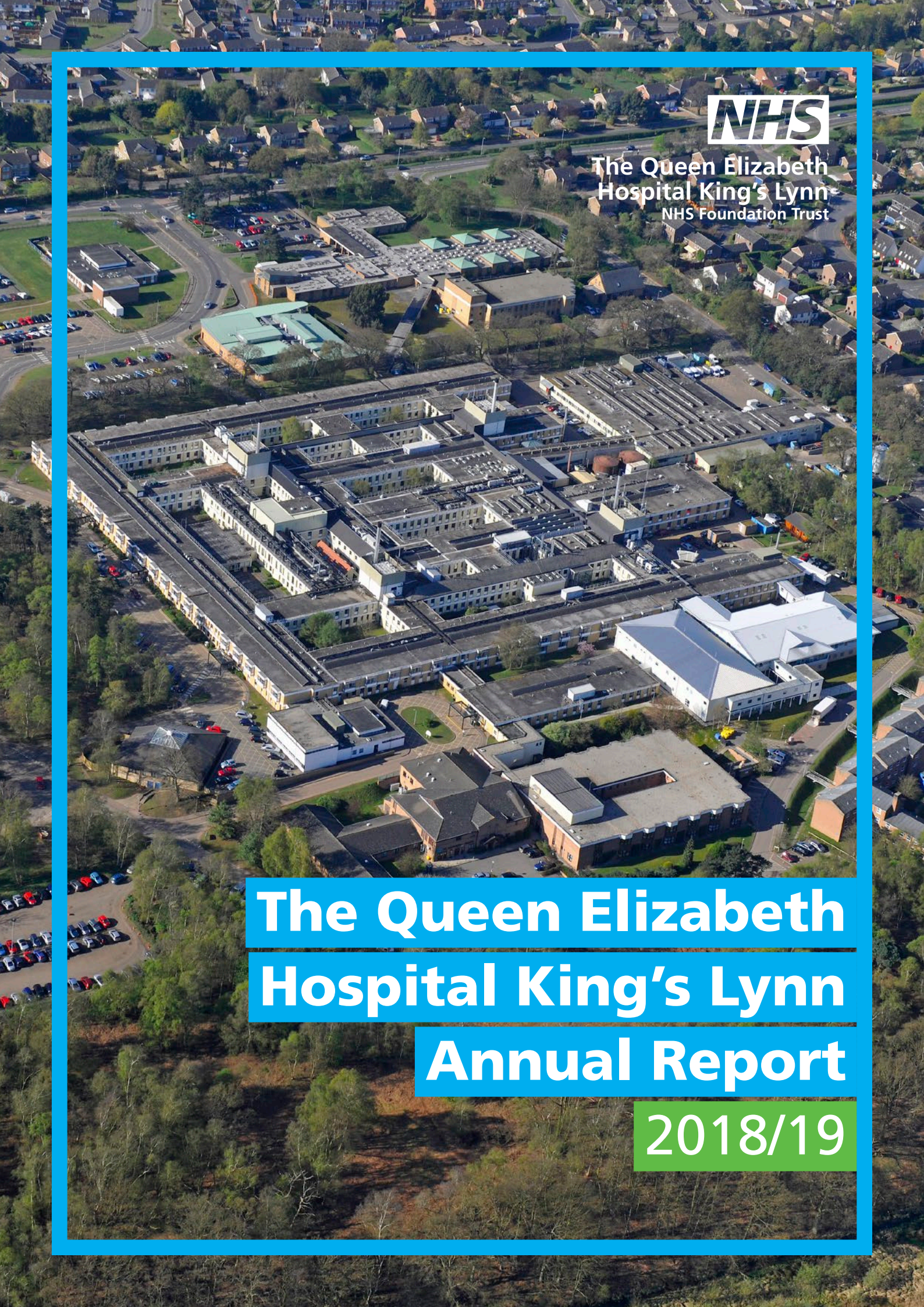

The Queen Elizabeth Hospital King's Lynn Annual Report 2018/19

Performance Report 2018/19

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The Queen Elizabeth Hospital
at a glance

Number of Emergency Department Attendances

2018/19
68,677
2017/18
65,003

Number of Inpatients Treated

2018/19
41,080
2017/18
39,007

Number of Outpatient Visits

2018/19
280,745
2017/18
304,996

Number of Day Case Procedures

2018/19
32,374
2017/18
30,458

Babies born at the hospital

2018/19
2,197
2017/18
2,211

Total Number of Staff (WTE)

2018/19
2,818
2017/18
2,790

Number of Whole Time Equivalent Nurses, Midwives and Health-Visiting staff

2018/19
805
2017/18
825

Number of Consultants and Doctors Employed

2018/19
339
2017/18
326

Total Income

2018/19
£185.8m
2017/18
£186.4m

Total deficit incurred

2018/19
£35.8m
2017/18
£21.97.m

Vectors designed by Freepik

Overview

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

Statement from the Chairman and the Chief Executive

Welcome to the 2018/19 Annual Report for The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust.

2018/19 has been a challenging year for the Trust and for Team QEH, not least following the Trust's latest Care Quality Commission (CQC) inspections in the first quarter of the year.

Even in the short time since we have been here, we have seen early signs of progress that we can be proud of and should celebrate, including the development of an Assessment Zone and a Surgical Extended Recovery Unit, both designed to alleviate pressure on our A&E.

Following input from our patients and colleagues, we have launched new values – Act Well, Listen Well, Care Well – and we are working to bring them to life across the organisation in all we do, including through our strengthened reward and recognition programme and Trust-wide safety and quality improvement work.

Since joining the Trust around the turn of the year, we have started to get to know the organisation and Team QEH and we have begun our journey of improvement. It is very clear that the Trust is central to the community of King's Lynn. We know our colleagues are very loyal, committed and want to deliver good care.

Thank you to our 2,818-strong workforce who make up Team QEH for their dedication and hard work. We are incredibly grateful also to our supporters and 'critical friends' for working with QEH as we strive to improve our services – by listening to and acting on feedback. This includes our patients and members, Governors, Volunteers, Charity, League of Friends, and our system partners among others whom we work with throughout the year.

The CQC report, published in September 2018, recommended that the Trust be placed in Special Measures, with strengthened support and monitoring from our Regulator. When the CQC returned to re-inspect our core services in March 2019, they acknowledged some improvement and pockets of innovation, however they concluded that insufficient progress had been made. It is particularly disappointing that the CQC issued two enforcement notices to the Trust for failing to deliver basic standards of care to our patients in some parts of the Trust, on which we took immediate action to address.

Our Well-Led review was completed by the CQC in April 2019, with a report due to be published in the coming months. We will embrace all the CQC recommendations as we work towards sustainable improvements for our patients, their families and our staff.

With regard to wider performance, we are seeing some pleasing results and areas of excellence: our stroke services, for example, are ranked 6th in England. Over the last year, we have risk assessed 97.40% of eligible patients within 24 hours (against the 95% national target) for venous-thromboembolism (VTEs or blood clots).

We more than halved the number of Clostridium difficile (C Diff) cases when we surpassed our target of having fewer than 53 cases of C Diff (22 cases for 2018/19 against 48 the previous year), and we had two cases of Meticillin-resistant Staphylococcus aureus (MRSA) bacteraemia. We continue to do all we can to reduce hospital-acquired infections.

We have delivered strong performance across the Cancer 2-Week Wait and 31-Day targets as well as in Diagnostics and Stroke Key Performance Indicators. Significantly, the Trust has achieved the national target in relation to elective waiting list size for the end of March 2019.

However, 2018/19 has been a challenging year with pressures across the Cancer pathways. The Trust achieved seven of the eight targets but did not achieve the 62-Day Wait target where we have been below the national standard for much of the year.

We also need to do further work to reduce the number of falls as we have not met the targets we set: In 2018/19, we had 13 falls (Adult inpatient, Moderate / Major / Catastrophic), compared with 11 in the previous year. See the Quality Report for further information.

The Trust has had another year of exceptional A&E demand with a 5.6% growth in A&E attendances in 2018/19 compared to 2017/18. Achievement of the national emergency access standard has been a challenge; we admitted, discharged or transferred 82.5% of patients against a national target of 95% from our A&E within four-hours of their arrival.

Significant work is being done across the system, led by the West Norfolk System Operational Resilience and Transformation Group to streamline patient flow across emergency pathways of care. The Trust continues to work with its partners to help inform demand management / admission avoidance schemes that may

help to control demand on A&E as well as to minimise delays in discharging patients to appropriate care settings.

Financially, we ended the year with a £35.8m deficit, £21m behind our financial plan. We made just £1.2m of the £8.2m financial savings required of us. 2019/20 will be equally challenging with a £2.6m deficit (control total) agreed with NHSI, after factoring in expected national and STP financial support and a £5.5m in-year savings plan to achieve, to help us to return to a healthier financial position, which is critical to our future sustainability as an organisation.

In other areas of Trust activity, we are committed to being a research and innovation-active organisation. In 2018/19, for the size of the Trust, we were one of the top recruiters in the country into research trials, with 1062 patients recruited to clinical trials last year.

The Health and Social Care System is also changing and we continue to play a full and active part in the development of the Sustainability and Transformation Partnership. For QEH, this includes more collaborative working between the three acute Trusts in Norfolk. Looking ahead we know where we need to focus our efforts to achieve the required improvements.

We have revised our Quality Objectives for 2019/20. You can read more about them in our Quality Account, which is also available on our website: https://bit.ly/2JWM9Jr

And, overall, our main areas of focus in 2019/20 include:

- Improving patient safety and the quality of services we deliver. It is clear that we are not delivering the basics consistently across the Trust
- Improving staff engagement and morale. We need to demonstrate that we are listening to, and valuing, our colleagues, and encouraging them to speak up when they have concerns, so that appropriate action must, and will be taken
- Living within our means and meeting the financial plan we have signed up to with NHSI, our regulator.

Full details of our 2019/20 priorities can be found in our Operational Plan: https://bit.ly/2VIm17i

We know that the improvements we need to make will not happen overnight, but with the support and commitment from our staff, Volunteers and stakeholders, we are determined to secure the necessary improvements at the Trust to ensure that the hospital consistently provides safe and high quality for our patients and their families.

Professor Steve Barnett – Chairman
Date: 21 May 2019

Caroline Shaw – Chief Executive
Date: 21 May 2019

Purpose and activities of the foundation trust

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

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

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

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

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

A brief history of the foundation trust

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

The Trust was placed in 'special measures' in October 2013 after a CQC inspection in May and a Rapid Response Review (RRR) in August of that year.

A re-inspection by the CQC in July 2014 identified improvements but the Trust remained in Special Measures.

A third inspection in June 2015 saw the Trust come out of Special Measures.

This improvement was not sustained and following a fourth inspection in September 2018 the CQC rated the Trust as "Inadequate" overall and gave the following ratings in the five domains:

- Safe.....Inadequate
- Effective.....Requires Improvement
- Caring .....Good
- Responsive.....Requires Improvement
- Well Led .....Inadequate

The CQC recommended that the Trust be placed back in Special Measures by NHS Improvement.

In March 2019 the CQC returned to carry out an inspection of our core services. This resulted in S31 and S29A warning notices placing conditions on our registration as a provider of healthcare. Actions needed to be carried out immediately to address the concerns of the CQC. These were carried out and are being monitored closely through the Trust Board with support from our commissioners and regulators.

The CQC returned to carry out a Well Led inspection in early April and we await their final report.

Key issues and risks in delivering the Trust's objectives

In September 2018, The Board set out its revised Corporate Objectives as:

- Care that is safe and supported
- Give our patients the best possible outcomes – involving and explaining effectively
- Provide a patient experience we can be proud of
- Sustain safe births and supported childhoods
- Strengthen our community's well-being throughout life
- Support our patients to age with dignity
- Optimise our use of resources
- Recruit and retain high calibre staff – and develop potential
- Innovate and harness technologies

Following the articulation of its revised Corporate Objectives, the Board reviewed and re-articulated its principal risks to the delivery of its corporate objectives through the Board Assurance Framework:

There is a risk that the Trust may be unable to establish and maintain an appropriate workforce to support the delivery of its objectives, with failures of:

- Leadership
- Engagement
- Capacity
- Capability

There is a risk that patients may receive sub-optimal care / treatment, with failures in:

- Outcomes
- Safety
- Experience

There is a risk that the Trust becomes unsustainable financially and/or clinically, due to failure to:

- Deliver financially, at pace
- Deliver productivity and efficiencies
- Transform services for the benefit of our patients

Going Concern

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

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

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

The Board considered its 'Going Concern' position at its meeting in April 2019 and after consideration of risks and uncertainties agreed that:

'The use of the 'Going Concern' basis is appropriate but there are material uncertainties related to events, or conditions that may cast significant doubt about the ability of the Trust to continue as a 'Going Concern'. These are disclosed in the notes to the Financial Accounts.

