage, or had been accused of, inappropriate behaviour. The intent is that this empowers all of our staff to have the confidence to raise and resolve issues themselves, or with the support of colleagues.

This approach was introduced in October 2018 and provides staff with step by step guides containing practical tools to help to decide the best route forward to help resolve issues as follows:-

- Our approach, your options – Guide to help individuals choose the steps open to them and who they can turn to for support

- Four quick guides for anyone experiencing, or involved in, inappropriate behaviour, including bullying:-
  - I'm experiencing …
  - I've witnessed…..
  - I've been accused ……
  - For managers, addressing inappropriate behaviour
- Safe culture team discussions - Guide to raising awareness of inappropriate behaviour and its impact, in teams
- Step 1 – Reflect - A guide developed by colleagues at our hospitals to help individuals think about the behaviours being experienced
- Step 2 – Direct feedback - Outlines our BUILD feedback approach and how to use it
- Step 3 – Supported resolution - Continuing to de-escalate to find a resolution that works for everyone
- Step 4 – Formal process

Communicating with Pride builds on the Trusts PRIDE values which details the types of behaviour the organisation likes to see and the behaviour it discourages

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.

In March 2019 the Trust appointed a Lead Freedom to Speak Up Guardian which reinforces the Trust's commitment to creating a safe environment for staff of all levels and volunteers to raise issues and concerns, and to ensure that they are appropriately addressed.

This role creates a link with the National Guardian's Office, an independent, non-statutory body with a remit to lead culture change in the NHS by making speaking up an everyday activity. The creation of a Lead Guardian post, in addition to our staff governor guardians, was one of the recommendations from The King's Fund work that took place at NNUH during 2018, alongside learning from feedback in our staff survey.

Freedom to Speak Up Guardians are there to listen to any concerns, however big or small, from worries about patient safety to bullying and harassment issues if there is something staff feel isn't right, we want them to feel able to tell us rather than go home and worry about it.

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.

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 2018 to 31 March 2019.

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 2019 for more than £245 per day lasting for longer than six months	
No. of existing engagements as of 31 March 2019	2
Of which:	
No. that have existed for less than one year at the time of reporting.	1
No. that have existed for between one and two years at time of reporting.	1
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

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, 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 2018 and 31 March 2019	1
Of which:	
Number assessed as within the scope of IR35	1
Number assessed as not within the scope of IR35	1
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	1
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 2018 and 31 March 2019	
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 was one new staff exit package in the year ended 31 March 2019 (2017/18:5).

Staff exit packages for the year ended 31 March 2019			
Range	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**
<£10,000	-		
£10,001 - £25,000	-	1	1
£25,001 - £50,000	-		
£50,001 - £100,000	-		
£100,001 - £150,000	-		
£150,001 - £200,000	-		
>£200,001	-		
	-	**1**	**1**

The post was made redundant after the bespoke service ceased, for a fixed period of time redeployment was sought. This was not successful and the employee's role was made redundant. The individual received pay in lieu of notice of £6,813 and redundancy pay of £14,804 totalling £21,617 (2017/18 £152k).

Exit packages: non-compulsory departure payments

Reason for Payment	Agreements Number	Total Value of Agreements £000
Voluntary redundancies including early retirement contractual costs	-	-
Mutually agreed resignations (MARS) contractual costs	-	-
Early retirements in the efficiency of the service contractual costs	-	-
Contractual payments in lieu of notice	6	£22,362
Exit payments following Employment Tribunals or court orders	-	-
Non-contractual payments requiring HMT approval*	-	-
Total	6	£22,362
Of which: Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	-	-

*Includes any non-contractual severance payment made following judicial mediation and there were no payments made relating to non-contractual payments in lieu of notice

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 have delivered preventative programmes in line with the Health & Wellbeing Strategy which was fully approved by Hospital Management Board in July 2017. This programme consists of four objectives:

- To take positive action on health and 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

Health & Wellbeing – positive action

An annual plan of health and wellbeing events was created and delivered to raise awareness of how important it is that we look after ourselves in order to look after others. We have used various channels for these events from increasing face to face interventions, stands for awareness campaigns to using social media and other communication forms.

Our @HWBNNUH twitter account has increased in activity and in addition, a 'closed NNUH staff HWB' Facebook group has been created and continues to increase its membership.

The HWB newsletter provides key information on wellbeing, past and forthcoming events as well as promoting our regular activities such as the running club, staff choir, yoga and pilates sessions as well as our monthly Schwartz rounds.

In this financial year, a number of Health & Wellbeing events have been undertaken including:

- Health Information Week - this event provided information on the various health activities and support available for NNUH staff including Insight (EAP service for NNUH), Staff Physiotherapy service, information on diet, nutrition, mental health & physical activity, NHS Wellbeing Service, UEA Sportspark, NNUH Library, Serco and NHS Smoking Cessation as well as promoting our in house Running club and staff choir (both are led by members of the workplace health & wellbeing team).
- In September a new 6 week Pilates course was introduced for staff and proved very successful. Further courses have been undertaken since.
- October saw an event which highlighted the importance of 'Work Life Balance', linking with National Work Life week. In November the team supported the Substance misuse team during the alcohol / substance misuse awareness day. Both events have led to conversations with staff about lifestyle choices and behavioural changes.
- A 'healthy advent calendar' proved very popular through the social media channels in December
- The new year saw promotion of the National Dry January campaign, two 'couch 2 5K' running courses and encouraging departments to take the 'time to talk' about mental health in February. This event was supported by our local Morrison's supermarket which provided biscuits so that staff could enjoy a cup of tea and biscuit together as they started these conversations.
- The importance of healthy nutrition and hydration was raised in March 2019. This included tasters of nutritious healthy foods and drinks for our staff to try. In addition the importance of smoking cessation was raised on National No Smoking day.

Our hospital choir continues to positively impact the wellbeing provision of our organisation – 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 and are pleased to represent the Trust in this way as well as singing at NNUH events such as the dementia fayre, Summer and Christmas fetes and the annual staff awards evening.

Mental wellbeing

Towards the end of last year, the WHWB team was enhanced by a HWB practitioner, whose key focus was to deliver key aspects of our preventative mental wellbeing plan. Since the arrival of this resource, a series of unique interactive workshops for employees, line managers as well as departmental specific sessions have been developed 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 sessions are extremely well evaluated and the WHWB team are also evaluating the longer term impact of the line manager sessions to demonstrate the importance of such training.

The team have also worked with matrons and our practice development department to develop a new wellbeing and resilience workshop to support newly qualified nurses on their preceptorship programme. This was an area of concern raised by matrons and ward managers as well as being identified from referrals to WHWB. It explores the key challenges that this group of staff face and then assists in developing individual and organisational strategies to assist. Other staff groups are also interested in their newly qualified staff attending this session in the future.

In May 2018, the organisation demonstrated its commitment to raising awareness of mental health in the workplace and supporting staff mental wellbeing by signing its organisational 'Time to Change' pledge after the submission of a successful action plan. Our Pledge states:

- We pledge to continue to raise the awareness of mental health in the workplace through consistent messages and discussions with staff.
- As an acute NHS Trust, we want to ensure that staff feel as comfortable talking about mental health as they do physical health. We will work to ensure that information and support is accessible to all staff. We will improve support for our employees by training our managers in how to support those with mental health problems and by recruiting mental health first aiders together with health and wellbeing champions across the organisation.
- We will continue to provide information to all staff on how they can maintain and improve their own mental wellbeing – raising the importance of caring for themselves, so that they can care for others – 'care for the people who care'

The components of the action plan have gradually been delivered over the course of the year.

In addition, through the support of our divisional areas, four cohorts of staff have completed the National Mental Health First Aid programmes and two divisional areas now have 40 Mental Health First Aiders.

Our monthly Schwartz Rounds have continued; 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 in continuing to provide great care to our patients.
In the last year, we have explored thought-provoking topics including the impact of making mistakes and the challenges of winter pressures. Each time those gathered are reminded of why we do the job that we do.

Musculoskeletal prevention

Our staff physio service increased in provision 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 areas are now receiving bespoke preventative education either through seminars or poster advice. This preventative area of work is extremely well evaluated as is the staff treatment service.

Prevent influenza transmission

A full influenza vaccination campaign was undertaken from October 2018 – February 2019 where 83% of our frontline staff received their vaccination. This programme had dedicated flu vaccine nurses as well as the support of over 70 local peer vaccinators. This level exceeds the challenging target from NHS England of 75% and is the highest level of uptake that our organisation has achieved in this area.

Our success in this programme, was undoubtedly as a result of increased resource to ensure high accessibility of the vaccines being available to all staff, alongside strong medical and nursing leadership together with the support of a prominent communication plan.

In other aspects of work, we successfully submitted our annual review of the Faculty of Occupational Medicine SEQOHS (Safe, Effective, Quality OH Service) accreditation programme following the full five year assessment in July 2017.
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 increasing. 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. As part of our team expansion, we have also been able to internally promote some members of the nursing team who have developed well into their new roles.

We were delighted to welcome to our department, our new Consultant in Occupational Medicine, Dr Rob Hardman. In a time when expert OH Consultants are not widely available, we are very fortunate to secure his employment. Dr Hardman brings a strong commercial focus to our team whilst also being passionate about considering the wider staff experience for our own organisation. In addition, he holds the position of Director of Quality, accreditation and audit with the Faculty of Occupational Medicine.

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.

Areas of work discussed have been staff survey results, the King's Fund Report which was commissioned following the staff survey results and contributing to the Communicating with PRIDE and Leading with PRIDE projects.

The group have assisted to expand the use of the outdoor courtyards as rest areas for staff who wish to take a break outside. In addition, during the hot summer weather, the group facilitated the purchase of picnic blankets for staff to use for the grass areas.

Within this year, further consultation took place surrounding the Smokefree policy review and these discussions have now progressed in forming a wider stakeholder group to take forward practical actions in preparation for a policy review launch.

Monthly PRIDE award scheme based on our Trust Values: People-focused, Respect, Integrity, Dedication and Excellence

Each month there are up to two members of staff and one team who receive recognition through this scheme. Some members of the staff experience working group review the monthly nominations and make decisions regarding winners.
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 a hospital service provider (Serco) providing the winning teams with cake and fruit to share. This initiative continues to be really well received.

Staff Development

Apprenticeships

This year has seen 209 members of staff commence an apprenticeship 78 of these are new apprentices and 44 are aged between 16-18 years. We continue to take a leading role within the locality and in 2018 won the Regional Macro Employer of the Year and Recruitment Excellence for the East of England Awards.

Following the introduction of the Apprenticeship Levy in 2017 we have successfully spent and utilised our contributions with no underspend identified to date. Access to this funding has allowed us to support a wide range of development activities for staff of all levels. An example of this is 34 senior members of staff undertaking the Senior Leaders Masters equivalent to the Executive MBA a further 9 will commence in September 2019.

Sarah Eley, a Nursing Assistant at Cromer Hospital and our Apprentice of the Year in 2016, was chosen to take part in the 2019 National 'Fire It Up' Campaign launched by the Department of Education to raise awareness of the variety of apprenticeship options available for people of all backgrounds and ages.

Our intensive work with local schools continues to raise awareness of the wide variety of career opportunities with the Health Sector. We have attended 82 school events and undertaken other events that has given us contact with over 6,000 students.

Two of our visits this year have been to local primary schools this will be increased in the coming year. We have also attended regional events including, Norwich Science Festival, Norwich PRIDE and the regional Norfolk Skills and Careers Festival.

Our aim for the coming year is to offer a Summer Science School to support local colleges and 6th form students who would like to explore the different career options available to them.

Project Search

Project SEARCH is a work focused Education programme for young people aged 18 to 25 years who have a learning difficulty or learning disability. It is a joint venture between City College Norwich, Serco and NNUH and has now been running for 10 years. The first cohort of students started in January 2009, and four of those students went on to get jobs at the NNUH and are still in employment today. Each year we take ten students who get involved in many different job roles around the hospital; every student gets an opportunity to work in three different job roles throughout the year. Our aim is for the young people to gain paid employment, either at the NNUH or within the wider community. It is a very successful project and so far 53 of our students have gained permanent paid employment as a direct result of Project SEARCH and many others have gone on to gain paid employment within six months of completing the course.

This year's cohort are now almost two thirds of the way through the course and many are already showing themselves to be extremely employable

We have begun our recruitment process ready for the 2019-2020 academic year and have already received many applications from very keen students. The project continues to go from strength to strength and we hope to it will remain an integral part of the work here at NNUH.

Step into Health

Following the adoption of our Step Into Health Programme by NHS Employers 72 Trusts have now signed up to supporting the programme across the UK. The aim is now to extend this to Scotland and Wales in the next year.

We achieved the Defence Employer Recognition Scheme Gold Award in 2018 for our support of the Armed Forces Covenant and associated work.

The Step Into Health Programme has been short listed for the British Ex Forces in Business Awards 2019, the outcome will be known in May.

Work this year has seen the development of an Information Day supported by Health and Social Care Organisations local to the region which has enabled us to offer a number of different career options to Service Leavers and Veterans.

Job Centre – Sector Based Work Academy

In partnership with Serco, Norfolk Community Health and Care, and Social Care the first Sector Based work Academy was run in October 2018. Fifteen Candidates commenced the programme with thirteen successfully completing. The aim of the programme is to enable participating candidates, who are unemployed, the opportunity to undertake work experience to develop their knowledge, skills, self-esteem and confidence in a supportive environment to prepare them to secure employment.

Of this first programme 54% were recruited to jobs both internal and external to the hospital one successfully securing a 4yr nursing apprenticeship. Recruitment has commenced for a second programme which will commence in June 2019.

In addition to this work we have received a Gold Award for our work with Norwich for Jobs initiative.

Prince's Trust

We continue to offer the 'Get into Health and Social Care' programme in partnership with Serco, Norfolk Community Health and Care, and Social Care. Our current programme has commenced with thirteen young people aged between 18 – 30 years. 10 of these will undertake work experience placements with us in a variety of different departments.

Pride Values

Responding to our staff survey results, a review by the King's Fund and the CQC report where staff expressed that NNUH could be a much better place to work, we have continued to support our 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

It is incredibly important that we invested in this programme as it presented an opportunity for us to create a positive change in culture that reaches all staff, and onwards to patient care and safety. The NNUH responded to this feedback at pace and at scale with the launch of the 'Leading with PRIDE' masterclasses in September with on-going support to staff and leaders within the organisation. The infographic attached as Appendix 1 outlines the journey for 2018 for the 'Leading with PRIDE programme.'

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 2018/19 were:

- Education and advice to staff due to major changes with waste contracts and suppliers. The Trust aims to ensure the safety of staff, patients, the public and the environment by the safe and effective segregation and management of all classes of waste leaving our sites.
- Involvement in major projects including building works around the sites. The team is involved in all planning processes to consider the safety of anyone affected by such works and to help ensure that relevant controls are in place for the safety of all users once works are completed.
- Working with clinical teams on assessments of our environments to safeguard our more vulnerable patients and to help equip staff with the skills to manage these patients.

- Control of Substances Hazardous to Health (COSHH) - working with clinical teams on the safe storage of chemicals and the continued development of our PPE /RPE processes to ensure the protection of staff and patients from infection.

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, prevention and management of aggression, chemicals and waste. We have identified staff in areas with specific need i.e. Theatres who can become key trainers in topics such as fire safety and manual handling; this means that training is more accessible and relevant to these areas.
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 7% decrease in reported staff safety incidents compared with the previous year.

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

During 2018/2019, the Health and Safety Department reported 24 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 an increase in reportable incidents of 41% 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 320 per 100,000 employees. The national incidence rate for healthcare in 2018 was 330.

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 2019.

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 2018/19. 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 2019. 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	2018/19 Q1 score	2018/19 Q2 score	2018/19 Q3 score	2018/19 Q4 score
Financial Sustainability	Capital Service Capacity	4	4	4	4
	Liquidity	4	4	4	4
Financial Efficiency	I&E Margin	4	4	4	4
Financial Controls	Distance from financial Plan	1	1	3	3
	Agency Spend	3	2	2	2
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.....

Chief Executive Date: 29 May 2019

NNUH hits best-ever flu jab total

A record number of staff at the Norfolk and Norwich Hospital have benefited from a flu vaccination over the past few months – one of the best levels of take-up amongst NHS staff in the country.

The “Proud to be an NNUH flu fighter” campaign has proved a massive success with over 6,000 staff receiving the protective vaccination, representing over 80 per cent of staff – the best-ever figure for NNUH.

Hilary Winch, Head of Workplace Health, Safety & Wellbeing, (pictured) said: “We take our duty of care very seriously at NNUH and are delighted so many members of staff have recognised their professional responsibility and taken up the offer of a flu vaccination.”

Jeremy Over, Director of Workforce, added: “The ‘Proud to be an NNUH flu fighter’ campaign has been going extremely well. I give my thanks to our flu fighter team and colleagues across the hospital for their incredible support and rolling up their sleeves so that we can protect our patients, our colleagues, families and community. We are proud to be a flu fighting Trust.”

The flu jab campaign had an amazing start back in October when 1,500 members of NNUH staff were vaccinated in four days, and the numbers have steadily risen week by week.

January 2019

Annual Governance Statement for the year ended 31 March 2019

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 Norfolk and Norwich University Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Norfolk and Norwich University Hospitals NHS Foundation Trust for the year ended 31 March 2019 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 been made available to all Trust staff through our intranet documents management system, called TrustDocs, and is accompanied by a Risk Management Policy. Operational responsibility for the implementation of risk management has been delegated to our Chief Nurse and other named staff.

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. During 2018/19 we have undertaken an extensive review of our risk management processes, with external facilitation and training across all key staff groups.

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 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 Oversight Committee is tasked, through defined Terms of Reference, to enhance 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, with close liaison with the divisional and clinical teams.

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.

Feedback from the CQC in its report of May 2019 was that, as part of the broader improvement that it found at the Trust since their last inspection, "*Governance processes, risk management and quality improvement had been reviewed and revised but needed to become embedded across the organisation*". In short, whilst our systems and processes have improved, we need to ensure that this progress continues and is maintained.

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, appraisal and 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 2018/19 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. Several of our specialities have hosted GIRFT inspections this year and, in its Use of Resources assessment (February 2019), NHSI commented positively on the Trust's engagement with the national programme including evidence of improvement resulting from GIRFT reviews.

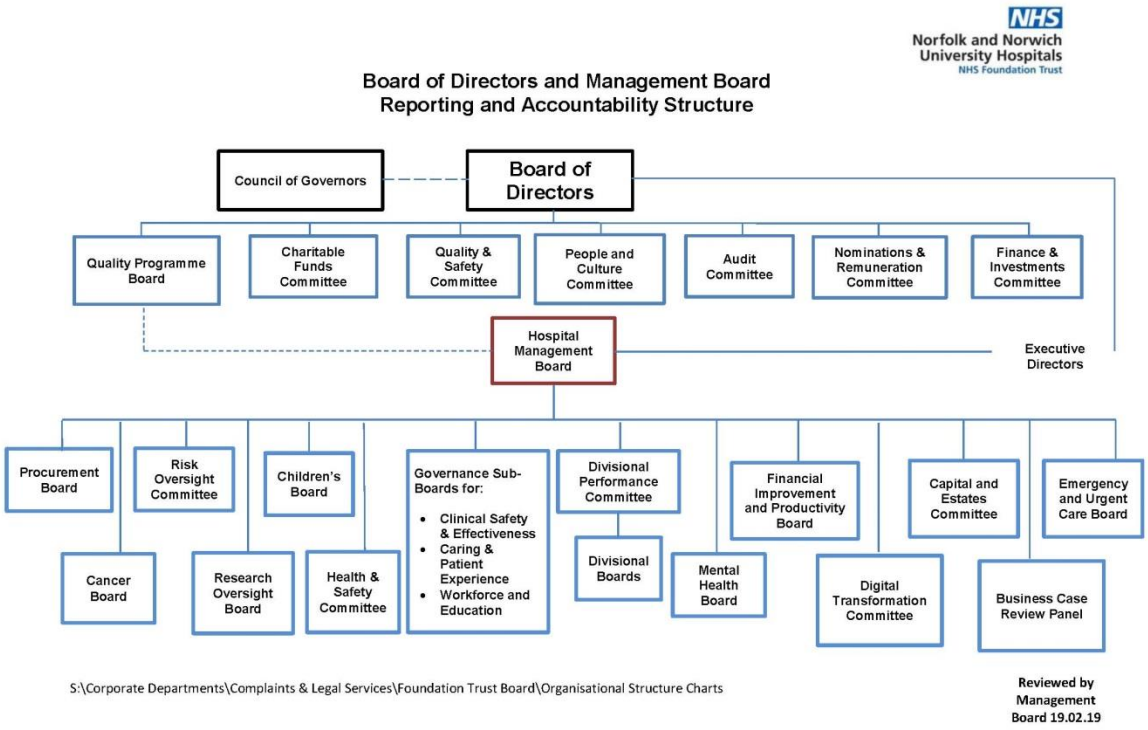
Reduction of risk and maintenance of quality are promoted by constantly reinforcing a culture of openness and transparency and encouraging staff to identify opportunities to learn from patient feedback and to improve the care and services we provide. Our processes for managing risk were reviewed by PWC as part of their Independent Review of Leadership and Governance in the Trust, which reported in October 2017. PWC reported that *"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".* During 2018/19 we have worked to further strengthen our risk management processes and, whilst there is more to do, this progress was recognised by the CQC in its report of May 2019.

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 Board committees and the Hospital Management Board with its Committees and Governance Sub – Boards. The Board regularly receives and reviews the Corporate Risk Register, which summarises the highest-rated risks on the Trust Risk Register.

The Board of Directors has established six Committees, in addition to a Charitable Funds Committee relating to the N&N Hospitals Charity. The Board receives regular reports

from each of its Committees and the overall governance and assurance structure is as represented below.



Two of these Board committees (the People and Culture Committee and the Quality Programme Board) have been established during 2018/19, reflecting increased focus and oversight on these aspects of the Trust.

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 2018/19.

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, Quality Programme Board, People and Culture Committee and Finance and Investments Committee;
- Work of internal and external audit, external reports and the Board programme of clinical and departmental visits.

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.

Those risks with a high residual risk rating (following the impact of appropriate mitigating actions) are detailed in a Corporate Risk Register – reported to both the Board of Directors and Management Board.

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 three 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:

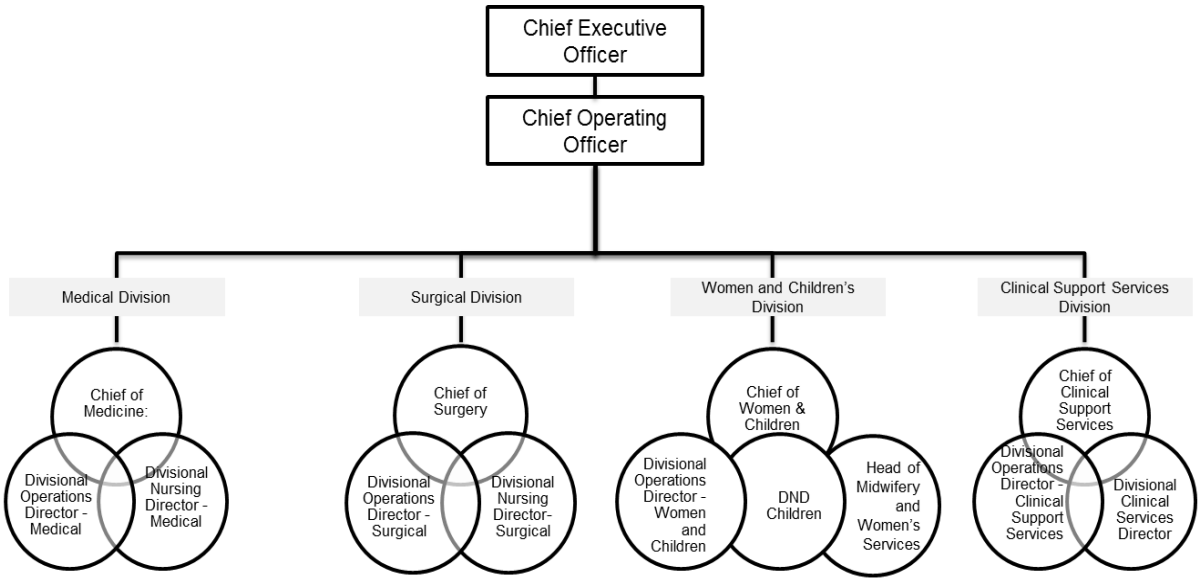
- Clinical Safety and Effectiveness
- Patient Engagement and Experience
- Workforce & Education

The Management Board has also established a number of other Committees to scrutinise and support areas such as Procurement, Financial Investment and Productivity, Research, and Capital Planning. 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.

During 2018/19, the Management Board has strengthened its governance and reporting structure and has established additional committees with specific responsibility for:

- emergency and urgent care;
- health and safety;
- digital transformation.

A Divisional Performance Committee also oversees the work of the four clinically-led Divisions. Our 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 its report of May 2019, the CQC found that there had been improvements in the Trust but that some Divisions were developing faster than others.

During 2018/19, we have been developing a Performance and Accountability Framework to support oversight of the Divisions and this framework will be in operation during 2019/20.

A schedule of Executive portfolios ('Who Leads on What') is well-established and is available to Management Board and Trust staff. It will continue to be reviewed periodically as part of the ongoing Executive Team and Board Development Programme, so that there remains clarity and assurance over capacity and capability with regard to leadership for all aspects of the Trust.

With regard to leadership capacity, capability and effectiveness at service level, during 2018/19 we have invested in training for service leaders in each of the divisions. The Trust also commissioned a review by the King's Fund of the Trust's Organisational Development, in response to which the Board established a People and Culture Committee. One of the roles of the Committee is to obtain assurance with regard to areas for improvement as identified by the King's Fund.

The last published report from a full inspection by the Care Quality Commission (CQC) was issued in May 2019. The overall rating for the Trust was that it 'Requires Improvement' to ensure full compliance with the registration requirements of the Care Quality Commission. This represented an improvement from the findings of the CQC in their report of June 2018 which resulted in the Trust being placed in Special Measures for Quality. Whilst the Trust is still in Special Measures, the CQC report of May 2019 confirms improvement in the Trust. In its report the CQC judged the Trust to be 'Good' for the domain of Caring, and 'Requires Improvement' in the domains of 'Safety, Effectiveness, Well-led and Responsiveness'. We look forward to welcoming the CQC team to the Trust again, so that we can demonstrate our continuing improvement.

In March 2019, the CQC also issued a Warning Notice relating to elements of the Trust's services in the Accident and Emergency Department. The CQC was particularly concerned about the waiting times in A&E, care of mental health patients and adequate numbers of nursing staff.

An action plan relating to all the recommendations made by the CQC has been established and its implementation is overseen by the Quality Programme Board (QPB) established by the Board of Directors for this purpose. This arrangement, and the rigor with which we are driving quality improvement through the QPB, was subject to Internal Audit review during 2018/19, providing *'substantial assurance'* that the control framework in place for delivery of the Action Plan was suitably designed and consistently applied.

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 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 additional costs, pressures on available staffing and on standards of patient experience and quality;
- the requirement to make very significant financial savings (>£26M) to limit the Trust's financial deficit, reduces the flexibility to invest in 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, especially with regard to diagnostic equipment and digital technology.

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".* Those Undertakings remain in place and 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 that 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 BAF to be subject to regular review by the Management Board, Board Committees 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. The extent of this demand, and the need for additional clinical space in the Trust, has been confirmed by an external review conducted by the Boston Consulting Group (BCG) commissioned by the Norfolk Great Yarmouth and Waveney STP. In compliance with the Undertakings, the Trust has developed plans to expand its capacity to treat patients.

During 2018/19, we expanded capacity in the Trust through opening our endoscopy unit and clinical research facility in the Quadram Institute. In addition, we created a new discharge suite (the Aylsham Unit) and an extension to the A&E Department for rapid assessment of patients arriving by ambulance. In the course of 2019/20, we will create a new interventional radiology unit, a dedicated centre for PET/CT scanning, a unit in Bowthorpe for renal dialysis patients and we will refurbish the Davison Unit at Cromer Hospital in partnership with Macmillan.

Our capacity to develop our services to meet the ongoing needs of our patient population on a sustainable basis will however require the availability of relevant capital funding and the significant constraints on the availability of capital represent a significant risk to the Trust.

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. We have developed a plan to create a Diagnostic and Assessment Centre to help 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 2018/19 the Trust also appointed a full-time Freedom to Speak-up Guardian to support staff in raising concerns and putting forward suggestions as to how we might make further improvement in the Trust and its services.

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 over 17,000 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 Patient Engagement and Experience Governance Sub-Board. In addition, during 2018/19 the Trust has appointed a Lead for Patient Experience and Engagement and established a Patient Panel, to strengthen the Patient Voice in the life of the Trust and in the development of its services.

Review of economy, efficiency and effectiveness of the use of resources
In 2016, 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. This information shows that the Trust has consistently low cost services compared with other Trusts, other than with regard to the PFI agreement.

An assessment by NHS Improvement of the Trust's Use of Resources was conducted in February 2019 and published May 2019. NHSI found that *"the Trust's performance across clinical services productivity metrics remains strong"* (p4) and that *"the Trust continues to compare well across workforce metrics, such as sickness and overall pay cost per WAU (Weighted Activity Unit)*" (p6). Overall the Trust was rated as 'requires improvement' for Use of Resources, reflecting deterioration in the Trust's overall financial position and non-achievement of a number of national operational standards (4-hour A&E wait, 18 week referral to treatment and 62-day cancer standards).

These two particular challenges (financial and operational performance) are inextricably linked, as reflected in the NHSI Use of Resources report. Very high levels of emergency demand, particularly in the extended winter months, has caused significant disruption to our elective surgery programme.

Not only does this delay treatment for patients who are awaiting booked procedures, it also results in a loss of income to the Trust (as elective work tends to attract a higher average tariff than non-elective work). This loss of income is further compounded by the additional costs inherent with treating high levels of emergency activity, through the need for employment of additional temporary staff and opening additional escalation areas to accommodate acutely unwell patients.

Our financial plan for 2018/19 involved a challenging savings target, together with delivery of very significant increases in clinical activity and income. During the year it became apparent however 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.

The underlying drivers of the Trust's financial deficit cannot be avoided. A central component of this 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.

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 2019/20 signed with the Trust's main Commissioners.

As part of providing assurance to the Board that resources are used economically, efficiently and effectively, the Audit Committee oversees the internal audit plan. The Trust's Internal Audit service 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 2018/19 we have continued to implement a web-based system for the transparent reporting of potential conflicts of interest. The Trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the national guidance on Managing Conflicts of Interest in the NHS.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations. Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. In particular, in 2018/19 the Board's People and Culture Committee has reviewed self-assessment data arising under the Workforce Race Equality Scheme (WRES) and has requested additional staff training, to strengthen our controls in this regard.

The Foundation Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its 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 Chief Nurse.

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.

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 Patient Engagement and 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 with particular regard to elective waiting time data. I note that two reviews were undertaken by our Internal Auditors during 2018/19 which concluded that the Board could take '*reasonable assurance*' with regard to Data Quality in both A&E performance reporting and with respect to relevant cancer metrics.

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 data and views reported. These are reflected as relevant in the final report.

Information Governance and Cyber Security

The NHS Information Governance Toolkit changed significantly in format for 2018/19 and became the Data Security & Protection Toolkit (DSPT). This change resulted in an increase from 45 requirements to 100 mandatory evidence items which are used to measure performance against the National Data Guardian's 10 data security standards. These standards are:

1. Personal Confidential Data
2. Staff Responsibilities
3. Training
4. Managing Data Access
5. Process Reviews
6. Responding to incidents
7. Continuity Planning
8. Unsupported systems
9. IT Protection
10. Accountable suppliers

The collection of evidence for the DSPT demonstrated that the new toolkit places a significant increase in emphasis on IT protection, cyber security, and ensuring that GDPR requirements in relation to data flows and data sharing, including completion of Data Protection Impact Assessments and contractual agreements, have been adopted as routine practice.

NHS Digital advised that for this DSPT assessment, organisations should aim to achieve a satisfactory standard by completing all of the mandatory evidence items and as many of the other non-mandatory items as possible. Despite, a huge amount of effort put into the DSPT work programme, the Trust has not yet successfully completed all the 100 mandatory requirements. The areas in which we were unable to collate evidence sufficient to gain assurance are as follows:

1. Evidence item 3.3.1 - 95% of the workforce need to complete the mandatory Information Governance training during the reporting financial year.
2. Evidence 4.1.2 - The organisation maintains a current record of staff and their roles for all systems they have access to.
3. Evidence item 4.1.2 - Staff roles are linked to IT accounts. Staff moves in, out or across the organisation are reflected by IT accounts administration.
4. Evidence 4.3.1 - All staff understand that their activities on IT systems will be monitored and recorded for security purposes.
5. Standard 10 - The organisation can name its suppliers, the products and services they deliver, the contract durations and that they are GDPR compliant.

Therefore the Trust's overall score was 'Standard Not Met' at the time of submission.

The classification of organisations under the DSPT is 'Standard fully Met', 'Standard Not Met', 'Standard Not fully Met – (Plan Agreed)'. The Trust submitted an action plan for the non-compliant mandatory evidence items which has been agreed by NHS Digital and therefore our assessment status is 'Standard Not fully Met – (Plan Agreed)'. This meets the requirement of our contracts with the CCG's and external suppliers.

The Trust continued to raise awareness of Information Governance and the importance of protecting personal information with its staff through a comprehensive training programme available online and face-to-face. To complement this learning, policies, guidance and best practice are made available to staff via the Trust's intranet.

The Information Commissioner's Office and NHS Digital has issued guidance with regard to preparation for data protection compliance if the UK leaves the European Union. Work is ongoing in the Trust to implement that guidance as the Brexit negotiations and parliamentary process proceeds.

Incidents relating to personal data are reported on the Trust's Incident Reporting Systems and reviewed at the Caldicott Approval Group and the Information Governance Steering group on bi-monthly basis. The lessons learnt are shared with staff 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 General Data Protection Regulation, Data Protection Act 2018 and the Caldicott principles. Information regarding personal data are reported to the Management Board through the Digital Transformation Committee.

Data Security and Information Governance risks are managed to achieve compliance with the Data Security and Protection Toolkit.

Identified risk is prioritised, control measures implemented, reviewed on a regular basis and escalated to the Trust's Risk Register as appropriate.

The Trust experienced and reported 3 Level 2 SIRIs to the ICO in 2018/19. The ICO concluded two of those incidents with no further action required. One incident is currently under investigation both locally and by the Information Commissioner's Office.