After making enquiries, and considering the reality of the uncertainty materialising, the Directors have a reasonable expectation that the Trust will have access to adequate cash resources to continue in operational existence for the foreseeable future. For this reason they continue to adopt the 'Going Concern' basis in preparing the accounts.

Performance Analysis

Financial Performance

In 2018/19 the Trust set a deficit budget of £9.9m. The planned "adjusted financial performance" for control total purposes deficit, excluding PSF (Provider Sustainability Funding) was £15.8m, achievement of this would then have triggered additional income of £6.1m of PSF.

Delivery of this deficit budget posed a significant challenge for the Trust. An expectation of increased productivity was built into the plan against a back-drop of increased difficulties in the recruitment and retention of both nursing and medical staff. A 4% Cost Improvement Target (£8m) was also a significant challenge.

In October 2018 the Trust presented a 'bottom line' recovery trajectory of £34.2m deficit to the regulator. The bottom line deficit of £35.8m (which includes PSF of £1.2m) is £1.6m adverse to the recovery trajectory driven by increased staff costs (£1.9m adverse), unexpected non-pay pressures (£1.9m adverse) offset by increased clinical income (£0.4m favourable), increased other income (£0.6m favourable) and unexpected PSF income (£1.2m favourable).

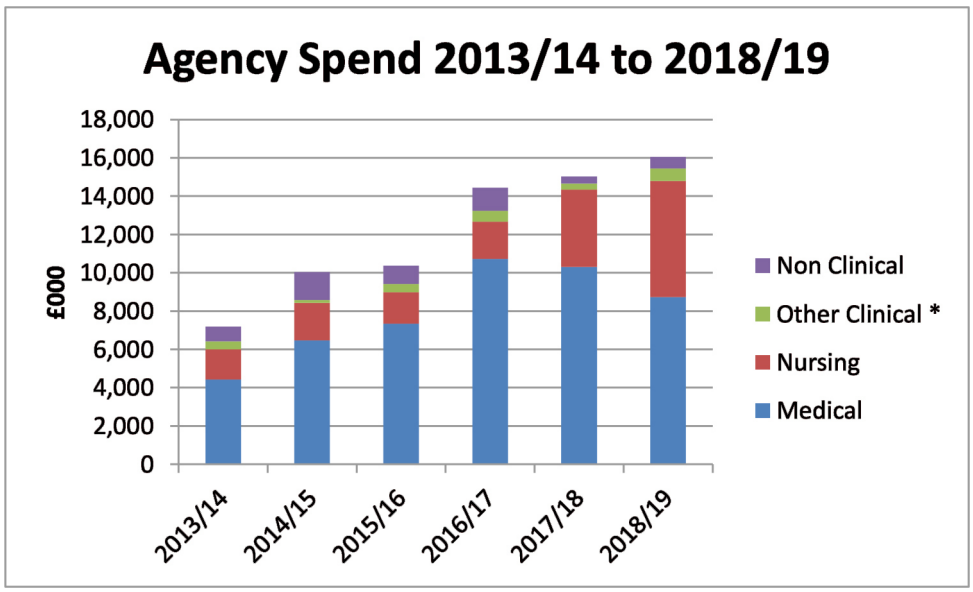
The Trust's core business of acute services in 2018/19 was funded by the standard 'payment by results' model of payment, with contracts for services agreed annually with local Commissioners at prices agreed by the Department of Health. The year on year income changes are illustrated in the table below:

NHS Clinical Revenue	2018/19 Activity No.	Revenue £000	2017/18 Activity No.	Revenue £000	Activity Variance		Revenue Variance	
					No.	%	£000	%
A&E	68,655	8,995	65,010	8,646	3,645	5.6%	349	4.0%
Elective Inpatients	4,794	11,132	5,060	11,240	(266)	(5.3)%	(108)	(1.0)%
Elective Excess Bed Day	1,022	249	599	151	423	70.6%	98	64.9%
Daycases	34,869	18,133	32,361	16,908	2,508	7.8%	1,225	7.2%
Non-elective Inpatients	38,493	64,728	37,978	62,946	515	1.4%	1,782	2.8%
Non-elective Excess Bed Days	10,940	2,594	9,842	2,348	1,098	11.2%	246	10.5%
Emergency Threshold Cap		(3,917)		(3,795)			(122)	3.2%
Outpatients	269,860	29,228	272,599	29,063	(2,739)	(1.0)%	165	0.6%
Other Clinical Income	91,766	38,532		39,850			(1,318)	(3.3)%
Total NHS Clinical Revenue		**169,674**		**167,357**			**2,317**	**1.4%**
Private Patient Income		64		72			8	11.1%
Other Clinical Income		658		591			67	11.3%
Total Income from Activities		**170,396**		**168,020**			**2,376**	**1.4%**

Clinical income at the end of March is £7.0m adverse to plan. The adverse variance includes a positive impact of £2.2m associated with DHSC Agenda for Change pay awards income giving an underlying adverse variance of £9.2m. £2.8m in emergency pods in relation to lower than planned volumes where activity levels are flat compared to 2017/18. Elective Inpatients including day cases were £3.7m adverse due to lower than planned volumes. Outpatients lower than plan by £1.4m. A number of other variances combine to be £0.9m favourable to plan.

Under-achievement of the Trust's income plan was compounded by an overspend, which is a combination of under-delivery of planned efficiencies and additional costs to support additional activity, safety and quality.

The cost of agency staffing remains a significant challenge to the Trust, with expenditure in 2018/19 totalling £16.0m. This is an increase of £1.0m on 2017/18 and £6.0m above the £10.0m expectation set by the Regulator. As can be seen from the graph below, the cost of agency staff remains the consistent area of increasing cost as the Trust has a number of vacancies in difficult to recruit to areas. Whilst agency medical staff costs show a decrease from £10.3m to £8.7m, agency nursing has risen from £4.0m to £6.0m (a rise of 50.31%). The Trust continues to try and minimise expenditure through implementation of DHSC-led cost control measures but a revised workforce strategy and plans to address recruitment and retention to specific posts substantively remain a priority for clinical and financial sustainability.



*Other clinical excludes the costs of Eastern Pathology Alliance

The Trust delivered £1.2m of efficiency savings associated with new schemes in 2018/19. The Trust received £37.6m of cash support from the Department of Health.

For 2018/19 the Trust has spent £4.8m on capital expenditure with the main areas being:
- Medical Equipment – £754.3K
- Backlog Maintenance – £381.3k
- Ultrasound Scanners – £308.3k
- End of Life IT Hardware – £118.7k
- Renewal of the Telephone Exchange – £118.7k
- Flexible Scopes – £325.6k (£60.0k PDC funding)
- Template Biopsy machine – £203.6k (£203.6k PDC funding)
- L1 Fire Alarm – £565.4k
- Car Park Expansion – £664.6k
- Heating Ring Main – £780.7k
- Minor capital works – £224.4k
- Emergency Lighting – £108.6k
- Various Other – £239.6k
- Donated Assets – £115k

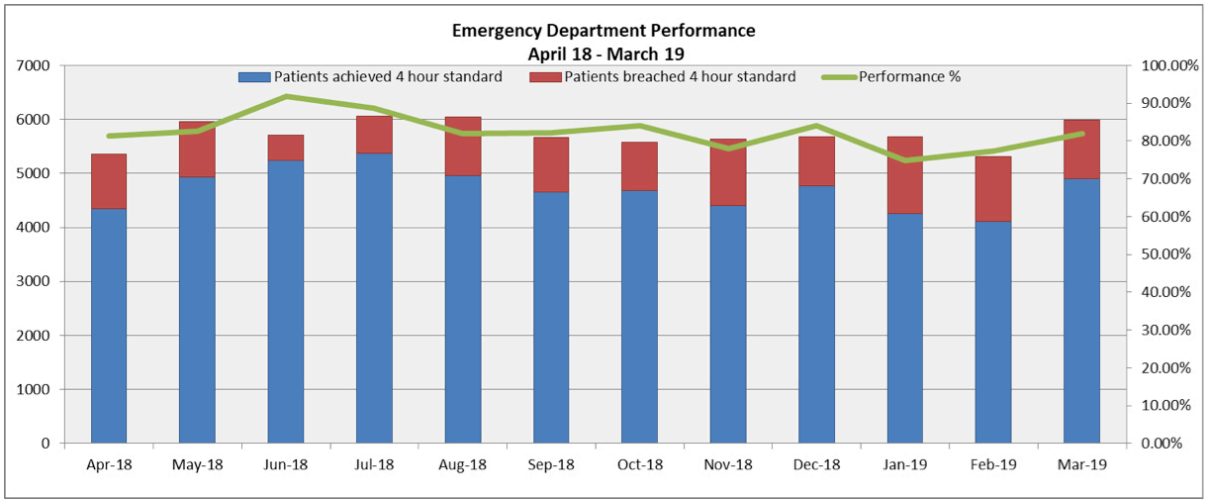
As at the 31 March 2019 the Trust has received over £120m of DHSC loans. The Trust remains in a financially unsustainable position and continues to work with partner organisations, developing long term strategies and service transformation plans that can return the overall health economy to a clinical and financially sustainable position.

Operational Performance

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

Accident and Emergency four-hour access target

The Trust has had another year of exceptional A&E demand. Across the year the Trust saw a 5.6% growth in A&E attendances in 2018/19 compared to 2017/18. Against this challenging backdrop the Trust has seen fluctuations in performance against achievement of the four-hour target. We admitted, discharged or transferred 82.5% of patients against a national target of 95% from our A&E within four-hours of their arrival. Significant work is being done across the system, led by the West Norfolk System Operational Resilience and Transformation Group to seek to streamline patient flow across emergency pathways of care. This work is being led by the QEH Chief Operating Officer and includes all system partners. The Trust continues to work with its partners to help inform demand management / admission avoidance schemes that may help to control demand on A&E as well as to minimise delays in discharging patients to appropriate care settings.



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
Total Numbers of Attendances	5351	5963	5707	6063	6051	5672	5572
Patients achieved 4 hour standard	4350	4927	5246	5377	4964	4659	4683
Patients breached 4 hour standard	1001	1036	461	686	1087	1013	889
% of standard achieved	81.29%	82.63%	91.92%	88.69%	82.04%	82.14%	84.05%

	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	18/19
Total Numbers of Attendances	5640	5678	5681	5311	5984	68673
Patients achieved 4 hour standard	4404	4769	4253	4108	4905	56645
Patients breached 4 hour standard	1236	909	1428	1203	1079	12028
% of standard achieved	78.09%	83.99%	74.86%	77.35%	81.97%	82.49%

Ambulance Handover

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

Ambulance Arrivals

The Trust has implemented a range of initiatives in partnership with East of England Ambulance Service (EEAST) supported by the Emergency Care Intensive Support Team (ECIST) to seek to reduce the length and number of Ambulance Handover delays. The Trust remains committed to improving this position and delivering a better patient experience.

Month	0 - 15 Minutes	15 - 30 Minutes	30 - 60 Minutes	60 Minutes+	Total Arrivals
April	716	807	159	89	1771
May	801	864	203	96	1964
June	777	902	108	36	1823
July	751	854	151	93	1849
August	698	768	198	103	1767
September	938	540	207	95	1780
October	919	538	192	104	1753
November	762	640	302	206	1910
December	1043	632	257	115	2047
January	1019	548	220	256	2043
February	876	501	196	206	1779
March	896	455	175	218	1744
18/19 Total	**10196**	**8049**	**2368**	**1617**	**22230**

Cancer access targets

While the Trust has consistently met the 14 day and 31 day standards, there have been dips in performance against the 62 day standard. This has been due to a range of reasons, which have been recognised by the Trust and several significant pieces of work have been undertaken to seek to ensure that we are delivering timely care for our patients. This work includes significant engagement and support from the Macmillan Transformation team.

Cancer Services have continued to focus on the 62-day backlog reduction and embedding escalation processes within operational teams to minimise breaches and rollovers from one month to the next. A detailed action plan and trajectory for delivery has been developed to ensure sustainable performance delivery. The trust undertakes harm reviews to ensure that patients waiting longer than the standard waiting time are not adversely impacted by the delay.

Cancer Performance

	Target	Q1	Q2	Q3	Q4
2 Week Wait	93.00%	96.94%	94.59%	97.69%	92.23%
31 Day DTT	96.00%	98.25%	97.44%	97.48%	96.72%
62 Day DTT	85.00%	82.79%	80.81%	83.00%	80.49%*

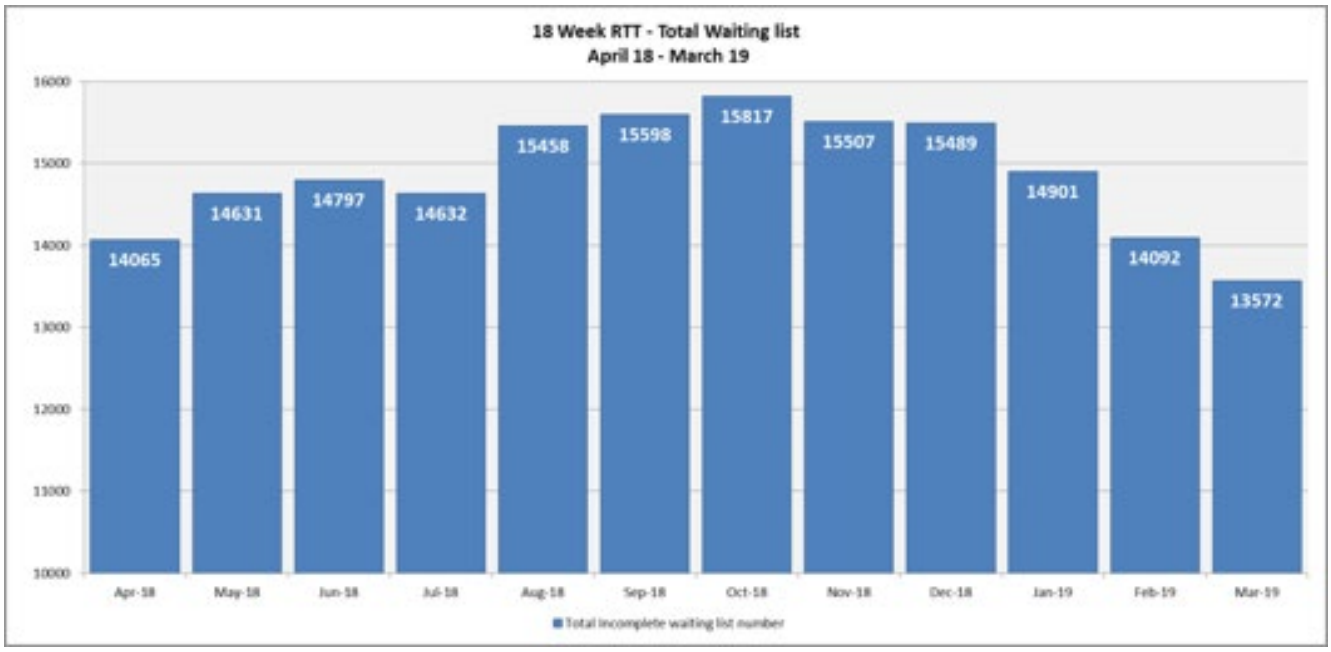
*Cancer Services exceeded the target in March 2019, achieving 85.91%.

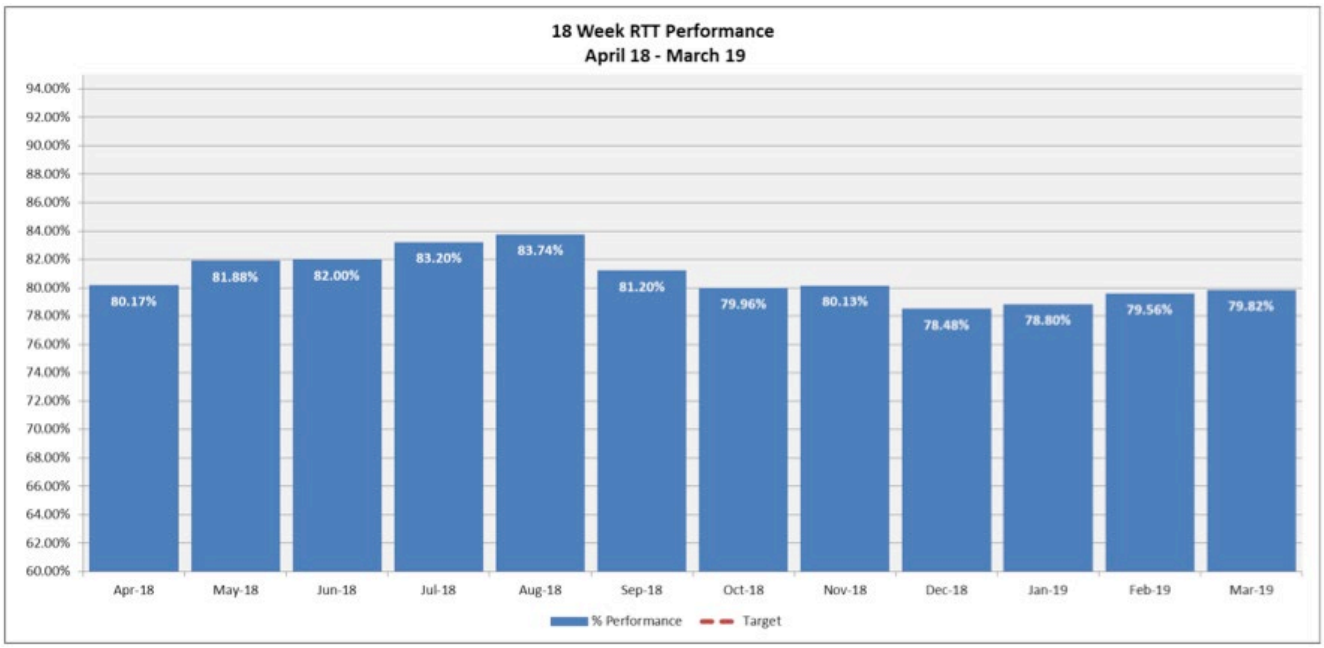
Eighteen Week RTT (Referral to Treatment Time)

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Total Incomplete waiting list number	14065	14631	14797	14632	15458	15598	15817	15507	15489	14901	14092	13572
Patients waiting under 18 weeks	11276	11980	12133	12174	12944	12665	12647	12426	12156	11742	11212	10833
Patients waiting over 18 weeks	2789	2651	2664	2458	2514	2933	3170	3081	3333	3159	2880	2739
% Performance	80.17%	81.88%	82.00%	83.20%	83.74%	81.20%	79.96%	80.13%	78.48%	78.80%	79.56%	79.82%

The Trust has focused on the reduction of the 18-week RTT elective waiting list. The action plans put in place for each specialty have ensured we have met the end of year target position. This is a significant achievement for the Trust.

Detailed plans are in place for 2019/20 for each specialty with clear forecast trajectories, which have been developed by the operational teams and are being supported by the CCG to ensure we deliver the agreed levels of performance by March 2020.




18 Week RTT Performance
April 18 - March 19
94.00%
92.00%
90.00%
88.00%
86.00%
84.00%
82.00%
80.00%
78.00%
76.00%
74.00%
72.00%
70.00%
68.00%
66.00%
64.00%
62.00%
60.00%
80.17%
81.88%
82.00%
83.20%
83.74%
81.20%
79.96%
80.13%
78.48%
78.80%
79.56%
79.82%
Apr-18
May-18
Jun-18
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
% Performance
Target


Hello, my name is
Donna
NHS
NHS
NHS

Accountability Report 2018/19

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

Caroline Shaw – Chief Executive

Date: 21 May 2019


Give your full support to our
Monitoring systems: alarm and sensor wired pad for beds & chairs
Scoop stretchers for moving and lifting patients
FALLS SUPPORT APPEAL
QEH
Transfer boards for beds or stretchers
HoverJack & HoverMatt inflatable kits for safe patient lifting
Target £35,000
Get involved
Organise, host or take part in a fundraising event. Give sponsorship money from event participation.
www.justgiving.com/qehkl-FallsSuppor
OR send cheques pay
'Falls Support
lease ask, everyone is here to
NHS
PORTERING DEPT

Directors' Report

How our hospital is governed

What is a foundation trust?

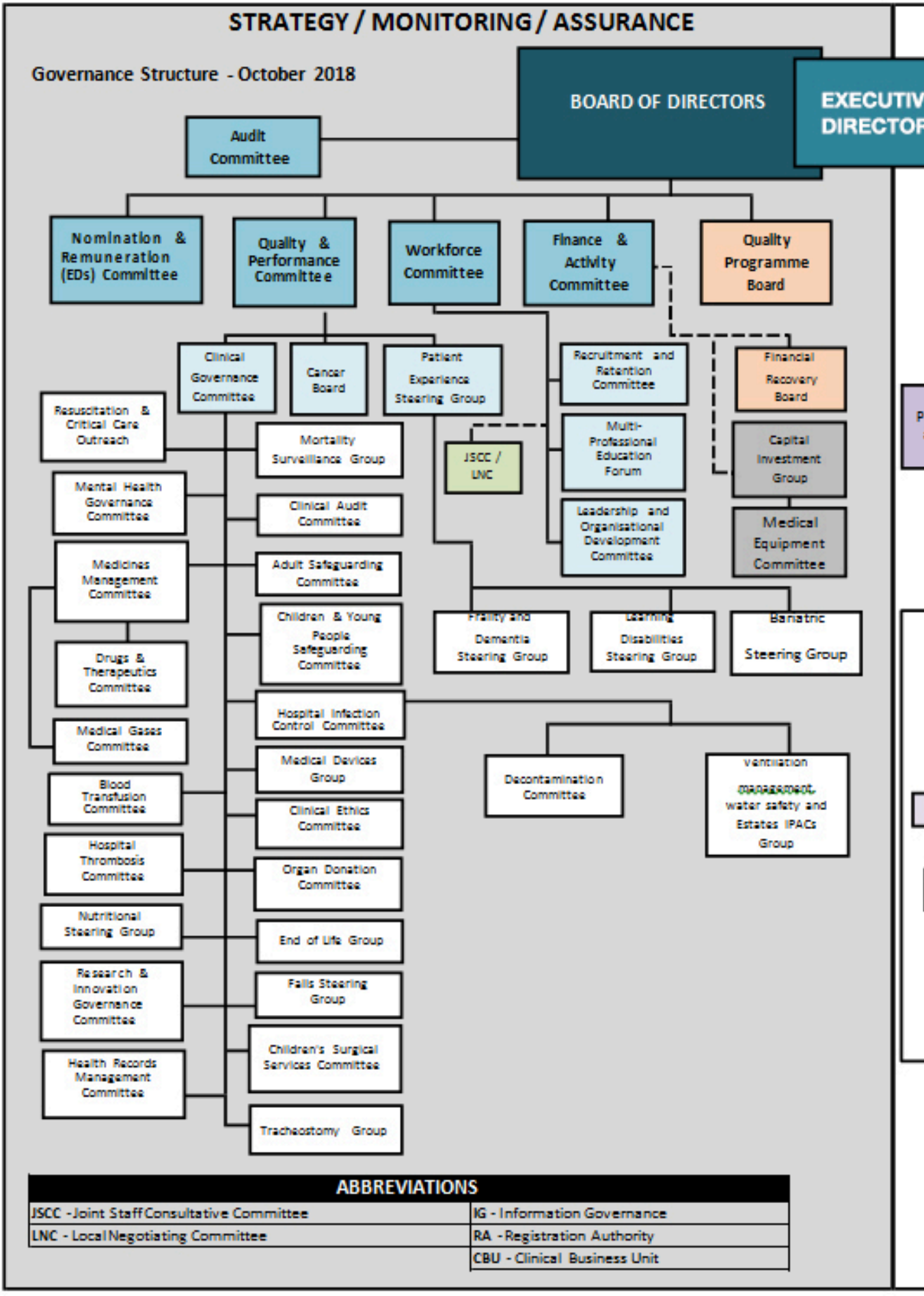
A Foundation Trust is a Public Benefit Corporation. This means that:

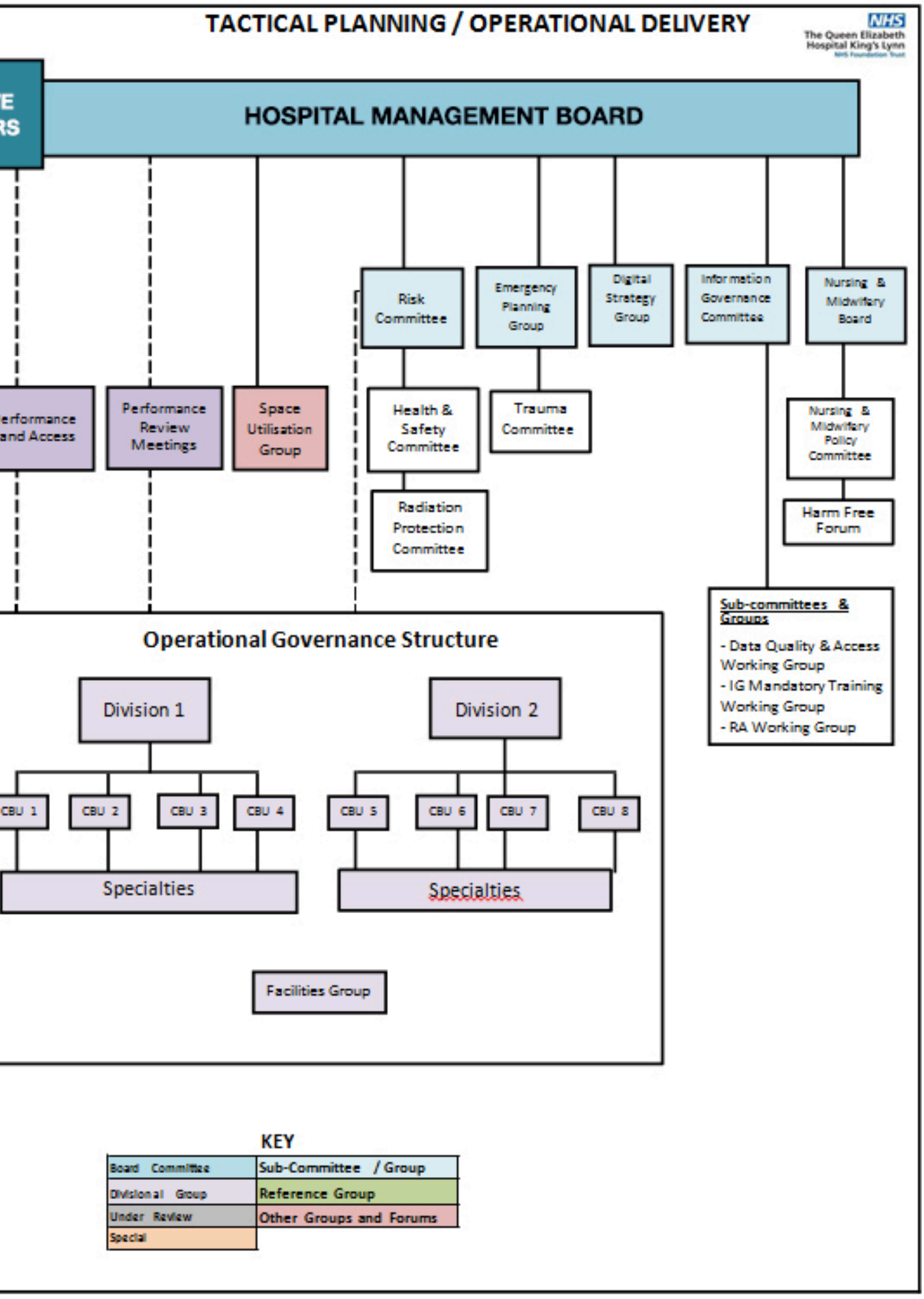
- The Trust is accountable to the communities we serve through the Governors' Council and Foundation Trust members
- Members of the Foundation Trust elect both public and staff representatives from the membership to serve on a Governors' Council
- The Trust is independent and accountable direct to Parliament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

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

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

The Queen Elizabeth Hospital King's Lynn Governance Structure




TACTICAL PLANNING / OPERATIONAL DELIVERY
NHS
The Queen Elizabeth Hospital King's Lynn
HOSPITAL MANAGEMENT BOARD
Risk Committee
Emergency Planning Group
Digital Strategy Group
Information Governance Committee
Nursing & Midwifery Board
Performance and Access
Performance Review Meetings
Space Utilisation Group
Health & Safety Committee
Trauma Committee
Radiation Protection Committee
Nursing & Midwifery Policy Committee
Harm Free Forum
Sub-committees & Groups
- Data Quality & Access Working Group
- IG Mandatory Training Working Group
- RA Working Group
Operational Governance Structure
Division 1
Division 2
CBU 1
CBU 2
CBU 3
CBU 4
CBU 5
CBU 6
CBU 7
CBU 8
Specialties
Specialties
Facilities Group
KEY
Board Committee
Sub-Committee / Group
Divisional Group
Reference Group
Under Review
Other Groups and Forums
Special

The Board

The Queen Elizabeth King's Lynn NHS FT Board* Non Executive Directors

Professor Steve Barnett
Trust Chairman

Steve has more than three decades of experience working in senior NHS positions. He is no stranger to our hospital, having previously supported the Trust's work on the quality improvement programme, which saw the Trust exit special measures in 2015.

Professor Mandy Ashton
Non Executive Director

Mandy has worked in healthcare for 31 years in various roles, including nursing and policy making. Mandy has worked in community and acute settings and has helped to develop education and training programmes for nurses in Uganda and Labrador. In 2008, she became a Professor of Clinical Leadership with De Montford University in Leicester. Two years later Mandy was awarded an OBE for services to Nursing and Healthcare.

Professor Ian Harvey
Non Executive Director
Retired 31 March 2019

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

David Thomason
Non Executive Director
Retired 31 March 2019

David retired from the post of Deputy Chief Executive, Executive Director for Resources, at the Borough Council of King's Lynn and West Norfolk just before taking on his role on the Trust's Board of Directors. He is a qualified accountant and was a member of the Chartered Institute of Public Finance and Accountancy (CIPFA).

Alan Brown
Non Executive Director

Alan has worked in IT for almost 40 years, the last 10 of which have been in healthcare. He has been a Non Executive Director for several years, initially at Hinchingbrooke Health and Care NHS Trust and, more recently, at North West Anglia NHS Foundation Trust. Alan moved to Norfolk in 2016 and continues to work, part time, as a partner in a consultancy company.

David Dickinson
Non Executive Director

David is retired from the post of Director of Resources at Newark and Sherwood District Council in Nottinghamshire and now lives in West Norfolk. He is a qualified accountant and was a member of the Chartered Institute of Public Finance and Accountancy (CIPFA). David is Chair of the Audit Committee.

*As at 31 March 2019

The Queen Elizabeth King's Lynn NHS FT Board Executive Directors

Caroline Shaw
Chief Executive
Joined 14 January 2019
Caroline joins The Queen Elizabeth Hospital from Nottingham University NHS Trust, where she was Deputy Chief Executive and Chief Operating Officer. Caroline started her NHS career as a nurse and midwife before moving into general management with more than three decades' NHS and leadership experience working at trusts around the country, including Leicester, Nottingham and Manchester. She has nine years' experience as a CEO. Caroline was awarded a CBE in 2013 for her service to healthcare.

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

Emma Hardwick
Chief Nurse
Emma is dual qualified as a nurse and midwife. She brings a wealth of nursing, midwifery and managerial experience in the East of England and London. Emma completed her Master's degree in 2008 and is a Nye Bevan graduate. She joined the Trust from the Ipswich Hospitals NHS Trust, where she was Associate Director of Nursing and Midwifery for three years. Emma was appointed substantively as Chief Nurse at the Trust in June 2017.

Roy Jackson
Director of Finance and Resources
Roy joined the Trust in spring 2017. Roy has been a Director of Finance for 17 years and has also served a period as an Acting Chief Executive Officer. Roy has very broad experience of the NHS, working right across the healthcare system in Commissioning, Mental Health Services, Community Services and Acute Services.

Jon Wade
Chief Operating Officer
Jon has been working in the NHS for eight years after starting his career at NHS South Gloucestershire. He moved to the Trust in 2011 where he has held the positions of Head of Information and Contracts, Financial Recovery Lead and Deputy Director of Contracting Information. Jon, who holds a Master's Degree, took on the role of Director of Strategy and IT in November 2016 and became Chief Operating Officer in April 2018.

Karen Charman
Director of Human Resources
Karen began work with the Trust as Director of Human Resources in the late spring of 2017. Karen is a qualified nurse who has developed a national senior leadership profile across a range of disciplines, including: Human Resources, including Workforce Design, Productivity, Transformational Change, Communications, Business Development and Integrated Performance Management.

Patrick Johnson
Chief Transformation Officer
Joined 29 October 2018 (Fixed term Contract)
Patrick looks after IT and the Information Strategy. With a background of working in food and manufacturing and global supply chains, Patrick moved into the NHS in 2008 after establishing the NHS Supply Chain. Since then he has been Chief Operating Officer in two Foundation Trusts.

Statutory Statements

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

- So far as the directors are aware, there is no relevant audit information of which the NHS foundation trust's auditor is unaware
- The directors have taken all the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the NHS foundation trust's auditor is aware of that information
- The Trust can confirm that it has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information Guidance
- The Trust has made no political donations to any individual, body or organisation in the 2018/19 financial year
- The Trust works to the Better Payment Practice Code. We aim to pay at least 95% of invoices within the agreed terms, unless there is a dispute or for other reasons. For most of our partners, this would be within 30 days of the date of invoice or receipt of goods and services. However, due to funding constraints within the Trust it has for the past few years paid suppliers between 47-53 days. As our Trust is committed to working with all of our supplier partners fairly, consistently and professionally, all suppliers are paid to these terms (unless they are very small local businesses). All suppliers do receive a payment each week if there is one due under the extended payment days.

The Trust's performance for 2018/19 is shown in the following table:

	Number	£'000
NHS Suppliers		
Total invoices paid to target	63	6,103
Total invoices paid in year	1,167	13,353
% paid within target	5.4%	45.7%
Non NHS Suppliers		
Total invoices paid to target	4,241	9,261
Total invoices paid in year	47,919	69,776
% paid within target	8.9%	13.3%
Combined		
Total invoices paid to target	4,304	15,364
Total invoices paid in year	49,086	83,129
% paid within target	8.8%	18.5%

'Well-Led' Framework

The regulatory definition of a 'well-led' organisation is one where the leadership, management and governance of the organisation ensure the delivery of sustainable high-quality person-centred care, support learning and innovation, and promote an open and fair culture.

The 2018 CQC inspection found the Trust to be 'Inadequate' in the 'Well-Led' domain. In 2018/19, the Governors' Council appointed a new Trust Chairman, who took up his post in November 2018. The Governors also appointed two new non-executive directors in 2018/19, including a new Chair of the Audit Committee.

The Trust has received 'Well-Led' support from NHSI and an independent Board Review was jointly commissioned by the Trust and NHSI in November 2018. The findings of this review have resulted in the development of an improvement plan, which was reported, together with progress to date, to the Board (in public) in January 2019. The Board's Development Programme for 2019/20 will support the Trust in addressing the issues raised by the independent review.

The Trust has had regard to NHS Improvement's 'well-led' framework in arriving at its overall evaluation of the organisation's performance, internal control, board assurance framework and quality improvement plans.

The Board believes that there are currently no material inconsistencies between:

- the annual governance statement
- the corporate governance statement, the quality report, and annual report
- reports arising from Care Quality Commission planned and responsive reviews of the NHS foundation trust and any consequent action plans developed by the NHS foundation trust.