A summary of Level 1 and 2 data-related incidents reported during the year is shown below:

Category	Breach Type	Level 1	Level 2
A	Corruption or inability to recover electronic data	0	0
B	Disclosed in Error	15	0
C	Lost in Transit	3	1
D	Lost or stolen hardware	0	0
E	Lost or stolen paperwork	4	0
F	Non-secure Disposal – hardware	0	0
G	Non-secure Disposal – paperwork	5	1
H	Uploaded to website in error	0	0
I	Technical security failing (including hacking)	1	0
J	Unauthorised access/disclosure	14	1
K	Other	0	0
Total		**42**	**3**

Cyber Security Annual Summary

During the last 12 months the Trust has strengthened its cyber security arrangements through establishment of a dedicated cyber security team. This reflects the importance that cyber security now plays in hospital operations.

The Trust has completed the European Network and Information Security (NIS) Directive Gap Analysis Audit. Together with an external auditor we have identified several areas where the Trust needs to establish or refine processes, procedures and documentation in order to become compliant. This review highlighted the need to treat establishing compliance as a project and a project manager is being recruited accordingly. Although the UK is set to leave the EU, it is the expressed intention of the UK government that operators of critical services (we are in this classification) should remain compliant with the NIS Directive. This will also provide us with a good foundation for moving towards our objective of ISO accreditation.

The Trust has completed an IT Security Health Check Audit. This audit was more substantial than any previously undertaken at the Trust and was focused on our technical infrastructure. Several opportunities for improvement were identified, a remediation plan has been put into place and work continues to close the gaps highlighted.

A number of new security tools, technologies and procedures have been established. These aid with ensuring compliance not only with the NIS Directive and other best practice guidance, they also provide greater day to day security benefits. We now have much greater awareness of activity occurring on the Trust network and infrastructure. Thanks to new monitoring tools now installed, security events are highlighted for further investigation that previously would have remained unidentified.

The migration of our workstation estate to Windows 10 will introduce enhanced security features and, combined with the implementation of centralised security settings via an updated group policy and AD infrastructure, will see a more secure workstation environment deployed in-line with recommended best practice.

The reintroduction of mobile device management software now allows the Trust to manage mobile devices more centrally and more securely, allowing our staff to take advantage of new mobile technologies and tools.

The recent migration of our email environment to Microsoft Office 365 (o365) will allow us to take advantage of the tools and knowledge available to better secure our email system, with the aim of increasing our current Microsoft Secure Score.

Other tools that will be implemented over the next 12 months include the Osirum credential management and auditing tool. This will allow for the better management of access rights for our users and ensure greater data integrity, confidentiality and availability.

The last 12 months has seen no severe technical security failings however with the new monitoring tools and technologies now in place we are in a better position to identify, remediate and record any such events.

Over the year, the Trust has experienced an increase in email phishing activity, reflecting a trend seen worldwide. Email phishing is where users are sent an email with the goal of either coercing the recipient into opening a link to a fraudulent website, downloading malicious software, giving up personal details such as their computer login details with the intention of performing malicious activity or attempts to extort the user into providing some form of payment.

Since the migration to o365, Microsoft and the configuration options we have put in place, have stopped approximately 86,000 of phishing threats from being delivered to Trust recipients. The migration to o365 provides tools and techniques to help further prevent such emails from being delivered, however given the scale of activity and its constant changing nature it is inevitable that some will get through to our users. By implementing an education and testing regime and combined with other best security practice, the Trust can further reduce the impact of phishing emails.

The next 12 months will see the expansion of the IT security team with two additional cyber specialists joining in addition to the project manager. The team's primary goal will be establishing NIS compliance and establishing Cyber Essential Plus accreditation. This will be in addition to ensuring that the Trust follows security best practice across its IT infrastructure.

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 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, Audit Committee and Quality and Safety 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 metrics that are agreed as indicative 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 areas of notable or 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*". As recommended by PWC we have continued to evolve the IPR and a new version is developed for launch during 2019/20 to further enhance the clarity and richness of information available to the Board and all levels through the Trust's governance structure.

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 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 is a member of the Trust's Clinical Safety and 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. The Plan is informed by previous internal and external audit work and discussion with the Executive Team.

The Trust's internal audit function is outsourced (to provide enhanced objectivity) and is provided by RSM. The work of internal audit is overseen by the Trust's Audit Committee which agrees the audit plan 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.

During 2018/19, Internal Audit completed 12 audits resulting in a formal assurance opinion. Of these, 7 confirmed that the Board could take either substantial or reasonable assurance that effective controls are in place. In 4 areas, ((i) External Reporting and Sign Off Processes; (ii) Procurement (Theatres); (iii) Tender Waivers; and (iv) Consultant Job Planning) the result was a partial assurance report. In each of these, actions to implement all recommendations have been identified and progress in implementing these actions is overseen by and regularly reported to the Audit Committee. Based on the work undertaken in 2018/19, 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 to accommodate patients; and in the frustration 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. Our ability to develop services to meet the ongoing needs of our patient population on a sustainable basis will however require the availability of capital funding and close liaison with our partners across the STP. The severe limitations to availability of capital must be noted as an item of concern with regard to the future sustainability of services. The vulnerability and immaturity of our IT infrastructure is only too evident and must also be addressed if the Trust is to be able to operate more efficiently. Likewise the need for replacement and supplementation of our ageing equipment is essential if the Trust is to deliver the national performance standards, particularly in relation to cancer. As NHSI found in its Use of Resources report (May 2019) "*the Trust's aged MRI and CT equipment have contributed to capacity constraints*" and we need to replace our scanners if we are to reliably provide patients with timely diagnostic investigations.

In his 2018/19 Annual Opinion, the Head of Internal Audit 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. The Trust remains resolute in its commitment to continuous improvement and to enhancing its financial and operational sustainability, in order to maintain its journey to being 'outstanding' in its delivery of the best possible care to our patients.

Signed:

Mark Davies
Chief Executive

Date: 29 May 2019

Approval of the Accountability Report

I confirm my approval of the Accountability Report.

Mark Davies
Chief Executive

Date: 29 May 2019

Quality Report 2018/19

Chief Executive's Statement on Quality

Information about this Quality Report

The Care Quality Commission Inspection between October 2017 and March 2018, published in June 2018, found the Trust had some outstanding practice and care. However, it also found that there were areas of poor practice, management and leadership that resulted in an overall rating of "Inadequate". The Trust Board fully accepted the findings of the CQC report but has remained committed to working with staff, patients, carers, partners and other stakeholders to improve the care provided to patients.

The inspection ran over 5 months, during and since that time, whilst we know and fully understand we have much to do, we have made many improvements to our estate and services: Children's ED moved its location and increased its capacity from 3 to 15 spaces; and the UK's first Older People's Emergency Department – to provide specialist care to patients over 80 years of age - opened as an extension of the A&E department in December 2017

The CQC revisited the Trust between January and February 2019. Their report was published in mid-May and said there had been great improvements at the Trust since March last year, raising the overall rating from "inadequate" to "Requires Improvement", though the Chief Inspector of Hospitals has recommended that the Trust remain in special measures. Recommendations were made to continue with improvements to cultural change and openness, mandatory training, record and medicines security, leadership development, and staffing levels.

I was pleased to see that special mention was given to a number of areas of outstanding practice including robotic surgery, Quick Response bar codes (QR) in theatres and Day Procedure Unit, improvements in critical care, with the new protocol to admit patients within one hour, and high levels of support for junior doctors

Whilst it is important to acknowledge our failures and continue on our Journey to Outstanding, we must also remember that there is a great deal to celebrate and commend.

We have introduced daily Serious Incident Group meetings, where all staff members are welcome to meet and discuss incidents that have occurred in the previous 24 hours in an open and non-confrontational setting. The initial information available regarding the incident is discussed and a decision is made about whether it meets the threshold for external reporting as a serious incident and the depth of investigation. These meetings have become increasingly well attended and will regularly see 20-30 staff meeting to discuss incidents and agree a way forward for them.

The number of whistle blowing issues raised with external stakeholders has reduced significantly which is a positive indication of the success of our new systems for speaking up. The Management Board now receive monthly updates on 'speak up' issues in order to increase its oversight of issues. A fulltime Speak-Up Guardian was recently appointed and joined us in March. This is an exciting appointment and the next step on our journey towards developing a value-based organisational culture more closely aligned with staff and public.

The Gastroenterology department has moved some of its services to the state-of-the-art Quadram Institute and welcomed its first patients in December 2018. The multi-million pound facility on Norwich Research Park will be able to conduct at least 40,000 procedures a year, making it one of the largest endoscopy centres in Europe, providing world class facilities for our patients.

A major expansion of radiology and cardiology services is also being planned in 2019. The number of interventional radiology and cardiology procedure rooms (cath labs) will increase from four to eight as part of the construction project, which will add an extra level on to the East wing of the hospital.

We are proud of our links and history of working with Veterans. The Veterans Covenant Hospital Alliance has accredited the Trust as a Veteran Aware Hospital in recognition of our work identifying and sharing best practice for care of members of the armed forces. We have also received the Gold Award for our work in supporting Defence People under the Ministry of Defence Employer Recognition Scheme and invited to join the Gold Alumni Association.

In January 2019, we celebrated three years of saving and transforming cancer patients' lives through robotic surgery. Robotic surgery has helped us improve our outcomes and provide a better experience for patients with quicker recovery and a shorter length of stay in hospital. We are a busy hospital with a high volume of cases and have reached 750 cases in three years, a symbol of our highly developed level of expertise in robotic surgery.

Our Friends and Family Test score remains high at over 96% in December 2018. The number of medication errors reported has continued on an upward trend with the vast majority causing low or no harm which is a positive indication of our reporting culture and we continue to widely share learning outcomes from these incidents in order to prevent recurrence of errors in the future.

The Trust's Pressure Ulcer Collaborative Team was awarded the peer nominated award for the most innovative pressure ulcer reduction initiative, and in January this year, Earsham and Dunston Wards each achieved 100 days without a patient developing a pressure ulcer, whilst Cley Ward marked 200 days free!

Our Quality Improvement Plan is focused on the immediate priorities arising from the 2018 Care Quality Commission inspection and in setting the baseline from which to develop our longer-term objectives and priorities.

Our Quality and Safety Improvement Strategy is just as explicit. It describes a five-year forward view of quality improvement and sets out how we will define, improve and assure the quality of our services and supports our 'journey to outstanding'. It aims to give our staff a clear focus and reflects the importance and commitment the Trust Board places on the quality of care and the requirement to continually learn and improve to meet the evolving demand and expectation of our patients and staff.

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

Priorities for improvement

The table below (Table 1) details the Trust's Quality Priorities for 2019/20. 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, patient and carer feedback, quality monitoring from commissioners, internal reviews of the quality of care provided across services, and staff suggestions.

Table 1

1.0 Quality Domain – Patient Safety To eliminate avoidable harm to patients in our care as shown through a reduction in number of incidents causing moderate harm and above due to lapses in care or failure to respond by 2023.		
The achievement of the Quality Priorities will be monitored through the monthly Integrated Performance Report and relevant sub boards.		
Improvement aim	**Baseline position 18/19**	**2019- 2020**
1.1 Reduction of hospital acquired pressure ulcers (HAPU)caused by lapses in care We will reduce Hospital acquired pressure (HAPU) ulcers by at least 20% per cent in year one.	Category 4 : 0 Category 3 : 49 Category 2 : 234 Unstageable Baseline to be agreed to be agreed in Q1 (2019/20)	Category 4: zero occurrence of hospital acquired pressure ulcers <40 x grade 3 HAPU per annum - demonstrating a 20% reduction Category 2 < 180 grade 2 HAPU per annum demonstrating a 20% reduction % age reduction to be agreed in Q2
1.2 We will continue to develop strategies that reduce the number of patients who fall and reduce the number resulting in moderate harm or above whilst under our care	23 – falls moderate harm or above Total number of falls 2154	< 20 falls 25% reduction in falls causing moderate or above harm Percentage reduction in falls to be agreed in Q2
1.3 Three high impact actions to prevent Hospital Falls (CQUIN)	Baseline to be agreed in Q1 (2019/20)	Achieving 80% of older inpatients receiving key falls prevention actions 1. Lying and standing blood pressure 2. No hypnotics or antipsychotics or anxiolytics given during stay OR rationale for giving hypnotics or antipsychotics or anxiolytics documented 3. Mobility assessment documented within 24 hours of admission to inpatient unit stating walking aid not required OR walking aid provided within 24 hours of admission to inpatient unit

1.4 We will have zero 'never events'.	6 never events	zero
1.5 Standardise processes to improve early detection of deterioration, and ensure timely response	Emergency Department (ED)sepsis screening 81%	95% of patients who met the criteria for sepsis screening were screened for sepsis.
	In patient sepsis screening	95% of patients who met the criteria for sepsis screening were screened for sepsis.
	Sepsis 6 compliance ED 92%	95% patients
	Sepsis 6 compliance In patients	95%
	NEWS 2	95% of admitted patients will have observations recorded accurately using NEWS2
1.6 We will reduce the number of out of-CCC/ED cardiac arrests calls from 2018 baseline	Number of out of CCC and ED cardiac arrest calls Baseline to be agreed Q1 (2019/20)	% reduction in the number of cardiac arrest calls agreed in Q1
1.7 To create and maintain a network of appropriately skilled ward based paediatric link nurses	Baseline to be agreed in Q1 (2019/20)	%age of named children link nurses have paediatric competences

2.0 Quality Domain – Clinical Effectiveness
People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence
Development and use of systems and structures that promote learning across the organisation and services.

Improvement aim	Baseline position 18/19	2019- 2020
2.1 Reduce inappropriate antibiotic prescribing, improve diagnosis (reducing the use of urine dip stick tests) and improve treatment and management of patients with UTI. (CQUIN)	Agree baseline in Q1 (2019/20)	Achieving 90% of antibiotic prescriptions for lower UTI in older people meeting NICE guidance for lower UTI (NG109) and PHE Diagnosis of UTI guidance in terms of diagnosis and treatment.
2.2 Reduce the number of doses used for colorectal surgery and improve compliance with antibiotic guidelines	Agree baseline in Q1 (2019/20)	Achieving 90% of antibiotic surgical prophylaxis prescriptions for elective colorectal surgery being a single dose and prescribed in accordance to local antibiotic guidelines

2.3 Improve the effectiveness of care through participation in research with a year on year increase in the number of patients recruited into research studies	TBC YTD Feb 2019 4352	10% increase from 2018 -2019 baseline
2.4 We will ensure mortality reviews are carried out using a standardised format whenever a patient dies in our care.		10% of in hospital deaths undergo Structured Judgement Review (SJR)
2.5 We will ensure Serious Incident investigations are carried out using a standardised format and improvement actions implemented to prevent recurrence	2018 SI Report submission compliance 53%	95% Serious Incident investigations are fully completed within 60 days
	To be agreed Q1 (2019/20)	95% of action plans completed from complaints and serious incidents within agreed timescales
	Duty of Candour compliance 81%	95% of duty of candour letters issued within 10 days
2.6 Evidence that themes from serious incidents, complaints and mortality reviews are utilised to prioritise our improvement programmes. Quarterly thematic reviews across SI's complaints and SJR process are shared trust-wide	Baseline taken from Thematic review for 2018/19 Q1	Reduction in recurring themes identified from baseline review Quarterly thematic reviews across SI's, complaints and SJR processes are shared Trustwide.
2.7. 100% of children and young people requiring high dependency or critical care are looked after in dedicated environment	Baseline to be agreed in Q1 (2019/20)	Improvement trajectory agreed in Q2

3.0. Quality domain : Carer & Patient Experience; Improve how we listen and respond to patients and their carers/ families going forward and use patient feedback and experience to design and improve services.		
Improvement aim	**Baseline position 18/19**	**2019- 2020**
3.1 We will improve our score in the national inpatient survey relating to responsiveness to patients' personal needs (five questions from national survey).	1: 55% 2: 52% 3: 14% 4: 82% 5: 62%	10% improvement in scores across the selected questions 1: Patients were involved as much as they wanted to be in decisions about care and treatment? 2: felt they were involved in decisions about discharge from hospital? 3: were asked to give views on the quality of their care? 4: felt care and support they expected was available when they needed it? 5: were able to get a member of staff to help within a reasonable time?
3.2 Personalised care and support planning and compliance with Accessibility Information Standard	Baseline compliance to be confirmed in Q1 (2019/20).	The Accessible Information Standard aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need from health and care services. Baseline survey and audit to be developed by Q3 and improvement actions agreed for Q4
3.3 We will increase our responsiveness to complaints and reduce their overall number of formal complaints	Response time 68% (December 2018) Number of formal complaints 1035	Agree performance improvement in Q2
3.4 Improvement in scores in key questions of National staff surveys Safety Culture Responding to incidents Ability to make improvements	75% Q7a 57% Q17a 66% Q17c 59% Q17d 65% Q18b 50% Q18c 67% Q21b 72% Q4b 48% Q4C 46% Q4d	10% improvement across the range of questions Q7a: am satisfied with the quality of care I give to patients / service users Q17a: My organisation treats staff who are involved in an error, near miss or incident fairly Q17c: When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again Q17d: We are given feedback about changes made in response to reported errors, near misses and incidents Q18b: I would feel secure raising concerns about unsafe clinical practice Q18c: I am confident that my organisation would address my concern Q21b: My organisation acts on concerns raised by patients / service users Q4b: I am able to make suggestions to improve the work of my team / department Q4C: I am involved in deciding on changes introduced that affect my work area / team / department Q4d: I am able to make improvements happen in my area of work

3.5 Age appropriate patient and family feedback mechanisms in place across the Trust to ensure that children and young people are always asked about their experience of the services they use.	Agree baseline and improvements in Q1 (2019/20)	Increased response rate from children, young people and their families (from agreed baseline)

Progress against our 2018/19 priorities

Table 2 describes the Trusts high level assessment of achievement against the 2018/19 priorities set within the 2017/18 Quality Report. Following this there is a more in depth review of each category.

Table 2

Rating Key

Red – Quality priority not achieved

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

Green – Quality priority achieved

	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	
	Change: Prompt recognition and treatment of deteriorating patient	• % of patients screened, and % of patients treated for sepsis • 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	CQUIN criteria	
	Increase safety through improved teamwork and better communication	• 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		
	Improvement in frailty provision and care	• Number of Comprehensive Geriatric Assessments completed at 'front door'. • National Audit of Dementia • Number of inpatient falls (age related) Number of avoidable pressure ulcers (age related)		

	Priority	Measure	Goal	Rating
Clinical Effectiveness	Keeping patients safe from infection	No. of hospital attributable C Diff cases Number of hospital acquired MRSA bacteraemias		
	Improve quality of care through research	Numbers of patients recruited into NIHR studies	3,300 recruitment into NIHR studies	
	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	7 day services survey	The NHS seven day services programme is designed to ensure that patients who are admitted as an emergency receive high quality consistent care whatever day they enter hospital. The Trust's five year strategy includes an objective to "Implement further measures to achieve a 24/7 acute hospital service"	
Carer and Patient Experience	To improve our care to those at the end of their life	• DNACPR compliance • Individualised care plans • Specialist palliative care coding rates • Quarterly Local EoL care audit National EoL care audit		
	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	
	To improve the assessment and quality of care for patients in Mental Health crisis	• Number of referrals to Psychiatric liaison from: • ED/ assessment areas (where) • Wards (and where). • Waiting time from referral to assessment • standard 1hr ED, 4hrs • 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. Patient feedback via FFT (not sure this is feasible but we should try)		

New tests to benefit rhesus negative pregnant women

The maternity department at NNUH is introducing a new test for rhesus negative pregnant women which will establish earlier in pregnancy whether they share their blood group with the baby they are carrying.

Women who have a rhesus negative blood type do not have a substance known as ‘D antigen’ on the surface of their red blood cells. In cases where these women do not share a blood group with their fetus, the woman’s immune system can develop antibodies against the rhesus (Rh) antigens carried by the baby causing potential harm.

To prevent this potential for harm, mothers are advised to receive an injection of anti-D, a treatment which prevents the production of these antibodies, at around 28 weeks of pregnancy and again shortly after birth, if the baby’s blood type has been established to be Rh positive. These injections can be painful and in some cases it can be necessary to administer further injections during the pregnancy because of sensitizing events.

Advances in laboratory technology mean that it is now possible to safely identify a baby’s blood type much earlier in pregnancy through a simple blood test, rather than waiting until the baby is born. The blood test will identify free fetal DNA from the baby in the mother’s blood and allow clinicians to understand whether or not women will require the anti-D treatment at this stage.

These developments will minimise unnecessary exposure to anti-D for pregnant women, as where it is definitively established that mother and baby share blood status, the injections will no longer be required.

April 2018

Patient Safety – Reduce medication errors focussing on insulin

What was our aim?

To have zero insulin errors causing National Patient Safety Agency (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 Incidents Review Group (subgroup of the Medicines Management Group) with a subsequent report to the Clinical Safety and Effectiveness Sub Board and Prof Jeremy Turner, Consultant Endocrinologist, who is developing an insulin strategy for the Trust.

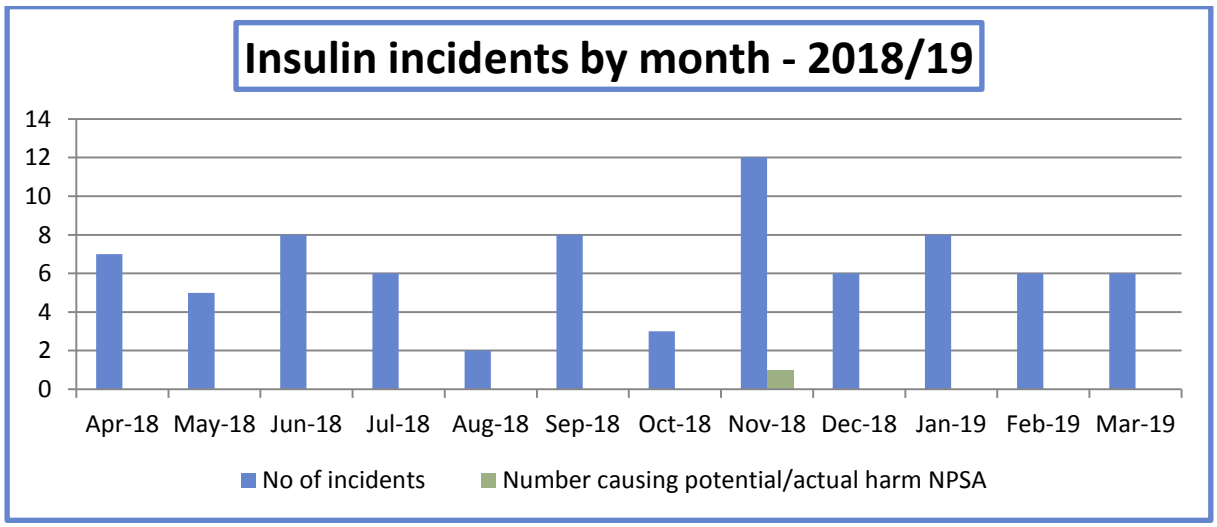
How did we do?

At the end of 2018/19 there had been one insulin error classified as causing 'moderate harm' according to NSPA category definitions. The incident involved a patient who was a newly diagnosed diabetic, who was discharged with no training or follow-up plan and subsequently re-admitted with hypoglycaemia.

Initiatives put in place aimed at the reduction of incidents involving insulin include:

- Pharmacy has appointed to the newly established role of Specialist Pharmacist for Endocrinology. The Specialist Pharmacist takes part in the newly introduced twice weekly diabetic ward rounds with a Consultant Endocrinologist to review the high risk diabetic patients in the Trust.
- A checklist for commencing Variable Rate Insulin Infusion in adult surgical patients has been developed and approved.
- A proposal to make changes to the Electronic Prescribing and Medicines Administration system (EPMA) that would minimise the risk of medication errors occurring involving insulin has been submitted to local and regional EPMA User Groups. If supported the proposal would then go to the National Group to recommend that the modifications set out in the proposal should be adopted by the provider JAC.
- A poster for display on wards and other relevant areas with pictures and information on insulins with similar-sounding names has been updated.
- The Specialist Pharmacist for Endocrinology is working with the Diabetes Team to review and improve the procedure for patients to self-administer insulin and monitor their own glucose levels whilst in hospital.

Insulin incidents by month



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

What was our aim?

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

How did we measure our performance?

- Sepsis CQUIN metrics

How did we do?

Trust performance during 2018-19 was measured using national Commissioning for Quality and Innovation (CQUIN) stipulated Key Performance Indicator (KPI) criteria

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.

The results for 2018 are as follows:

Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18
82%	82%	86%	82%	84%	88%	75%	74%	77%	81%	90%	82%
83.3%			84.6%			75.3%			84.3%		

The sepsis lead consultant is currently leading a working group (supported by the Chief Operating Officer and Chief Information Officer) with an aim to procure and implement an electronic observation system at NNUH during 2019/20 and with the introduction of this we would expect (in line with experience from other Trusts nationally), inpatient screening performance to improve dramatically. The Sepsis Lead has presented the case for E-Observations at the Clinical Informatics Group and this has been approved as a priority. The Sepsis Lead has also presented the case to the Hospital Management Board and priming funding has been approved to progress to the development of a full business case. In October the Outline Business Case for Electronic Observation was presented to the Hospital Management Board and approved in principle

Performance remains excellent in both the emergency and admission sepsis groups with 91% patients receiving antibiotics within an hour of diagnosis. This is in keeping with previous performance and reflects well embedded pathways for the prompt delivery of antibiotics in sepsis in both admission and inpatient areas and a continuous educational programme is in place for medical staff across the NNUH about the importance of timely sepsis management.

Jan 18	Feb 18	Mar 18	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sept 18	Oct 18	Nov 18	Dec 18

94%	92%	92%	97%	90%	92%	89%	94%	92%	91.5%	88.7%	96%
92%			92%			92%			91.3%		

The NNUH sepsis processes are included within induction for new doctors, are incorporated into the annual Foundation Year Teaching program and are taught on the Acute Life Threatening Events – Recognition and Treatment (ALERT) and Deteriorating Ward Patient (DWP) courses. Key facts training on the inpatient sepsis pathway is included within the NNUH mandatory training program having been incorporated within the mandatory annual resuscitation training for all clinical staff.

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

What was our aim?

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 did we measure our performance?

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

How did we do?

A **PROMPT** Human Factors Training programme (PROMPT = **PR**actical **O**bstetric **M**ulti-**P**rofessional **T**raining) was devised and introduced into Obstetrics and Gynaecology during 2018, with an aim to develop an understanding of what human factors are and how they influence outcomes in maternity care by exploring the vital role that nontechnical skills play in improving team working, communication and patient safety. It aimed to improve maternity outcomes and staff satisfaction through development of individual and team human factors skills.

16 staff attended a 'train the trainers' session in October 2018 – 9 Midwives and 7 Doctors from Anaesthetics and Obstetrics. Of the 300 staff invited to attend the training, 88.9% have attended in total, including 92.4% of all midwives. The course has now been opened up to other related staff groups, including Theatre staff, although capacity is limited.

Although the PROMPT programme is aimed specifically at obstetrics and gynaecology services, the Human Factors content is fairly generic and could be adapted for other departments and staff groupings.

In July 2018 the Norfolk and Norwich University Hospital initiated a human factors training project within the operating theatre surgical teams to develop their understanding and awareness of human factors in their workplace. This was achieved through half day workshops delivered to multidisciplinary staff groups and 3 day workshops delivered to key multidisciplinary staff who have since developed an in house training programme.

The human factors training programme at the Norfolk and Norwich University Hospital commenced in January 2019 after planning meetings agreed how the training was to be initiated.
This included the utilisation of a human factors e-learning course available through the NHS Electronic staff records, learning management course catalogue. This e-learning course provides the foundations of human factors training which is then explored and built on through discussion, interactive workshops and simulation training with small groups of staff on a monthly basis. Half day workshops were attended by 80 staff, 3 day workshops were attended by 15 staff who are now involved in the delivery of human factors training. The in-department workshops have supported the development of a further 51 staff.

Feedback gathered from the in-department workshops has been positive and well received. Staff have identified that human factors training has helped them to understand the importance of good communication and team work, about how seemingly small changes and events can easily add up to a significant error and that the in-department training enables them to consolidated eLearning and knowledge, good to recap for safety, good to discuss with teams, must foster better outcomes.

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

What was our aim?

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

How did we measure our performance?

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.

How did we do?

Ordinary admissions discharged in month who are flagged as having frailty

MonthYear	Discharge Month	Frail Inpatient Discharges
Apr-18	30/04/2018	690
May-18	31/05/2018	760
Jun-18	30/06/2018	753
Jul-18	31/07/2018	688
Aug-18	31/08/2018	740
Sep-18	30/09/2018	649
Oct-18	31/10/2018	740
Nov-18	30/11/2018	675
Dec-18	31/12/2018	740
Jan-19	31/01/2019	793

ED Attendances that were screened for frailty

MonthYear	Discharge Month	Total Frailty Screenings in ED
Apr-18	30/04/2018	1391
May-18	31/05/2018	1554
Jun-18	30/06/2018	1325

Jul-18	31/07/2018	1388
Aug-18	31/08/2018	1552
Sep-18	30/09/2018	1550
Oct-18	31/10/2018	1413
Nov-18	30/11/2018	1470
Dec-18	31/12/2018	1502
Jan-19	31/01/2019	1709

Clinical Effectiveness - Keeping patients safe from infection

What was our aim?

- *Methicillin-resistant Staphylococcus aureus* (MRSA) blood stream infections (BSI), to have 0 cases of hospital attributable cases
- *Clostridium difficile* infection (CDI) to be under the trajectory target of 48 hospital attributable cases

1. **Reducing Gram Negative Blood Stream Infections (BSIs)**

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

E. coli BSI figures have been published by Public Health England since 2011. In 2017 it also became mandatory to submit *Klebsiella spp.* and *Pseudomonas aeruginosa* blood stream infection data to PHE.

How progress will be achieved, monitored and measured

The NNUHFT Infection Prevention and Control Team (IPCT) will continue to collect and review surveillance data for all Gram negative BSIs and complete enhanced mandatory surveillance for any healthcare-associated Gram-negative BSI.

NNUHFT IPCT and the Antimicrobial Stewardship Team will enforce the following measures to reduce healthcare associated Gram negative BSIs in 2019/20 :-

- Update the Trust guidelines for the use and care of urethral and suprapubic catheters and the urinary catheter monitoring chart.
- Provide guidance on when it is appropriate to dipstick urine and why.
- Provide guidance on collecting urine samples and provide a patient information leaflet on Urinary Tract Infection (UTI).
- Implement the Antibiotic CQUIN 2019/20 Diagnosing and Treating UTIs in the over 65's.
- Enforce principles of good antimicrobial stewardship through education, dedicated antimicrobial stewardship ward rounds and audits, and use of supportive national guidance such as Start Smart Then Focus
- Continue collaboration with other Norfolk acute, community and CCG infection Control teams who are participating in the Norfolk Urinary Tract Infection Collaborative project (NUTIC) to improve the quality of urine sampling across the county, and decrease unnecessary sampling and antimicrobial treatment.
- Review the safety thermometer data for the Trust: number of catheters and catheter associated urinary tract infections (CAUTI).

•

2. Carbapenemase-producing Enterobacteriaceae (CPE)

Public Health England (PHE) has said "*the spread of **Carbapenemase-producing Enterobacteriaceae** (CPE) is a matter of national and international concern as they are an emerging cause of healthcare-associated infections, which represent a major challenge to health systems. CPE remains a significant concern because the trend in detections is increasing on a year-on-year basis. Infections caused by CPE are associated with an increase in morbidity, attributable mortality, and healthcare costs".*
PHE publications gateway 2019

How progress will be achieved, monitored and measured
The PHE acute trust toolkit for the early detection, management and control of carbapenemase-producing Enterobacteriaceae (CPE) 2013 is embedded in the Trust guidance for staff to follow. It provides practical advice for the management of colonisation or infection, risk assessment tools and patient information leaflets. The toolkit has been reviewed and during 2019 a Framework of Actions to contain CPE will be published. The IP&CT will update the Trust guidance accordingly.

The IP&CT will continue to collect and review surveillance data for CPE positive cases and complete enhanced surveillance for any new cases of CPE identified.

CPE figures will be reported to the Board via the Integrated Performance Report (IPR).

3. IP&C Improvement Programme

In February 2019 the Trust was risk rated as red for IP&C following an IP&C inspection by NHSI. An IP&C rapid recovery plan was put in place and will continue into 2019/20.

How progress will be achieved, monitored and measured
IP&C and Quality Improvement Teams are working with the clinical teams to support the improvement programme ahead of the NHSI return visit in July 2019. IP&C recovery action plans are in place with measures for improvement e.g. cleaning and IP&C audit results. Monitoring will be via oversight meetings and as part of the QIP programme.

A series of Matrons and Ward manager master classes and education will commence. The IP&C link practitioner programme has been reviewed and the divisions have made a commitment pledge to increase the number of link practitioners so that there is at least one in each of the clinical areas.

A communication strategy has commenced to ensure that audit results, changes made and outcomes reach all staff within teams and that learning is shared.

How did we measure our performance?
Since April 2004 it has been mandatory for NHS acute Trusts to report all cases of MRSA BSI. Also CDI for patients aged 65 years and over. For CDI in April 2007 this was then extended to include all cases in patients aged 2 years and over.

Public Health England uses the surveillance data we send to produce spread sheets and graphs that we used to measure our performance against other acute Trusts.

Internally the Infection Prevention and Control (IP&C) monthly report continues to be distributed with surveillance and alert organism data in graphs and tables updated monthly. Local CDI and MRSA BSI data by ward is available to staff on the IP&C dashboard as part of on-going surveillance. Results are monitored via the hospital infection control committee.

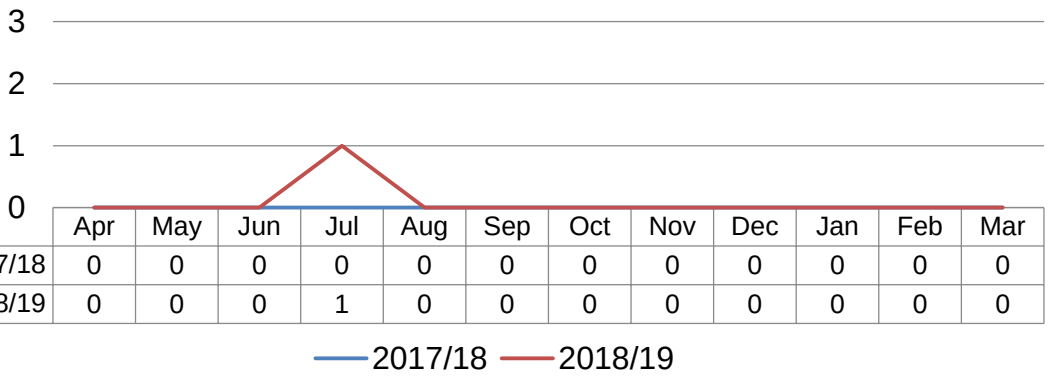
For any hospital attributable cases of MRSA BSI and CDI the clinical teams from the hospital and IP&C nurses from the clinical Commissioning Group (CCG) and the hospital review every case.