Remuneration Report

Foundation Trust Remuneration Report

The Remuneration Report has been audited

Annual Statement on Remuneration

In accordance with the Regulator's Code of Governance, The Queen Elizabeth Hospital, King's Lynn, NHS Foundation Trust has two Nomination and Remuneration Committees, dealing with the remuneration of the non-executive directors (NEDs) and executive directors (EDs) respectively. Director membership and meeting attendance in respect of the Nomination and Remuneration Committee is set out in the governance section 'Board of Directors' 2018/19 table.

The Nomination and Remuneration Committee (NED appointments) is a governor committee, making recommendations in respect of non-executive director remuneration to the Governors' Council (the Governors' Council is not permitted to delegate any of its powers to a committee). The committee is chaired by the Trust Chairman (unless the committee is considering the remuneration of the Trust Chairman). Non-executive director remuneration is benchmarked using NHS Providers' annual survey analysis, and, as a reflection of spending restraint in the NHS and the very low pay awards made to staff subject to Agenda for Change in the organisation in recent years, there have been no changes to the remuneration of the non-executive directors in 2018/19.

The Nomination and Remuneration Committee (ED appointments) is a committee of the Board, with delegated authority to approve the terms and conditions, including the remuneration of the executive directors. The members of the committee are the non-executive directors and the CEO (unless the committee is considering the remuneration of the CEO), chaired by the Trust Chairman. Executive remuneration is benchmarked using NHS Providers' annual survey analysis, on appointment and annually. As a reflection of spending restraint in the NHS, and, the very low pay awards made to staff subject to Agenda for Change in the organisation in recent years, the Nomination and Remuneration Committee (ED appointments) have made no changes to the remuneration of executive directors in post in 2018/19.

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

Professor Steve Barnett
Trust Chairman and Chairman of the Remuneration Committee
Date: 21 May 2019

Senior Managers' Remuneration Policy

The Trust has an Executive Director Pay Policy in place.

The Chief Executive undertakes the appraisals of the executive directors and the Chairman undertakes the Chief Executive's appraisal, making an assessment of overall performance against annually agreed objectives.

The Trust had no 'Performance–Related Pay' incentives in place in 2018/19 for executive directors or other very senior managers.

The Trust had two executive directors earning more than £150,000, in post in 2018/19. Both directors were appointed and remuneration agreed after seeking the views of ministers via NHS Improvement as required by the June 2015 guidance from the Department of Health before making executive / VSM appointments with a higher salary than the Prime Minister (£150,000), with justification. All executive salaries are within the benchmarked range for foundation trusts of the size of The QEH.

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

The checklist assimilates guidance relating to:
- Proposed VSM remuneration of more than £150,000
- Board members, including interims should be 'on-payroll', except in exceptional, short-term cases
- Where there are exceptional, short term cases - interim daily rates paid should not normally exceed what would be paid to substantive appointees
- 'Retire and Return' – VSMs, particularly those leading organisations receiving additional tax payer support, should not be better off by taking their pension and returning almost immediately, to work for the NHS
- The new redundancy terms for NHS staff in England (within section 16 of Agenda for Change) should apply to all newly appointed VSMs (unless they are on statutory redundancy terms)
- Senior staff should not be leaving on significantly better compensation packages than more junior colleagues.
- The approval process for management consultancy costs
- 'Fit and Proper Person' test – All Board level appointments to be subject to the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 19 – 'Fit and Proper Person' test
- Revised tax guidance responsibilities from April 2017
- Employment or engagement following NHS Redundancy

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

Non-executive and Governor Expenses
Expenses are reimbursed to both directors and governors in accordance with the Trust's policies. Aggregate non-executive director expenses for 2018/19 were £1,325. Aggregate governor expenses were £7,128.

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

Remuneration Committee
Details of the membership and attendance at the Nomination and Remuneration Committees (EDs) can be found in the Governance Section of the Annual Report table, 'The Board of Directors and Supporting Executive Portfolio Holders - in 2018/19.

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

Details of Remuneration and Audited Information
Details of Directors' remuneration for the period ended 31 March 2019 is set out in the remuneration tables. The median remuneration of the reporting entity's staff is based on annualised, full-time equivalent remuneration of all staff (including temporary and agency staff) as at the reporting date.

The calculation uses the basic salary of each employee, part time staff have had their salary grossed up to their full time equivalent salary. The banded remuneration of the highest paid director, calculated for comparison purposes on a full time basis at The Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust in the financial year 2018/19 was £180,000 -£190,000 (2017/18 - £160,000-£165,000); this was 7.74 (2017/18 – 7.16) times the median remuneration of the workforce, which was £24,214. In 2018/19, 17 members of the workforce received remuneration in excess of the highest paid director. Remuneration ranged from £5,254 to £275,429.

This information is presented in this way to:
- ensure transparency in executive remuneration;
- provide the trust with an opportunity to monitor their own remuneration and note any adverse or anomalous trends.

Fair Pay multiple	2018/19	2017/18
	£	£
Midpoint of banded remuneration of highest paid* director - full year effect	187,500	162,500
Median total remuneration	24,214	22,683
Ratio	7.74	7.16

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

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

The highest paid director of the Trust in 2018/19 was the Chief Executive whilst in 2017/18 it was the Medical Director.

Foundation Trust Directors Remuneration Report

1 April 2018 to 31 March 2

		(a) Salary	(b) Expense payments (taxable)	(c) Performance pay and bonuses	(d) Lo te performan pay a bonus
		Bands of £5,000	To nearest £100	Bands of	Bands £5,0
Edward Libbey (to 22/10/18)	Chairman	25-30	1,200	-	
Prof Steve Barnett (from 5/11/18)	Chairman	20-25	-	-	
Ian Pinches (to 30/9/18)	Non-executive	5-10	-	-	
John Rees (to 30/09/2017)	Non-executive	-	-	-	
Maureen Carson (to 21/12/2017)	Non-executive	-	-	-	
David Thomason	Non-executive	10-15	-	-	
Ian Harvey	Non-executive	10-15	-	-	
Mandy Ashton (from 21/08/2017)	Non-executive	10-15	120	-	
Alan Brown (from 1/5/18)	Non-executive	10-15	100	-	
David Dickinson (from 2/7/18)	Non-executive	5-10	-	-	
Caroline Shaw (from 14/1/19)	Chief Executive	50-55	-	-	
Jon Green (from 01/05/17 to 14/1/19)	Chief Executive	155-160	-	-	
Karen Croker (from 01/04/2017 to 05/05/2017)	Chief Executive	-	-	-	
Nick Lyons	Medical Director	155-160	-	-	
Emma Hardwick	Chief Nurse	115-120	-	-	
Roy Jackson	Director of Finance and Resources	135-140	-	-	
David Stonehouse (to 02/08/17)	Finance Director	-	-	-	
Jon Wade	Chief Operating Officer	120-125	6,700	-	
Karen Charman	Director of Human Resources	120-125		-	
Ciara Moore (to 28/8/18)	Chief Operating Officer	50-55	2,700	-	
Karen Croker (to 31/03/2017)	Chief Operating Officer	-	-	-	
Patrick Johnson (from 29/10/18)	Chief Transformation Officer	50-55	-	-	

Foundation Trust Directors Remuneration Report

		(a) Real increase in pension at pension age	(b) Real increase in pension lump sum at pension age	a
		Bands of £2,500	Bands of £2,500	
Jon Green (to 14-Jan-19)	Chief Executive	2.5-5	0-2.5	
Emma Hardwick	Chief Nurse	0-2.5	0-2.5	
Roy Jackson	Director of Finance and Resources	0	0	
Jon Wade	Chief Operating Officer	2.5-5.0	7.5-10	
Karen Charman	Director of Human Resources	0-2.5	0-2.5	
Ciara Moore (to 28/8/18)	Chief Operating Officer	0-2.5	0	
Patrick Johnson (from 29/10/18)	Chief Transformation Officer	5-7.5	-	

Secondment | Prior year only | Left in year | Off-payroll

019			1 April 2017 to 31 March 2018					
ng rm ce nd ses of 000	(e) All pension-related benefits Bands of £2,500	(f) TOTAL (a to e) Bands of £5,000	(a) Salary Bands of £5,000	(b) Expense payments (taxable) To nearest £100	(c) Performance pay and bonuses Bands of £5,000	(d) Long term performance pay and bonuses Bands of £5,000	(e) All pension-related benefits Bands of £2,500	(f) TOTAL (a to e) Bands of £5,000
-	-	30-35	50-55	1000				55-60
-	-	20-25						
-	-	5-10	10-15					10-15
-	-	-	5-10	100				5-10
-	-	-	5-10	300				5-10
-	-	10-15	10-15					10-15
-	-	10-15	10-15	100				10-15
-	-	10-15	5-10	100				
-	-	10-15						
-	-	5-10						
-	-	50-55						
-	65-67.5	220-225	145-150				120-122.5	270-275
-	-	-	0-5					0-5
-	-	155-160	160-165	2,100				160-165
-	5-7.5	120-125	120-125				192.5-195	310-315
-	-	135-140	125-130				47.5-50	175-180
-	-	-	40-45				62.5-65	105-110
-	92.5-95	215-220	105-110				77.5-80	185-190
-	45-47.5	165-170	90-95				82.5-85	175-180
-	25-27.5	75-80	125-130				222.5-225	345-350
-	-	-	20-25	2,000				25-30
-	-	50-55						

Pension Benefits 1st April 2018 to 31st March 2019

(c) Total ccrued pension at pension age as at 31 March 2019 Bands of £5,000	(d) Lump sum at pension age related to accrued pension at 31 March 2019 Bands of £5,000	(e) Cash equivalent transfer value at 1 April 2018 £000	(f) Real increase in Cash Equivalent Transfer Value £000	(g) Cash Equivalent Transfer Value at 31 March 2019 £000	(h) Employer's contribution to stakeholder pension £000
80-85	55-60	403	107	522	65
150-155	110-115	727	88	838	17
235-240	175-180	1,318	107	1,465	0
70-75	50-55	217	101	325	93
90-95	65-70	440	88	541	45
80-85	55-60	393	65	471	27
10-15	-	-	92	220	0

Benefits aid include travel and subsistence and relocation expenses

Staff Report

Our Staff

The Trust is one of the largest employers in the West Norfolk area, employing 2,818 Whole Time Equivalents (WTE) staff as at 31 March 2019. The Trust is developing a people strategy to ensure that the Trust is able to attract, recruit, develop and retain employees to meet the needs of our patient services. In reviewing the present workforce we look to the future to forecast the future demands and the effect these demands will place on our workforce.

The Trust will continue to use a triangulated approach to continue to make informed, safe and sustainable workforce decisions to ensure we have the right staff, with the right skills, in the right place at the right time. This will be measured by improvements to patient outcomes, people productivity and financial sustainability. The Trust will continue to report, investigate and act on incidents and use patient, carer and staff feedback.

An analysis of average staff number (whole time equivalent)

	31 March 2019			31 March 2018		
	Permanent	Other (Agency & Bank)	Total	Permanent	Other (Agency & Bank)	Total
	WTE	WTE	WTE	WTE	WTE	WTE
Medical and Dental	339	45	384	307	53	360
Ambulance Staff	6	0	6	3	0	3
Administration and Estates	573	19	591	563	13	576
Healthcare Assistants and other Support Staff	714	125	839	276	25	301
Nursing, Midwifery and Health Visiting Staff	805	133	938	1,254	179	1,433
Nursing, Midwifery and Health Visiting Learners	2	0	2	3	0	3
Scientific, Therapeutic and Technical Staff	325	12	337	316	8	324
Healthcare Science Staff	54	3	58	55	4	59
Social Care Staff	0	0	0	0	0	0
Total Average Numbers	**2,818**	**339**	**3,156**	**2,777**	**282**	**3,059**

Staff Gender

A breakdown of staff by gender as at 31 March 2019 is included in the table below:

Category	Female	Male	Total
Exec	3	4	7
Non Execs	1	5	6
Senior Manager	37	25	62

Staff Costs

It is recognised that staff costs is the largest area of Trust spend and that costs have increased over the last year to ensure high quality safe patient care. There will be a focus during 2019/2020 on developing a People Strategy which will encompass recruitment and retention to ensure a sustainable affordable workforce with the aim of reducing the reliance on agency workers resulting in enhanced consistency of care and reducing costs.