The post-infection review process establishes whether there have been any lapses in care that can be learnt from. Learning is then shared throughout the Trust via the monthly IP&CT organisational wide learning [OWL] and as part of the divisional governance meetings.

How did we do? MRSA BSI

The Trust 2018-19 MRSA BSI objective was 0 hospital acquired cases and the Trust had **1** case. A post infection review meeting was undertaken and the overall impression was that the positive blood culture was unlikely to represent a genuine MRSA infection.

MRSA HAI BSI Cases

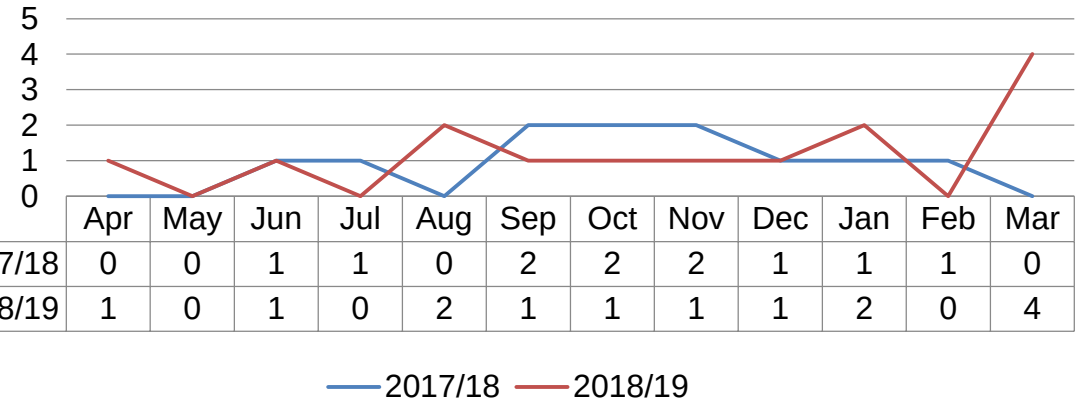


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	0	0	0	0	0	0	0	0	0	0	0	0
2018/19	0	0	0	1	0	0	0	0	0	0	0	0

How did we do? CDI The CDI objective was to stay below 48 hospital attributable cases which we have achieved, along with an improvement on the 2017/18 figures, see table 1. The final total was **31** CDI cases deemed to be hospital acquired. We successfully appealed **17** cases resulting in a final trajectory target total for the year of **14**.

Table 1 CDI summary all cases	Non-Trajectory	Trajector	Pending	Total
Quarter 4	**2**	**6**	**0**	**8**
Quarter 3	**1**	**3**	**0**	**4**
Quarter 2	**8**	**3**	**0**	**11**
Quarter 1	**6**	**2**	**0**	**8**
April 18 to March 19	**17**	**14**	**0**	**31**
April 17 to March 18	***24***	***11***	***0***	***35***

HAI CDI Cases (excluding non-trajectory)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	0	0	1	1	0	2	2	2	1	1	1	0
2018/19	1	0	1	0	2	1	1	1	1	2	0	4

Helping to develop tailor-made treatments

More than 500 people have joined a groundbreaking project at NNUH to help develop tailor-made treatments.

The world-leading 100,000 Genomes Project was launched two years ago to sequence 100,000 complete sets of DNA from patients with cancer and rare diseases.

Almost 350 cancer patients at the NNUH have so far opted for their blood and tissue samples to be sequenced as part of the nationwide scheme, which will help to develop new clinical trials and targeted treatments for a range of cancers. More than 200 participants have also been recruited to the rare diseases part of the project.

The NNUH started recruiting patients with colon, kidney, testicular and ovarian cancers when 100,000 Genomes Project launched in 2016.

Matt Keeling, Cancer Manager at the Trust, said the initiative had been extended to include head and neck, skin, prostate, breast, endometrial and blood cancers.

He said: “For the last 50 years we have been diagnosing cancers under the microscope and the future of cancer diagnostics will be through sequencing DNA. Cancer starts with a mutation in our genetic make-up, which triggers an uncontrolled growth of cells. If we can identify where the mutation has occurred in the DNA makeup, we can tailor a treatment that is known to be successful with that cancer.

“There is nothing else like this in the world. With some cancers such as colorectal and some lung and skin cancers we already have targeted treatments because patients have a specific mutation in their DNA.”

The NNUH is one of the country’s biggest cancer centres and diagnoses almost 2% of all cancers in the UK.

May 2018

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 increased recruitment into NIHR studies in 2019-20.

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 2018/19, our total recruitment was 4112 compared against 2017/18 recruitment of 3884.

The chart below shows that at the end of February we achieved our stated goal of recruiting 3300 participants into National Institute of Health Research (NIHR) studies in 2018/19.

Recruitment into Research Studies

Recruitment for 18/19	Number	Percent
Portfolio recruitment target	3300	
Total Recruitment	4122	
NIHR Portfolio	3702	90%
Non Portfolio	420	10%
Commercial Studies	163	4%
Non Commercial Studies	3959	96%

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 375 clinical research studies (335 in 2017/18) in a wide range of medical specialities during 2018/19. 112 new studies were opened in 2018/2019 (104 in 2017/18). There were around 150 clinical staff (Consultants) participating in research approved by a research ethics committee during 2018/19; 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 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 2018/19 building work has finished on the Quadram Institute (QI). The Clinical Research Facility (CRF) in QI, which is committed to becoming the leading facility for undertaking human health and nutrition research trials in the UK, opened its doors to research participants in September 2018. 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.

Clinical Effectiveness – 7 Day Services

What was our aim?

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 executive 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.

How did we do?

Standard		Mar 2018	Mar 2020	NNUH Assessment of compliance by March 2020
2	Time to first consultant review within 14 hours of admission	Target = 50% **Actual = 69%**	Target = 100%	To achieve compliance, investment in resources will be required. All specialties are reassessing rotas and capability. Any requirements to deliver will be signed off by divisions.
5	Part a - Availability – scheduled seven-day access to diagnostic services: Part b - Performance - Consultant-directed diagnostic tests and completed reporting will be available seven days a week: 1 hour for critical patients; 12 hours for urgent patients and 24 hours for non-urgent patients	Availability Target = 50% **Actual = 94%** Performance Target = 50% **Actual = N/A**	Target = 90%	NNUH are currently assessed on availability of scheduled access to diagnostic tests and not the performance targets. 100% compliance to scheduled availability will be achieved in summer 2019 with a new seven day echocardiography service. To achieve compliance against the performance targets investment in resources is likely to be required. NNUH are currently aligning Diagnostic Imaging requesting and reporting to the seven day services performance standards through the Norfolk Imaging Alliance (NNUH, James Paget University Hospital and Queen Elizabeth Hospital) and developing an internal workforce gap analysis to be signed off by the Clinical Support Services division.
6	Access to consultant-directed interventions	Target = 50% **Actual = 100%**	Target = 100%	NNUH intends to maintain 100% compliance to this standard
8	Ongoing review by consultant, twice daily for high dependency patients, daily for others	Target = 50% **Actual = 97%**	Target = 95%	March 2020 targets are being achieved with current processes

Key results / themes of the internal autumn 2018 audit:

- 72% of patients received a consultant review within 14hrs.
- Compliance is lower if a patient is admitted in the afternoon (between 13:00-18:00) than in the morning / evening - 55% in the afternoon compared to 80% at other times – see table 1.
- There was no marked difference in weekend (75%) v weekday (71%) performance.
- 89% of patients received a senior review from an ST3+ within 14 hrs.

▪

	Autumn 2016	Spring 2017	Autumn 2017	Spring 2018	Autumn 2018
Clinical Standard 2: Time to first consultant review	76%	61%	60%	69%	72%
Clinical Standard 5: Access to consultant directed diagnostics	N/A	94%	N/A	94%	N/A
Clinical Standard 6: Access to consultant directed interventions	N/A	94%	N/A	100%	N/A
Clinical Standard 8: Ongoing daily consultant review	Once daily: 98% Twice daily 96%	94%	N/A	97%	N/A

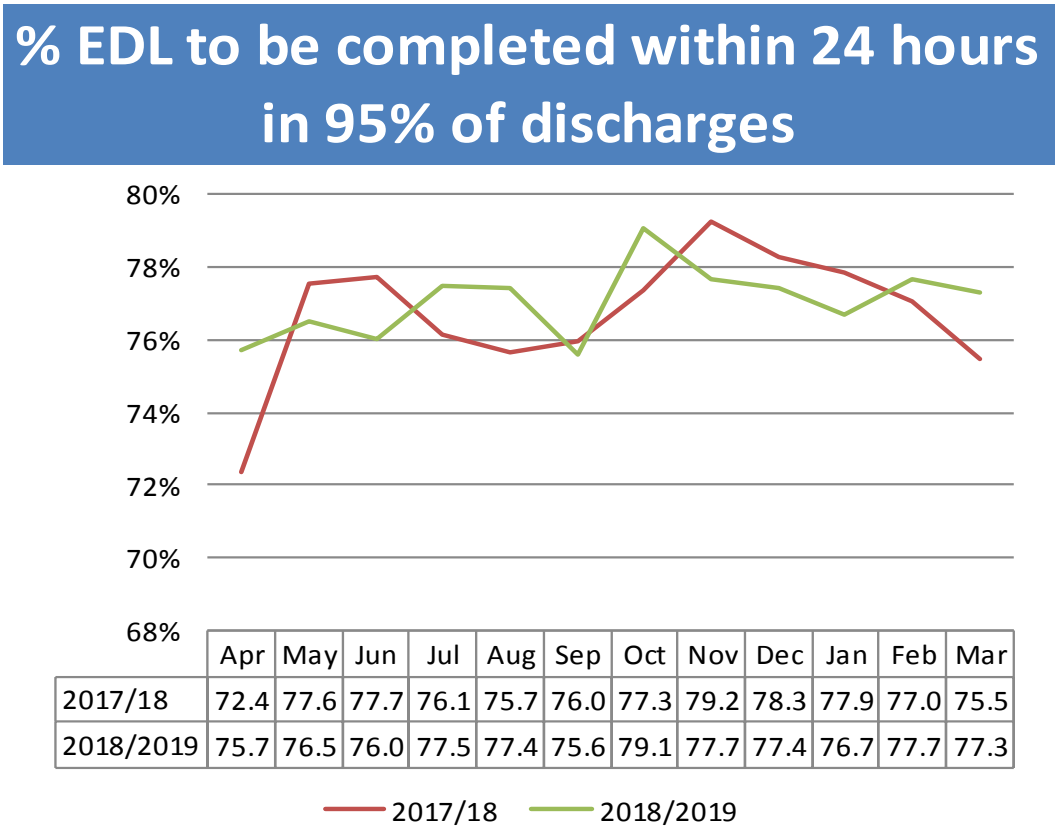
The next internal audit is due in March 2019 and will be reported in June 2019.

Carer and Patient Experience - Change: Improved discharge processes and communication

What was our aim?
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 (EDL) as at present but updated to include Outpatient letters according to required electronic format.

How did we do?



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
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
2018/2019	75.7	76.5	76.0	77.5	77.4	75.6	79.1	77.7	77.4	76.7	77.7	77.3

As the chart above demonstrates, we have now started reviewing the Estimated Date of Discharge (EDD) for the majority of our patients on admission. There is further work needed to fully embed this and the SAFER Flow bundle is being re-launched to support this, which will complement the STP transformation plan.

EDL performance continues to be a challenge. What has been identified is that the cause of this is multifaceted; this means that we can now continue to address issues such as IT hardware availability, process clarification and inclusion definitions during 2019/20 to further improve performance.

Carer and Patient Experience - Improved continuity of care and experience through reduced ward moves and reduced numbers of outliers

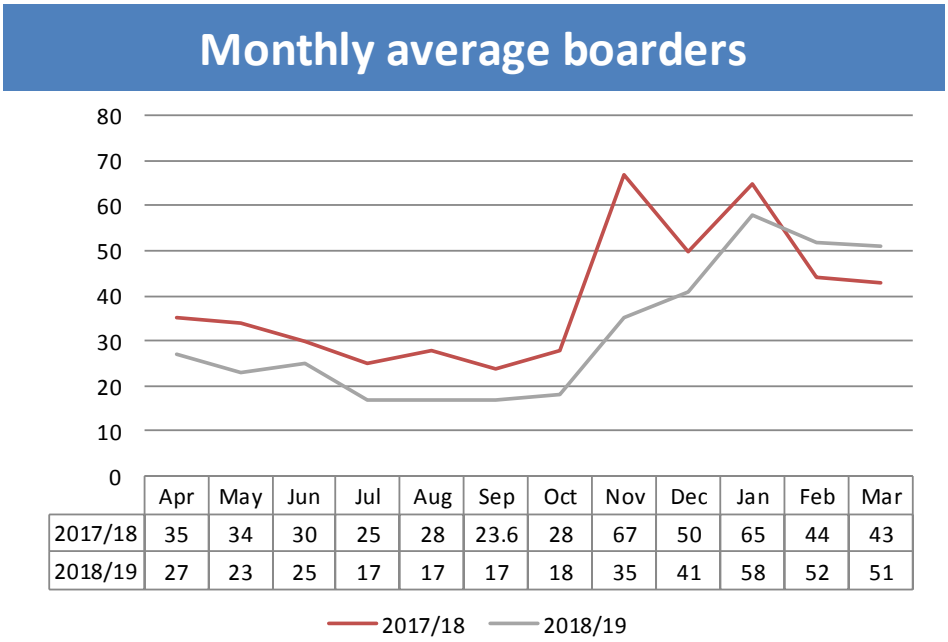
What was our aim?

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

How did we do?



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	35	34	30	25	28	23.6	28	67	50	65	44	43
2018/19	27	23	25	17	17	17	18	35	41	58	52	51

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

What was our aim?

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

How did we do?

DNACPR compliance – Local audits demonstrate these forms have been completed. 85% of patients who died (Nov/Dec) have had this decision discussed with their next of kin. 50% of patients at end of life had this discussed with them (many too poorly or lacked capacity to have this discussion).

No of Individualised care plans in place – see No 4 this is audited here and No 5. Local Audit November/December 2018 45% patients audited were on an Ind. Care Plan (this is not just the text of the notes but on the specific care plan).

Weekly audits of 5 patients who have died are now being undertaken. Results discussed at bi-monthly end of life steering group (undertaken and report written by education team). Item to be added as standing agenda item.

End of Life audit: undertaken on 80+ sets of notes – results have been received and are very promising. Once approved by Trust board, an action plan will be written and disseminated through the end of life steering group and CaPE board.

NNUH Oesophago-gastric Cancer Unit named as one of the best in UK for eighth year running

The Oesophago-gastric Cancer Centre at NNUH is celebrating results from the recent National Oesophago-gastric Cancer Audit (NOGCA), which names the Trust as one of the best centres in the UK for the eighth year running.

The audit highlighted how NNUH has one of the lowest mortality rates after major complex operations for cancer of the oesophagus, as well as the shortest length of stay for patients post-operation. The national average of length of stay for these patients is 12-15 days, however NNUH patients stay on average just 7 days after their operation. This means we have one of the quickest recovery rates following this type of surgery for our patients in the country.

Each year, NNUH performs around 50-60 Minimally Invasive Oesophagectomy (MIO), a procedure which removes part of the oesophagus (gullet). This means we're continuing to perform the highest percentage in the UK.

Mr Edward Cheong, Upper GI Cancer Lead and Consultant Oesophago-Gastric Surgeon said: "This is fantastic news for both our patients and for NNUH. It's been a massive multi-disciplinary effort from the whole OG Cancer team, and I'm so proud of what we have achieved."

In addition to his clinical role, Mr Cheong is leading the 'Blow Your Whistle on Oesophageal Cancer' campaign, which seeks to raise awareness of oesophageal cancer.

May 2018

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

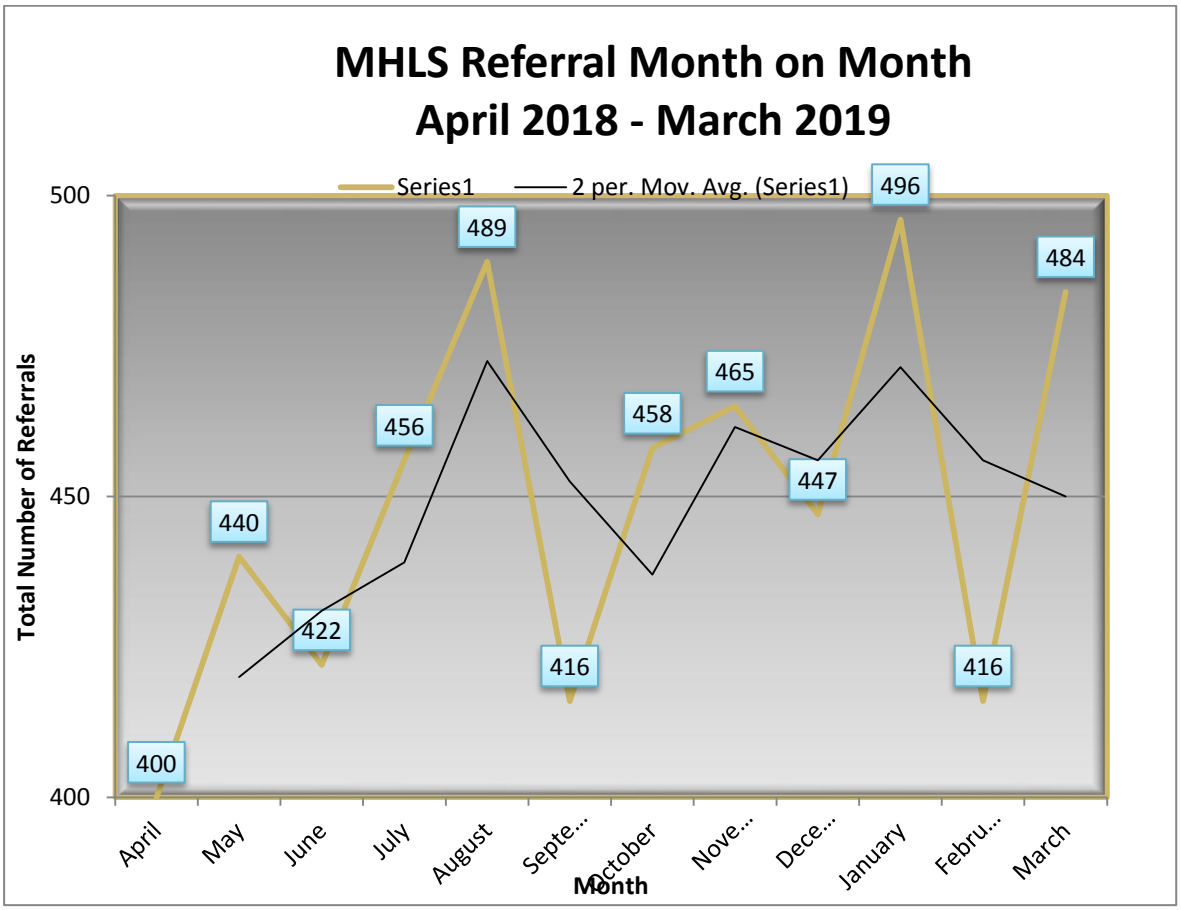
What was our aim?

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

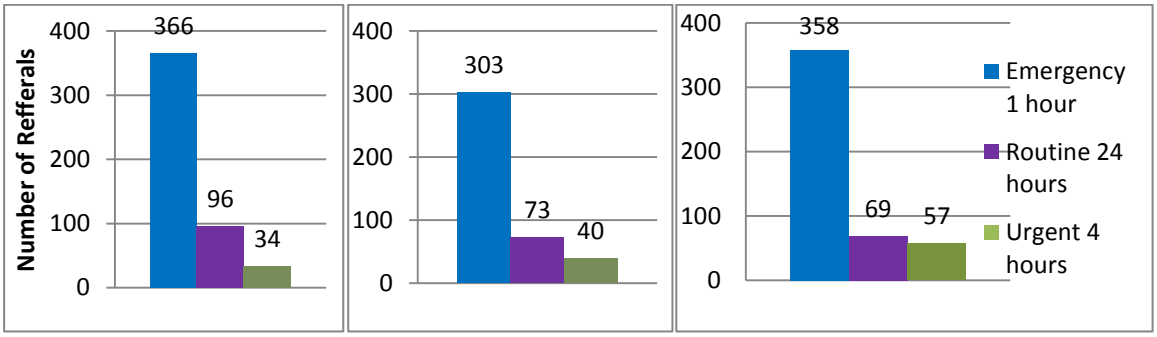
- Number of referrals to Psychiatric liaison from:
  - ED/ assessment areas (where)
  - Wards (and where).
  - Waiting time from referral to assessment
  - standard 1hr ED, 4hrs
  - assessment areas including EAUS
  - 24hrs response for wards
- Staff training – numbers trained in year and outcome of 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.

How did we do?



Number of referrals to Psychiatric liaison by NNUH Locations

	16/17	17/18	18/19
Number of referrals	3900	5224	5432



NNUH Referrals to MHLS by priority Jan-March 2019

Staff Training

In 2018, the Trust commenced a Mental Health (MH) Training workstream as part of the Mental Health Improvement Plan. However, due to operational pressures and a need to prioritise elements of work within the Improvement Plan, this workstream did not progress at the intended pace. Consequently, the Training Workstream is scheduled to recommence in April 2019.

The purpose of the training workstream is to pull together all elements of mental health training provision across the Trust, to ensure that there is a joined up strategy for delivery.

Going forward, it is intended that the NNUH will hold a full one day Mental Health Induction course, which will be applicable to all new employees (clinical and non-clinical). The training plan will be pragmatic so as to include details regarding how this new induction will also be rolled out to existing employees.

The induction will consist of the following four topic areas (to become known as Tier 1, Core Mental Health Training):

- Mental Health Awareness – Introduction to Common MH Presentations in Acute Hospital Population: Recognising Signs and Symptoms.
- Cognitive Impairment: Introduction to Delirium, Dementia and Mental Capacity.
- Trauma-Informed Care.
- Communicating Positively in Challenging Circumstances: An Introduction to Non-Violent Communication.

In addition to the Tier 1 Core Training, there will also be area specific (Tier 2) training available, which will provide more in depth specialist knowledge into key areas, for example delivery of Eating Disorders training for Gastroenterology wards, delivery of Dementia training for Older People's Medicine wards, and so forth.

More specialist knowledge, or specific individual topics, will be covered on a case by case basis (Tier 3 training) and will include topics such as:

- Understanding Self-Harm
- Understanding Personality Disorder
- Introduction to Medically-Unexplained Symptoms.

In addition to the development and delivery of the planned Mental Health Induction programme, the training workstream will naturally incorporate those elements of future training developments that have already been mentioned above (specifically but not exclusive to Restrictive Interventions, Learning Disabilities and Dementia).

Board Assurance Statements

Review of services

During 2018/19 the Norfolk and Norwich University Hospitals NHS Foundation Trust provided and/or sub-contracted 83 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 83 of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19 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 2018/19.

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

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

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

During 2018/19 52 national clinical audits and 4 national confidential enquires covered relevant health services that Norfolk and Norwich University Hospitals NHS Foundation Trust provides.

During that period Norfolk and Norwich University Hospitals NHS Foundation Trust participated in 98% national clinical audits (51/52) and 100% national confidential enquires (4/4) which it was eligible to participate in. We also participated in other National Audits which fall outside of the Quality Account recommended list.

The national clinical audits and national confidential enquiries that Norfolk and Norwich University Hospitals NHS Foundation Trust was eligible to participate in during 2018/19 are below. The number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry is given.

National Clinical Audit (alphabetical order)	Eligible y/n	Took part y/n	Participation Rate Cases Submitted	Completed/ In-progress/ Ongoing
Adult Cardiac Surgery	N	N/A	N/A	N/A
Adult Community Acquired Pneumonia	Y	Y	Data currently being entered 100% anticipated	Ongoing
British Association of Urological Surgeons (BAUS) Urology Audit – Cystectomy	Y	Y	Figures not yet available, 100% anticipated	Ongoing
British Association of Urological Surgeons (BAUS) Urology Audit – Female Stress UrinaryIncontinence (SUI)	Y	Y	Figures for 2018/19 not yet available, 100% anticipated	Ongoing
British Association of Urological Surgeons (BAUS) Urology Audit – Nephrectomy	Y	Y	Figures not yet available, 100% anticipated	Ongoing
British Association of Urological Surgeons (BAUS) Urology Audit - Percutaneous Nephrolithotomy (PCNL)	Y	Y	Figures for 2018/19 not yet available, 100% anticipated	Ongoing

British Association of Urological Surgeons (BAUS) Urology Audit – Radical Prostatectomy	Y	Y	83/83 (100%) (01/04/18 – 31/12/18)	Ongoing
Cardiac Rhythm Management (CRM)	Y	Y	Electro-Physiology 319/320 (99.7%) Pacemakers 1101/1102 (99.9%)	Ongoing
Case Mix Programme (CMP)	Y	Y	1456/1456 (100%) (01/04/18 – 31/12/18)	Ongoing
Child Health Clinical Outcome Review Programme	Y	Y	No data required to be submitted in 2018	Ongoing
Elective Surgery (National PROMs Programme)	Y	Y	Hip 547/483 (88%) Knee 462/129 (93%)	Ongoing
Falls and Fragility Fractures Audit Programme (FFFAP)*	Y	Y	Data currently being entered 100% anticipated	Ongoing
Feverish Children (care in Emergency Departments)	Y	Y	128/128 (100%)	Complete
Inflammatory Bowel Disease programme / IBD Registry	Y	Y	5/5 100%	Ongoing
Learning Disability Mortality Review Programme (LeDeR)	Y	Y	15 cases submitted to LeDeR (100%) LeDeR allocated 8 for review by NNUH 6 of those completed (75%)	Ongoing
Major Trauma Audit	Y	Y	342/647 (53%) for the period April to December 2018, anticipated final submission for year 80%	Ongoing

Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Y	Y	MRSA Blood Stream Infection: 1 Hospital Acquired Infection (HAI) MSSA Blood Stream Infection: 10 HAI 73 Community Acquired Infection (CAI) 83 Total C. difficile: 25 HAI, 15 Non-Trajectory, 8 Trajectory, 2 Pending Cases, (NHS England Target <48) E. coli: 48 HAI 247 CAI, 295 Total Klebsiella Species – 12 HAI 46 CAI, 56 Total Pseudomonas aeruginosa – 14 HAI 26 CAI, 40 Total	Ongoing
Maternal, Newborn and Infant Clinical Outcome Review Programme	Y	Y	100% of required data submitted Maternal death 1 Late Fetal Loss 6 Terminations 1 Stillbirth 26 Early Neonatal Death 5 Late Neonatal Death 2	Ongoing
Medical and Surgical Clinical Outcome Review Programme	Y	Y	Pulmonary Embolism Study: 5/6 clinician forms (83%) 6/6 notes extracts for review (100%)	Ongoing
Mental Health Clinical Outcome Review Programme	N	N/A	N/A	N/A
Myocardial Ischaemia National Audit Project (MINAP)	Y	Y	937/1027 (91.2%)	Ongoing
National Asthma and Chronic Obstructive Pulmonary Disease (COPD) Audit Programme*	Y	Y	Asthma Audit data currently being entered 100% anticipated COPD 279/279 (100%)	Ongoing

National Audit of Anxiety and Depression	N	N/A	N/A	N/A
National Audit of Breast Cancer in Older People	Y	Y	259/259 (100%)	Ongoing
National Audit of Cardiac Rehabilitation	Y	Y	3180/3325 (95.6%)	Ongoing
National Audit of Care at the End of Life (NACEL)	Y	Y	150/150 (100%)	Complete
National Audit of Dementia	Y	Y	50/50 (100%)	Complete
National Audit of Intermediate Care	N	N/A	N/A	N/A
National Audit of Percutaneous Coronary Interventions (PCI)	Y	Y	1490/1657 (89.9%)	Ongoing
National Audit of Pulmonary Hypertension	N	N/A	N/A	N/A
National Audit of Seizures and Epilepsies in Children and Young People	Y	Y	137/137 100%	Ongoing
National Bariatric Surgery Registry (NBSR)	N	N/A	N/A	N/A
National Bowel Cancer Audit (NBOCA)	Y	Y	337/337 (100%)	Ongoing
National Cardiac Arrest Audit (NCAA)	Y	Y	38/38 (100%) (01/04/18 - 30/09/18) No further figures available until April 2019	Ongoing
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis (NCAREIA)	Y	Y	162 (Unable to determine percentage)	In progress (2 years)
National Clinical Audit of Psychosis	N	N/A	N/A	N/A
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	N	N/A	N/A	N/A
National Comparative Audit of Blood Transfusion programme*	Y	Y	Management of major haemorrhage 10/10 (100%) Audit of use of Fresh Frozen Plasma, Cryoprecipitate and of Transfusions for Bleeding in neonates and children 5/5 (100%)	In progress
National Congenital Heart Disease (CHD)	N	N/A	N/A	N/A

National Diabetes Audit – Adults*	Y	Y	National Diabetes Audit 3611/3611 (100%) Adult Foot Inpatient Audit 246/246 (100%) Diabetes in Pregnancy Audit 39/39 (100%)	Ongoing
National Emergency Laparotomy Audit (NELA)	Y	Y	242/242 (100%) April 2018 to End of Jan 2019	Ongoing
National Heart Failure Audit	Y	Y	185/686 (27%)	Ongoing
National Joint Registry (NJR)	Y	Y	1099/1099 (100%) over 2018, figures only available per calendar year	Ongoing
National Lung Cancer Audit (NLCA)	Y	Y	Data taken by the Royal College of Physicians 2018/19 figures not yet available 100% anticipated	Ongoing
National Maternity and Perinatal Audit (NMPA)	Y	Y	All births have been registered nationally, data is taken directly by NHS Digital	Ongoing
National Mortality Case Record Review Programme	Y	N	0	Did not participate as recommended methodology not in place will participate in future
National Neonatal Audit Programme (NNAP)	Y	Y	All discharges from Neonatal Intensive Care Unit (NICU) registered on the BadgerNet data-base 1206 cases 100%	Ongoing
National Audit of Oesophago-gastric Cancer (NAOGC)	Y	Y	Data currently being inputted Anticipated to be 200 (100%)	Ongoing
National Ophthalmology Audit	Y	Y	4407/4407 (100%)	Ongoing
National Paediatric Diabetes Audit (NPDA)	Y	Y	All data has been submitted as required. Actual numbers currently unavailable until publication of report	Complete
National Prostate Cancer Audit	Y	Y	431/431 (100%) (01/04/18 – 31/12/18)	Ongoing
National Vascular Registry	Y	Y	Acute Aortic Aneurysms – 104/104 (100%) Carotid Endarterectomy – 54/65 (83%)	Ongoing

			Lower Limb Angioplasty – 4/255 (2%) Infra-inguinal Bypass – 43/88 (49%) Lower Limb Amputation – 66/66 (100%)	
Neurosurgical National Audit Programme	N	N/A	N/A	N/A
Non-Invasive Ventilation – Adults	Y	y	Data currently being entered 100% anticipated	Ongoing
Paediatric Intensive Care (PICANet)	N	N/A	N/A	N/A
Prescribing Observatory for Mental Health (POMH-UK)*	N	N/A	N/A	N/A
Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)*	Y	Y	Timely identification of sepsis 900/900 (100%) Timely treatment for sepsis 641/641 (100%) Antibiotic Review 191/191 (100%) Reduction in antibiotic consumption per 1,000 admissions and proportion of antibiotic usage 100%	Ongoing
Sentinel Stroke National Audit programme (SSNAP)	Y	y	1047/1047 (100%)	Ongoing
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Y	Y	16/16 (100%)	Ongoing
Seven Day Hospital Services	Y	Y	April 2018 245/245 (100%) October 245/245 (100%)	Completed
Surgical Site Infection (SSI) Surveillance Service	Y	Y	Vascular SSI 209 Quarters 1 and 2 (percentage not available) Lower Segment Caesarean Section 787 Quarters 1 and 2 (percentage not available) Further data not yet available	On –going
UK Cystic Fibrosis Registry	Y	y	77/77 (100%)	ongoing
		Y	120/120	Complete

Vital Signs in Adults (care in emergency departments)			(100%)	
VTE risk in lower limb immobilisation (care in emergency departments)	Y	Y	132/132 (100%)	Complete

The reports of 18 national clinical audits were reviewed by the provider in 2018/19 and Norfolk and Norwich University Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see Table A).

Examples of 43 local clinical audits reviewed by the provider in 2018/19 and Norfolk and Norwich University Hospitals NHS Foundation Trust are given below (See Table B, page 37).

Table A

Audit and Survey Title	Results/Actions Taken / Planned
National Audit of Cardiac Rehabilitation (NACR)	This audit was undertaken to determine if the Norfolk and Norwich cardiac rehabilitation services are fulfilling national standards. The audit for a partial year found that we are exceeding the minimum standards for 5 of the 7 standards. Following the audit we are in discussion with the National Audit of Cardiac Rehabilitation for the acceptance of our 42 day programme, which is slightly shorter than their standard of 56 days to help improve patient care.
Audit to British Society of Gastroenterology (BSG) quality and safety indicators for endoscopic ultrasound (EUS)	This audit was undertaken to assess standards of clinical quality in endoscopic ultrasound (EUS) against those set by the Joint Advisory Group (JAG) on gastrointestinal endoscopy. This audit found that over the year of 2017 the department achieved high compliance with the JAG standards. Results were fed back to the department and no further action needed.
Serious Hazards of Transfusion (SHOT): United Kingdom National Audit and Haemovigilance Scheme	The aim of this national audit was to collate and identify themes from all incidents reported through the Serious Hazards of Transfusion (SHOT) scheme and where risks and problems are identified produce recommendations to improve patient safety. SHOT produced an annual report in July 2018 covering incidents which had taken place during 2017 and made three key recommendations. We are meeting recommendations about training in blood groups and use of information technology. We do not have a formal pre-transfusion risk assessment for transfusion associated circulatory overload (TACO). We reduce risk of TACO with single unit transfusions and mandatory training.
United Kingdom Renal Registry (UKRR) Audit	This national audit was undertaken to compare quality of care indicators from renal centres across the United Kingdom. The annual report was published in July 2018. The report was presented and discussed at the Renal Governance meeting. Further work into transplantation, anaemia and vascular access is being undertaken to improve patient care.
Case Mix Programme (CMP) Audit	The aim of this on-going audit was to collect data on all patients admitted to the Critical Care Unit. The annual quality report for 2017/8 was reviewed. Data completion was close to 100% in all domains. On reviewing the quality dashboard the Trust was consistent with United Kingdom data. We have a large unit with high through put. Overall our Standardised Mortality Ratio (SMR) was below 1. Following review of the report, no actions were necessary.

National Cardiac Arrest Audit (NCAA)	This audit was undertaken to identify patients who had a cardiac arrest at the NNUH; to see if the arrest could have been prevented or if a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) order should have been made; and to disseminate these findings to improve care. The National Cardiac Arrest Audit Report was published 20th November 2018 and was circulated to the Resuscitation Officer. The audit found a low incidence of cardiac arrests per 100 admissions compared to other hospitals. Initial survival was 52.3% and survival to discharge was 15.8%. The report was discussed at the Recognise and Respond Committee meeting. A Development of Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) Implementation Group was initiated to improve education of staff and patient care.
Audit of Potential Organ Donation	The Potential for Organ Donation National Audit is a summary of the number of potential donors, actual donors, patients transplanted, average number of organs donated per donor and organs donated, obtained from the UK Transplant Registry. The Report of Actual and Potential Deceased Organ Donation (1 April 2018 to 30 September 2018) was published in November 2018. The Trust referred 27 potential organ donors during the first six months of 2018/19. From 13 consented donors the Trust facilitated 8 actual solid organ donors resulting in 22 patients receiving a life-saving or life-changing transplant. There was 1 occasion where a potential organ donor was not referred. The results of the report were discussed at the Trust Organ Donation Committee. The missed opportunity rates were reviewed at the Critical Care Governance Meeting and actions discussed.
National Audit of Breast Cancer in Older People (NABCOP)	This audit was undertaken to evaluate the quality of care provided to women aged 70 years and older by breast cancer services in England and Wales. The national annual report was published in June 2018, and reviewed at the Breast Surgery Departmental meeting where it was determined that all recommendations in the report are followed and no further action was required.
National Emergency Laparotomy Audit (NELA)	This audit was undertaken to assess the delivery of key processes of care for patients undergoing emergency laparotomy, and to report outcomes at hospital level for patients undergoing emergency laparotomy in England and Wales. The annual report was published on 8th November 2018 and reviewed by the Specialty Audit Lead. The Trust achieved a 100% risk assessment rate, had a lower length of stay (9 days against national median 11 days) and better mortality rate (10.3% against national mean of 10%). Areas of concern were the rate of admissions to critical care (70% against national rate 88%), and Consultant presence in theatres (58% against national rate 83%). Work is ongoing in respect of these and Surgical Consultant input in theatre has improved to 100% and Anaesthetic Consultant input to above 80%.
National Vascular Registry (NVR)	The National Vascular Registry (NVR) purpose is to provide comparative figures on the performance of vascular services in NHS hospitals and support vascular specialists with local benchmarking and quality improvement. The annual report was published on28th November 2019 and was shared with the Specialty Audit Lead for review. Elective Abdominal Aortic Aneurysm (AAA) and Carotid Endarterectomy (CE), case ascertainment above the national standard of 90% was achieved (100% for AAA and 98% for CE). The Trust was the 6th busiest Aortic Centre in the United Kingdom, with excellent adjusted mortality rate for AAA, despite performing a larger proportion of open AAA repairs than the national average. The Trust achieved 98.2% risk adjusted 30 day stroke free survival rate in relation CE, and had one of the shortest symptom to surgery times; median 8 [5-10] days, lower than the National Institute for Health and Care Excellence (NICE) guidelines recommendations and NVR aspiration standard of 14 days.

National Hip Fracture Database (NHFD) *(Part of Falls and Fragility Fractures Audit Programme)*	The National Hip Fracture Database (NHFD) was established as part of the Falls and Fragility Fractures Audit Programme, and aims to improve the care and secondary prevention of hip fracture. The annual report was published on 15th November 2018. The Trust had a reduction in crude and adjusted 30 day mortality rates; the Trust is no longer an outlier for mortality. Acute length of stay was reduced. There was a low rate of 120 day follow up, admission to an orthopaedic ward within 4 hours, physiotherapy review on day 1 post-procedure. Improvements have been made since the data was submitted and almost all patients are seen by a physiotherapist on day 1 post-procedure.
National Joint Registry (NJR)	The National Joint Registry (NJR) was established to collect data relating to joint replacement surgery in order to provide an early warning of patient safety issues, and continuously drive improvements in the quality of patient outcomes. The annual report was published on 25th September 2018. The outcomes and recommendations in the annual report were reviewed within the specialty. The new Minimum Data Set (MDS7) has been introduced into the Bluespier system and coordinated with the perioperative theatre management system to ensure ongoing data compliance. A review of local level surgeon data was undertaken and no actions were required.
British Association of Urological Surgeons (BAUS) Urology Audits: Radical Prostatectomy Audit	This audit was undertaken to determine standards across the UK. The data for 2017 was published on 23rd July 2018. 100% of the 83 cases were reported to the national British Association of Urological Surgeons (BAUS) data base. The outcome data in comparison with the national figures for 2017 was excellent. There were no transfusions; median length of stay was 1 day in line with national figures. No further actions were required.
National Neonatal Audit programme (NNAP)	This national audit was undertaken to assess whether babies admitted to Neonatal Units in England receive consistent care in relation to several audit questions. Data on all discharges from the Neonatal Intensive Care Unit (NICU) are entered onto the NICU data capture system BadgerNet NICU was highlighted as an outlier for documented consultation with parents within 24 hours of admission. The proportion of admitted babies having measurement of temperature within 1 hour of birth and being given antenatal steroids was lower than the national average. Actions implemented include; adding a new entry on the nursing admission checklist to confirm the admission time with the admitting doctor; new reminder signs on notes trolleys and to all clean incubators and cots and Review of BadgerNet entries for accuracy. Modification of the care bundle and a "warm chain" audit has been implemented.
Learning Disability Mortality Review Programme (LeDeR Programme) Audit	This national project is aimed at identifying, through structured mortality reviews of all deaths of people aged 4+ with a learning disability, learning points, areas for improvement, themes, mortality trends, and good practice. The audit has helped us to commence collaborative working relationships as well as identifying key areas for improvement and action to improve patient care. A combined Speech and Language Therapy and Learning Disability (LD) Liaison structured judgement review on risk-feeding pathway and mortality has taken place. LD Liaison staff now participate in the Restrictive Intervention Group and the Mental Health Operational Board.
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. Following publication of benchmarking data, case selection processes have been revised to enable more timely submissions, a review of time to definitive airway in patients with Glasgow Coma Scale less than 9 and formal peer review of unexpected deaths is being undertaken.

Elective Surgery National Patient Reported Outcome Measures (PROMS) Programme	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.
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 reports on Heart Failure, Cancer in Children, Teens and Young Adults, and on Perioperative Diabetes. The self-assessment document for the Heart Failure Study is still in progress. Actions implemented following review of compliance to recommendations from the Perioperative and Cancer studies included; ensuring all systemic anti-cancer therapy prescriptions available on the Trust Information Technology systems and education of staff to ensure the safe handover of patients with diabetes from theatre recovery to the ward.

NNUH's first Diabetes Consultant Nurse appointed

A senior nurse has spoken of her delight after being appointed as the first Diabetes Consultant Nurse at NNUH.

Maggie Heels joined the hospital in 1987 and has more than 25 years' experience as a diabetes specialist nurse.

Maggie, who is currently Senior Diabetes Nurse Facilitator at NNUH, added that her new role would also involve developing the strategy and commissioning for diabetes services in Central Norfolk.

She said: "I am looking forward to starting the new job. I feel that my hard work and dedication and my master's degree are being utilised to their full potential. This will raise the profile of specialist diabetes nursing in Norfolk."

Professor Jeremy Turner, Service Director for diabetes and endocrinology at NNUH said*: "*We are delighted to have appointed a Diabetes Consultant Nurse as part of our strategy to improve the quality and range of services for people with diabetes in Norfolk. In particular this appointment will help us to work more closely and productively with diabetes services in primary care.

"Maggie's expertise, leadership, passion for diabetes and drive will help us to bring the best possible care to all with diabetes in Norfolk who need it."

Professor Mike Sampson, from the Elsie Bertram Diabetes Centre, added: "This is great news, and it has taken Maggie nearly 20 years to grow our intermediate diabetes service so that it now covers 72 Norfolk general practices, and this has been supplemented recently by our NHS England funded consultant outreach model, now covering 40 practices. This post will be central to all these developments."

June 2018

Table B Local Audits

Audit and Survey Title	Results/Actions Taken / Planned
Re-Audit of World Health Organisation (WHO) checklist in Cardiology Catheter Labs	This audit was undertaken to ensure that all components of the WHO checklist and handover signatures are completed for patients undergoing a procedure in the Cardiology Catheter Laboratory. This audit found improvement since the previous audit in completeness of documents such as the safe surgery checklist and handovers signatures. There are still some areas requiring improvement. The results were communicated to staff and posters created. Regular spot checks of documentation are undertaken and a re-audit completed. The re-audit demonstrated a marked improvement in completion of the documents. The audit is on-going.
Re-Audit of World Health Organisation (WHO) surgical checklist	This audit was undertaken to monitor the use of the WHO checklist for procedures carried out in the Endoscopy Unit. A sample of procedures was audited each month. The use of the WHO checklist has remained high over the audit period. No further action needed.
Audit of Compliance to local Safety Standards for Invasive Procedures (LocSSIP) for Botulinum Toxin Injections	This audit was undertaken to determine compliance with the Local Safety Standards for Invasive Procedures (LocSSIP) for Botulinum Toxin Injections. The results found that 100% of patients had documented consent prior to the first injection, however only 25% of patients had full documentation completed. As a result, documentation has been streamlined by updating the LoCSSIPs form and a re-audit will be undertaken to monitor compliance.
Audit of World Health Organisation (WHO) checklist	The aim of this audit was to ensure that all components of the World Health Organisation (WHO) checklist and handover signatures are completed for patients undergoing a procedure in the Respiratory Investigations Unit (RIU) The results found that there was an overall good compliance achieving on average 99-100% in Bronchoscopy and Pleural Procedures, however post procedure checks accounted for 1% of incomplete checks. As a result, observational audits have been introduced auditing 10% of weekly procedures carried out in RIU and the audit is ongoing to monitor compliance.
Audit of Transnasal Oesophagostomy (TNO) Local Safety Standards for Invasive Procedures (LocSSIP)	This audit was undertaken to determine compliance with the Local Safety Standards for Invasive Procedures (LocSSIP) in the Ears, Nose and Throat (ENT) Department. The Trust demonstrated an overall compliance rate of 85%. As a result of the audit, nursing staff check all notes and place LocSSIP's and consent forms inside the notes prior to the day of the procedure. Following the actions there has been an increase in awareness of utilizing LocSSIPs and the importance of ensuring they are completed by the medical staff. Compliance has risen to 100%. A re-audit has been planned in 19/20.
Re-Audit of compliance to LocSSIP (Local Safety Standards for Invasive Procedures) for Lumbar Puncture	This audit was undertaken to determine compliance to the use and completion of the local safety standard for invasive procedures for lumbar punctures on the Neonatal Intensive Care Unit (NICU). The results demonstrated good compliance to both audit standards and no specific actions were required.

Audit of compliance to LocSSIP (Local Safety Standards for Invasive Procedures) for Chest Drain	This audit was undertaken to determine compliance to the use and completion of the local safety standard for invasive procedures (LocSSIP) for chest drains in NICU. The findings highlighted documentation of the procedure could be improved along with completion of the LocSSIP form. As a consequence the LocSSIP has been incorporated into a condensed sticker format to be placed in the notes. A re-audit will be undertaken.
Audit of checklist completion for Local Safety Standards for Invasive Procedures (LocSSIP): Removal and Replacement of Surgical Voice Prosthesis (SVR)	This audit was undertaken to ensure that the Removal and Replacement of Surgical Voice Prosthesis LoCSSIP was being appropriately completed prior to patients undergoing this treatment. The audit demonstrated that the LocSSIPs were being fully completed in 100% of cases and due to high compliance, no immediate actions were required. A re-audit is planned for 2019/20.
Infection Control Alerts Transcription Audit	This audit was undertaken to monitor compliance of transcription of Infection Control alerts onto Casualty Cards by reception staff. The results of the audit found the trend line is positive overall with an 80% compliance frequently achieved however high staff turnover and new intake can have a significant negative impact on compliance. As a result, Patient Administration System alerts should be automatically transferred to symphony. This has been added to the symphony project team agenda and is currently with the software suppliers to look at feasibility. Audits will continue on a monthly basis until the process is automated.
Emergency Department Mental Capacity Documentation Audit	The aim of this audit was to ensure Mental Health (MH) risk assessment documentation is being completed and to identify actions to improve accuracy and consistency of information recording for patients with mental health aspects to their attendance. The results found that there was a poor compliance in general with inconsistent use of documentation. As a result the MH triage form has been re-designed and all clinical staff instructed how to use the form. Monthly audits will continue.
Re-Audit of Removal of Epidural Catheter Risk Assessment Tool (RAT) – compliance with use	This audit was undertaken to measure compliance with completion of the risk assessment tool for epidural catheter removal in areas that support epidural analgesia. A key success showed that at least one Registered Nurse per shift with epidural / patient controlled analgesia (PCA) enhanced practice training was on duty. Key concerns included the discharge Patient Care Record (PCR) document and risk assessment tool was not completed on all occasions; Key actions included feeding back to individual Ward Managers, including pain team members to highlight potential safety risks. A re-audit will be undertaken.
Re-Audit of epidural observations compliance	This audit was undertaken to measure compliance with Trust guidelines for the safe management of epidural analgesia for adults and children. Key successes demonstrated that Buxton Ward, Critical Care Unit (CCU) and Cringleford Ward were 100% compliant with the audit standards. No key concerns were identified. Key actions included discussing results with individual ward areas and the Pain Service. A re-audit has also been planned.

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) in the Paediatric and Emergency Departments. Overall compliance with the documentation aspects of this audit remained poor although Quarter 3 results demonstrated an improvement in the frequency of observations matching the clinical guideline and consistency in the documented evidence of a medical review. The findings have continued to highlight the complexity of early warning scoring systems. A study morning in December was held to discuss possible alternative methods to address different requirements across the Emergency and Ward environments. A national survey regarding the use of CEWS by NHS England was completed by the Trust. The CEWS audits will continue for 2019-20.
Do Not Attempt Cardio Pulmonary Resuscitation Documentation Audit	This audit was undertaken to ensure that Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) orders are appropriately completed in the patient notes. The results identified that compliance with all audit standards were not achieved, particularly in relation to documentation of assessment of capacity. As a result of the audit, an action plan implemented which included ongoing monitoring of the DNACPR orders by the Matrons as well as the introduction of ReSPECT to help integrate the DNACPR decision making with overall advance care planning.
Audit of the Adherence to Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards - Emergency Department	This audit was undertaken to identify if compliance to the MCA was undertaken in the Emergency Department (ED). The audit identified that the Trust assessment of capacity form is not always being used. As a result, electronic documentation within ED went live on 22nd January 2019. The MCA 'pop up' is active for all patients over 16 and both questions "Is there an impairment in the mind or brain?" and Type of impairment/disturbance" are now mandatory fields. A re-audit will be undertaken in 19/20.
Audit of Resus Equipment	This audit was undertaken to determine the compliance with the completion of the resuscitation trolley checklist and to ensure that the correct checklist was used. The results found that 74% of trollies used the correct checklists, 67% of trollies had been checked daily and 99% of sealed contents of trolleys checked once weekly on a Monday. As a result of the audit, Matrons have now incorporated audits of compliance into their regular checks.
Audit of Folfirinox Chemotherapy	The audit was undertaken to ascertain if Folfirinox was being administered as per Trust Protocol and to compare outcomes with clinical trials. This audit found high compliance with the Protocol and patient outcomes were better than those quoted in published trials. The results were discussed by clinicians. No further actions needed.
Audit of Sepsis Commissioning for Quality and Innovation (CQUIN) element	This audit was undertaken to determine compliance with the National Sepsis Commissioning for Quality and Innovation (CQUIN). Key successes included 100% of eligible patients were screened in the Emergency Department (ED) due to the electronic screening process. There was a full achievement of patients with a confirmed diagnosis of sepsis receiving antibiotics within 1 hour of diagnosis, and of patients receiving an empiric antibiotic review within 72 hours. Key concerns identified the lack of an electronic observation and patient recorded system which meant that the audit burden for sepsis screening in inpatient areas remains high, and patients with learning disabilities and autism have been identified with an increased mortality from sepsis. Key actions included the Sepsis Team liaising with the Learning Disabilities and Autism Team. The Sepsis Audit and Improvement Nurse has implemented a rotational education programme in the ED where all staff will have received training by the end of March 2019.

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 determine 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.
Audit Weight Loss in Orthognathic Patients	This re-audit was undertaken to identify if the introduction of improved diet advice given to patients undergoing orthognathic surgery. The re-audit demonstrated a lower average weight loss than the last audit cycle, suggesting successful implementation of a diet advice sheet. Following the audit, protein shakes have been included on the diet advice sheet and a re-audit will be undertaken.
Re-Audit of infant feeding standards	This audit was undertaken to identify if minimum standards in infant feeding and relationship building practices were achieved. The results found that the United Nations Children's Fund (UNICEF) Baby Friendly Initiative standards were met for Staff Knowledge and Neonatal Unit Audits. A small proportion of standards in the Mothers Audit achieved less than the 80% target compliance. As a result; antenatal breastfeeding workshops in the community will be piloted, supplementation rates will be subject to spot check audits, staff will be asked to emphasise in l training the importance of responsive feeding and the findings shared via the Infant Feeding Team newsletter. A re-audit will be undertaken.
Parkinson's Disease missed dose audit	This audit was undertaken to ensure that patients with Parkinson's Disease do not miss a dose of a medication and that medication is given in timely in terms of the patient's personal drug regimen. The results of the audit demonstrated that our outcomes were better than the national average. The Specialist Nurses are now involved in training of general ward staff to improve practice further.
Audit of physiotherapy rehabilitation following hip fracture against national standards	This audit was undertaken to establish a baseline performance level measured against the new national standard for Physiotherapy provision following hip fracture. The audit found some standards met completely. Some areas required improvement to achieve compliance. An action plan included; development of local Physiotherapy management guidelines to reflect core elements of the national standard; the introduction of an education and training package to support the guideline implementation and induction of new staff and ongoing training for the physiotherapy team.
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 96% 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% for 2 consecutive audits, a follow up is sent to the sister/charge nurse to action learning outcomes. Results are available on the Nursing Dashboard. The audits will continue.
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 0.69 per 1000 line days and in quarter 2 it was 0.28 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 Infection Prevention and Control 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 2019/20 audit cycle.

Audit of compliance to Clinical Audit Policy	This re-audit of compliance to the Trust Clinical Audit Policy reviewed a random selection of 32 audit evidence folders from the 17/18 Trust Audit Plan. Following the audit a number of actions were implemented. These included; Audit Policy and Staff Guidance for Staff under taking clinical audit at NNUH updated to include reporting flow chart for completed audits. Divisional Governance Managers will ensure Bi-monthly Clinical Standards Group and Annual Audit Report are submitted to Divisional Board. Audit Learning Forum 29th January 2018. Audit OWL created and sent out to staff twice a year. A re-audit will be undertaken in 19/20.
Pressure Ulcers Audit	An on-going surveillance audit reviews all pressure ulcers in the Trust. Various methods are utilised for the audit including: daily 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, sent by the Tissue viability service, which includes all community acquired pressure ulcers and hospital acquired category 2 and above, is circulated to Senior Staff. A Root Cause Analysis (RCA) is undertaken by ward staff, deputy director of nursing and the Divisional Matron for any reported category 2 or above pressure ulcers. A weekly meeting, which has recently been changed to an Essential Care Scrutiny Panel, is held to discuss the category 2 and above pressure ulcers and falls that have occurred in hospital. It is chaired by the Deputy Director of Nursing and attended by the ward staff concerned in the pressure ulcer or fall, Tissue Viability Specialist, Senior Matron and now includes members of the multidisciplinary team. An action plan is formulated following each RCA and learning is disseminated within the Divisions to determine learning is shared across the organisation. In January 2019 NHSI identified some major changes to the way pressure ulcers were categorised and documented. These changes have had a big impact on the Tissue Viability eservice and teaching is ongoing across the trust to ensure compliance with the new guidelines is undertaken by all areas.
Diabetes Department Patient Satisfaction Audit	This audit was undertaken to evaluate patient experience and satisfaction of the Diabetes Centre. The results of the audit were positive and demonstrated a good level of satisfaction with the service provided. Patients did express concerns in relation to the appointments system and the appearance of the waiting area. As a result there is a plan for refurbishment to be undertaken to the waiting area and to update the appointment system.
Audit of Patient Experience of the Headache Clinic	The aim of the audit was to evaluate patient experience and satisfaction of the Headache Clinic. The results found that 100% of patients felt that staff were friendly and supportive, they were treated with dignity, listened to and were offered adequate psychological support. 3 patients commented they found the lights too bright in clinic rooms. A re-audit will be undertaken over a longer period to include a larger percentage of patients and a request has been made for minor works in order to improve the blinds and lighting in 2 of the clinic rooms.
Nurse Led Assessment and Treatment Delivery Clinics Audit	This audit was undertaken to determine if patients are satisfied with Nurse-led Oncology Clinics. Results were positive. Patients felt well informed, not rushed, able to ask questions, respected and good relations with clinical staff. Patients do not like the parking at the hospital, and some commented about the waiting area being dark, or crowded. Results were shared with clinical team and the waiting area has recently been refurbished.

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 results found that; there was good documentation that it is recognised the patient is dying and the patient and their next of kin have been communicated with in most cases. Bereavement booklets were not being given out regularly. As a result the department have raised the profile of the bereavement booklet and introduced bite size education on wards where compliance was lower.
Renal Replacement Therapy Education and Information Audit	This audit was to determine patient views of the information available for stage 5 Chronic Kidney Disease (CKD) patients and if they felt supported in their decisions around the type of Renal Replacement Therapy (RRT) used. Questionnaires were given out to patients who had attended the Renal Replacement Therapy Education Clinics. The audit demonstrated a high level of satisfaction with the information and with the support of the staff. No further action currently needed.
Audit of Critical Care Follow up Clinic Feedback	This audit was undertaken to ascertain patient satisfaction of the Critical Care Follow up Clinic (CCFuC). Key successes showed that 100% of surveyed patients found the CCFuC a positive aid to recovery long term, and 100% of patients thanked the staff for the care and compassion they (and their families) received during their stay. Key concerns included poor patient attendance as well as insufficient information specific to the CCFuC on the clinic invitation letter. Key actions included telephoning patients 48 hrs prior to appointment as a reminder and confirm, and re-drafting the invite letter.
Audit of Patient Information about Anaesthesia	This audit was undertaken to check that information about venous thromboembolism (VTE) and risks of anaesthesia and surgery were being given to patients. Key successes demonstrated that VTE information and admission paperwork scored highly and 100% of patients were able to describe in their own words what their procedure entailed. Key concerns showed that information relating to local and spinal anaesthetic was weaker and the Surgical Information Leaflet was recalled by only 32% of patients. Key actions included ensuing leaflets on local and spinal anaesthetics are available on the Intranet and given to patients. Paperwork will be mailed to patients if they cannot attend Pre-operative Assessment, or it will be flagged up so that on arrival they receive the paperwork. The new anaesthetic chart has a specific section to document risks.
Audit of Patient Satisfaction in Paediatric Audiology	The aim of this audit was to determine if service users were satisfied with the Paediatric Audiology Service. The results were positive and demonstrated a high level of satisfaction with the service provided. 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 Bone Conduction Hearing Systems Service	The aim of this audit was to determine if service users were satisfied with the Bone Conduction Hearing Systems Service. The results of the audit were positive and found a high level of satisfaction with the service. No actions were required but a re-audit will be undertaken to ensure that patients remain satisfied with the service provided.
Audit of Dietetic Services - Patient Feedback	This audit was undertaken to assess patient feedback with the Dietetic Renal Service. This audit demonstrated that patients were satisfied with the nutritional support they were given (96%). All patients said they would recommend the service. Patients were less satisfied with the timeliness of the input (Cromer 18% dissatisfied). An action plan was implemented which included; a review of Cromer provision of Dietitians; a standard of care for all patients from pre dialysis through the initial period for managing on dialysis and a review of diet sheets with regards to content.

Audit of Medical Illustration Patient Satisfaction	This audit was undertaken to find the level of service user satisfaction whilst being in Medical Illustration. The results of this audit demonstrated high levels of user satisfaction and as a result, no immediate actions were required
Audit of Pet Therapy - Patient Feedback	This Audit was undertaken to ascertain patient and staff feedback with regard to Pets as Therapy (PAT) dog visits. The results of the audit demonstrated high levels of satisfaction with the use of PAT dogs with patients. No immediate actions were required. As the service is now established, amendments were made to the feedback forms to allow further monitoring.
Audit of in-patient and out-patient quality standards	These series of audits were undertaken to offer continuous quality assurance against standards derived from the Care Quality Commission's Fundamental Standards. Monthly quality rounds and weekly spot check audits were undertaken as routine across the Trust's inpatient and outpatient settings throughout the year. All findings were shared with the Matrons and other Senior Ward/Department staff of the areas audited and where required, actions implemented. The audit programme will continue for 2019/20.
Audit of Patient Advice and Liaison Service (PALS) - 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. PALS now have a twitter account to allow more flexibility for patients and carers wishing to contact them.
Audit of Ionising Radiation (Medical Exposure) Regulations (IRMER) Operator and Practitioner Training	This audit was undertaken to determine if Practitioners and Operators were compliant with national training requirements. Audit results demonstrated a high percentage of Practitioners and Operators had theoretical training in radiation protection. The audit demonstrated a need for improved compliance with IRR (Ionising Radiation Regulations) 2017 regulation 15 as Practitioners and Operators are required to have theoretical training in radiation protection in the last 3 years. As a result of the audit, Radiation Protection modules were made an annual mandatory training requirement to Norfolk and Norwich University Hospital workers. Annual self-competency documents were introduced for Medical Physician Operators and Practitioners such as Cardiologists, Radiologists, Urologists and Consultant Anaesthetists (Pain Relief).
Audit of the Adherence to Mental Capacity Act 2005 and Deprivation of Liberty Safeguards - Staff Survey	This audit was undertaken to help understand staff attitudes and thoughts around Mental Capacity. Staff appeared to lack confidence in applying for a Deprivation of Liberty Safeguards (DoLS). As a result of this audit, bespoke training for all staff via Clinical Governance Meetings, Ward training and Staff Study Days was introduced

Creating a state-of-the-art research environment at NNUH

A development to increase and enhance research at NNUH will take a big step forward later this year.

A new Clinical Research Facility (CRF) in the state-of-the-art Quadram Institute will be home to a host of research initiatives to aid the development of new treatments and improve patient care.

The NNUH-run facility will bring together researchers and scientists from the hospital, Quadram Institute Bioscience (QIB), University of East Anglia (UEA) and across the Norwich Research Park.

Dr Melanie Pascale said she was “delighted” to take up the new post as manager of the CRF, which will be an integral part of the collaboration between researchers and scientists at the Quadram Institute on Norwich Research Park.

The CRF will champion research studies that will explore how food and nutrition affect health and disease and a vast array of other clinical trials, which will involve patients and volunteers. The results of these trials will lead to new strategies and treatments for improving health and preventing related disease.

Mark Davies, NNUH Chief Executive, said: “I’m delighted that the Trust is leading on this exciting partnership, which will bring together some of the brightest research talent under one roof. I look forward to seeing the many innovations that will come out of the CRF over the coming years, which will help to improve patient care.”

The NNUH-run CRF will be the hospital’s primary facility for clinical trials that do not need to be located within the main hospital building. In a facility designed by researchers and hospital clinicians, it will provide a mixture of outpatient clinical and laboratory space as well as a food-preparation area for diet-related studies. It is estimated to have capacity to accommodate around 5,000 research participants a year.

September 2018

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 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 4122 (as at Jan 2019) (3,228 in 2017/18).

Commissioning for Quality and Innovation (CQUIN)

A proportion of the Norfolk and Norwich University Hospitals NHS Foundation Trust's income in 2018/19 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. Preventing ill health by risky behaviours – alcohol and tobacco (2018/19 only)
6. Reinforcing the critical role Providers have in developing and implementing local STPs
7. Clinical Utilisation Review (NHS England Commissioning)
8. Hospital Pharmacy Transformation and Medicines Optimisation (NHS England Commissioning)
9. Nationally standardised Dose banding for Adult Intravenous Anticancer Therapy (SACT) (NHS England Commissioning)
10. Development of the Breast Screening Network within the STP footprint for Norfolk.

Further details of the agreed goals for 2018/19 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 2018/19 is £9.53 million conditional on achieving goals.

The monetary value of CQUIN available to the Norfolk and Norwich University Hospitals NHS Foundation Trust in 2017/18 was £7.3 million, plus £1.5 million CCG Risk Reserve.

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.

The Care Quality Commission Inspection between October 2017 and March 2018, published in June 2018, found the Trust had some outstanding practice and care. However, it also found that there were areas of poor practice, management and leadership that resulted in an overall rating of “Inadequate”.

CQC Ratings Grid June 2018

Ratings for Norfolk and Norwich hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Inadequate ↓ Jun 2018	Requires improvement ↓↓ Jun 2018	Good ↓ Jun 2018	Requires improvement ↓ Jun 2018	Inadequate ↓↓ Jun 2018	Inadequate ↓↓ Jun 2018
Medical care (including older people’s care)	Requires improvement Aug 2017	Good Mar 2016	Good Mar 2016	Requires improvement Aug 2017	Requires improvement Aug 2017	Requires improvement Aug 2017
Surgery	Inadequate ↓ Jun 2018	Good →← Jun 2018	Good →← Jun 2018	Requires improvement →← Jun 2018	Inadequate ↓ Jun 2018	Inadequate ↓ Jun 2018
Critical care	Requires improvement Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016	Good Mar 2016
Maternity	Requires improvement Aug 2017	Requires improvement Aug 2017	Good Aug 2017	Good Aug 2017	Good Aug 2017	Requires improvement Aug 2017
Services for children and young people	Requires improvement Aug 2017	Good Mar 2016	Good Mar 2016	Good Aug 2017	Good Aug 2017	Good Aug 2017
End of life care	Requires improvement →← Jun 2018	Requires improvement →← Jun 2018	Good →← Jun 2018	Requires improvement →← Jun 2018	Requires improvement →← Jun 2018	Requires improvement →← Jun 2018
Outpatients	Requires improvement Jun 2018	Not rated	Good Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018
Diagnostic imaging	Requires improvement Jun 2018	Not rated	Good Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018
Overall*	Inadequate ↓ Jun 2018	Requires improvement →← Jun 2018	Good →← Jun 2018	Requires improvement →← Jun 2018	Inadequate ↓ Jun 2018	Inadequate ↓ Jun 2018

For full details of the recommendations contained in the Report and the action plan, please see Appendix 1.

The CQC revisited the Trust between January and February 2019. Their report was published in mid-May and said there had been great improvements at the Trust since March last year, raising the overall rating from “inadequate” to “Requires Improvement”, though the Chief Inspector of Hospitals has recommended that the trust remain in special measures. Recommendations were made to continue with improvements to cultural change and openness, mandatory training, record and medicines security, leadership development, and staffing levels.

Special mention was given to a number of areas of outstanding practice including robotic surgery, Quick Response bar codes (QR) in theatres and Day Procedure Unit, improvements in critical care, with the new protocol to admit patients within one hour, and high levels of support for junior doctors

CQC Ratings Grid May 2019

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement ↑ Apr 2019	Requires improvement →← Apr 2019	Good →← Apr 2019	Requires improvement →← Apr 2019	Requires improvement ↑ Apr 2019	Requires improvemen ↑ Apr 2019
Medical care (including older people's care)	Requires improvement →← Apr 2019	Requires improvement ↓ Apr 2019	Good →← Apr 2019	Good ↑ Apr 2019	Requires improvement →← Apr 2019	Requires improvemen →← Apr 2019
Surgery	Requires improvement ↑ Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Requires improvement →← Apr 2019	Requires improvement ↑ Apr 2019	Requires improvemen ↑ Apr 2019
Critical care	Requires improvement →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Requires improvement ↓ Apr 2019	Requires improvemen ↓ Apr 2019
Maternity	Requires improvement Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Requires improvement Apr 2019	Requires improvemen Apr 2019
Services for children and young people	Requires improvement →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Requires improvement ↓ Apr 2019	Requires improvement ↓ Apr 2019	Requires improvemen ↓ Apr 2019
End of life care	Requires improvement Jun 2018	Requires improvement Jun 2018	Good Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018	Requires improvemen Jun 2018
Outpatients	Requires improvement →← Apr 2019	Not rated	Good →← Apr 2019	Requires improvement →← Apr 2019	Requires improvement →← Apr 2019	Requires improvemen →← Apr 2019
Diagnostic imaging	Requires improvement Jun 2018	Not rated	Good Jun 2018	Requires improvement Jun 2018	Requires improvement Jun 2018	Requires improvemen Jun 2018
Overall*	Requires improvement ↑ Apr 2019	Requires improvement →← Apr 2019	Good →← Apr 2019	Requires improvement →← Apr 2019	Requires improvement ↑ Apr 2019	Requires improvemen ↑ Apr 2019

The full CQC report can be viewed here: http://www.cqc.org.uk/provider/RM1

Data Quality

The Norfolk and Norwich University Hospitals NHS Foundation Trust submitted records during 2018/19 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%	99.4%	100.0%	99.9%
Outpatient care	99.9%	99.6%	100.0%	99.8%
Accident & emergency care	99.0%	97.5%	100.0%	99.3%

Pioneering lung biopsy begins at NNUH

A pioneering procedure has begun at NNUH to improve care for patients with suspected lung cancer.

The hospital has become the first in the UK to establish a service with its own equipment to carry out navigational bronchoscopies, which is the medical equivalent of creating a sat nav map around a patient's lung to take a biopsy.

The procedure uses an ultrasound probe – Radial EBUS in conjunction with real time Navigational Equipment – to take a sample of a patient's suspected tumour, which will enable hospital staff to diagnose the cancer.

The NNUH is leading the way after buying the state-of-the-art technology and is less invasive than other biopsy methods.

The first navigational bronchoscopy with radial EBUS at the hospital was carried out by consultants Ajay Kamath and Luaie Idris working closely with the Trust's radiology department.

Dr Kamath said: "We do a CT scan and identify the areas where we want to do a biopsy. We then reconstruct an image of the lungs, which creates a road map of the lungs and shows how we can reach the tumour.

"It is a less invasive procedure to get the biopsy and the risks of puncturing the lung are less. It will help us to do biopsies of more deep-seated tumours that are not accessible by a standard camera (bronchoscope).

"By doing the biopsy we will be able to see what kind of cancer it is and the patient will receive the best treatment for that cancer. We have worked very closely with our colleagues in radiology to develop this service."