	31 March 2019			31 March 2018		
	Permanent	**Other**	**Total**	**Permanent**	**Other**	**Total**
Salaries & wages	88,729	23,905	112,634	102,623	3,063	105,686
Social Security Costs	10,695	497	11,192	8,044	1,836	9,880
Employer's contribution to NHS Pension	11,932	505	12,437	11,091	548	11,639
Apprenticeship Levy	444	95	539	483	22	505
Agency/Contract staff		16,037	16,037		15,032	15,032
	111,800	**41,039**	**152,839**	**122,241**	**20,501**	**142,742**

Communications, Consultation and Staff Engagement

The Trust recognises that by developing an engaged, enabled and empowered workforce, which is well-led and supported, the Trust can ensure its staff are getting the best possible experience, and would recommend the Trust as a place to work and receive care. Staff engagement is one of the top three priorities for the Trust to concentrate on improving in 2019 and beyond, and the Trust's pledge is to encourage staff to be committed to their organisation's goals and values, motivated to contribute to organisational success, and enhance their own sense of job satisfaction.

The Trust is an active participant in the NHSI Change Programme and is currently undertaking the phase one diagnostic part of this work to improve the culture of the Trust and increase staff engagement.

Staff engagement is supported by a comprehensive internal communications programme which includes a weekly round- up, Knowledge magazine and a Better Together fortnightly blog from the Chief Executive.

The Trust has developed a listening forum with the Chief Executive and Chairman of the Trust, which is open to all staff to provide feedback on the key issues and allows staff to have the opportunity to ask any questions of the Chief Executive and Chairman.

Staff are kept up to date on a range of performance and finance issues affecting our Trust both through the Integrated Performance Report, which is shared with staff and also through regular email correspondence on the key issues. Where there are issues affecting particular staff groups, including service changes, we will consult with staff and hold regular meetings with those staff groups and staff side representatives, as appropriate.

Trust Values

Our staff and patients have developed a set of values: Better Together @ Team QEH. These are the values that should characterise all that we do, and our behaviours with our patients and families, and each other. Our values are that we:

- Act Well
- Listen Well
- Care Well

These values are extremely important to us and we expect everyone who works at the QEH in any capacity, including employees, bank staff, contractors, agency staff, people who hold honorary contracts, students and volunteers to share and uphold our values. Each value is underpinned by behavioural standards and employees are expected to display these behaviours at all times.

The Trust also expects that everyone who works at the Trust will act in such a manner as to justify public trust and confidence and to uphold and enhance the good standing and reputation of The Queen Elizabeth Hospital King's

Lynn NHS Foundation Trust. Individuals must at all times carry out their duties with due regard to the Trust's Equality at Work Policy.

Our values define who we are. They encompass what we believe and how we will work together to achieve our objectives.

Recognition Awards

We believe that it is important for members of TeamQEH to be recognised when they go above and beyond their duties, and so in February 2019 the Trust launched 'Living our Values' awards. In addition the Trust has also developed a Team of the Week award. The Trust will be re-introducing an annual awards evening. Event planning for this is underway.

Staff sickness

Staff sickness absence

Figures Converted by DHSC to Best Estimates of Required Data Items			Statistics Published by NHS Digital from ESR Data Warehouse	
Average FTE 2018	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Day per FTE	FTE-Days Available	FTE-Days Lost to Sickness Absence
2,808	33,058	11.8	1,025,018	53,627

Source: NHS Digital - Sickness Absence and Publication - based on data from the ESR Data Warehouse
Period covered: January to December 2018

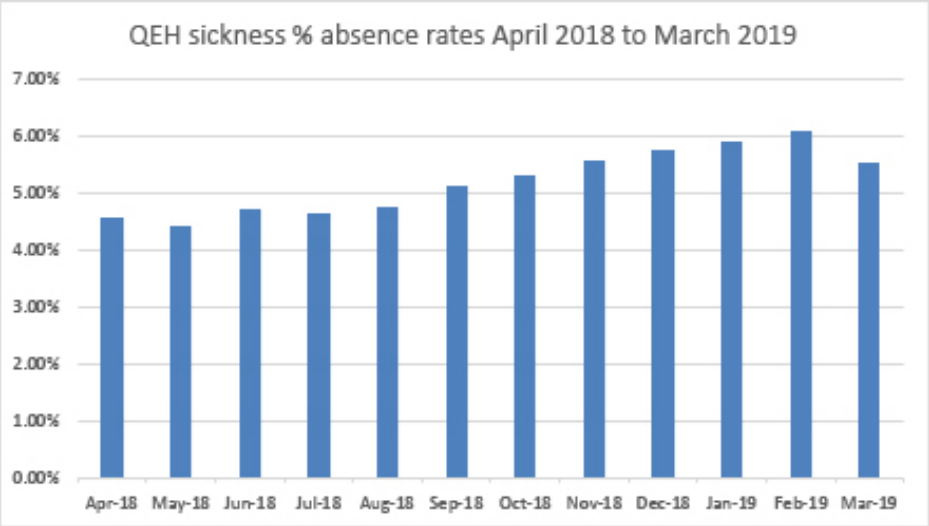
Data items: ESR does not hold details of normal number of days worked by each employee. Data on days available and days recorded sick are based on a 365 – day year.

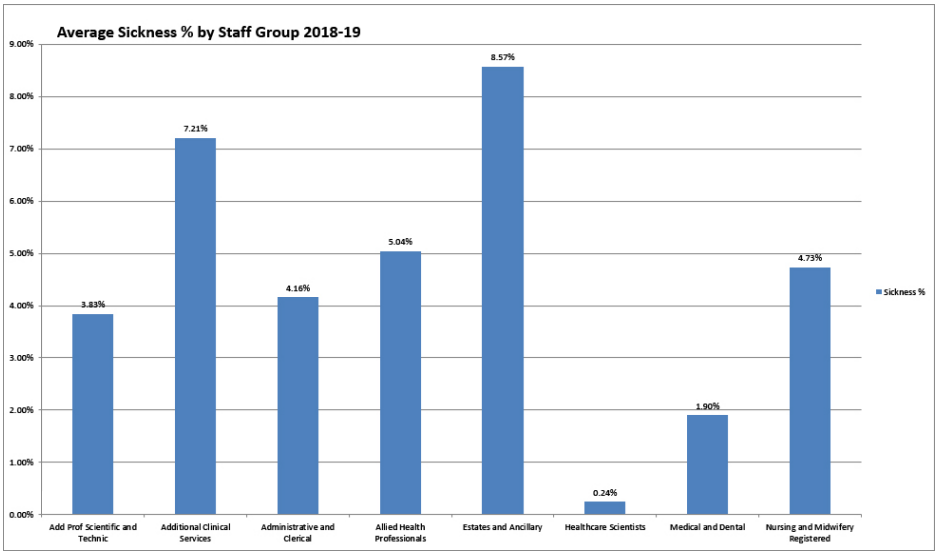
The number of FTE-days available has been taken directly from ESR. This has been converted to FTE years in the first column by dividing by 365 (with a further adjustment where the figures are based on less than 12 months' data).

The number of FTE-days lost to sickness absence has been taken directly from ESR. The adjusted FTE days lost has been calculated by multiplying by 225/365 to give the Cabinet Office measure (with a further adjustment where the figures are based on less than 12 months' data).

Average Annual Sick Days per FTE has been estimated by dividing the estimated number of FTE – days sick by the average FTE, and multiplying by 225 (the typical number of working days per year).

The table below shows the current sickness absence levels within the Trust.





The current Trust sickness rate is 5.53% as at 31 March 2019, against a target of 4%. From 1 April 2019 all areas have been tasked with putting measures in place to reduce sickness rates. Progress against assigned sickness targets will be closely monitored at divisional and Trust performance meetings. To reduce the absence rate to reach the target of 4% by 31 March 2020, the Trust is putting into place a number of initiatives which include further training to support managers, auditing current processes and data and undertaking a further review of Trust policy. In addition, a number of workshops will be made available to our staff including mindfulness and mental health first aid training.

Staff Development

The Trust is embarking on a journey whereby it will support and develop new roles; develop individualised career pathways including higher engagement with a range of schools, colleges and the local community and services to offer pre-employment and volunteering opportunities to attract a diverse workforce from the local community.

The new roles will seek to ensure that the Trust is able to attract individuals to hard-to-recruit posts and contribute to the planned reduction in agency spend, as will the focused recruitment plans. The 'Talent for Care' programme supports the workforce to grow and develop the skills needed to excel in service delivery. The Trust offers a range of learning routes including pre-employment, volunteering, apprentices and student placements leading to pre-professional and professional careers in all clinical and non-clinical areas of the Trust. The Trust is developing its staff through offering supported learning and professional development opportunities. In addition, flexible routes are being developed for other professions such as Nursing, Occupational Therapy and Physiotherapy. A leadership development programme will be established for all leaders in the organisation, including a bespoke Board Development Programme.

The Trust will be developing a new talent map to support its succession plans to determine the relevant leadership development required. For Medical Education, the Trust works with Health Education England (HEE), the Postgraduate Deanery, the Medical Director, Norwich Medical School and University of East Anglia (UEA) to ensure medical education at postgraduate and undergraduate level delivers high quality training and education, resulting in high quality feedback. The Trust will continue to develop and explore how new roles and new ways of working will support the delivery of the Trust strategy and ensure safe levels of staff. These include Physician Associate, Nurse Specialist, Assistant Practitioner and Nurse Associate roles. The Trust's aim is to not only cover for ongoing hard to fill vacancies but also to be prepared for any future shortages through introducing new ways of working and introduction of new posts.

The Trust continues to work in strong partnership with HEE, UEA and other universities to support and lead the educational development of nursing, midwifery and allied health professional students to offer quality clinical learning. The Education and Practice Development Team work closely across all disciplines, to increase inter-professional learning and development opportunities.

The Trust will work with partner organisations to secure the benefits from national and regional systems and continue to develop electronic systems to support more streamlined working, aiming to reduce manual paper processes. The Trust is developing a culture in which the Trust can transform its services and meet the wider health and social care agenda in the Sustainability Transformation Partnership by equipping managers with strong transformational leadership skills to positively engage staff in service changes, development and delivery both internally and across the system.

'Lifelong Learning' is a partnership programme between the Trust and our recognised trade unions. It aims to give staff learning opportunities to help with confidence and encourage access to personal development. The opportunities do not necessarily relate to work, with classes including well-being activities such as pilates, yoga, dancing and sewing, as well as continuing support for dementia awareness, mindfulness and mental health first aid.

Equality and Diversity

We are committed to promoting diversity and equality of opportunity in all its forms. Our patients, their carers and our staff deserve to expect an environment in which they feel respected, valued and empowered. We recognise that some groups in society continue to experience discrimination and also that some groups may not be protected by law. We are committed to ensuring that not only our legal duties are carried out, but also that we promote a culture in which all forms of discrimination are considered unacceptable and that diversity is valued. In order for us to deliver services in line with our equality policies and for us to achieve our objectives, it is important for us to understand who our staff and patients are and what is important to them. We continue to analyse this information and look for key issues, which in turn enables us to provide better care for all.

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;
- 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.

In March 2019 the Trust completed the NHS Employers' Diversity and Inclusion Partners programme. This programme supports Trusts to progress and develop their equality performance over a period of 12 months and is closely aligned to Equality Delivery System (EDS2).

Raising Concerns

Patient safety is our prime concern and our staff are often best placed to identify where care may be falling below the standard our patients deserve. In order to ensure our high standards continue to be met, we want every member of our staff to feel able to raise concerns with their line manager, or another member of the management team. We want everyone in the organisation to feel able to highlight wrongdoing or poor practice when they see it and confident that their concerns will be addressed in a constructive way.

This trust supports the Nursing Times Speak Out Safely campaign. This means we encourage any staff member who has a genuine patient safety concern to raise this within the organisation at the earliest opportunity.