August 2018

Information Governance Toolkit Attainment Levels

Information governance (IG) training is mandatory for all staff members and is renewed on an annual basis. The Trust continued to raise awareness of Information Governance and the importance of protecting personal information with its staff members through a comprehensive training programme. To complement this learning, a wealth of policies, guidance and best practice are made available to staff members via the Trust's intranet. The Trust did not attain Level 2 in Requirement 112 of the IG Toolkit (IG Training) and an action plan is in place to resolve this anomaly.

IG Toolkit Assessment Summary Report
NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
(Acute Trust)
Prepared on 20/02/2019

Assessment	Stage	Overall Score	Self-assessed Grade	Reviewed Grade
Version 14.1 (2017-2018)	Published	76%	Not Satisfactory	Satisfactory

Grade Key

Not Satisfactory	Not evidenced Attainment Level 2 or above on all requirements (Version 8 or after)
Satisfactory with Improvement Plan	Not evidenced Attainment Level 2 or above on all requirements but improvement actions provided (Version 8 or after)
Satisfactory	Evidenced Attainment Level 2 or above on all requirements (Version 8 or after)

The Norfolk and Norwich University Hospitals NHS Foundation Trust Information Governance Assessment Report overall score for 2018/19 was 76% and was graded: Green – 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 2018/19 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 2018/19:

18 Weeks Referral to Treatment (RTT)

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 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 2018/19 results

26 Audits were completed

11 Specialties improved on 2017/18 results
04 Specialities achieved the Trust target of 90%
03 Specialties achieved the same results as 2017/18
12 Specialties decreased in performance

The Trust reviewed the results and patterns of errors from the 2018/19 audit programme and have 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.

Staff Training

The 18 week eLearning package 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.

2019 Training Programme

The Data Quality team plan to roll out a 12 month training programme starting April 2019. The team will be taking a back to basics approach. Policy, process and RTT validation coaching/workshops will be scheduled with all Admin Managers, Deputy Admin Managers and RTT Validators. Knowledge and skills can then be shared to all team members within Specialty.

The training time is protected and allows the data quality team to schedule training around busy operational requirements.

Key System Audit Programme 2018/19

The Key Systems rolling audit programme aims to ensure the Trust maintains accurate data, is able to report correctly attracting the correct level of income for work undertaken and to ensure information used in the service line reporting is accurate, valid, reliable, timely, relevant and complete. The Data Quality Team maintains an audit program of Key Systems and databases within the Trust. The audit programme will be made up of the following components which will provide data quality assurance to the Trust as well as providing vital evidence required under Information Governance:

- A rolling Key System audit work plan.
- A Data Quality Key Systems Questionnaire to ensure compliance of NHS standard definitions and values.
- Cost & Volume (C&V) data criteria as provided by Commissioning Information Department, which forms the basis for the sample of data selected to be analysed. The C&V criteria will be updated by Commissioning Department on an annual basis.
- Comprehensive audit report listing all findings and recommendations.

The audit progression and outcomes are reported to the Information Governance Steering Group (IGSG) which feeds into the Trust Access Group chaired by the COO.

7 audits have been completed to date:

Somerset Cancer Register
RIS
ORSOS
Symphony
eMEDRenal
Cystic Fibrosis
CaptureStroke

3 Key Systems Audits are currently in progress:

ARIA (Training of new Auditor)
Intellect
Direct Access Orthotics

Status of Audit Actions to date

STATUS	HIGH	MODERATE	LOW	VERY LOW	TOTAL
Escalation 1	0	0	0	0	**0**
Escalation 4	0	0	0	0	**0**
Active	18	20	0	5	**43**
In Progress	7	3	2	4	**16**
New Action	4	5	2	1	**12**
Re-Opened	1	5	0	0	**6**
Closed	3	6	0	0	**9**
Resolved	39	28	3	4	**74**
TOTAL	**72**	**67**	**7**	**14**	**160**

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 (APC), Outpatient Care(OPC) and A&E (the only exception is Data Item – Patient pathway ID on APC & OPC)

Data Quality Maturity Index (DQMI)

The roll out of the Data Quality Maturity Index (DQMI) provides healthcare data submitters with timely and transparent information about their data.
Moving forward the NNUH will be using this tool to benchmark performance as the DQMI will highlight any data issues or in fact give assurance we have no issues.

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/

Summary of In-Hospital deaths and deaths within 30 days of discharge for 2018/19

	Total discharge	In-hospital deaths	Deaths within 30 days of Discharge	Total Deaths	Deaths with Learning Difficulties (1)	Deaths with Severe Mental Illness (2)	Still births (3)	Neonatal Deaths (4)
Q1	22484	602	273	875	8	9	11	2
Q2	22420	525	280	805	3	6	5	3
Q3	22476	547	298	845	7	12	4	3
Q4	21995	679	329	1008	2	13	1	5

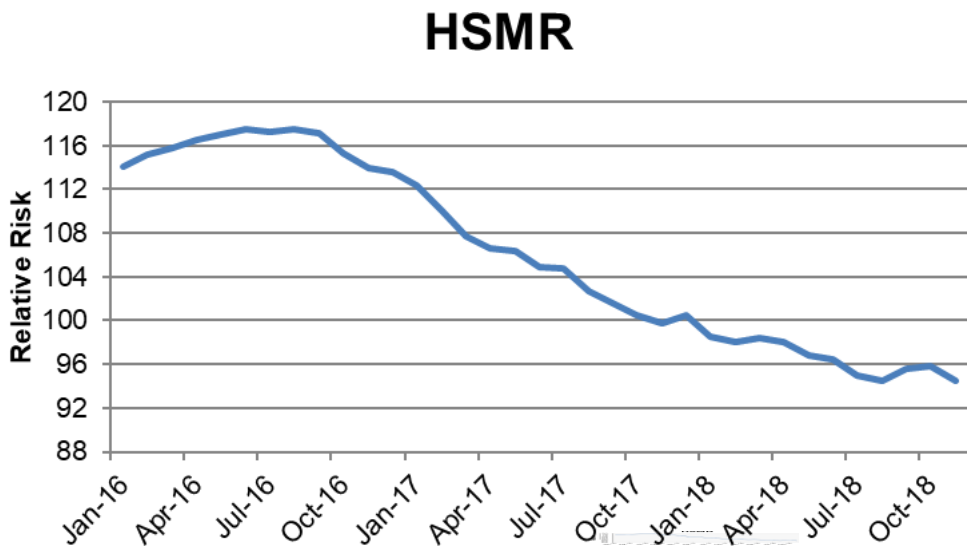
(1) As notified to LeDeR mortality review process
(2) Please note that the diagnostic criteria for SMI are currently under review for 2019/20
The diagnosis codes included for 2018/19 are:
a. F20 to F29 schizophrenia, schizotypal and delusional disorders
b. F30.2 mania with psychotic symptoms
c. F31.2 bipolar, current episode with psychotic symptoms
d. F31.5 bipolar, current episode severe depression with psychotic symptoms
e. F32.3 severe depressive episode with psychotic symptoms
f. F32.3 recurrent depressive disorder, current episode severe with psychotic symptoms
g. X60 to X84 intentional self-harm
(3) Stillbirths delivered from 24 weeks notified to MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK)
(4) Neonatal deaths from 22 weeks notified to MBRRACE-UK

During 2018/19, 3533 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: 875 in the first quarter; 805 in the second quarter; 845 in the third quarter; 1008 in the fourth quarter.

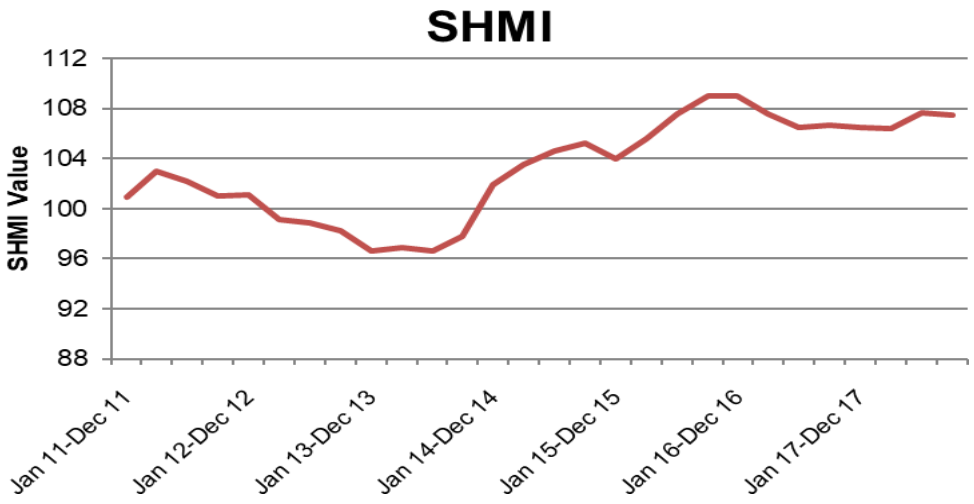
By 1st April 2019, there were1256 case record reviews carried out and 10 deaths, on review, were considered potentially preventable.

The number of deaths in each quarter for which a case record review or an investigation was carried out was: 403 in the first quarter; 409 in the second quarter; 309 in the third quarter; 135 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.

The 10 cases where a death was considered potentially preventable, represents 0.28% of the patient deaths during the reporting period. In relation to each quarter, this consisted of: 4 representing 0.46% for the first quarter; 2 representing 0.25% for the second quarter; 3 representing 0.36% for the third quarter; 1 representing 0.10% for the fourth quarter.



HSMR (hospital standardised mortality ratio) is an indicator of healthcare quality that measures whether the number of deaths in hospital is higher or lower than you would expect



SHMI (Summary Hospital-level Mortality Indicator) reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published monthly as a National Statistic by NHS Digital. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.

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; the Quality and Safety team has been redesigned and now has an increased focus on family liaison; a Medical Examiner business case is being developed.

World Sepsis Day: NNUH staff praised for quick treatment of sepsis

Staff have been praised for their screening and speed of sepsis treatment at NNUH.

More than 90% of sepsis patients received treatment within an hour of diagnosis, according to new figures.

Time is of the essence when a patient is confirmed to have sepsis, which is why NNUH launched sepsis emergency kits two years ago to speed up the treatment.

New figures show that in April, May and June, 92.6% of patients received intravenous antibiotics within 60 minutes to fight the infection. Almost 85% of patients were screened for sepsis across the hospital during that time.

Dr Michael Irvine, Consultant in Intensive Care Medicine at NNUH, said: “Timely treatment is critical when treating patients for sepsis as survival rates are improved significantly if antibiotics can be administered within 60 minutes of diagnosis.

Patients are also less likely to have serious health complications if we provide prompt treatment. However, sepsis is more difficult to identify than conditions like heart attacks and strokes, as the symptoms are often more generalised and non-specific, so it is important that all staff are aware of the risks and remain vigilant.”

“Performance remains excellent with over 92.6% patients receiving antibiotics within an hour of diagnosis. This is testament to the good awareness across the Trust, embedded pathways for the prompt delivery of antibiotics in sepsis and a continuous educational programme for medical staff across the NNUH about the importance of timely sepsis management,” he said.

The Trust developed an electronic sepsis screening tool in the Emergency Department, which has helped staff detect the condition when carrying out observations on patients, and a project is being worked on to expand electronic screening across the whole hospital.

September 2018

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 2018/19. 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, 2017/18 and 2016/17, are as published by NHS Digital.

SHMI value and banding

Indicator	2017/18 NHS Digital not available				NNUH 17/18	NNUH 16/17
	NNUH Oct-17-Sep-18 Published by NHSI	National Average	Best performer	Worst performer		
SHMI value and banding	1.0748 Band 2	No data yet published	No data yet published	No data yet published	1.0639 Band 2	1.056 Band 2

Location: https://digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi > Download Feb-18 publication > SHMI data at trust level, select from value and banding columns

Latest version available covers Oct-17- Sep-18, published Feb-19

% of patient deaths with palliative care

Indicator	2017/18 NHS Digital not available				NNUH 17/18	NNUH 16/17
	NNUH Oct-17-Sep-18 Published by NHSI	National Average	Best performer – Lowest %	Worst performer – highest %		
% of patient deaths with palliative care coded at either diagnosis or specialty level for the reporting period	43.1%	33.6%	14.3%	59.5%	34.3%	22.1%

Location: https://digital.nhs.uk/data-and-information/publications/clinical-indicators/shmi > Download Feb-18 publication > SHMI data at trust level, select from value and banding columns

Latest version available covers Oct-17- Sep-18, published Feb-19

National Average- https://app.powerbi.com/view?r=eyJrIjoiZDA0NzE1NjYtMGYyNC00ZTJkLTljYTQtYzYzMzFlMjNmZjUxIiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9

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	0.069 (Apr-Sep 2017)	0.089 (Apr-Sep 2017)	0.137 (Apr-Sep 2017)	0.029 (Apr-Sep 2017)	0.099	0.095 (Apr-Sep)

Patient reported outcome scores for varicose vein surgery	(Apr-Sep 2017)	0.096 (Apr-Sep 2017)	0.134 (Apr-Sep 2017)	0.035 (Apr-Sep 2017)	0.099	0.088 (Apr-Sep)
Patient reported outcome scores for hip replacement surgery	0.456 2017/18	0.458 2017/18	No data published	No data published	0.495	0.421 (Apr-Sep)
Patient reported outcome scores for knee replacement surgery	0.342 2017/18	0.337 2017/18	No data published	No data published	0.259	0.293 (Apr-Sep)

Location: https://digital.nhs.uk/data-and-information/publications/statistical/patient-reported-outcome-measures-proms/hip-and-knee-replacement-procedures---april-2017-to-march-2018

Current version uploaded: Apr-17 – March-18 Published Feb 2019
Adjusted average health gain 'EQ-5D Index' scores

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	12.74 Apr-18 – Jan-19	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

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	2017/18 NHS Digital				NNUH 17/18	NNUH 16/17
	NNUHFT	National Average	Best performer	Worst performer		
Trust's responsiveness to the personal needs of its patients during the reporting period.	68.8	68.6	85.0	60.5	68.8	68.2

Location: https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework/current > 4.2 Responsiveness to Inpatients' personal needs
Current version uploaded: Aug-18 // Next version due: Aug-19

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	2018 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.	61.9%	62.6%	81%	39.2%	60.7%	56.3%

Reporting and analysis of the NHS Staff Survey has been changed this year, with the 32 key findings now presented as 10 high level themes, benchmarked against other hospital trusts (see page 61 for full details)

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	2018/19 (Trust Reported)				NNUH 17/18 (Trust reported)	NNUH 16/17
	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	98.89% Q2 2018/19	95.49% Q2 2018/19	100% Q2 2018/19	68.67% Q2 2018/19	98.94	99.31 (Oct-Mar)

Location: https://improvement.nhs.uk/resources/vte-risk-assessment-data-q2-201819/

Data published quarterly

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	2017/18 NHS Digital				NNUH 17/18	NNUH 16/17
	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	11.10	13.65	91.00	1.44	11.10	11.97

Latest data available for 2017/18

Location: https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data#history > use Table_8

Current version uploaded: July-18 // Next version due: July-19

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	2017/18 NHS Digital				NNUH 16/17	NNUH 15/16
	NNUHFT	National Average	Highest	Lowest		
Number and rate of patient safety incidents per 100 admissions	38.55 Q1/2 Rate 42.6 (n6623) Q3/4 Rate 34.5 (n5564)	No data published	No data published	No data published	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	Q1/2 Rate 0.06 (n9) Q3/4 Rate 0.06 (n10)	No data published	No data published	No data published	Q1/2 Rate 0.07 (n12) Q3/4 Rate 0.06 (n10)	0.12 No: 9 (Apr-Sept)

Location: https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework/current/domain-5-treating-and-caring-for-people-in-a-safe-environment-and-protecting-them-from-avoidable-harm-nof/5-6-patient-safety-incidents-reported-formerly-indicators-5a-5b-and-5-4

Current version uploaded: Nov-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. 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.

Review of Implementation of 7 Day Services

Please see page 21.

Review of Speak Up Policy

The Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy (formally the Speak Up Policy) was introduced in August 2018 and carefully explains the four step process to raise and escalate a concern. The Freedom to Speak Up Policy is explained to new staff as part of their Corporate Induction and posters detailing the names and contact details of the Freedom to Speak Up Guardians are displayed across the Trust's premises.

The Policy details the various concerns that should be raised - unsafe patient care, unsafe working conditions, inadequate induction or training for staff, lack of, or poor, response to a reported patient safety incident, suspicions of fraud, or a bullying culture (across a team or organisation rather than individual instances of bullying) – then outlines the process of reporting to a line manager or tutor, or, if unable to raise it with them, details of others who can be approached: Chief Nurse, Medical Director, Chief Operating Officer, etc., and the aforementioned Freedom to Speak Up Guardians. Finally it speaks of contacting the Trust's Chief Executive or Chairman, and if necessary, outside bodies such as NHS England or the CQC.

The Policy talks about confidentiality, and advice and support available for those raising concerns, and then explains how the Speak Up process works. It also addresses the subject of detriment and stresses that if a staff members raises a genuine concern under this policy, they will not be at risk of losing their job or suffering any form of reprisal as a result and that the Trust will not tolerate the harassment or victimisation of anyone raising a concern. Nor will the Trust tolerate any attempt to bully the staff member into not raising any such concern. Any such behaviour is a breach of the Trust's values as an organisation and, if upheld following investigation, could result in disciplinary action. It also says that provided the staff member is acting honestly, it does not matter if they are mistaken or if there is an innocent explanation for their concerns.

A fulltime Speak-Up Guardian, who was recently appointed and joined the Trust in March, supplies the Management Board with monthly updates on 'speak up' issues in order to increase its oversight of issues.

Prestigious accolade for NNUH surgeon

A consultant surgeon has received a prestigious accolade for his work in leading robotic colorectal surgery at NNUH.

Irshad Shaikh has become the first surgeon in Norfolk to be certified by the European Academy of Robotic Colorectal Surgery (EARCS) after completing a robust training and assessment programme.

The first surgeries at NNUH were performed in collaboration with Professor Amjad Parvaiz, one of the country's leading robotic surgeons. A number of recorded procedures were also submitted for independent review.

Mr Shaikh said: "We are one of the few centres in the country to have gone down the EARCS training programme. Safety is our priority and this certificate gives reassurance to our patients.

"It is all about teamwork and this was all made possible because we have a dedicated theatre team."

The Trust has so far carried out 30 robotic colorectal cancer surgeries since carrying out its first in October 2017.

Robotic surgery offers a minimally invasive approach and is more precise because it offers a three-dimensional view and full freedom of movement.

Mr Shaikh added: "We have had fantastic results so far with great clinical outcomes, quicker recovery for patients and we have reduced the length of hospital stay for patients who have received robotic surgery to remove their cancer."

"I would like to thank Richard Wharton, service director, the Urology team, Prof Parvaiz , the theatre scrub team, anaesthetic team, Dilham Ward team, secretarial staff and specialist nurse team."

October 2018

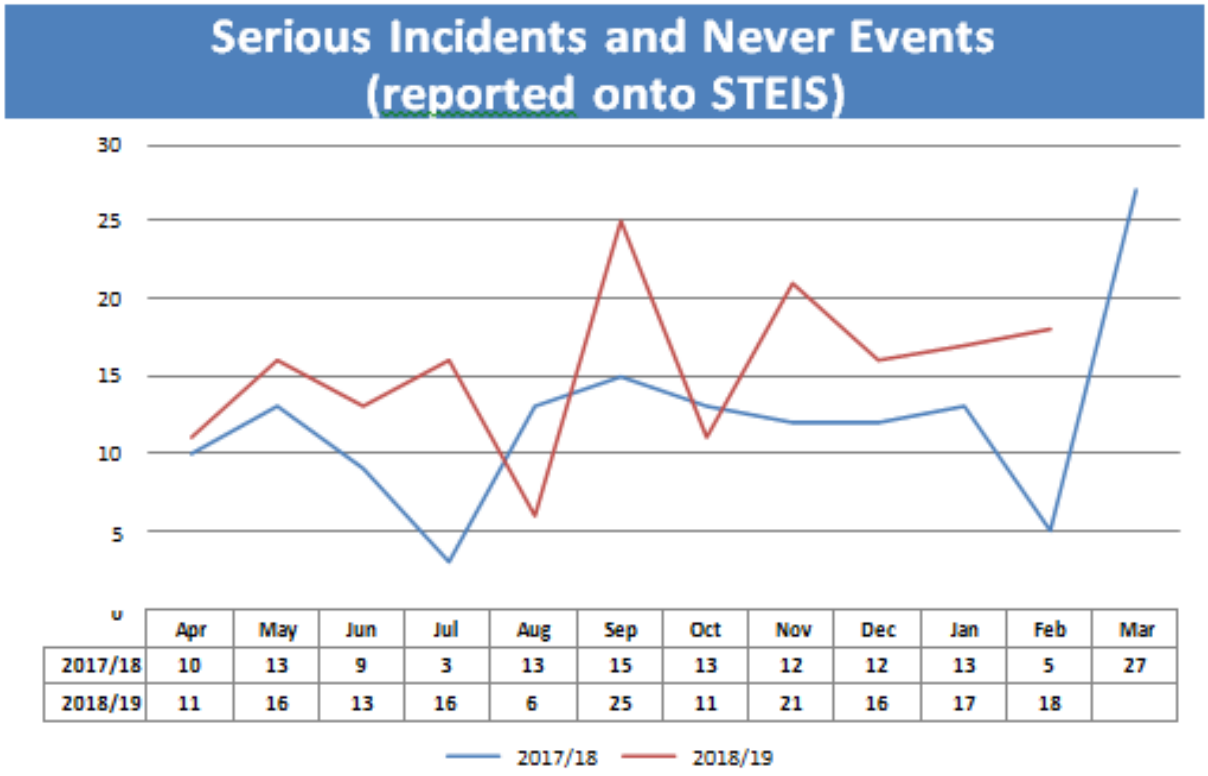
Other Information

Patient Safety – Serious Incidents (SIs)

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

In the twelve months ending 31st March 2019, 17,222 incidents were recorded on DATIX. Of these, 96.85% caused either no harm or low harm to patients. In 2017/18 there were 14,358 reported incidents, of which 98.2% caused no harm or low harm.

The number of reported incidents has increased dramatically in 2018/19 due to an increased awareness of safety issues and an improved quality and safety culture.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	10	13	9	3	13	15	13	12	12	13	5	27
2018/19	11	16	13	16	6	25	11	21	16	17	18	

All incidents reported provide an opportunity for learning and continuous improvement in care delivery. The Trust has continued to support a culture of reporting and in 2018/19 governance structures within Divisions were strengthened providing greater oversight of incidents.

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.

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 (six in 2017/18).

- Insertion of wrong implant (April)
- Retained guidewire (May)
- 'Misplaced' NG Tube (June)
- Retained drain (September)
- Wrong side nerve injection (November)
- Wrong side hip aspiration (January)

Since January 2019 the Trust has adopted a new approach to the governance of Never Events and Serious Incidents – the CEO Assurance Panel. This is an Assurance Panel which is the highest form of governance for the organisation and held only for the most serious of incidents. Incidents are presented to the panel and immediate learning opportunities identified and disseminated with the clinical teams invited to present their updates on the action plan 3 months later. The Panel does not replace the full Root Cause Analysis (RCA) process but will seek to understand what went wrong, what can be done to put things right and most importantly what action needs to be taken to minimise a risk of re-occurrence. The whole purpose is to closely examine the facts of an incident, in order to learn from it.

Patient Safety – Duty of Candour

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.

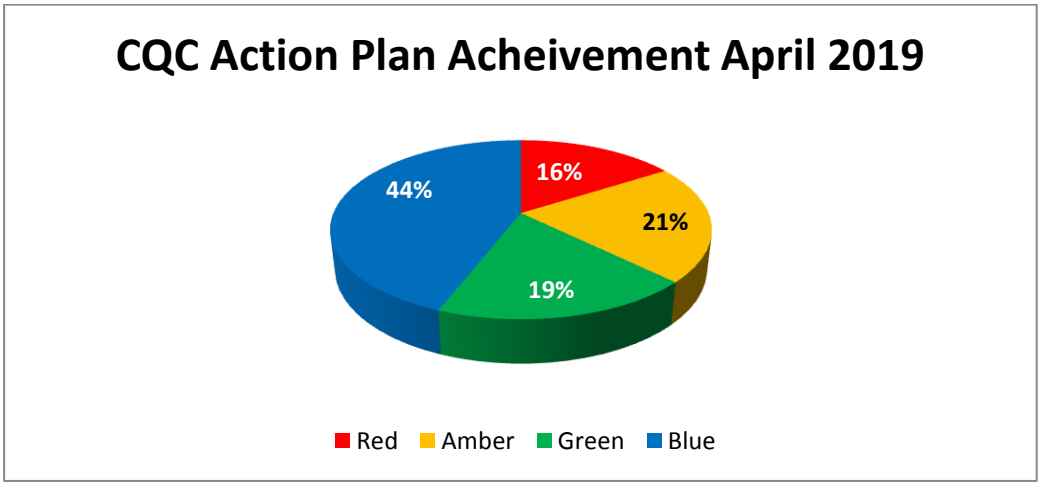
All Moderate Harm or above severity incidents which are reported on Datix are verified at the Trust daily Serious Incident Group Meeting – if moderate Harm or greater is confirmed, Duty of Candour is requested to be met by the relevant clinician within the statutory time frame. Evidence of the completed letter is kept with the Datix investigation report and forms a formal part of the patient 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.

Patient Safety – Care Quality Commission (CQC) ratings and action plan

The Care Quality Commission Inspection between October 2017 and March 2018, published in June 2018, found the Trust had some outstanding practice and care. However, it also found that there were areas of poor practice, management and leadership that resulted in an overall rating of “Inadequate”.

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 the recommendations within the June 2018 inspection report.



Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Full details of CQC Action Plan can be found in Appendix 1.

Clinical Effectiveness – Achieving cancer referral and treatment times

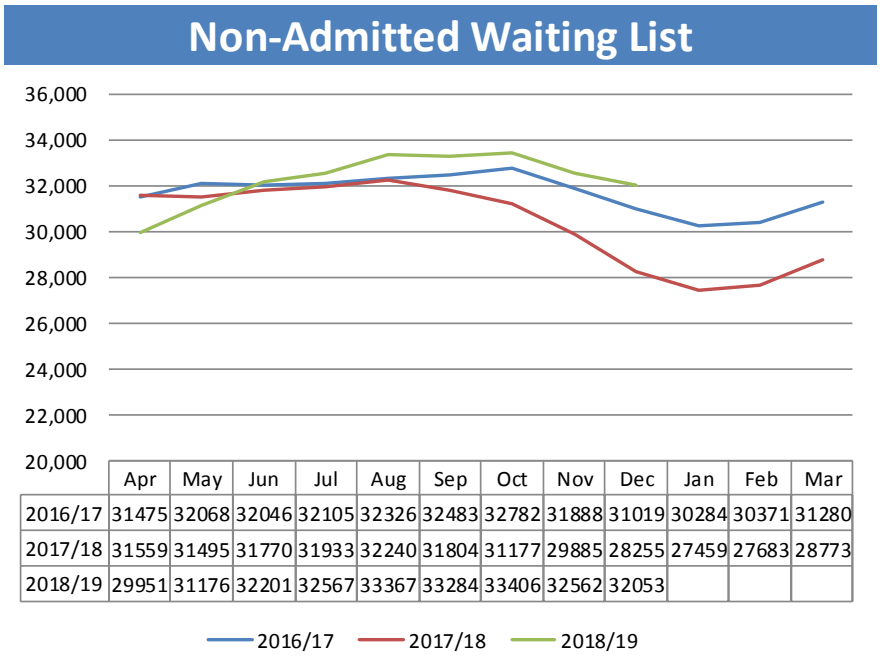
	National Standard	Q1 1819	Q2 1819	Q3 1819
GP 2WW	93%	87.70%	74.09%	75.07%
Breast Sympt 2WW	93%	95.67%	95.96%	55.36%
31 Day First Treat	96%	96.90%	96.56%	96.11%
31 Day Subs ACD	98%	100.00%	99.76%	99.50%
31 Day Subs RT	94%	98.66%	97.99%	97.81%
31 Day Subs Surgery	94%	90.68%	84.50%	83.52%
62 Day GP	85%	73.72%	71.72%	71.85%
Reallocated 62 Day GP**	85%	76.50%	74.15%	72.23%
62 Day Upgrade		53.90%	44.88%	40.78%
62 Day Screening	90%	85.71%	84.93%	78.29%
62 Day Breast Sympt	85%	80.00%	80.00%	0.00%

***Please note that the Reallocated 62 Day GP figures are calculated internally by Cancer Management and not done on a quarterly basis, as such this is the aggregated value of each month within the quarter.*

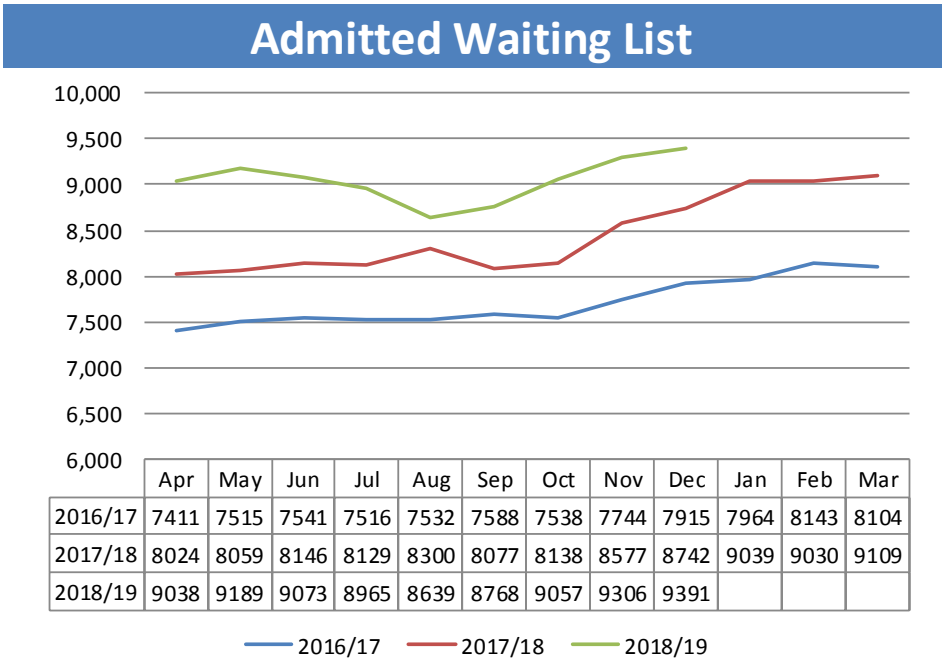
Clinical Effectiveness – 18 week RTT waiting times

In line with National reporting, 2018/19 has seen congestion from increased non elective admissions, particularly over the severe winter period, 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.

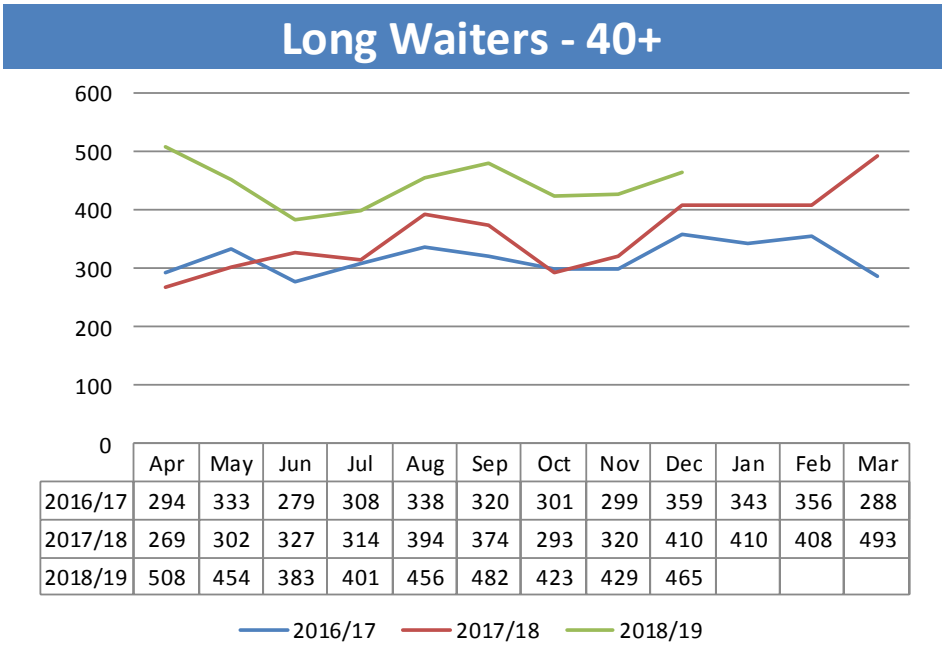
These factors have impacted on the Trusts 18 week referral to treatment performance, however recovery trajectories have been remodelled to take into account revised operational plan and impact of outpatient/daycase/inpatient procedures cancelled during adverse weather.



	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
2018/19	29951	31176	32201	32567	33367	33284	33406	32562	32053			



	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
2018/19	9038	9189	9073	8965	8639	8768	9057	9306	9391			



	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
2018/19	508	454	383	401	456	482	423	429	465			

Clinical Effectiveness – Clinical research and development

Please refer to page 45.

Staff Experience – NHS Staff Survey

All hospitals' staff survey reports are published online at:
http://nhsstaffsurveys2018.com/files/NHS_staff_survey_2018_RM1_full.pdf

3,517 Trust Staff returned the survey form. The report shows a slight decline in overall involvement of 46% (as opposed to 47% in 2017) but still higher than the national average of 44%.

Reporting and analysis of the survey has been changed this year, with the 32 key findings now presented as 10 high level themes, benchmarked against other hospital trusts.

The Significance Testing section of the report, which details the Trust's theme scores for 2017 and 2018 and the number of responses each of these are based on, shows just two of the ten as being 'significantly' lower – Health & Wellbeing: 6.0, with 3495 responses, in 2018 as opposed to 6.2 and 3517 responses in 2017; and Quality of Care: 7.1, with 3125 responses, in 2018 as opposed to 7.3 and 3121 responses in 2017.

Staff engagement with the Trust remains positive, with 61.9% of respondents saying, "I would recommend my organisation as a place to work", up from 60.7% in 2017; and over 75% agreeing "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation".

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

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.

World first for cancer treatment at NNUH

Patients at NNUH were the first in the world to benefit from a new cancer treatment machine.

The state-of-the-art device, called the Varian Bravos afterloader system for brachytherapy treatments, will be used to treat some gynaecological and prostate cancers with a form of radiotherapy at the hospital's Colney Centre.

The new system, made by Varian, can potentially reduce the amount of treatments patients need by directly targeting tumours with high dose rate (HDR) radiotherapy.

Bravos replaces a cancer treatment machine that had been used at NNUH since 2003 and has been funded through the Trust's managed equipment service contract with Medipass Healthcare Ltd.

Vicki Currie, Lead Clinical Scientist for Brachytherapy at the NNUH, said standard radiotherapy uses radiation directed at the tumour from outside the body. Brachytherapy places radioactive sources inside or near a tumour to reduce long-term side effects and reduces the risk of damaging healthy tissue.

She added that brachytherapy can result in less visits to hospital for some patients.

"We hope it will make a difference to patients in Norfolk and the wider area as the only other centres that offer brachytherapy in the region are in Cambridge and Colchester. They can have this done as a day case and it gives us capacity for more patients to be treated," she said.

The new machine received its global launch by Varian at the American Society for Therapeutic Radiotherapy and Oncology conference in San Antonio, Texas, on 20th October 2018.

Patient Experience – Frailty Strategy

During 2018/19 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.

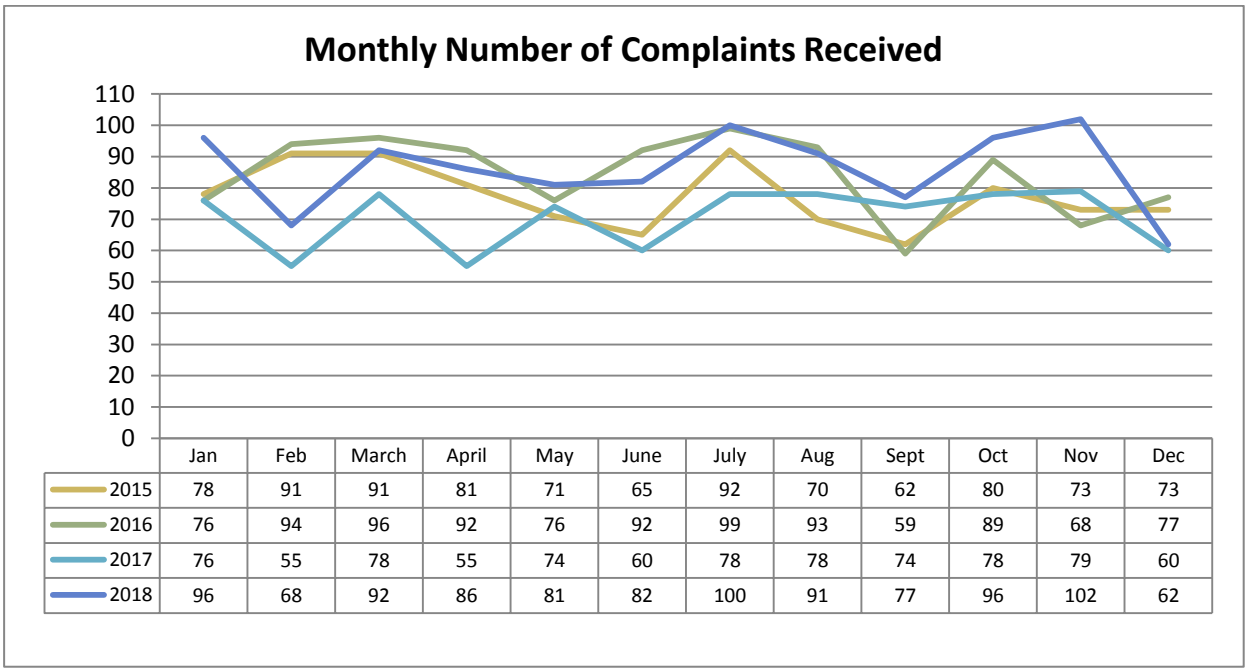
Details of comprehensive Geriatric assessments undertaken on admission during 2018/19 is detailed on page 16.

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



	Jan	Feb	March	April	May	June	July	Aug	Sept	Oct	Nov	Dec
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
2018	96	68	92	86	81	82	100	91	77	96	102	62

To ensure that our complaints processes are ‘patient-focussed’, every year we welcome a team from Healthwatch Norfolk to carry out an independent review of complaints files, most recently in July 2018. We are grateful to Healthwatch for their work with us to provide an additional means of independent assurance with regards to our approach to handling complaints. The Healthwatch Team has been consistently complimentary of our approach to managing complaints and we have been pleased to implement a number of recommendations made by the Healthwatch team.

Each month, based on feedback from senior matrons and clinical teams, as well as using data collected from the QAA process and Friends and Family Test, the CaPE Governance Sub-Board is provided with a 'deep dive' report focusing on a particular theme. In the last year, themes have included reviews of: infection control, premises, medicines management, communication, car parking, end of life care, and clinical treatment in

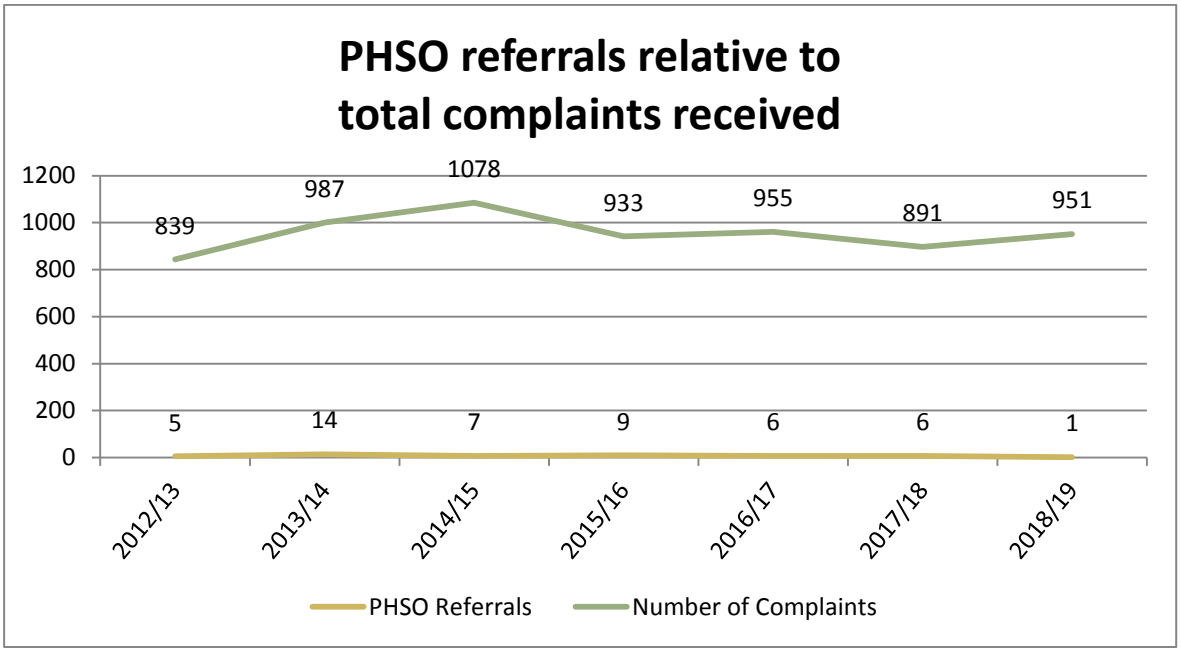
various specialities. This data is used alongside other sources to improve learning across the organisation.

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.

PHSO referrals

The role of the Parliamentary and Health Service Ombudsman (PHSO) in the NHS Complaints Procedure relates particularly to complaints that remain unresolved even once efforts at 'Local Resolution' by the individual Trust are completed. To ensure that the option to appeal to the PHSO is known to our complainants, we provide every complainant with information about how to contact the PHSO if they remain dissatisfied following our complaints investigation.

During the period covered by this report, the number of complaints 'appealed' to the PHSO was as shown below. The number of PHSO referrals from this Trust is low, suggesting success in resolving matters at the first stage of the complaints procedure. The number of appeals to the PHSO in 2018/19 represents approximately 0.1% of complaints received by the Trust:



Plans for year ahead

In 2019/20 responsibility for dealing with formal complaints received by the Trust will transfer to our Patient Experience Team, so that this is integrated with the broader work of improving the experience of our patients across the Trust.

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 the Norfolk and Norwich University Hospital Foundation Trust (NNUHFT) on behalf of the Norfolk and Waveney CCGs (Norwich, North Norfolk, South Norfolk, West Norfolk and Great Yarmouth & Waveney), supports the Trust in its publication of the 2018/19 Quality Account.

Having reviewed the mandatory detail of the report, the CCGs are partially assured that the Quality Account incorporates the mandated elements that are required.

The CCG recognises that NNUHFT has developed and delivered a significant number of quality improvement initiatives during 2018/19. This has included plans to successfully expand the children's and adult's emergency department including the provision of a high dependency unit for children outside of the resuscitation department. The CCG also recognises the ongoing work to ensure that incidents are reported and investigated in a timely way by trained investigators and the more transparent and collaborative working relationship with external agencies to better understand any identified issues and to ensure shared learning.

The CCGs recognise the challenges experienced by the Trust and the impact that this has had on the organisation as a whole, not least on its frontline staff, including feedback from the two Section 29a letters submitted by the CQC and the outcome of the CQC inspection undertaken in March 2018. SNCCG is assured that the Trust has taken ownership of the issues identified in both letters and that good progress is being made towards successful resolution of these. The CCGs also recognise the investment being made into improving leadership and culture across the organisation.

There are two areas that have not been identified by the Trust as priorities for 2019/20 that the CCGs feel would be of benefit and as such should be considered for continued inclusion; Infection Prevention and Control and Electronic Discharge Letters.

The CCGs recognise that while keeping patients safe from infection was achieved based on the number of hospital attributable *Clostridium Difficile* cases and the number of hospital acquired MRSA bacteraemia cases during 2018/19, the NHS Improvement Infection Prevention (IP) visit on 11 February 2019 identified a significant number of concerns, therefore we would expect to see this as a continued quality priority for 2019/20.

The CCG also wishes to receive assurance as to how the NNUHFT will continue to monitor the delivery of seven-day services. We note that this has been rated as 'green' despite Quarter Four data not yet being available.

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 via the Clinical Quality Review Group meetings (CQRG) and the Oversight and Assurance Group. We have also welcomed the opportunity to work with the Trust at Evidence Review Meetings and to be involved in the new Executive level oversight of serious incidents.

Quality Priorities 2018/19

Patient Safety

1) Reduction in medication errors: zero insulin errors causing moderate harm or above.

   The CCGs confirm that NNUHFT only had one incident where a patient had sustained moderate harm or above arising from an insulin error at the end of 2018/19 and welcomes the continued inclusion unchanged in the Trust's quality priorities for 2019/20. The CCGs would encourage the Trust to demonstrate any learning from the investigation into this incident both internally and externally with system colleagues

2) Focus on sepsis to reflect outcomes of Root Cause Analysis (RCA) investigations and themes arising out of mortality review.

   The Trust has included narrative derived from 2018/19 CQUIN submissions which demonstrates an average compliance of 81.4% for sepsis screening and 91.7% for antibiotic administration during quarters one to three. However, no narrative has been included to demonstrate reflection on the outcomes of RCA investigations and themes arising from mortality review. The CCGs request that this continues to be included in the Trust's quality priorities for 2019/20.

3) Improving safe practice through the learning from Never Event (NE) investigations particularly in relation to culture change, teamwork and communication.

   The CCGs recognise the excellent work undertaken with Human Factors training within Obstetrics and Gynaecology and looks forward to seeing this adopted in other areas and staff groups. The Trust should consider how it will report and evidence improvements in clinical practice following training in the forthcoming year.

4) To reflect increased emphasis on older persons care and changes instituted in the NNUHFT for older peoples medicine.

The Trust identified the following as indicators of success:

- Number of Comprehensive Geriatric Assessments undertaken on admission.
- National Audit of Dementia.
- Number of inpatient falls (age related).
- Number of avoidable pressure ulcers (age related).

From the data presented it is only possible to assess how many frailty screening were completed therefore it is not possible to determine if the ambition was achieved.

Clinical Effectiveness.

1) Infection Prevention and Control
   - Methicillin-Resistant Staphylococcus Aureus (MRSA) blood stream infections (BSI), to have 0 hospital attributable cases.
   - *Clostridium Difficile* infection (CDI) to be under the trajectory target of 48 hospital attributable cases.

   The CCG recognises that while keeping patients safe from infection was achieved based on the number of hospital attributable C Difficile cases and the number of hospital acquired MRSA bacteraemia for 2018/19,

following the NHS Improvement Infection Prevention (IP) visit post CQC on 11th February 2019 whereby a significant number of issues were identified the CCG would recommend that this is a continued area of priority for 2019/20.

The evidence presented appears to conflate last year's ambition and the newly defined priority for 2019/20. The CCG also notes that CPE and IP&C Improvement Programme quality priorities are not included.

2) Seven Day Services

The Trust have rated this priority as Green for the year in the absence of quarter four data. It has not been identified as a priority area for 2019/20 as such the CCG would look to the Trust for further detail as to how they will monitor delivery and provide assurance going forward.

Patient and Carer Experience

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

The CCG is not assured from the data presented that the performance has improved significantly as stated and would ask the Trust to confirm that this is the correct data set or if it is incomplete. The CCG would encourage the Trust to continue with this quality priority in 2019/20.

2) Improved continuity of care and experience through reduced ward moves and reduced numbers of patients being nursed in areas that are not primarily focused on the speciality their condition requires.

The Trust has rated this as Green against an ambition of a monthly average of no more than 20. From the evidence presented it would appear that there were only four months where there were less than 20 outliers, with numbers increasing from November 2018. The data for February and March 2019 is incomplete. As such the CCG feels this should be rated Amber and continued as a quality priority going forwards.

3) To improve our care to those at the end of their life.

The Trust has rated this Green but goes on to state that only 45% of patients audited were on an end of life care plan. The CCG would like to receive assurance regarding the remaining 55% of patients.

It is also reported that 50% of patients at end of life had this discussed with them. The CCGs would like to receive assurance regarding the remaining 50% and to better understand the learning behind the information shared and what plans are in place to improve the patient / carer experience.

Quality Priorities 2019/20

The CCGs support the key quality priorities identified for 2019/20. The CCGs do however recommend that the Trust ensures that those quality priorities that were not realised in 2018/19 are continued. NNUHFT 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. NNUHFT should also ensure that improvements are measureable and demonstrable by designing comprehensive measures and patient outcomes against each quality priority identified for 2019/20, especially in those areas where data is incomplete.

The CCGs 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:

- Improvement in frailty provision and care – the CCGs previously stated that they would like to understand in more detail what this priority wanted to achieve and do not feel that the evidence presented demonstrates success or improved outcomes for patients. The CCG recommends and welcomes the continued focus on falls prevention, reducing urinary tract infections and reducing the number of Grade Two and Grade Three Pressure Ulcers.
- Infection Prevention and Control – the Trust should ensure this is a continued priority for 2019/20.
- Serious Incident Investigations – the CCG welcomes the addition of this priority however would encourage the Trust to have an ambition of 100% compliance with national standard with agreed exceptions as opposed to 95% compliance.
- To improve the score in the national inpatient survey relating to responsiveness – The CCG welcomes the addition of this priority, not least as the response rate is currently lower than we would like, as such we recommend that the Trust also include an ambition to increase the overall response rate as well as the score.
- To improve the assessment and quality of care for patients in Mental Health crisis – the CCG is very pleased to see this new priority and commend you on its ambition. The CCG would ask that this includes those patients with a Learning Disability in crisis also.

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. We particularly value the inclusion of children and young people. 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 as noted above. The Trust should continue to explore different ways of increasing and improving feedback and patient / family / carer engagement.

Finally the CCGs recognise, that while the recent staff survey has shown some improvement there are areas that continue to be of concern. The CCG does welcome however NNUH's commitment to improve staff satisfaction through the implementation of a robust Workforce and Organisational Plan.

The CCG looks forward to continuing to work in a positive and collaborative manner with the Trust to promote improvements in patient care and outcomes during the coming year.

Alison Leather
Chief Quality Officer (SNCCG & NNCCG)
1st May 2019

Statement from Norfolk Health Overview and Scrutiny Committee

No return at the time of publication

Statement from Healthwatch Suffolk

No return at the time of publication

Statement from Healthwatch Norfolk

Healthwatch Norfolk Statement –NNUH Quality Report 2018/19

Healthwatch Norfolk appreciates the opportunity to make comments on the NNUH Quality Report.

The introduction from the Chief Executive quite rightly initially focusses on the critical findings of the CQC report, but also emphasizes positive developments – more specialised emergency department provision for children and people over 80 for example. The introduction of a daily serious incident meeting for all staff, the appointment of a full time Right to Speak Up Guardian and the arrival of patients in the new Quadram Institute, in December 2018, are all very welcome developments. Healthwatch Norfolk is also delighted to read that the Trust is accredited as a Veteran Aware hospital.

Current Pressures

Healthwatch Norfolk is aware that the NHS is under pressure for many reasons – for example, 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 the Trust scores 96% on the Friends and family Test. It is also good to note that MRSA (one case) was very low and that CDI reduced slightly by comparison to 2017/18. However, in common with many other hospitals cancer referral and treatment times did not reach the national standard nor did performance in ED.

Format of the Report

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. The provision of a glossary is 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 priorities for improvement for 2018/9 are clearly stated, as objectives, but at this point a large number are only defined as “to be established in quarter 1”.

Incidents

The number of reported incidents at the Trust has increased dramatically in 2018/19 – 17,222 compared with 14,358 the previous year. However the Trust states that 96.85% caused either no harm or low harm to patients and attributes the increase to an “increased awareness of safety issues and an improved quality and safety culture”.

Pressure ulcers and falls have together accounted for the majority of the recorded serious incidents, which have been recorded as averaging 17 per month. There were six never events, the same as the previous year.

Complaints

The number of complaints has increased in 2018, as reported, and Healthwatch are very pleased to have participated in an independent review of complaints files in July 2018, following which recommendations have been implemented by the Trust. It is not possible to say whether an increase in complaints reflects a more open culture or an increase in actual problems.

The Trust has participated in 51/52 national clinical audits and 4/4 national confidential enquiries, which it was eligible to take part in. Details are provided in the Report.

CQC Report

Although the Trust was able to respond to many of the August 2017 CQC report recommendations, unfortunately the follow up June 2018 CQC report put the Trust in special measures, with a finding of inadequate on Safe and Well Led ratings. The Quality report provides a CQC Action Plan, which gives the situation at April 2019, Blue for complete, Amber for Risk to Delivery and Red – Not on Track to Deliver, thereby demonstrating that measures of improvement have been defined, but are currently ongoing.

Workforce

Staff engagement with the Trust remains fairly positive, with 61.9% saying ”I would recommend my organisation as a place to work” up from 60.7% the previous year and over 75% agreeing that “If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation”.

Healthwatch Norfolk remains 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 recommendations for change, where appropriate.

Alex Stewart

Chief Executive

May 2019

Statements from Governors

From: Nina Duddleston
Sent: 29 April 2019
Subject: Quality Report NNUH

Good morning
I have now completed reading through the 114 pages of the report.
My comments are:
As much as the glossary is appreciated a list of Acronyms would also be very useful.
I am aware that when information is first written the Acronym is detailed but when used further in the text it takes time to trawl back through the pages if you need to remind yourself of its meaning.

The tables that are displayed are not very user friendly to those that are not medically trained, a written summary of the contents of these tables would very useful.
Other than these two comments an excellent piece of work. Any other queries I have can hopefully be discussed at future governors meetings.

Kind regards
Nina Duddleston
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 2018/19 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 2018 to March 2019
    - papers relating to quality reported to the board cover the period April 2018 to March 2019
    - feedback from commissioners dated May2019
    - feedback from governors dated April 2019
    - feedback from local Healthwatch organisations dated May 2019
    - feedback from Overview and Scrutiny Committee dated May 2019
    - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2019
    - the 2018 national patient survey
    - the 2019 national staff survey
    - the Head of Internal Audit's annual opinion of the trust's control environment dated May 2019
    - CQC inspection report dated 19/06/2018
- 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 **29 May 2019**

Mark Davies
Chief Executive **29 May 2019**

Glossary of terms

Acute Medical Unit (AMU) Rapid assessment and diagnosis unit for emergency patients

Bacteraemia An infection resulting from presence of bacteria in the blood

BCIS British Cardiovascular Intervention Society

Clinical Audit The process of reviewing clinical processes to improve them

Clinical Governance Processes that maintain and improve quality of patient care

Clostridium difficile, C difficile or C.diff A bacterium that can cause infection

Coding or clinical coding An internationally agreed system of analysing clinical notes and assigning clinical classification codes

CQC, or Care Quality Commission The independent regulator of all health and social care services in England.

CQUIN Commissioning for Quality and Innovation. Schemes to deliver quality improvements which carry financial rewards in the NHS.

CT scan Computed Tomography scanning, a technique which combines special x-ray equipment with computers to produce images of the inside of the body.

DAHNO Data for Head and Neck Oncology, a database of information on head and neck cancer patients

Data Quality The process of assessing how accurately the information and data we gather is held

Datix Datix is a patient safety web-based incident reporting and risk management software for healthcare and social care organizations.

Decile A statistical term, meaning one tenth of the whole.

Delayed Transfers of Care, or DToCs Term for patients who are medically fit to leave a hospital but are waiting for social care or primary care services to facilitate transfer

Dementia The loss of cognitive ability (memory, language, problem-solving) in a previously unimpaired person, beyond that expected of normal aging

Dr Foster A company that has developed a Hospital Standardised Mortality Rate and other data comparisons across the NHS

Drugs, Therapeutics and Medicines Management Committee (DTMM) An internal committee that considers all drug related issues

Early Warning Score (EWS) A clinical checklist process used to identify rapidly deteriorating patients

East of England Ambulance Service (EEAST) The Ambulance Service which covers Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk.

Escherichia coli or E.coli Part of the normal intestinal microflora in humans and warm-blooded animals. Some strains can cause disease in humans, ranging from mild to severe.

GPs General Practitioners i.e. family doctors

Health Protection Agency (HPA) An independent body that protects the health and well-being of the population.

HPV Human papillomavirus – a DNA virus from the papillomavirus family that is capable of infecting humans.

Hospital Standardised Mortality Ratio (HSMR) An indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than should be expected.

ICNARC CMP Intensive Care National Audit and Research Centre Case Mix Programme

LoS Length of stay

MDT Multi-disciplinary Team, composed of doctors, nurses, therapists and other health professionals

MI or Myocardial Infarction A heart attack, usually caused by a blood clot, which stops the blood flowing to a part of the heart muscle

MINAP Myocardial Infarction Audit Project

MRSA Methicillin Resistant Staphylococcus aureus, a strain of bacterium that is resistant to one type of antibiotic

MSSA Methicillin-sensitive Staphylococcus aureus, a strain of bacteria that is sensitive to one type of antibiotic

NBOCAP National Bowel Cancer Audit Programme

NCAA National Cardiac Arrest Audit, the national, clinical audit for in-hospital cardiac arrest

NCE – National Confidential Enquiries A system of national confidential audits which carry out research into patient care in order to identify ways of improving its quality.

Neonates Medical term for babies born prematurely in the first 28 days of life

NHFD National Hip Fracture Database

NICE National Institute for Health and Clinical Excellence

NICU – Neonatal Intensive Care Unit The unit in the hospital which cares for very sick or very premature babies

NIHR National Institute for Health Research

NLCA National Lung Cancer Audit

Norovirus Sometimes known as the winter vomiting bug, the most common stomach bug in the UK, affecting people of all ages

NNAP National Neonatal Audit Programme

NRLS National Reporting and Learning System – A database of patient safety information

Palliative Care Form of medical care that concentrates on reducing the severity of disease symptoms to prevent and relieve suffering

Paediatrics The branch of medicine for the care of infants, children and young people up to the age of 16.

Perinatal Defines the period occurring around the time of birth (five months before and one month after)

PHSO Parliamentary and Health Service Ombudsman

PLACE – Patient Led Assessment of Clinical Environment A national programme that replaced PEAT from April 2013.

PPCI – Primary Percutaneous Coronary Intervention A treatment for heart attack patients which unblocks an artery by opening a small balloon, or stent, in the artery

Prescribing The process of deciding which drugs a patient should receive and writing those instructions down on a patient's drug chart or prescription

Pressure Ulcer Pressure ulcers are a type of injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure. They are also sometimes known as "bedsores" or "pressure sores".

PROM - Patient Reported Outcome Measures A national programme whereby patients having particular operations fill in questionnaires before and after their treatment to report on the quality of care

Quartile A statistical term, referring to one quarter of the whole

RCA or Root Cause Analysis A method of problem solving that tries to identify the root causes of faults or problems

Screening Assessing patients who are not showing symptoms of a particular disease or condition to see if they have that disease or condition

Sepsis Sometimes called blood poisoning, sepsis is the systemic illness caused by microbial invasion of normally sterile parts of the body

Serco The company that provides support services like catering, cleaning and engineering to the Norfolk and Norwich University Hospital

STEMI - ST segment elevation myocardial infarction A heart attack which occurs when a coronary artery is blocked by a blood clot.

Stent A small mesh tube used to treat narrow or weak arteries. Arteries are blood vessels that carry blood away from your heart to other parts of your body.

Streptococcus A type of infection caused by a type of bacteria called streptococcal or 'strep' for short. Strep infections can vary in severity from mild throat infections to pneumonia, and most can be treated with antibiotics.

Stroke The rapidly developing loss of brain function due to a blocked or burst blood vessel in the brain.

Surgical Site Infection (SSI) Occurs when microorganisms enter the part of the body that has been operated on and multiply in the tissues.

TARN Trauma Audit and Research Network

Thrombolysis or thrombolysed The breakdown of blood clots through use of clot busting drugs

Thromboprophylaxis Any measure taken to prevent coronary thrombosis

Thrombosis The process of a clot forming in veins or arteries

Thrombus A clot which forms in a vein or an artery

TIA or Transient Ischaemic Attack This happens when blood flow to a part of the brain stops for a brief period of time. A person will have stroke-like symptoms for up to 24 hours, but in most cases for 1 – 2 hours. A TIA is felt to be a warning sign that a true stroke may happen in the future if something is not done to prevent it.

Tissue Viability (TV) The medical specialism concerned with all aspects of skin and soft tissue wounds including acute surgical wounds, pressure ulcers and leg ulcers

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST ON THE QUALITY REPORT

We have been engaged by the Council of Governors of Norfolk and Norwich University Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Norfolk and Norwich University Hospitals NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following two national priority indicators:

- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge;
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers;

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 2018/19* ('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 Guidance.

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 2018 to May 2019;
- papers relating to quality reported to the board over the period April 2018 to May 2019;
- feedback from commissioners, dated 22 May 2019;
- feedback from governors, dated 22 May 2019;
- feedback from local Healthwatch organisations, dated 22 May 2019;
- feedback from Overview and Scrutiny Committee, not received at time of publishing.
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the 2018 national patient survey, dated February 2019;

- the 2017 national staff survey, dated June 2018;
- Care Quality Commission Inspection, dated 15 May 2019;
- the 2018/19 Head of Internal Audit's annual opinion over the trust's control environment, dated 29 May 2019; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Norfolk and Norwich University Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Norfolk and Norwich University Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may

change over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Norfolk and Norwich University Hospitals NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- 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 indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP

KPMG LLP
Chartered Accountants
Botanic House
100 Hills Road
Cambridge
CB2 1AR
22 May 2019

29 May 2019

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

A&E Waiting Times – Total time in the A&E department

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 (two-week 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

APPENDIX 1 – CQC ACTION PLAN APRIL 2019

CQC Domain	Recommendation	Desired Outcome ('What does good look like?)	Recommended Completion Date	Estimated OUTCOME delivery date	Status
Caring	The trust must ensure that patients are treated with dignity and respect at all times.	QAA evidence and collection of feedback which reflects patients are treated with dignity and respect and in accordance with guidance and policy; Patients involved as core members of all quality committees; Formal Patient Panel has been implemented	01/04/2019	01/04/2019	**AMBER - Risk to delivery**
Caring	The trust should review its communication aids available to assist staff to communicate with patients living with a sensory loss, such as hearing loss.	We self-assess against national accessible information standards & action plan in place Patients and carers involvement Identify pilot site for next phase to test	01/04/2019	01/04/2019	**BLUE - Complete & evidenced**
Effective	The trust must review the knowledge, competency and skills of staff in relation to the Mental Capacity Act and Deprivation of Liberty safeguards.	i) QAA evidence that staff have appropriate understanding of MCA/DOLs, know when, how and why to invoke the guidance and can talk with confidence about a positive MH culture ii) > 90% of appropriate staff are compliant with MCA & DOLs training iii) Audit - 100% compliance with	02/01/2019	31/03/2019	**BLUE - Complete & evidenced**

		accurate recording of MCA/DOLs decision in patient notes iv) Reduction in complaints related to contravention of MCA/DOLs guidance			
Effective	The Trust must ensure that staff annual appraisal completion improves	Trust appraisal completion for AfC staff should be at or above 80%.; There will also be an associated improvement noted within the staff survey questionnaire	01/02/2019	01/02/2019	**BLUE - Complete & evidenced**
Effective	The trust must ensure that local audit findings are utilised to identify actions for improvement and that these are monitored, and reviewed.	i) QAA evidence that staff have appropriate understanding of audits local to their area, and can talk with confidence about audit action plans and outcomes ii) Documentary evidence (meeting minutes, action logs etc.) to show that audit outcomes are discussed widely (Divisional, Directorate, Departmental, Clinical Governance and Team meetings), that action plans are drawn up, and that the learning/feedback loop is closed, and learning disseminated through a regular	01/04/2019	31/01/2019	**BLUE - Complete & evidenced**

		Audit OWL			
Effective	The trust must ensure that the healthcare records for patients' subject to restraint are complete and in line with the trust's policy and procedure.	Named lead for Reduction of Restrictive Intervention (RRI) in place; RRI strategy and protocol signed off and in place; Clear reporting and performance monitoring measures available; Staff training plan in place and trajectory agreed; Scenario based training sessions carried out in high risk areas to embed learning	01/10/2018	30/06/2019	**AMBER - Risk to delivery**

Effective	The trust must review 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms to ensure they are completed fully and in line with trust policy and national guidance.	i) QAA evidence that staff have appropriate understanding of DNACPR, feel confident of their ability to initiate and record conversations and can talk with confidence about a positive culture around care of the dying ii) Audit - Improved recording of DNACPR conversations in patient notes iii) Reduction in complaints related to contravention of DNACRP documented conversations iv) Evidence of shared approach with partner agencies	01/03/2019	01/04/2019	**GREEN - On track to deliver**
Responsive	The trust should ensure effective processes are in place for the timely completion of diagnostic reports.	Diagnostic reports are available to clinicians within a time period that is appropriate for clinical risk.	01/12/2018	31/03/2020	**AMBER - Risk to delivery**
Responsive	The trust should ensure that diagnostic imaging services are provided on a seven-day basis, in line with national guidance.	Scheduled seven-day access to diagnostic imaging services is available to inpatients	01/06/2019	31/03/2020	**AMBER - Risk to delivery**
Responsive	The trust must review the bed management and site management processes within the organisation to	Increased capacity and flow resulting in improved performance in key flow metrics (e.g. 4 hour target,	External review August 2018. Discharge Lounge open by 1 November 2018	01/12/2019	**BLUE - Complete & evidenced**

	increase capacity and flow and ensure effective formalised processes are in place to ensure patient safety in all escalation areas.	stranded patients and median time of discharge)			
Responsive	The trust must embed the recently formalised processes for review and assessment of escalation areas to reduce the risk to patient safety	Increased capacity and flow resulting in improved performance in key flow metrics (e.g. 4 hour target, stranded patients and median time of discharge)	External review August 2018. Discharge Lounge open by 1 November 2018	01/12/2019	**GREEN - On track to deliver**
Responsive	The trust must ensure that lessons learnt from concerns and complaints are used to improve the quality of care.	Divisions have easy access to their complaint and PALS enquiries via Datix system A monthly complaints synopsis is discussed at Monthly Governance meetings Documentary evidence of dissemination of learning and closing the loop (e.g. OWLs)	01/02/2019	30/04/2018	**AMBER - Risk to delivery**
Responsive	The trust should ensure that the management of referrals into the organisation reflects national guidance in order that the backlog of patients on an 18-week pathway are seen.	Patients complete their first definitive treatment or are discharged within the standards set out in the NHS Constitution (Achievement of RTT targets and standards) Patients that sit outside of 18W	01/10/2018	31/10/2019	**BLUE - Complete & evidenced**

		criteria have clinical review			
Responsive	Ensure complaints are responded to in line with the complaints policy deadline of 25 working days.	Complaints response time within 25 days reported through monthly complaints report, received by CaPE	01/09/2018	30/11/2018	**RED - Not on track to deliver**
Responsive	The trust must improve its performance times in relation to national time of arrival to receiving treatment (which is no more than one hour), four-hour target and monthly median total time in A&E.	ED is meeting all access targets that are either contractual or recommended by the College of Emergency Physicians including: Percentage of Patients admitted, transferred or discharged within four hours. Percentage of patients waiting between four and 12 hours from the decision to admit until being admitted. Number of patients waiting more than 12 hours from decision to admit until being admitted. Percentage of patients that left the trust's urgent and emergency care services before being seen for treatment.	01/08/2018	01/08/2019	**AMBER - Risk to delivery**

		Median total time in A&E per patient			
Safe	The trust must ensure that observational audits of the quality of the World Health Organisation (WHO) and five steps to safer surgery checklists are undertaken.	The WHO and five steps to safer surgery checklists are correctly completed and recorded for every procedure for which they are required. Learning from checklist completion is disseminated across the organisation.	01/10/2018	31/12/2018	**BLUE - Complete & evidenced**
Safe	The trust must ensure that specialist personal protective equipment, such as the integrity of lead aprons, is checked on a regular basis.		01/09/2018	31/12/2018	**BLUE - Complete & evidenced**
Safe	The trust must ensure that the call bell system within nuclear medicine is fit for purpose.	Patients in nuclear medicine are able to alert staff for their need for help in an emergency.	01/12/2018	31/12/2019	**BLUE - Complete & evidenced**