Freedom to Speak Up

The Board of Directors of The Queen Elizabeth Hospital, King's Lynn, NHSFT commits to the further development of its patient safety culture, where people who have concerns about patient safety know how to 'speak up', and where:

- People feel confident to speak up
- People feel safe to speak up
- Concerns are investigated
- Speaking up makes a difference
- Concerns are well-received

The Trust has appointed an independent Freedom To Speak Up Guardian, reporting to the Board and The National Guardian's Office.

Whistleblowing

Members of staff and their colleagues can also refer to the Trust's Whistleblowing Policy if they wish to raise concerns.

Local Counter Fraud Service (LFCS)

The Trust works closely with our designated local counter fraud specialist as part of the national scheme led by the '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 Counter-fraud authority. This process is detailed in the organisation's Anti-Fraud and Bribery Policy.

Health and Well-being

In the year ahead our vision and mission is to continue to enhance the offer we make to our workforce and make a positive impact on individuals' lives and for the organisation. The Occupational Health service continues to deliver programmes to promote the health and well-being of our staff. Over the past year, the team has 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 Well-being. The key elements of this strategy are to develop a preventative programme in addition to the reactive support that we currently have available to staff.

This programme consists of four objectives:

- To take positive action on health & well-being 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 well-being
- Prevent influenza transmission to staff

Mental Well-being

The Trust has introduced monthly Schwartz Rounds which is an evidenced based programme to support the emotional demands on healthcare workers. This programme is enabling staff to reflect on aspects of our work and re-charge their emotional batteries and is so important for us to continue providing great care to our patients. Each time, those gathered are reminded of why we do the job that we do.

In addition, staff have access to the Mental Health Well-being Service which works in partnership with NHS and Voluntary organisations in the Norfolk and Waveney area and who provide telephone based treatment, workshops, stress control, computer-based therapy, one-to-one work, access to community-based support and mental health first aid.

Musculoskeletal Prevention

The Trust employs a staff physiotherapist to provide dedicated support to enable staff to reduce the risk of musculoskeletal injury.

Prevent Influenza Transmission

A full influenza vaccination campaign was undertaken from October 2018 – March 2019 where over 80% of our frontline staff received their vaccination.

Well-being at work programme

The Trust recognises that stress and anxiety may impact on an individual's home and work life. There is a variety of support available for those employees who are experiencing issues in their life which are having an adverse effect upon them. The Trust offers a free well-being service available to all staff and managers who provide support 24 hours per day, 7 days per week and access to self-help guides on a range of issues, i.e., relationship problems, financial and legal issues.

Be Well

A new Intranet page called 'Be Well' has been developed, which provides a range of information about opportunities, initiatives and services which have been provided by the Trust to support the health and well-being of our members of staff.

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:

- On-going monitoring of health and safety folders in all departments via scheduled H&S audits. This provides assurance that the folders are being used, and generic risk assessments are completed to support safe working practice
- Improving the dust extraction system in the dental laboratory
- Continual development of the Trust's electronic web-based system for the safe management of Control of Substances Hazardous to Health (COSHH). The Trust database of assessments continues to develop and expand
- Supporting the development of the network of health and safety confident and competent staff across the Trust, and at all levels, from senior managers to local risk champions
- Involvement in groups such as falls and bariatric steering groups, and closer working with patient safety and experience
- Consolidating the Estates and Facilities risk register into one combined register, with regular monthly updates to the Risk Committee.

Training

The Health and Safety team develops and delivers training packages and ensures that there are competent trainers to cover the mandatory training needs of the organisation related to fire, health and safety, manual handling, risk assessment, prevention and management of aggression, chemicals and waste. The team also compiles e-learning packages and assessments used for revision training for staff in various health and safety topics. The training process is regularly evaluated and reviewed to ensure it is effective.

Incidents

There are five categories of health and safety related incidents that are reported most frequently by staff. These are slips, trips and falls, needle-stick and sharps injury, patient moving and handling, verbal aggression and physical aggression.

There was a 20% overall increase in total reported staff safety incidents in 2018/19 (402) compared with the previous year (335).

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

During 2018/2019, the Health and Safety Department reported 15 staff injuries to the Health and Safety Executive. These were due to the employee sustaining injuries during work related activities or being absent for or requiring a change of duties for more than seven days. This is a decrease in reportable incidents of 18 in 2017/18 on the previous year. The number of RIDDOR incidents is reflected as an incidence rate against the national average. The Trust's overall RIDDOR reportable incidence rate has decreased from 569 per 1,000 employees in 2017/18 to 473 in 2018/19; the national incidence rate of over-7-day abscence injury per 100,000 workers for healthcare in 2017/18 was 323. More detail on health and safety performance is included within the Health and Safety Annual Report that will be presented to the Trust Health and Safety Committee in July 2019.

Staff Survey

The Staff Opinion Survey provides an opportunity for staff to provide feedback on their experience of working in our Trust and provides evidence of where things are going well and where there are potential areas for improvement,

Staff participation with the NHS staff survey is not compulsory, although staff are strongly encouraged to use the opportunity to give their opinions and views about the organisation in which they work.

The following key areas are included in the staff survey questionnaire:
- Staff engagement and involvement including job satisfaction
- Leadership and management
- Equality and Diversity
- Appraisal and support for development
- Raising Concerns
- Errors and Incidents
- Staff Health and Well being
- Working patterns
- Patient care and experience
- Violence, harassment and bullying

The response rate to the survey was 44%.

The table below presents the results of significance testing conducted on this year's theme scores and those from last year. It details the organisation's theme scores for both years and the numbers of responses each of these are based on and whether there has been a change between the two years results.

Theme	2016 Scores	2016 Benchmark	2017 Scores	2017 Benchmark	2018 Scores	2018 Benchmark
Equality, Diversity and Inclusion	9.0	9.2	8.9	9.1	8.7	9.1
Health and Well-being	6.1	6.1	6.0	6.0	5.7	5.9
Immediate managers	6.5	6.7	6.5	6.7	6.4	6.7
Morale					5.7	6.1
Quality of Appraisal	4.9	5.3	4.9	5.3	4.8	5.4
Quality of Care	7.7	7.6	7.5	7.5	7.1	7.4
Safe Environment – Bullying and Harassment	7.8	8.0	7.7	8.0	7.6	7.9
Safe Environment – Violence	9.2	9.4	9.2	9.4	9.2	9.4
Safety Culture	6.5	6.6	6.4	6.6	6.0	6.6
Staff Engagement	7.0	7.0	6.9	7.0	6.5	7.0

A Trust-wide action plan has been developed to address the areas of concern within the staff survey, which includes the following key actions:
- Implementing Trust-wide "you said, we did" sessions
- Introducing staff recognition awards
- Developing a leadership development plan for the organisation, which includes leadership skills, behaviours framework, underpinned by leadership training needs analysis and NHSI cultural diagnostic work
- All leaders will undergo a 360˚ appraisal within the next 12 months
- Improving staff engagement
- Roll out of #bettertogether@teamQEH
- Providing opportunities for managers to feed back
- Audit of quality of appraisals

In addition to the Trust-wide action plan, all the Divisional Triumvirates and Corporate leads have been asked to identify the top five areas they are going to work on. As a result, a structured and deliverable programme of work and an action plan was developed by 1 May 2019 that will address the results of the staff survey at both a Trust

wide and divisional/ corporate level. The action plan will be monitored through the Trust performance review process and the Workforce Committee will receive quarterly updates on progress against this action plan.

Expenditure on Consultancy

The Trust has spent £766k on consultancy in 2018/19; the level of expenditure on consultants has increased from £282k in 2017/18. This increase reflected the greater level of support required by the Trust to identify areas of medium and long-term financial improvement during 2018/19. The expenditure on consultants was split between PricewaterhouseCoopers, Four Eyes, MNO Consultancy Limited, Attain, Transformation Nous and Morgan Law.

Off-payroll engagements

The Trust can confirm that all existing off-payroll engagements, outlined below, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where neccessary, that assurance has been sought.

Reporting high paid off-payroll arrangements **All off-payroll engagements as of 31 March 2019, for more than £220 per day and that last for longer than six months**	**2018/19 Number of engagements**
2018/19 Number of engagements	
No. of existing engagements as of 31 March 2019	1
Of which:	
Number that have existed for less than one year at the time of reporting	1
Number that have existed for between one and two years at the time of reporting	0
Number that have existed for between two and three years at the time of reporting	0
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	0
Confirmation: The Trust can confirm that all existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.	

For all new off-payroll engagements, or those that reached six months in duration, between 01 Apr 2018 and 31 Mar 2019, for more than £220 per day and that last for longer than six months	**2018/19 Number of engagements**
Number of new engagements, or those that reached six months in duration between 01 Apr 2018 and 31 Mar 2019	**1**
Number of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and national insurance obligations	1
Number for whom assurance has been requested	1
Of which:	
Number for whom assurance has been received	1
Number for whom assurance has not been received*	0
Number that have been terminated as a result of assurance not being received	0

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 Apr 2018 and 31 Mar 2019	2018/19 Number of engagements
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	1
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements.	1

Exit packages

Exit packages: other (non-compulsory) departure patyment

	Expected sign	Payments agreed 2018/19 No.	Total value of agreements 2018/19 £0000	Payments agreed 2017/18 No.	Total value of agreements 2017/18 £0000	Subcode
Voluntary redundancies including early retirement contractual costs	+					STA0720
Mutually agreed resignation (MARS) contractual costs	+			1	25	STA0730
Early retirement in the efficiency of the service contractual costs	+					STA0740
Contractual payments in lieu of notice	+	2	13	4	33	STA0750
Exit payments following employment tribunals or court orders	+					STA0760
Non-contractual payments requiring HMT approval (special severance payments)*	+					STA0770
Total	+	**2**	**13**	**5**	**58**	
of which non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their salary	+					STA0790

Trade Union Facility Time

The Trade Union (Facility Time Publication Requirements) Regulations 2017 came into force on 1 April 2017. The regulations require the Trust to publish information regarding trade union facility time in accordance with Schedule 2 of the regulations. The Trust published the results for the period of time from 1 April 2017 to 31 March 2018. The total percentage of the total pay bill spent on facility time was 0.01%. 21 employees (19.12 WTE) were relevant union officials, four of which spent 0% of their working hours on facility time; 17 relevant union officials spent between 1% and 50% of their working hours on facility time. 27.03% of facility time was spent on paid trade union activities as a percentage of total paid facility time.

Disclosures set out in the NHS Foundation Trust Code of Governance

Compliance with the NHS Foundation Trust Code of Governance

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

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

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012. The Trust is required to report against the provisions of The Code in a variety of ways, as set out below.

At 31 March 2019, the Board of Directors declares compliance with the provisions of **The Code of Governance, Schedule A1 (Statutory Requirements)**.

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

Provision	Provision Summary	Supporting Explanation
A.1.1	This statement should also describe how any disagreements between the Governors' Council and the Board of Directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the Board of Directors and the Governors' Council operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the Board of Directors.	The Trust has in place an Engagement Policy, which describes how Governors may engage with the Board of Directors when they have concerns about the performance of the Board of Directors, compliance with the Licence Conditions or the welfare of the Trust. The Trust also has in place a 'Dispute Resolution Procedure', to deal with disputes relating to the Trust's constitution. Summary statements outlining how the Board and Governors' Council operate, including a summary of the types of decisions taken, are set out in the Annual Report, in 'The role of the Board of Directors' and 'The role of the Governors' Council' respectively.
A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors.	See table – 'The Board of Directors in 2018/19'.
A.5.3	The annual report should identify the members of the Governors' Council, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	See table - 'The Governors' Council composition in 2018/19'.