Safe	The trust must ensure that the environment, equipment storage, medicines management and infection control procedures are appropriate in the interventional radiology unit. (S)	(NB - this recommendation actually refers to the CT/MRI anaesthetic area). An appropriate environment is maintained in the CT/MRI anaesthetic area.	01/12/2018	01/12/2018	**BLUE - Complete & evidenced**
Safe	The trust should ensure that diagnostic imaging equipment remains fit for use through the implementation of a capital replacement programme.	All diagnostic imaging equipment is fit for purpose, correctly maintained and replaced when necessary.	01/03/2019	31/03/2020	**BLUE - Complete & evidenced**
Safe	The trust must ensure that there is effective governance, safety and quality assurance processes within the theatre department that are structured, consistent, and monitored to improve practice and reduce risk to patients.	Theatre governance meetings and theatre governance lead role established. Theatre OWL (per Specialty) highlighting risk - disseminated monthly by Theatre Governance Facilitator Consistent approach across all directorates is evident at Directorate Governance Leads Meetings Identified risks acted on appropriately or in a timely manner with supporting	01/03/2019	01/03/2019	**RED - Not on track to deliver**

		actions in place			
Safe	The trust must ensure that the World Health Organisation (WHO) and five steps to safer surgery checklist is completed appropriately, and that learning from incidents and regular monitoring processes become embedded to empower staff to challenge and report any poor practice.	Audit data and learning outcomes displayed in department and discussed in Theatre management group Observational and compliance audit programme in place Regular reporting of output from both compliance and observational audits provided All specialties / departments and divisions review learning from incidents and other forms of intelligence in their governance meetings and this is clearly documented in the minutes template and action log	01/03/2019	01/03/2019	**BLUE - Complete & evidenced**

Safe	The trust should ensure that theatre staff adhere to the dress code policy.	Theatre dress code policy reviewed and updated, where appropriate. All theatre staff aware and adhere to policy Regular audit of compliance of dress code in theatres and feedback process in place	01/10/2018	30/03/2019	**GREEN - On track to deliver**
Safe	The trust must ensure that mandatory training attendance improves to ensure that all staff are aware of current practices. (TW)	Trust Mandatory Training compliance is above 90% with no significant pockets of low achievement either by department or course, and all staff complete the appropriate level associated with their roles. QAA evidence to show that staff are also able to exhibit knowledge gained from these courses. Any new mandatory courses will be expected to....	02/01/2019	31/03/2019	**AMBER - Risk to delivery**
Safe	The trust must ensure that there is an effective process for quality improvement and risk management in all departments	We have a Trust Wide QI Strategy with an implementation plan in place, communicated to staff	Strategy completed and agreed by 1 October 2018 - other dates to be set against the implementation plan that will be within the strategy	31/01/2019	**BLUE - Complete & evidenced**

Safe	The trust must ensure that there is an effective process for quality improvement and risk management in all departments.	An informed understanding of high operational risks, reflected through a revised risk register and managed through an effective risk management group Risk management systems that are fit for a high performing health organisation Risk information that flows from specialities through Divisions to the board and aligned to the Board Assurance Framework Board members that provide strong leadership in a risk-based approach embedded within the quality governance framework and set a clear expectation to all staff regarding the management of risk Wider teams and individual staff are equipped to use a risk-based approach for the challenge of delivering revised expectations and are prepared for an environment where continual improvement and	External Governance review completed by 1 November 2019. Risk Registers reviewed and refreshed by 2 January 2019. Revised Governance structure in place together with Risk management procedures by 1 March 2019	01/03/2019	**RED - Not on track to deliver**

		management of risk is the norm			
Safe	The trust must ensure that resuscitation equipment is checked in accordance with trust policy.	Policy reviewed, updated and available on the intranet Trollies replaced and meet current standards Compliance audit of checking equipment completed Process for ongoing monitoring agreed (included real time dashboard visibility to identify check status) and communicated by Divisional Nursing Directors following audit analysis	01/10/2018	31/12/2018	**RED - Not on track to deliver**

Safe	The trust must ensure that action plans are monitored and that action is taken following the investigation of serious incidents	i) QAA evidence that staff have appropriate awareness of incidents and know when, how and why to log incidents and 'great catches' on DATIX and can talk with confidence about a positive safety culture ii) Increased recording of incidents and 'great catchs' on DATIX iii) Minuted evidence of incident reviews & RCAs, eg. a SI OWL iv) Evidence that SIs are being discussed at Departmental Clinical Governance meetings v) Documentary evidence of dissemination of learning and closing the loop across divisions	01/10/2018	31/03/2019	**BLUE - Complete & evidenced**
Safe	The trust must ensure that there are effective systems and processes in place to ensure assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are healthcare associated.	QAA evidence that staff, patients and visitors have appropriate awareness of IP&C guidance, act in accordance with guidance and policy, and can talk with confidence about a positive IP&C culture Metric: Remain within the NHSI objectives for MRSA and C. diff. Documentary evidence of	01/08/2018	31/12/2018	**BLUE - Complete & evidenced**

		dissemination of learning and closing the loop (e.g. IP&C OWLs) Improved IP&C audit outcomes, in particular the HII audits which should attain a minimum of 80% Reduction in complaints related to IP&C			
Safe	The trust must ensure staff compliance improves for major incident training	90% or more of all staff members that need major incident training have received the required training. Staff members are able to articulate the nature of a major incident, their individual actions and escalation processes.	01/12/2018	31/12/2018	**RED - Not on track to deliver**
Safe	The trust must ensure that oxygen cylinders are stored safely, that oxygen is readily available in all patient areas, and that this equipment is properly maintained.	Oxygen cylinders are stored in accordance with Health and Safety Executive (HSE) guidance, specifically to keep cylinders chained or clamped to prevent them from falling over. Piped oxygen equipment is checked at the required frequency with records kept of checks made. All oxygen equipment is maintained according to the	01/10/2018	31/12/2018	**BLUE - Complete & evidenced**

		required schedule.			
Safe	The trust must ensure that patient venous thromboembolism (VTE) risk assessments are completed.	i) QAA evidence that junior doctors and nursing staff have appropriate awareness of the importance of TRA and can explain how to carry out & record a TRA and how to administer appropriate thromboprophylaxis ii) Metric: XX% reduction in preventable PEs and DVTs iii) Documentary evidence of dissemination of learning and closing the loop (e.g. RCAs and incident reporting)	01/12/2018	31/03/2019	**BLUE - Complete & evidenced**
Safe	The trust must ensure that necessary risk assessments and healthcare records are complete for mental health patients.	i) QAA evidence that staff have appropriate understanding of MH risk assessments, know when, how and why to conduct & record them, and can talk with confidence about a positive MH culture	01/11/2018	01/05/2018	**GREEN - On track to deliver**

		ii) >90% of appropriate staff are compliant with MH risk assessment training iii) Audit - >90% compliance with accurate recording of MH risk assessments in patient notes iv) Reduction in complaints related to contravention of MH policies			
Safe	The trust must ensure that computers are locked and that patient healthcare records are stored securely.	Patient records and trust computer equipment are secure and protected at all times.	01/12/2018	31/03/2019	**AMBER - Risk to delivery**
Safe	The trust must ensure that incidents are reported and investigated in a timely way by trained investigators	A robust system of incident review is in place with an agreed response time target for incident review and ongoing monitoring of compliance levels The Trust have a Serious Incident Group (SIG) in place Reporting and incident investigation training available to staff and guidance material provided	01/03/2019	01/03/2019	**BLUE - Complete & evidenced**
Safe	The trust must ensure that medicines and contrast media are stored securely and in line with national guidance	i) QAA evidence that staff have appropriate understanding of the storage of medicines and contrast media,	02/01/2019	28/02/2019	**BLUE - Complete & evidenced**

		and are compliant with SOPS ii) Audit - Improved audit outcomes			
Safe	The trust must ensure temperature charts for blood and medicine fridges are appropriately completed and records held in line with national requirements.	Audit process in place. Reported via Medicine Management Committee and feedback provided to areas. Part of the Perfect Ward suite of metrics included as part of the performance dashboard. QAA evidence that staff have appropriate awareness of national requirements when completing records concerning temperature charts for blood and medicine fridges	01/11/2018	31/12/2018	**RED - Not on track to deliver**
Safe	The trust should ensure that effective processes are in place for correct handling and disposal of clinical waste, including sharps bins, and that storage of chemicals is secure in line with the Control of Substances Hazardous to Health (COSSH) guidelines.	Clinical waste is handled and disposed of appropriately and risks to staff safety are minimised	01/11/2018	01/11/2018	**BLUE - Complete & evidenced**

Safe	The trust should ensure morbidity and mortality meeting minutes include sufficient detail of background information, discussions and those in attendance.	i) Evidence to show that Morbidity and Mortality meetings are multi-disciplinary, attended by the appropriate people, minuted, and the outcomes/learning are disseminated appropriately ii) Improved HSMR	01/09/2018	30/06/2019	**AMBER - Risk to delivery**
Safe	The trust should ensure that specialist personal protective equipment is checked on a regular basis and worn appropriately by staff.	Processes are in place to ensure staff receive sufficient protection effectively from radiation and hazardous materials: 1) Policies and processes are in place that cover the logging, checking and maintenance of specialist PPE 2) Functioning specialist PPE is available to staff at the point of need 3) Staff are trained on the appropriate use of specialist PPE	01/09/2018	31/12/2018	**RED - Not on track to deliver**
Safe	The trust should continue to monitor and actively recruit to ensure that there is an adequate number of nursing staff with the appropriate skill mix to care for patients in line with national guidance.	Comprehensive staffing review to include the exploration of different roles to support frontline care delivery and against national recommendation carried out; e-rostering policy in place and communicated to	01/04/2019	01/04/2019	**AMBER - Risk to delivery**

		staff; Staffing establishment agreed that is fit for purpose and supports a flexible acuity demand with recruitment plan agreed and in place; Three times a day cross divisional staffing meetings and review of red flag events in place			
Safe	The trust should ensure that staff carrying out Root Cause Analysis (RCA) investigations for serious incidents receive appropriate RCA training.	Rolling programme of RCA training with sufficient capacity to meet demand established; Protected time for staff to undertake training in place; Target number of staff trained in each specialty; Uptake and compliance monitored .	01/12/2018	01/12/2018	**BLUE - Complete & evidenced**
Safe	The Trust must ensure that the premises for urgent and emergency services protect patients from potential harm and used for the intended purpose. This includes all areas of the service for both children & adults.	The ED department will have: - Suitable Handwashing sinks throughout the department - A sluice within Children's ED - A HDU for Children and Young people outside of Resus. - Children and young people ED area is large enough to accommodate all children and young people.	01/10/2018	01/11/2018	**BLUE - Complete & evidenced**

		- Waiting facilities for Children and Young people large enough to accommodate all children and young people separate from adult waiting space. - Secured access to Children's ED for both entry and exit. - Piped oxygen and suction available in all ED patient areas. - Suitable areas for mental health patients that can be isolated from environmental and ligature risks if required following patient environmental risk assessments.			
Safe	The trust must ensure that there is a system in place, which is adequately resourced, to ensure that patients are assessed, treated and managed in a time frame to suit their individual needs. (The trust should review its use of the Rapid Assessment and Treatment (RAT) system and ensure this is embedded into practice.)	The RAT column on symphony is used consistently or replaced with another system of identifying RATs patients and their outcomes. That all appropriate patients go through the RATs process in its operational hours or staff member working.	01/11/2018	01/10/2019	**GREEN - On track to deliver**

Safe	The trust must action its plans to expand the children's and adults emergency department, including the provision of a high dependency unit for children outside of the resuscitation department.	The Emergency Department will have: Additional space in adult and paediatric areas compared to November 2017 as outline in plans submitted to the CQC. A HDU area for children outside of the resuscitation area	01/09/2018	01/11/2018	**BLUE - Complete & evidenced**
Safe	The trust must review its nursing and medical staffing numbers for the urgent and emergency services and plan staffing acuity accordingly	The medical and nursing numbers within ED reflect the acuity and volume of patients. Allowing all shifts to be equally busy and the ability for 95% of patients to be discharged, transferred or admitted within 4 hours when all policies and procedures are followed. Follow policy on weekend and night shifts	01/10/2018	01/10/2019	**GREEN - On track to deliver**
Safe	The trust must review its nursing and medical staffing numbers for the urgent and emergency services and plan staffing acuity accordingly	The medical and nursing numbers within ED reflect the acuity and volume of patients. Allowing all shifts to be equally busy and the ability for 95% of patients to be discharged, transferred or admitted within 4 hours when all policies and	01/10/2018	01/10/2019	**GREEN - On track to deliver**

		procedures are followed.			
Safe	The trust must ensure that there is one registered children's nurse at all times within the children's emergency department and take necessary action to increase the number of registered children's nurses employed.	A children's nurse is available 24/7 within Children's ED in a sustainable manner. This will be noted on roster and also in QAA a paediatric nurse will also be available.	01/10/2018	01/10/2019	**GREEN - On track to deliver**
Safe	The trust must ensure a good skill mix within the children's ED nursing workforce.	There is a nursing establishment that reflects the Children's ED SOP recommended levels. With shifts rostered to ensure appropriate seniority of staff on shifts.	01/12/2018	01/10/2019	**GREEN - On track to deliver**

Safe	The trust must ensure audio and visual separation between adults and children being assessed and waiting within the emergency department and minor injuries unit.	There must be suitable sized facilities for Children to ensure that they can always wait and be treated in a paediatric only environment other than those requiring resuscitation. Children should not have to walk through adult treatment areas to access paediatric areas.	31/03/2019	31/03/2019	**AMBER - Risk to delivery**
Safe	The trust must ensure emergency equipment, including ligature cutters and children's resuscitation equipment is readily available.	The ED department will have: - Suitable Handwashing sinks throughout the department - A sluice within Children's ED - A HDU for Children and Young people outside of Resus. - Children and young people ED area is large enough to accommodate all children and young people. - Waiting facilities for Children and Young people large enough to accommodate all children and young people separate from adult waiting space. - Secured access to Children's ED for both entry and exit. - Piped oxygen and suction available in	01/10/2018	01/11/2018	**BLUE - Complete & evidenced**

		all ED patient areas. - Suitable areas for mental health patients that can be isolated from environmental and ligature risks if required following patient environmental risk assessments.			
Safe	The trust must ensure that there is a medical lead appointed for the service.	A medical lead is in post and working as part of the departmental triumph ate. The staff within ED can identify their medical lead in QAA.	01/08/2018	01/08/2018	**BLUE - Complete & evidenced**
Safe	The trust must ensure that there is a local audit programme in place for the service, that action plans are in place and necessary improvements are made to practice following audit.	All audit plans are complete including the dates. That audit samples are appropriate and not too low and that all audits have associated action plans. All audits with action plans should have a date of repeat audit planned.	01/09/2018	31/03/2019	**AMBER - Risk to delivery**
Safe	The trust should ensure that regular and minuted mortality and morbidity meetings take place for urgent and emergency services.	Morbidity and mortality are discussed in a meeting either within another meeting or a separate meeting. This meeting must be fully minuted. The learning and lessons from these are reported to the divisional and trust wide meetings to share practice.	01/09/2018	01/11/2018	**BLUE - Complete & evidenced**

Safe	The trust should ensure that a safety thermometer is implemented for children's and adult urgent and emergency services.	A method of showing the prevalence patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in harm free care. It is suggested this is via the safety thermometer and national paediatric safety thermometer. N.B. the CQC are aware that this information is reported in the nursing dashboard and still requested the safety thermometer implementation.	01/10/2018	31/03/2019	**BLUE - Complete & evidenced**
Safe	The trust should ensure that sepsis training is available to all staff providing urgent and emergency care.	All staff have a record of receiving Sepsis training and a standard programme of training is available to deliver the training. QAA all staff are able to discuss how to identify and treat a patient with suspected sepsis	01/12/2018	01/12/2018	**RED - Not on track to deliver**
Safe	The trust must ensure there are effective governance processes in place to ensure timely and appropriate capacity and risk assessments for mental health patients are undertaken	The service has a robust process to monitor the quality of medical documentation, including a programme of weekly audits to evaluate compliance with use of:			**RED - Not on track to deliver**

		• The deliberate self-harm proforma • Mental capacity assessment, including second stage assessments • Risk assessments for patients with MH concerns to ensure steps are taken to keep patients safe. • The ED Adult Mental Health Triage Form with the results presented at clinical governance meetings and the mental health board, and disseminated monthly through the ED newsletter			
Safe	The trust must review and monitor the use of the Clinical Decisions Unit for patients who present with mental health requirements, to ensure that patients are protected from potential harm	• The CDU SOP and CDU Deliberate Self Harm Protocol have been revised to ensure that the circumstances under which patients can be transferred is made explicit • CDU pathways for patients who present with mental health requirements have been reviewed to ensure patients are not admitted to CDU with solely a mental health requirement. • Patients at high risk of deliberate self-harm have a further risk assessment prior to their transfer from			**RED - Not on track to deliver**

		ED to CDU, to facilitate the documentation of changes in risk. • An audit programme is in place to monitor compliance with the policies, with the audit results presented at clinical governance meetings and the mental health board, and disseminated through the ED newsletter			
Safe	The trust should continue to monitor and actively recruit to ensure that there is an adequate number of nursing and medical staff with the appropriate skill mix to care for patients in urgent and emergency services	Nursing vacancies have been filled, to enable the three new MH treatment rooms to open appropriately to meet need			**GREEN - On track to deliver**

Safe	The trust must ensure that effective governance and quality assurance processes are in place to measure service improvement. Including escalation of concerns and monitoring of actions arising from meetings, local audits, recommendations from regulators and external reviews.	A documentation audit programme and associated action plan is in place, with the audit results presented at clinical governance meetings and disseminated through the ED newsletter. The audit to cover: • cannula insertion and documentation • IP&C e.g. commode and bed pan cleaning, cleaning log audits • deliberate self-harm risk assessment completion • use of PPE • MH documentation (including MH triage form and safeguarding referrals) ED Clinical Governance meetings take place monthly, with multi-disciplinary attendance, and are fully and comprehensively minuted to evidence that all agenda items are discussed and that audit outcomes and action plans are reviewed.			**GREEN - On track to deliver**

Safe	The trust must ensure that effective processes are in place, and monitored, to ensure clinical policies and guidelines are regularly reviewed and updated in line with national guidance	• The Deliberate Self Harm and Shared Decision Making Policies have been reviewed, and updated versions are available to all staff on Trust Docs and ED notice boards • Compliance with the ED SOP for ambulant patients is monitored at monthly clinical governance meeting, as evidenced by Agendas and meeting minutes • Compliance with the ED Protocol for the Management of Patients with a Mental Health Need within the ED Interview Room is monitored at monthly clinical governance meeting, as evidenced by Agendas and meeting minutes • An up to date risk assessments is in place for all areas used for the assessment and treatment of patients with MH concerns • The Consent working group has completed all the actions on its Action Plan, and the plan has been signed off at a Clinical Governance			**AMBER - Risk to delivery**

		meeting.			
Safe	The staff must improve staff understanding of isolation procedures and ensure that compliance is regularly monitored	♦Compliance with Isolation procedures is monitored through the Clinical Governance meeting, as evidenced by Agendas and meeting minutes ♦There is a programme of regular audit for IP&C, cannula insertion etc. and results are monitored and acted upon through the Clinical Governance meeting, as evidenced by Agendas, meeting minutes and action plans ♦The consistent use of Infection Risk cards is used in areas where patients are being isolated, and compliance is monitored through the Clinical Governance meeting, as evidenced by Agendas, meeting			**GREEN - On track to deliver**

		minutes			
Safe	The trust should ensure that the emergency department strategy is regularly reviewed	There is an agreed and published ED strategy available to all staff on Trust Docs and ED notice boards, and review dates are set to ensure that the strategy remains current.			**GREEN - On track to deliver**
Safe	The trust should ensure that all relevant information is gathered and reviewed during incident investigations, including input from all relevant staff, external stakeholders and specialist providers	• Staff carrying out incident investigations are fully trained in RCA • The MH Liaison Team is fully involved in all incident investigations relating to patients whom they have reviewed • A review has been carried out on the effectiveness of joint working and communication between the trust and the mental health liaison team, and changes have been implemented as a result of the review • The quality of Serious Incident RCA is monitored through the Clinical Governance meetings, as evidenced by			**BLUE - Complete & evidenced**

		meeting minutes and agendas.			
Safe	The trust should ensure that information is gathered to monitor whether areas within the urgent and emergency service are being utilised as intended	• There is a process in place to collect and analyse data showing where patients have been treated in inappropriate environments such as the Review Clinic room and CDU. • This data is reviewed, monitored and acted upon at monthly Clinical Governance meetings, as evidenced by Agendas, minutes and action logs.			**RED - Not on track to deliver**
Safe	The trust should review the level of scrutiny and oversight that the mental health board provides	• The Mental Health Board agenda allots sufficient time in each meeting for a full discussion of learning from incidents, risk register review and review of local audit findings and action plans • Agenda and meeting minutes evidence that these items have been fully discussed at each meeting			**AMBER - Risk to delivery**

Well-Led	The trust should ensure that there is ongoing monitoring of the outpatient service, including the re-development of an outpatient dashboard.	Improved outpatient services as evidenced by achievement of key performance targets in the Outpatient Dashboard.	01/10/2018	31/12/2019	**AMBER - Risk to delivery**
Well-Led	The trust must ensure that leadership, culture and behaviours within the operating theatre department are actively addressed.	Standard operating procedures in place to support consistent approach and accountability from the senior leads across the theatre specialities Appropriate leadership structure in place with additional leadership roles of Senior Matron and Operational Manager for Anaesthetics and Theatres within Surgical Division Theatre OWL (per Specialty) - disseminated monthly by Theatre Governance Facilitator Speak Up Guardian role promoted in theatres Theatre Safety Huddle in place Surgical teams have participated in Human Factors	01/05/2019	01/05/2019	**GREEN - On track to deliver**

		training to improve communication/team work			
Well-Led	The trust must improve the relationship and culture between the site management team and the Senior Nursing and Clinical teams to ensure open dialogue where patient safety is equally weighted to operational pressure to reduce risks to patients and staff.	The operational meetings and decision making takes place within Trust policy, which is well known by staff and ensures the best Trust wide safety. QAA evidence that staff can challenge and raise safety issues within the operational meetings and with the site operational team. Where decisions are made against standard Trust policy they are recorded as to why policy was breached and the mitigating action to return to normal service ASAP.	31/12/2018	31/03/2019	**RED - Not on track to deliver**

Well-Led	The trust must review process for whistleblowing and take definitive steps to improve the culture, openness and transparency throughout the organisation.	An updated whistleblowing policy. Evidence that whistle blows and speak up reports are reviewed and actioned as appropriate. QAA evidence that all staff know how to whistle blow and raise concerns and would feel they could do so without negative consequence.	Clarity regarding approach to staff engagement by 1 September with expected start of implementation of a Trust wide programme by 2 January 2019	02/01/2019	**BLUE - Complete & evidenced**
Well-Led	The trust must improve the functionality of the board and ensure formalised processes are in place for the development and support of both current and new executive directors. The trust must improve the level of oversight, scrutiny and challenge from the chair and non-executive directors (NEDS). (The trust should ensure that regular review of the executive portfolio takes place to ensure capacity and capability to deliver requirements.)	Development plans being in place for members of the board. Evidence ? Board minutes highlighting the challenges from NEDs.	01/03/2019	01/03/2019	**BLUE - Complete & evidenced**

Well-Led	The Trust must ensure consistency processes are in place for recruitment, fit and proper persons regulation and line management at executive level.	Review of Fit and Proper Persons regulation and ensuring all executives are compliant. 80% of Executives having current appraisals in line with the Trust target. All Executives have a current Personal Development Plan.	01/08/2018	30/11/2018	**BLUE - Complete & evidenced**
Well-Led	The Trust should review the support managers provide to support staff in times of increased demand	Structured Management programme for all line managers. A reasonable maximum number of staff to report to each member of management to allow us to "know our staff". Clear lines of operational, medical and nursing management in all areas 24/7.	01/08/2018	31/03/2019	**AMBER - Risk to delivery**
Well-Led	The trust should ensure that staff carrying out Duty of Candour applications receive appropriate training.	Training provision reviewed, alternative approaches utilised and clear guidance for staff on their responsibilities provided Divisional Governance Managers trained to ensure that there is a local 'expert' to support staff All COS / Ward and Department leads trained in DoC	02/01/2019	02/01/2019	**BLUE - Complete & evidenced**

FINANCIAL STATEMENTS
FOR THE YEAR ENDED 31 MARCH 2019

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Contents

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 2019 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Equity and 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 2019 and of its 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 2018/19 and the Department of Health and Social Care Group Accounting Manual 2018/19.

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: financial statements as a whole	£12m (2018:£11.5m) 2% (2018: 2%) of total income

Risks of material misstatement		vs 2017/18
Recurring risks	Valuation of land and buildings	◀▶
	Revenue Recognition	◀▶
	New: Non-pay expenditure recognition	◀▶

2. Material uncertainty related to going concern

	The risk	Our response
We draw attention to note 1 to the financial statements which indicates that The Trust's outturn position for 2018/19 was a deficit of £60.6 million against a planned deficit of £55 million. The Trust's financial plans for 2019/20 show a forecast deficit position of £20.7 million. This includes cost savings of £26.6 million and also includes an assumption of further DHSC cash support of £29.3 million. Without this cash support, the Trust would not be able to continue to operate. At present, there are no viable means for the Trust to repay its existing DHSC support loans, or any new ones which are received during 2019/20. The Trust forecasts its support borrowings to be £140.4 million at 31 March 2020. 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.	**Disclosure quality** There is little judgement involved in the Accounting Officer's conclusion that the risks and circumstances described in note 1 to the financial statements represent a material uncertainty over the ability of the Trust to continue as a going concern for a period of at least a year from the date of approval of the financial statements. However, clear and full disclosure of the facts and the Accounting Officer's rationale for the use of the going concern basis of preparation, including that there is a related material uncertainty, is a key financial statement disclosure and so was the focus of our audit in this area. Auditing standards require that to be reported as a key audit matter.	Our procedures included: — **Assessing transparency:** we assessed the completeness and accuracy of the matters covered in the going concern disclosure by: — Using our professional judgement to determine whether the basis of preparation note adequately describes the challenges facing the Trust; and — Agreeing the financial balances disclosed back to the Trust's financial statements for 2018/19 and financial plan for 2019/20.

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2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on:the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In arriving at our audit opinion above, the key audit matters, in decreasing order of audit significance, were as follows:

	The risk	Our response
Valuation of land and buildings (£228 million; 2017/18: £219 million) *Refer to pages 15 to 18 (accounting policy) and pages 32 to 34 (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 Trust commissioned a full revaluation as at 31 March 2015 and an interim revaluation as at 31 March 2017. In the current year the Trust has commissioned its valuer to perform an assessment as to whether any material movements have occurred. The valuation of land and buildings relies on the expertise of the valuer and the appropriateness of the assumptions adopted. The effect of these matters is that, as part of our risk assessment, we determined that the valuation of land and buildings has a high degree of estimation uncertainty, with a potential range of reasonable outcomes greater than our materiality for the financial statements as a whole.	Our procedures included: — **Assessing valuer's credentials:** critically assessing the scope, qualification, expertise 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.

2. Key audit matters: our assessment of risks of material misstatement (continued)

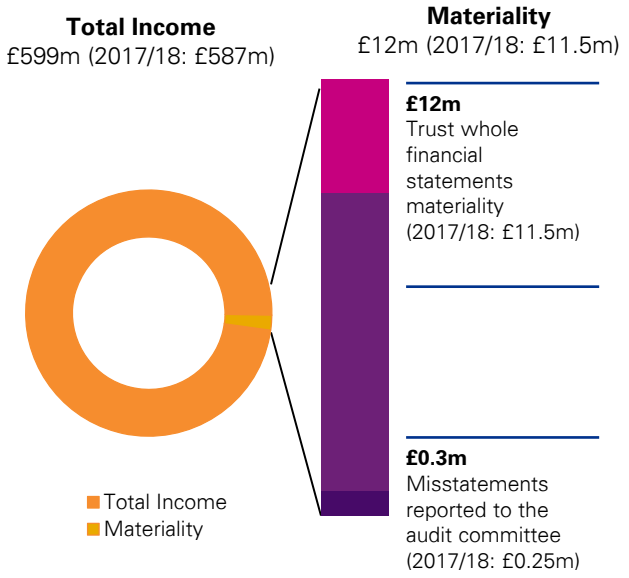
	The risk	Our response
NHS and non-NHS Revenue Recognition (£599 million; 2017/18: £587 million) *Refer to pages 14 to 15 (accounting policy) and page 25 (financial disclosures).*	**Subjective estimate:** The main source of income for the Trust is the provision of healthcare services to the public under contracts with NHS commissioners. NHS revenues are subject to an 'agreement of balances' exercise which is undertaken between all NHS bodies. 'Mismatch' reports are available setting out discrepancies between the submitted transactions and 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 revenue. These mismatches can arise at year end due to disagreements regarding activity levels and contract performance. The Trust reports £78.6 million of other operating income. Other operating income includes education and training revenues of £24.4 million and £5.6 million of research and development revenues. There is a risk that the Trust recognises income to which it is not entitled and which should not be recognised in the year.	Our procedures included: — **Test of detail:** obtaining the outcome of the agreement of balances exercise with other NHS bodies. Where there were mismatches over £300,000 we sought explanation and supporting evidence to verify the Trust's entitlement to the revenue. — **Test of detail:** obtaining copies of the Trust's must significant contracts by value. Where there were significant variances we sought explanation and supporting evidence to verify the Trust's income balance. — **Test of detail:** testing a sample of NHS and non-NHS revenue transactions before and after the year end to supporting documentation to agree the items were recorded in the correct year. — **Test of detail:** Assessing the assumptions behind the Trust's non-NHS bad debt provision and compare those assumptions against our own broader knowledge of the NHS sector, and against the Trust's specific bad debt history.
Non-pay expenditure recognition Accruals (£27 million; 2017/18 £24 million) Provisions (£2 million; 2017/18 £2 million) *Refer to pages 21 (accounting policy) and page 36 to 40 (financial disclosures)*	**Effects of irregularities:** As most public bodies are net spending bodies, then the risk of material misstatement due to fraud related to expenditure recognition may be greater than the risk of fraud related to revenue recognition. There is a risk that the Trust may manipulate expenditure to meet externally set targets and we had regard to this when planning and performing our audit procedures. This risk does not apply to all expenditure in the period. The incentives for fraudulent expenditure recognition relate to achieving financial targets and the key risks relate to the manipulation of accrued non-pay expenditure and provisions at year-end.	Our procedures included: — **Test of detail:** we tested payments made and invoices received in April 2019 to identify whether they indicate that an accrual or provision is missing from the 31 March 2019 Statement of Financial Position; and have performed a sample test of accruals and provisions to supporting evidence to ensure these are accurate and valued appropriately. We critically appraised the basis on which provisions were made and considered the appropriateness of significant estimates supporting the provisions. — **Test of detail:** we compared provisions and accruals recognised at the previous year-end against actual outturn, to evaluate management's ability to accurately estimate year-end liabilities and have performed a year-on-year review of accruals and provisions, and sought explanation for significant movements; — **Test of detail:** We reviewed releases of accruals and provisions in March 2019 to ensure the release was appropriate.

3. Our application of materiality

Materiality for the Trust financial statements as a whole was set at £12 million (2017/18: £11.5 million), determined with reference to a benchmark of total income (of which it represents approximately 2%). We consider total 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 £0.3 million (2017/18:(£0.25 million), in addition to other identified misstatements that warranted reporting on qualitative grounds.

Our audit of the Trust was undertaken to the materiality level specified above and was all performed at the Trust's headquarters in Norwich.



4. 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 2018/19.

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 2018/19, 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.

5. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 104, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are 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; 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 adverse

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.

Adverse 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 2019.

Basis for adverse conclusion

The Trust's outturn position for 2018/19 is a deficit of £60.6 million. The £60.6 million deficit represents a £5.6 million deterioration against its budget of a £55 million deficit. The Trust has £112 million of interim revenue support facility borrowings from the Department of Health and Social Care at year end and is forecasting a further requirement of support totalling £28 million during 2019/20.

The Trust does not currently have agreed plans in place to return to breakeven in the medium term. Current plans and forecasts do not indicate that the Trust will be able to repay the revenue support borrowings in the medium term.

During the year the Trust was placed in special measures by the CQC and as at the year end the overall CQC rating for the Trust was 'inadequate'. Since year end the Trust has been rated as 'requires improvement' but remains in special measures.

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 2018/19, 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 for securing 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 NHS Improvement exposes the Trust to operational and financial challenges in terms of financial sustainability.	Our work included: — Performing an analysis of the Trust's outturn position against plan and CIP target at year-end; — Considering the forecast future performance in the Trust's 2019/20 Annual Plan submission and assessing the Trust's requirement for further borrowings to support the cash position. **Our findings on this risk area:** The Trust's 2018/19 outturn position shows a deficit of £60.6 million which represents a £5.6 million deterioration to budget of £55 million deficit. The 2019/20 Operational Plan shows that the Trust is forecasting a deficit of £20.7 million. The Trust's interim revenue support facility borrowings increased to £112 million at year-end. The Trust is forecasting an additional requirement of £28 million in borrowings during 2019/20. The Trust's deficit, deterioration against plan, and future borrowings requirement are evidence of weaknesses in proper arrangements for planning finances effectively to support the sustainable delivery of the Trust's strategic priorities.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources (continued)

Significant risk	Description	Work carried out and judgements
Regulatory findings	In June 2018 the Trust was placed into special measures after being rated inadequate by the CQC. Since the year end this rating has been improved to 'requires improvement' however the Trust remains in special measures.	Our work included: — Reviewing the CQC's reports on the Trust during the year; and — Reviewing the Trust's action plan in response to the CQC findings. **Our findings on this risk area:** For the majority of the year the Trust was rated as 'inadequate' and the Trust continues to be in special measures. Therefore we have qualified our value for money opinion in respect of this finding.

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
29 May 2019

KPMG

Foreword to the Accounts

These accounts, for the year ended 31 March 2019, 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: 29 May 2019

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2019

STATEMENT OF COMPREHENSIVE INCOME	Note	Year ended 31 March 2019 £'000	Year ended 31 March 2018 £'000
Operating income	3	520,914	491,180
Other operating income	4	78,579	95,489
Operating expenses	6	(627,948)	(575,861)
OPERATING (DEFICIT) / SURPLUS		**(28,455)**	**10,808**
FINANCE INCOME AND EXPENSES			
Finance income	12	160	58
Finance expense - financial liabilities, including unwinding of discount on provisions	14	(32,347)	(30,421)
PDC dividends payable	28	0	0
NET FINANCE COSTS		**(32,187)**	**(30,363)**
(DEFICIT) FOR THE YEAR		**(60,643)**	**(19,555)**
Other comprehensive income			
Revaluations	15	0	0
TOTAL COMPREHENSIVE (EXPENSE) FOR THE YEAR		**(60,643)**	**(19,555)**

The accompanying notes form an integral part of the Financial Statements

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2019

STATEMENT OF FINANCIAL POSITION	Note	31 March 2019 £'000	31 March 2018 £'000
Non-current assets			
Property, plant and equipment	15	232,598	234,750
Trade and other receivables	18	78,154	71,245
Total non-current assets		**310,752**	**305,995**
Current assets			
Inventories	17	10,438	9,369
Trade and other receivables	18	29,638	28,544
Cash and cash equivalents	19	7,462	5,733
Total current assets		**47,538**	**43,646**
Current liabilities			
Trade and other payables	20	(65,376)	(58,164)
Other liabilities	22	(5,851)	(5,138)
Borrowings	21	(24,890)	(2,847)
Provisions	25	(282)	(307)
Total current liabilities		**(96,399)**	**(66,456)**
Total assets less current liabilities		**261,892**	**283,185**
Non-current liabilities			
Trade and other payables	20	0	0
Other liabilities	22	(5,875)	(4,606)
Borrowings	21	(280,859)	(246,249)
Provisions	25	(2,128)	(2,159)
Total non-current liabilities		**(288,862)**	**(253,014)**
Total assets employed		**(26,970)**	**30,171**
Financed by (taxpayers' equity)			
Public dividend capital		31,909	28,408
Revaluation reserve		14,969	15,003
Income and expenditure reserve		(73,848)	(13,239)
Total taxpayers' equity		**(26,970)**	**30,171**

The financial statements on pages 10 to 47 were approved by the Board on 29th May 2019 and signed on its behalf by:

Signed: .....(Chief Executive) Date: 29 May 2019

The accompanying notes form an integral part of the Financial Statements

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2019

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total Taxpayers' Equity
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018	**28,408**	**15,003**	**(13,239)**	**30,171**
Deficit for the year	0	0	(60,643)	**(60,643)**
Other transfers between reserves	0	(34)	34	**0**
Public dividend capital received	3,501	0	0	**3,501**
Taxpayers' equity at 31 March 2019	**31,909**	**14,969**	**(73,848)**	**(26,970)**

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**
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 CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2019

	Note	Year ended 31 March 2019 £'000	Year ended 31 March 2018 £'000
Cash flows from operating activities			
Operating (deficit) / surplus		(28,455)	10,808
Operating (deficit) / surplus		**(28,455)**	**10,808**
Non-cash income and expense:			
Depreciation	6	10,438	10,604
Loss on disposal of non-current assets		(23)	1
Income recognised in respect of capital donations (cash and non-cash)		(1,157)	(1,731)
Decrease/(Increase) in trade and other receivables		(1,483)	(7,321)
Decrease/(Increase) in inventories		(1,069)	(965)
(Decrease) in trade and other payables		9,132	(12,327)
(Decrease) in provisions		(62)	(707)
Net cash used in operations		**(12,680)**	**(1,638)**
Cash flows from investing activities			
Interest received	12	155	53
Purchase of property, plant, equipment and investment property		(15,259)	(15,001)
Sales of property, plant, equipment and investment property		1,531	12
Net cash used in investing activities		**(13,573)**	**(14,936)**
Cash flows from financing activities			
Public dividend capital received		3,501	3,291
Movement on loans from the Department of Health		58,935	36,393
Capital element of finance lease rental payments		(174)	(168)
Capital element of PFI, LIFT and other service concession payments		(2,673)	(2,981)
Interest paid on finance lease liabilities		(16)	(21)
Interest paid on PFI, LIFT and other service concession obligations		(30,382)	(29,524)
Other interest paid		(1,504)	(778)
PDC dividend paid		295	585
Net cash from financing activities		**27,982**	**6,797**
Increase / (Decrease) in cash and cash equivalents	19	1,729	(9,777)
Cash and Cash equivalents at start of the year	19	5,733	15,510
Cash and Cash equivalents at 31 March	19	**7,462**	**5,733**

The accompanying notes form an integral part of the Financial Statements

NOTES TO THE ACCOUNTS

1. Accounting Policies and Other Information

1.1 Basis of Preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 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 the accounts.

1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment.

1.2 Going Concern

The Board is required under IAS 1 Presentation of Financial Statements to undertake an assessment of the Trust's ability to continue as a going concern. Due to the materiality of the financial deficit, the Board has carefully considered the advice in the Department of Health and Social Care Group Accounting Manual 2018/19 that “The anticipated continuation of the provision of a service in the future, as evidenced by inclusion of financial provision for that service in published documents, is normally sufficient evidence of going concern.” These accounts have been prepared on a going concern basis and the factors taken into consideration in making this assessment are set out below.

The Trust is forecasting a deficit of £20.7m for 2019/20 following a reported deficit of £61.8m in 2018/19 and a deficit of £19.6m in 2017/18. The forecast deficit for 2019/20 is based on a number of assumptions including the delivery of cost savings of £26.6m. The Trust forecast cash position as at 31 March 2020 is a total revenue support borrowing of £140.4m. This assumes that the deficit support required in 2019/20 of £29.3m will be made available. However no agreement for this has been received to date. As with any Trust placing reliance on the DHSC for financial support, the directors acknowledge that there can be no certainty that this support will continue although, at the date of approval of these financial statements, they have no reason to believe that it will not do so.

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 £20.7m for 2019/20 and it is recognised that the plan contains demanding cost improvement targets. The revenue support funds required of £29.3m 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 2019/20 have been signed with the Trust’s main Commissioners.

Based on these indications the directors believe that it remains appropriate to prepare the accounts on a going concern basis. However, the matters referred to above represent a material uncertainty that may cast significant doubt on the Trust’s ability to continue as a going concern and, therefore, to continue realising its assets and discharging its liabilities in the normal course of business. The financial statements do not include any adjustments that would result from the basis of preparation being inappropriate.

1.3 Consolidation

NHS Charitable Fund

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.

1.3.1 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.

NOTES TO THE ACCOUNTS

1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The Trust does not receive income where a patient is readmitted within 30 days of discharge from a previous planned stay. This is considered an additional performance obligation to be satisfied under the original transaction price. An estimate of readmissions is made at the year end this portion of revenue is deferred as a contract liability.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

NHS injury cost recovery scheme

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, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

NOTES TO THE ACCOUNTS

1.4.1 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy 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.

Pension Costs - NHS Pension Scheme

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. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore the schemes are accounted for as though they are defined contribution schemes.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

1.6 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.

1.7 Property, plant and equipment

1.7.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential 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
- 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, had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.
- 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 lives.

NOTES TO THE ACCOUNTS

1.7.2 Measurement

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. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings and dwellings– market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

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 2018/19 for all of the land and property estate.

A full valuation is planned for 31 March 2020.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful 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.

NOTES TO THE ACCOUNTS

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'.

1.7.3 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'
  - the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.7.4 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.

1.7.5 Private Finance Initiative (PFI) transactions

PFI and LIFT 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 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, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to 'Finance Costs' in the Statement of Comprehensive Income.

NOTES TO THE ACCOUNTS

1.7.6 Useful live of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table:

	Min life Years	Max life Years
Buildings, excluding dwellings	2	82
Plant & machinery	1	30
Transport equipment	5	12
Information technology	1	10
Furniture & fittings	5	15

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

1.8 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in first out method. This is considered to be a reasonable approximation to fair value due to the high turnover of inventories.

1.9 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.

1.10 Carbon Reduction Commitment Scheme (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

NOTES TO THE ACCOUNTS

1.11 Financial assets and financial liabilities

1.11.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provision of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes 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 and are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

1.11.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

NOTES TO THE ACCOUNTS

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected credit losses for assets relating to Non NHS bodies are determined by reference to an unbiased probability-weighted approach using recent actual recovery experience. A separate assessment is employed for each of the main sources of Non NHS income.

Expected credit losses in relation to NHS bodies are not normally recognised. They are subject to a separate credit note risk assessment.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

1.11.3 Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.12 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

1.12.1 The Trust as lessee

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 charge 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.

NOTES TO THE ACCOUNTS

Operating leases

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 susequently 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.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.12.2 The Trust as lessor

Operating leases

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.

1.13 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.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to the NHS Resolution, which, in return, settles all clinical negligence claims. Although the NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHS Resolution on behalf of the Trust is disclosed at note 25 but is not recognised in the Trust's accounts.

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 NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.14 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.

NOTES TO THE ACCOUNTS

1.15 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.

At any time the Secretary of State can issue new PDC to, and require payments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.16 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.

1.17 Corporation Tax

The Trust does not fall within the scope of Corporation Tax for the year ended 31 March 2019, neither did it for the year ended 31 March 2018.

1.18 Foreign Exchange

The functional and presentational currency of the Trust is sterling. A transaction denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the dates of the transaction. 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.

1.19 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.

1.20 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

NOTES TO THE ACCOUNTS

1.21 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

An assessment of the Trusts 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 assets 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 assurances that the carrying value for its specialised buildings remains reasonable as at 31 March 2019.

1.22 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

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 2019 or 31 March 2018, 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 describe in 1.7 using estimated useful economic lives.

1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early-adopted in 2018/19.

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.

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.

2018/19:

	Medicine	Clinical Support	Surgery and Cromer	Women, Children and Sexual Health	Emergency	Services	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Pay	75,206	63,001	105,172	39,082	42,148	28,210	**352,819**
Non Pay	84,344	32,264	50,048	6,951	3,868	65,566	**243,041**
Total	**159,550**	**95,265**	**155,220**	**46,033**	**46,016**	**93,776**	**595,860**

2017/18 :

	£'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	39,676	7,473	3,843	55,492	**218,494**
Total	**149,901**	**90,685**	**138,355**	**44,205**	**41,217**	**79,045**	**543,408**

Reconciliation - Pay

	2018/19	2017/18
	£'000	£'000
Employee Expenses - Executive directors (note 6)	0	0
Employee Expenses - Non-executive directors (note 6)	139	139
Employee Expenses - Staff (note 6)	352,665	324,714
VSS & Redundancy (note 6)	15	61
Total	**352,819**	**324,914**

Reconciliation - Non Pay

	£'000	£'000
Operating Expenses (note 6)	627,948	575,860
Less: Pay (see above)	(352,819)	(324,914)
Less: Depreciation (note 6)	(10,438)	(10,604)
Less: Consortium payments (note 6)	(15,870)	(16,321)
Less: Loss on disposal (note 6)	23	(1)
Less: Research and development (note 6)	(5,804)	(5,526)
Total	**243,040**	**218,494**

3. Operating income

3.1 Income from activities

	Year ended 31 March 2019 £'000	Year ended 31 March 2018 £'000
NHS Foundation Trusts	12	0
NHS Trusts	45	66
CCGs and NHS England	511,824	487,461
Local Authorities	0	0
Department of Health	5,190	0
NHS Other	97	97
Non-NHS: Private patients	1,386	1,381
Non-NHS: Overseas patients (non-reciprocal)	300	311
NHS injury scheme (formerly RTA)	1,534	1,314
Non-NHS: Other	526	550
Total income from activities	**520,914**	**491,180**

Substantially all income from activities comes from mandatory services.
NHS injury scheme income is subject to a provision for impairment of receivables of 21.89% (2017/18: 22.84%) 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 (27.31%) and NHS South Norfolk CCG (21.21%, NHS Norwich CCG (22.42%) and NHS North Norfolk CCG (19.12%).

3.2 Income from activities by category

	Year ended 31 March 2019 £'000	Year ended 31 March 2018 £'000
Elective income	94,071	89,779
Non elective income	146,547	138,285
Outpatient income	73,703	68,663
A & E income	17,686	16,020
Other NHS clinical income	180,496	175,427
Private patient income (including overseas visitors)	1,687	1,692
Other non-protected clinical income	1,534	1,314
AfC pay award central funding	5,190	0
Total income from activities	**520,914**	**491,180**

3.3 Overseas Visitors (patient charged direct by the Trust)

	Year ended 31 March 2019 £'000	Year ended 31 March 2018 £'000
Income recognised this year	300	311
Cash payments received in year (all years)	193	197
Amounts added to provision for impairment of receivables (all years)	15	113
Amounts written off in-year (all years)	0	50

3.4 Income from Commissioner Requested Services

Operating income includes income from Commissioner Requested Services as follows:

	Year ended 31 March 2019	Year ended 31 March 2018
Commissioner Requested Services	518,702	488,938
Non-Commissioner Requested Services	2,212	2,242
	520,914	**491,180**

4. Other operating income

	Year ended 31 March 2019 £'000	Year ended 31 March 2018 £'000
Research and development	5,560	5,379
Education and training	24,370	24,263
Donations/grants of physical assets (non-cash) - received from NHS charities	842	1,657
Donations/grants of physical assets (non-cash) - received from other bodies	315	74
Rental revenue from operating leases	203	256
Sustainability and transformation fund (STF)	0	8,357
Other:		
Staff recharges	15,166	14,879
Car parking	2,879	2,886
Pharmacy sales	1,132	1,029
Staff accommodation rentals	835	778
Clinical tests	174	185
Clinical excellence awards	1,052	1,205
Grossing up consortium arrangements	15,870	16,321
Other income	10,181	18,220
Total other operating income	**78,579**	**95,489**

5. Total operating income

Income is from the supply of services.

6. Operating expenses

	Year ended 31 March 2019 £'000	Year ended 31 March 2018 £'000
Services from NHS trusts	56	24
Employee expenses - non-executive directors	139	139
Employee expenses - staff and executive directors	352,665	324,714
Supplies and services - clinical	65,814	63,926
Supplies and services - general	20,518	13,477
Establishment	8,253	8,003
Research and development	5,804	5,526
Transport	504	507
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT) on IFRS basis	23,033	21,152
Premises	18,018	16,500
Movement in credit loss allowance: contract receivables	(163)	0
Movement in credit loss allowance: all other receivables	146	675
Change in provisions discount rate(s)	(21)	21
Inventories written down	173	116
Inventories consumed	78,282	74,799
Rentals under operating leases	5,836	2,139
Depreciation on property, plant and equipment	10,438	10,604
Audit fees payable to the external auditor*		
audit services- statutory audit	68	68
other auditor remuneration (external auditor only)	10	10
Clinical negligence	14,134	11,668
Loss on disposal of non-current assets	(23)	1
Legal fees	75	64
Consultancy costs	1,636	1,536
Internal audit	79	77
Training, courses and conferences	689	486
Patient travel	1,699	1,709
Redundancy	15	61
Insurance	28	80
Other services, eg external payroll	513	44
Grossing up consortium arrangements	15,870	16,321
Losses, ex gratia & special payments	16	11
Other	3,644	1,403
Total operating expenses	**627,948**	**575,861**

* 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 2019 £'000	Year ended 31 March 2018 £'000
Audit Fees- statutory audit	68	68
Assurance services	10	10
TOTAL	**78**	**78**

The Trust's auditors, KPMG LLP (2017/18 KPMG LLP), also audit the associated charity (Norfolk and Norwich University Hospitals NHS Foundation Trust Charitable Fund) for a fee of £6k (2017/18 £6k).

7. Operating leases

7.1 As lessee

Payments recognised as an expense	Year ended 31 March 2019 £'000	Year ended 31 March 2018 £'000
Minimum lease payments	5,836	2,139
Total	**5,836**	**2,139**

Total future aggregate minimum lease payments	Year ended 31 March 2019 £'000	Year ended 31 March 2018 £'000
Payable:		
Not later than one year	6,274	1,640
Between one and five years	24,082	5,500
After 5 years	33,401	16,719
Total	**63,757**	**23,859**

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 2019 £'000	Year ended 31 March 2018 £'000
Rents recognised as income in the year	87	87
Contingent rents recognised as income in the year	115	168
Total	**202**	**255**

Total future aggregate minimum lease payments	Year ended 31 March 2019 £'000	Year ended 31 March 2018 £'000
Receivable:		
Not later than one year	87	87
Between one and five years	350	350
After 5 years	700	787
Total	**1,137**	**1,224**

8. Employee costs and numbers

8.1 Employee costs

	Year ended 31 March 2019 £'000	Year ended 31 March 2018 £'000
Salaries and wages	277,840	258,743
Social security costs	26,861	24,011
Apprenticeship levy	1,383	957
Employer's contributions to NHS pensions	33,731	31,342
Pension cost - other	25	0
Termination benefits	15	61
Agency/contract staff	12,825	9,661
Total	**352,680**	**324,775**

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 2019 Number	Year ended 31 March 2018 Number
Medical and dental	1,109	1,034
Administration and estates	622	559
Healthcare assistants and other support staff	2,890	2,623
Nursing, midwifery and health visiting staff	2,320	2,119
Nursing, midwifery and health visiting learners	7	0
Scientific, therapeutic and technical staff	547	569
Healthcare science staff	373	396
Total	**7,868**	**7,300**

The above numbers are based on whole-time equivalents.

8.3 Staff exit packages

Staff exit packages for the year ended 31 March 2019

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10k	-	-	-
£10k - £25k	1	-	1
£25k - £50k	-	-	-
£50k - £100k	-	-	-
£100k - £150k	-	-	-
£150k - £200k	-	-	-
>£200,000	-	-	-
	1	**-**	**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	-	-	-
	-	**5**	**5**

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 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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 latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

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 2018/19 there were 3 (2017/18: 3) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements are £173k (2017/18: £170k). 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 2019		Year ended 31 March 2018	
	Number	£'000	Number	£'000
Total Non-NHS trade invoices paid in the year	154,153	275,398	156,772	277,444
Total Non-NHS trade invoices paid within target	123,166	237,653	110,233	206,800
Percentage of Non-NHS trade invoices paid within target	80%	86%	70%	75%
Total NHS trade invoices paid in the year	3,149	37,300	3,078	34,461
Total NHS trade invoices paid within target	2,041	17,875	1,345	12,630
Percentage of NHS trade invoices paid within target	65%	48%	44%	37%

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 (2017/18: £nil)

12. Finance income

	Year ended 31 March 2019 £'000	Year ended 31 March 2018 £'000
Interest receivable on bank deposits	160	58
Total	**160**	**58**

13. Other gains and losses

	Year ended 31 March 2019 £'000	Year ended 31 March 2018 £'000
(Loss) on disposal of land, property, plant and equipment	(23)	1
Total	**(23)**	**1**

14. Finance expense - financial liabilities including unwinding of discount on provisions

	Year ended 31 March 2019 £'000	Year ended 31 March 2018 £'000
Interim Revenue Support Facility Cost - Dept. of Health	1,946	873
Finance leases	16	21
Finance Costs in PFI obligations:		
- Main finance costs	17,070	17,327
- Contingent finance costs	13,310	12,197
Unwinding of discount on provisions	6	3
Total	**32,347**	**30,421**

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 2018	**11,710**	**207,284**	**4,278**	**71,293**	**78**	**15,878**	**870**	**311,391**
Additions - purchased	0	4,638	340	3,045	0	611	0	**8,634**
Additions - leased	0	0	0	0	0	0	0	**0**
Additions - donated	0	414	0	705	0	38	0	**1,157**
Reclassifications	0	3,957	(4,104)	1	0	146	0	**0**
Revaluation	0	0	0	0	0	0	0	**0**
Disposals	0	0	0	(3,818)	0	0	0	**(3,818)**
Cost or valuation at 31 March 2019	**11,710**	**216,293**	**514**	**71,226**	**78**	**16,673**	**870**	**317,364**
Accumulated depreciation at 1 April 2018	**0**	**9,089**	**0**	**53,565**	**53**	**13,086**	**848**	**76,641**
Provided during the year	0	6,184	0	3,144	6	1,098	6	**10,438**
Reclassifications	0	0	0	0	0	0	0	**0**
Revaluation Eliminated	0	0	0	0	0	0	0	**0**
Disposals	0	0	0	(2,313)	0	0	0	**(2,313)**
Accumulated depreciation at 31 March 2019	**0**	**15,273**	**0**	**54,396**	**59**	**14,184**	**854**	**84,766**
Net book value								
NBV - Owned at 31 March 2019	11,710	36,396	514	13,247	19	2,439	10	**64,335**
NBV - Finance lease at 31 March 2019	0	0	0	373	0	0	0	**373**
NBV - PFI at 31 March 2019	0	153,997	0	0	0	0	0	**153,997**
NBV - Government Granted at 31 March 2019	0	0	0	0	0	0	0	**0**
NBV - Donated at 31 March 2019	0	10,627	0	3,210	0	50	6	**13,893**
NBV total at 31 March 2019	**11,710**	**201,020**	**514**	**16,830**	**19**	**2,489**	**16**	**232,598**
Net book value								
NBV - Owned at 1 April 2018	11,710	29,231	4,278	13,922	25	2,749	14	**61,929**
NBV - Finance lease at 1 April 2018	0	0	0	550	0	0	0	**550**
NBV - PFI at 1 April 2018	0	158,563	0	0	0	0	0	**158,563**
NBV - Government Granted at 1 April 2018	0	0	0	0	0	0	0	**0**
NBV - Donated at 1 April 2018	0	10,401	0	3,256	0	43	8	**13,708**
NBV total at 1 April 2018	**11,710**	**198,195**	**4,278**	**17,728**	**25**	**2,792**	**22**	**234,750**

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	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**
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**
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 - 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 1 April 2017	11,710	29,504	0	13,538	5	2,449	21	**57,227**
NBV - Finance lease at 1 April 2017	0	0	0	726	0	0	0	**726**
NBV - PFI at 1 April 2017	0	163,134	0	388	0	0	0	**163,522**
NBV - Donated at 1 April 2017	0	9,980	0	2,708	0	47	2	**12,737**
NBV total at 1 April 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)

During the year assets to the value of £1,157k (2018: £1,731k) 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 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.

For 2015/16 and 2016/17 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 2018/19 and 2017/18 the Trust took professional valuation advice which has had regard to the movement in the BCIS index, being a slight upward movement for the 2018/19 period and downward for the 2017/18 period. In addition consideration has been given to the wider circumstances affecting the UK Construction industry and the uncertainties caused by Brexit. Against that backdrop the Trust is assured that the carrying value remains reasonable without adjustment. A full IFRS compliant revaluation is planned for 31 March 2020.

Details of the methodology and valuer used can be found in note 1.7.2.

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 2019 £'000	31 March 2018 £'000
Property, Plant and Equipment	5,928	6,883
Total	**5,928**	**6,883**

17. Inventories

17.1. Inventories

	31 March 2019 £'000	31 March 2018 £'000
Drugs	3,358	2,645
Consumables	7,080	6,724
Total	**10,438**	**9,369**

17.2 Inventories recognised in expenses

	Year ended 31 March 2019 £'000	Year ended 31 March 2018 £'000
Inventories recognised as an expense in the year	138,637	133,752
Write-down of inventories (including losses)	173	116
Total	**138,810**	**133,868**

18. Trade and other receivables

18.1 Trade and other receivables

	31 March 2019		31 March 2018	
	Current £'000	Non - Current £'000	Current £'000	Non - Current £'000
Trade receivables due from NHS bodies	0	0	23,098	0
Contract receivables invoiced	14,136	0	0	0
Contract receivables (not yet / non invoiced)	12,167	1,574	0	0
Allowance for impaired contract receivables	(1,088)	0	0	0
Allowance for other receivables	(1,953)	0	(3,132)	0
Prepayments (non-PFI)	4,534	920	4,081	1,035
PFI prepayments:				
Lifecycle replacements	0	75,660	0	68,850
Accrued income	0	0	1,294	0
Interest receivable	10	0	5	0
PDC dividend receivable	0	0	295	0
VAT receivable	1,763	0	1,612	0
Other receivables	69	0	1,291	1,360
Total	**29,638**	**78,154**	**28,544**	**71,245**

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 2019 £'000	31 March 2018 £'000
At 1 April as previously stated	**3,132**	**2,586**
Increase in provision	253	920
Amounts utilised	(74)	(129)
Unused amounts reversed	(270)	(245)
At 31 March	**3,041**	**3,132**

19. Cash and cash equivalents

	Year ended 31 March 2019 £'000	Year ended 31 March 2018 £'000
Balance at 1 April	5,733	15,510
Net change in year	1,729	(9,777)
Balance at 31 March	**7,462**	**5,733**
Comprising:		
Cash at commercial banks and in hand	105	275
Cash with the Government Banking Service	7,357	5,458
Cash and cash equivalents as in statement of financial position and statement of cash flows	**7,462**	**5,733**

20. Trade and other payables

	31 March 2019 Current £'000	31 March 2019 Non-current £'000	31 March 2018 Current £'000	31 March 2018 Non-current £'000
NHS trade payables	8,560	0	9,240	0
Amounts due to other related parties	4,795	0	4,376	0
Capital payables	2,133	0	1,948	0
Social security costs	7,599	0	6,855	0
Other payables	15,710	0	12,211	0
Accruals	26,579	0	23,534	0
Total	**65,376**	**0**	**58,164**	**0**

Included in Amounts due to other related parties at 31 March 2019 is £4,795k (31 March 2018: £4,376k) of outstanding pension contributions.

21. Borrowings

	31 March 2019 Current £'000	31 March 2019 Non-current £'000	31 March 2018 Current £'000	31 March 2018 Non-current £'000
Interim Revenue Support Facility - Dept. of Health	21,798	89,871	0	52,393
Capital Loans - Dept. of Health	0	224	0	0
Obligations under finance leases	180	254	174	434
Obligations under Private Finance Initiative contracts	2,912	190,510	2,673	193,422
Total	**24,890**	**280,859**	**2,847**	**246,249**

Details of the PFI schemes comprising the liabilities detailed above can be found in note 24.

22. Other liabilities

	31 March 2019 Current £'000	31 March 2019 Non-current £'000	31 March 2018 Current £'000	31 March 2018 Non-current £'000
Deferred Income	5,851	5,875	5,138	4,606
Total	**5,851**	**5,875**	**5,138**	**4,606**

23. Finance lease obligations

	31 March 2019 Minimum Lease Payments £'000	31 March 2019 PV of Minimum Lease Payments £'000	31 March 2018 Minimum Lease Payments £'000	31 March 2018 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;	269	269	463	463
- later than five years.	0	0	0	0
Finance charges allocated to future periods	(24)	(24)	(45)	(45)
Net lease liabilities	**435**	**435**	**608**	**608**
Split into:				
- not later than one year;	181	181	174	174
- later than one year and not later than five years;	254	254	434	434
- later than five years.	0	0	0	0
Net lease liabilities	**435**	**435**	**608**	**608**

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 1.7.5.

The service element of the contract was £23,000k (2017/18: £21,200k), with contingent rent being £13,300k (2017/18: £12,200k).

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 was 15 years with an estimated capital value of £7,100k. This has now expired, however forms part of the comparative period - 2017/18. Accordingly the notes below continue to be required. 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 2018/19 being £0k (2017/18: £300k).

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 2018/19 being £0k (2017/18: £100k). This has also expired.

24.2 PFI schemes on-Statement of Financial Position (on-SoFP)

Total obligations for on-statement of financial position PFI contracts are:

	31 March 2019 £000	31 March 2018 £000
Gross PFI, LIFT or other service concession liabilities	**923,247**	**949,409**
Of which liabilities are due:		
- not later than one year;	41,536	40,072
- later than one year and not later than five years;	178,355	171,315
- later than five years.	703,355	738,022
Lifecycle Maintenance expenditure	(75,781)	(82,592)
Finance charges allocated to future periods	(654,043)	(670,722)
Net PFI, liabilities	**193,422**	**196,095**
- not later than one year;	2,912	2,673
- later than one year and not later than five years;	20,048	16,753
- later than five years.	170,462	176,669
	193,422	**196,095**

Gross PFI liabilities includes £75,781k (2017/18: £82,592k) 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 2019 £'000	31 March 2018 £'000
Within one year	0	0
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)	41,536	40,072
Total	**41,536**	**40,072**

24.4 The Trust is committed to make the following payments in respect of the service element of the On-SoFP PFIs.

	31 March 2019 £'000	31 March 2018 £'000
Charge in respect of the service element of the PFI, LIFT or other service concession arrangement for the period	23,033	21,152
Commitments in respect of the service element of the PFI, LIFT or other service concession arrangement:		
- not later than one year;	24,744	21,847
- later than one year and not later than five years;	105,015	92,651
- later than five years.	414,133	399,139
Total	**543,892**	**513,637**

25. Provisions

	Current 31 March 2019 £'000	Non-current 31 March 2019 £'000	Current 31 March 2018 £'000	Non-current 31 March 2018 £'000
Pensions - Early departure costs	118	881	121	914
Pensions - Injury benefits	85	1,247	83	1,245
Legal claims	79	0	103	0
Total	**282**	**2,128**	**307**	**2,159**

2018/19

	Pensions £'000	Legal claims £'000	VSS & Redundancy £'000	Total £'000
At 1 April 2018	2,363	103	0	**2,466**
Change in the discount rate	(21)	0	0	**(21)**
Arising during the year	240	4	0	**244**
Utilised during the year	(257)	(28)	0	**(285)**
Unwinding of discount	6	0	0	**6**
At 31 March 2019	**2,331**	**79**	**0**	**2,410**
Expected timing of cash flows:				
Within one year	203	79	0	**282**
Between one and five years	788	0	0	**788**
After five years	1,340	0	0	**1,340**
	2,331	**79**	**0**	**2,410**

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 2019 of £188,053k (31 March 2018; £170,111k) in respect of clinical negligence liabilities of the Trust.

25. Provisions (continued)

2017/18

	Pensions relating to other staff £'000	Legal claims £'000	VSS, redundancy and other £'000	Total £'000
At 1 April 2017	1,294	96	22	**1,412**
Change in the discount rate	6	0	0	**6**
Arising during the year	0	42	0	**42**
Utilised during the year	(122)	(35)	(22)	**(179)**
Reversed unused	(145)	0	0	**(145)**
Unwinding of discount	3	0	0	**3**
At 31 March 2018	**1,035**	**103**	**0**	**1,138**
Expected timing of cash flows:				
Within one year	121	103	0	**224**
Between one and five years	465	0	0	**465**
After five years	449	0	0	**449**
	1,035	**103**	**0**	**1,138**

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.

26. Financial Instruments

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

26.1 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2019 under IFRS 9	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Trade and other receivables excluding non financial assets	24,915	0	0	**24,915**
Other investments / financial assets	0	0	0	**0**
Cash and cash equivalents at bank and in hand	7,462	0	0	**7,462**
Total at 31 March 2019	**32,377**	**0**	**0**	**32,377**

Carrying values of financial assets as at 31 March 2018 under IAS 39	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available-for-sale £000	Total book value £000
Trade and other receivables excluding non financial assets	31,253	0	0	0	**31,253**
Other investments / financial assets	0	0	0	0	**0**
Cash and cash equivalents at bank and in hand	5,733	0	0	0	**5,733**
Total at 31 March 2018	**36,986**	**0**	**0**	**0**	**36,986**

26. Financial Instruments (continued)

26.2 Carrying values of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost £000	Held at fair value through the I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Loans from the Department of Health and Social Care	111,893	0	**111,893**
Obligations under finance leases	434	0	**434**
Obligations under PFI, LIFT and other service concession contracts	193,422	0	**193,422**
Other borrowings	8,503	0	**8,503**
Trade and other payables excluding non financial liabilities	49,273	0	**49,273**
Other financial liabilities	0	0	**0**
Provisions under contract	2,410	0	**2,410**
Total at 31 March 2019	**365,935**	**0**	**365,935**

	Other financial liabilities £000	Held at fair value through the I&E £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Loans from the Department of Health and Social Care	0	52,516	**52,516**
Obligations under finance leases	0	608	**608**
Obligations under PFI, LIFT and other service concession contracts	0	196,095	**196,095**
Other borrowings	0	0	**0**
Trade and other payables excluding non financial liabilities	0	58,040	**58,040**
Other financial liabilities	0	0	**0**
Provisions under contract	0	2,466	**2,466**
Total at 31 March 2018	**0**	**309,725**	**309,725**

26.3 Fair values of financial assets and liabilities

Book value (carrying value) is a reasonable approximation of fair value of the above financial assets and liabilities.

26.4 Maturity of financial liabilities

	31 March 2019 £000	31 March 2018 £000
In one year or less	82,946	61,318
In more than one year but not more than two years	34,730	24,528
In more than two years but not more than five years	76,270	45,848
In more than five years	171,990	178,031
Total	**365,935**	**309,725**

26.5 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.

26.5.1 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.

26.5.2 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.

26.5.3 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 2019 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.

26.5.4 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 (PDC)

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 2018/19 this equated to a £0k charge (£0k in 2017/18).

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 and Social Care is regarded as a related party. It is the parent department for DHSC group bodies. Accordingly we are required to provide a note of the main entities within the public sector with which we have had dealings. They are: Norfolk CCGs, NHS England, HMRC and NHS Pension Schemes.

Related Party Transactions	**Income Year ended 31 March 2019 £'000**	**Expenditure Year ended 31 March 2019 £'000**	**Income Year ended 31 March 2018 £'000**	**Expenditure Year ended 31 March 2018 £'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:				
- Department of Health	0	0	0	0
- Other NHS Bodies	0	0	0	0
- Charitable Funds	1,004	0	1,788	0
- Other	483	3,356	184	3,320
- NHS Shared Business Services	0	538	0	419

Related Party Balances	**Receivables 31 March 2019 £'000**	**Payables 31 March 2019 £'000**	**Receivables 31 March 2018 £'000**	**Payables 31 March 2018 £'000**
Value of balances (other than salary) with related parties in relation to doubtful debts	(1,953)	0	(1,860)	0
Value of balances with other related parties:				
Department of Health	0	0	0	0
Other NHS Bodies	0	0	0	0
Charitable Funds	138	0	77	0
Other	175	890	88	886
NHS Shared Business Services	0	41	0	26

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 2019 £'000	**Year ended 31 March 2018 £'000**
Short term employee benefits (pay)	1,116	1,166
Post-employment benefits (employers pension contribution)	114	107

The highest paid Director in 2018/19 received remuneration of £232k, excluding pension related benefits and exit packages, for their services as Chief Executive. In 2017/18 the highest paid Director received remuneration of £229k, 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 £288k (2017/18: £40k) from charitable funds.

During the year assets to the value of £1,157k (2017/18: £1,731k) were donated to the Foundation Trust, of which £842k (2017/18: £1,657k) 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 £162k (2017/18: £124k) 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 £3k (2017/18: £46k) 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 £356k (2017/18: £316k) to Norwich Research Partners LLP. The Chief Executive Officer and a Non-Executive director are members of the board of this organisation.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has made payments of £2,462k (2017/18:£3,004k) to the University of East Anglia. A Non-Executive director is the Vice-Chancellor of this organisation.

30. Third Party Assets

The Trust held £2k (2017/18: £4k) cash at bank and in hand at 31 March 2019 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 1,849 cases of losses and special payments totalling £211k paid during the year (2017/18: 2,252 cases totalling £207k).

	31 March 2019		31 March 2018	
	Number	£'000	Number	£'000
Losses				
Cash losses (including overpayments, physical losses, unvouched payments and theft)	0	0	5	1
Bad debts and claims abandoned (excluding cases between FT and other NHS bodies)	1,783	22	2,172	79
Stores losses (including damage to buildings and other properties as a result of theft, criminal damage and neglect)	3	173	3	116
Special Payments				
Ex gratia payments	63	16	72	11
	1,849	**211**	**2,252**	**207**

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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