Provision	Provision Summary	Supporting Explanation
B.1.1	The Board of Directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	In respect of the criteria set out in The Code of Governance, all non-executive directors are judged to be independent in character and judgement. No relationships or circumstances have been identified that are likely to affect, or could appear to affect, directors' judgement.
B.1.4	The Board of Directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	See Board of Directors' Biographies. The Board is substantively appointed as at 31 March 2019, with the exception of the CEO, who is seconded into her position and the interim Chief Operating Officer. The skills and experience reflected in the Board membership mean that the Board is balanced and appropriate to the requirements of the Trust. The Board's capacity will be strengthened further in 2019/20.
B. 1. 10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	See 'Committees of the Governors' Council - The Nomination and Remuneration Committee (Non-Executive Director appointments).
B. 3. 1	A chairperson's other significant commitments should be disclosed to the Governors' Council before appointment and included in the annual report. Changes to such commitments should be reported to the Governors' Council as they arise and included in the next annual report.	The Trust Chairman has no commitments likely to impact on his work with the Trust.
B. 5. 6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the Board of Directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Governors canvass the opinion of the Trust's members and the public in a variety of ways, including through engagement with Healthwatch Norfolk and the Patient Participation Groups of the GP surgeries within the Trust's catchment area. The Trust's appointed Governors represent the views of a range of local strategic partners.
B. 6. 1	The Board of Directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	Board and Director performance evaluation methodologies employed include: • Self-assessment (after each Board meeting) • ED appraisal • NED appraisal (involving the Governors) In 2018/19, the Board self-certified compliance with general condition 6 of the NHS provider licence and made its corporate governance statement, AHSCs and training of governors. See also 'Evaluating the Board's Performance'. The Trust jointly commissioned, with NHSI, an independent Board Review in November 2018. The review findings and recommendations / actions to address the recommendations were reported to the Board in public, in January 2019.

Provision	Provision Summary	Supporting Explanation
B. 6. 2	Where an external facilitator is used for reviews of governance, they should be identified, and a statement made as to whether they have any other connection with the trust.	The Trust jointly commissioned, with NHSI, an independent Board Review in November 2018. The review findings and recommendations / actions to address the recommendations were reported to the Board, in public, in January 2019. The independent review was undertaken by PwC. PwC was also engaged in 2018/19 to support the Trust's Financial Recovery. Paul Moores was engaged late in 2018/19 to undertake a review of the Trust's Risk and Governance processes and structures. He has no other connection with the Trust. Governance-related reviews were undertaken by RSM as part of the Trust's Internal Audit programme during 2018/19.
C. 1. 1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy. There should be a statement by the external auditor about their reporting responsibilities. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	See sections on: • 'The Directors' Report' • 'The Audit Committee and External Audit' • 'The Annual Governance Statement'
C. 2. 1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	See: 'The Annual Governance Statement'.
C. 2. 2	A trust should disclose in the annual report: a. if it has an internal audit function, how the function is structured and what role it performs; or b. if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	See 'The Audit Committee and External Audit'.
C. 3. 5	If the Governors' Council does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the Board of Directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the Governors' Council has taken a different position.	Not applicable in 2018/19

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

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

Provision	Provision Summary	Supporting Explanation
A. 1. 3	The Board of Directors should make available a statement of the objectives of the NHS foundation trust showing how it intends to balance the interests of patients, the local community and other stakeholders, and use this as the basis for its decision-making and forward planning.	Annual Report and on website.
B. 1. 4	A description of each director's expertise and experience, with a clear statement about the board of director's balance, completeness and appropriateness.	Annual Report and on website.
B. 2. 10	The main role and responsibilities of the nominations committee should be set out in publicly available, written terms of reference.	On request and in Annual Report – 'Committees of the Governors' Council'.
B. 3. 2	The terms and conditions of appointment of non-executive directors.	On request and in Annual Report.
C. 3. 2	The main role and responsibilities of the audit committee should be set out in publicly available, written terms of reference.	On request and in Annual Report – 'The Audit Committee and External Audit'.
D. 2. 1	The remuneration committee should make available its terms of reference, explaining its role and the authority delegated to it by the Board of Directors. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the NHS foundation trust.	On request and in the Annual Report – 'Committees of the Governors' Council'. No remuneration consultants have been appointed during 2018/19.
E. 1. 1	The Board of Directors should make available a public document that sets out its policy on the involvement of members, patients and the local community at large, including a description of the kind of issues it will consult on.	On request.
E. 1. 4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website.	Website and Annual Report – 'Contacting the Governors'.

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

	Provision	Information
A4	B. 7. 1	In the case of re-appointment of non-executive directors, the chairperson should confirm to the governors that after formal performance evaluation, the performance of the individual proposed for re-appointment continues to be effective and to demonstrate commitment to the role.
A5	B. 7. 2	The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to take an informed decision on their election. This should include prior performance information.

In respect of **The Code of Governance, Schedule A6 (Provisions requiring a compliance statement or explanation where the Trust has departed from the Code)**, the Board declares compliance with all provisions as at 31 March 2019.

A 4.1 - The Senior Independent Director stood down from the Board of Directors on 31 March 2019. The Board (in consultation with the Governors' Council) made a new appointment to this post, following the early 2019 non-executive recruitment and section process.

B 6.5 - Following a change in Board / Governors' Council meeting sequencing late in 2018/19, the Governors' Council will, after 3 cycles under the new arrangements, undertake a review of the effectiveness of the Governors' Council. The outcome of the review will be reported at the Annual Members' Meeting.

The Board of Directors

The Board of Directors has, during 2018/19, met in public on six occasions. The Board has also met in private where its debate has considered commercially sensitive and/or involved confidential issues. The Board meets in less formal workshop settings to undertake strategic planning and development activities.

As at 31 March 2019, the Board of Directors was made up of the Chairman, five non-executive directors and five voting executive directors. The five voting executive board positions at 31 March were: the Chief Executive; the Director of Finance and Resources; the Medical Director, the Chief Nurse and the Chief Operating Officer. As at 31 March 2019, the Trust is compliant with the Code of Governance provision B.1.2., requiring at least half the Board of Directors, excluding the chairperson, to be non-executive directors, determined by the Board to be independent.

During 2019/20, the Trust Chairman will be leading the Governors' Council in undertaking non-executive director recruitment and selection, with a view to increasing the non-executive complement on the Board in line with the Trust's constitutional provisions. It is expected that this development will improve non-executive director oversight and scrutiny, as the Trust puts its quality and financial recovery plans in place and undertakes its comprehensive organisational engagement and development work.

The Role of the Board of Directors

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

Some of the responsibilities of the Board of Directors

- To ensure that the Trust meets its statutory duties and complies with its terms of authorisation and its constitution
- To ensure that the organisation's policy framework is developed in accordance with the rights, pledges and responsibilities contained in the NHS Constitution
- To provide leadership for the organisation in respect of agreed organisational values and standards of conduct, in accordance with accepted standards of behaviour in public life, which include the principles of selflessness, integrity, objectivity, openness, honesty and leadership (Nolan)
- To establish a robust performance management framework and support the Executive Team in meeting the organisation's performance targets; monitoring the performance of the Trust and ensuring that the Executive Directors manage the Trust within the resources available, in such a way as to:
  - ensure the quality and safety of healthcare services
  - plan for continuous improvement
  - protect the health and safety of Trust employees and all others to whom the Trust owes a duty of care
  - use Trust resources efficiently and effectively
  - promote the prevention and control of Healthcare Associated Infection
  - comply with all relevant regulatory, legal and code of conduct requirements
  - maintain high standards of ethical behaviour, corporate governance and personal conduct in the business of the Trust
  - maintain the high reputation of the Trust both with reference to local stakeholders and the wider community
- To engage, as appropriate, with the Governors' Council, in accordance with the statutory and regulatory framework.

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

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

The Chairman, the Vice Chair and the Senior Independent Officer

In a Foundation Trust, the Trust Chairman chairs both the Board of Directors and the Governors' Council. The Queen Elizabeth Hospital's constitution makes provision for the Board's appointment of a Senior Independent Director, who has particular duties regarding working with the Governors' Council and the Board of Directors to address any issues where it is inappropriate for the Chairman to do so. The Trust's Senior Independent Director was appointed by the Board in 2016. The appointment was supported by the Governors' Council. The Vice Chair, also appointed in

2016, stood down in 2018/19 and the Governors' Council appointed a non-executive director as the new Vice Chair in January 2019.

In 2018/19, the Trust Chairman has had no other significant commitments that have had an adverse impact on his role as Chairman of the Foundation Trust.

Register of Directors' Interests

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

Delegation and the Committees of the Board of Directors

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

Committees reporting and accountable to the Board of Directors at 31 March 2018:

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

The Audit Committee and External Audit

The Audit Committee met five times during 2018/19. Its purpose is to maintain oversight of the adequacy of the control environment of the Trust, including those controls related to financial reporting procedures and quality. This work involves the monitoring of the effectiveness of internal controls and risk management processes. The Audit Committee approves strategies and plans for countering fraud and receives reports from the Trust's Local Counter Fraud Specialist at each meeting. The Chair of the Audit Committee is a qualified accountant.

The Audit Committee approves the Internal Audit work programme and monitors the effectiveness of the Internal Audit function. The committee also receives and considers reports and opinion from both internal and external auditors. RSM provided the Trust's Internal Audit function in 2018/19. The Internal Auditors audit a range of both financial and quality controls at the Trust and provide levels of assurance accordingly.

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

The Trust's external auditor for the period covered by this Annual Report was KPMG. KPMG was re-appointed in 2016/17 as the Trust's external auditors by the Governors' Council after a transparent process, overseen by a group of governors, appointed by the full Council. KPMG has provided no additional non-audit services in 2018/19.

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

Evaluating the Board's Performance

The Board of Directors uses a number of methods to evaluate the performance of the Board and its committees. In 2018/19, performance evaluation methodologies employed include:

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

In 2018/19, the Board self-certified its compliance with General Condition 6 of the NHS Provider Licence. In 2017/18 the Board also made its Corporate Governance Statement and declarations concerning AHSCs and the training of governors.

The Trust jointly commissioned, with NHSI, an independent Board Review in November 2018. The review findings and recommendations / actions to address the recommendations were reported to the Board, in public, in January 2019. The independent review was undertaken by PwC.

The Constitution

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

Director **1 April 2018 - 31 March 2019**	Date of end of current NED terms of office	Audit Committee 5 meetings		Nomination and Remuneration Committee (ED Appointments) 6 meetings		Meetings attended out of 12 Board of Director (Ordinary) Meetings inc March 2015
Steve Barnett – NED Trust Chairman From 5 November 2018	Nov 2021			✓	2/2	5/5
David Thomason – NED Chair of Finance & Activity Committee From 3 August 2015-31 March 2019	March 2019	✓	4/5	✓	3/5	10/12
Ian Harvey – NED Chair of Quality & Performance Committee (until January 2019) From 4 January 2016- 31 March 2019	March 2019			✓	3/5	11/12
Amanda Ashton – NED Chair of Workforce Committee Chair of Quality & Performance Committee (from January 2019) From 21 August 2017	Aug 2020	✓	2/5 (Sub. sent for 1 meeting)	✓	3/5	9/12
Alan Brown – NED Chair of Charitable Funds Committee From 1 May 2018	May 2021			✓	3/5	10/11
David Dickinson – NED Chair of Audit Committee From 2 July 2018	July 2021	Chair	3/3	✓	1/2	8/10
Caroline Shaw Chief Executive Officer From 14 January 2019				✓	2/2	3/3
Jon Wade Chief Operating Officer From 21 November 2016						12/12 (1 sub)
Emma Hardwick Chief Nurse From 16 January 2017						12/12 (3 sub)
Nicholas Lyons Medical Director From 1 April 2017						11/12 (2 sub)

Director **1 April 2018 - 31 March 2019**	Date of end of current NED terms of office	Audit Committee 5 meetings		Nomination and Remuneration Committee (ED Appointments) 6 meetings		Meetings attended out of 12 Board of Director (Ordinary) Meetings inc March 2015
Roy Jackson Director of Finance & Resources From 2 May 2017 (Interim) From 1 February 2018 (Substantive)						12/12
Karen Charman Director of HR & OD From 3 July 2017						12/12 (3 sub)
Patrick Johnson Chief Transformation Officer (Fixed term, 12 months) From 29 October 2018						6/6
Ciara Moore Chief Transformation Officer From 13 March 2017 to 24 August 2018						3/5
Jon Green Chief Executive Officer (CEO) From 1 May 2017 – 14 Jan 2019 (secondment)				✓	3/3	7/7
Edward Libbey Non-Executive Director (NED) Trust Chairman From 1 July 2014 to 22 October 2018				Chair	3/3	6/6
Ian Pinches - NED Chair of Audit Committee and Charitable Funds Committee – From 12 November 2012 to 28 September 2018		Chair	3/3	✓	3/3	6/6

✓ = Committee Member = No longer serving on the Board of Directors

The Role of the Governors' Council

The Governors' Council:

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

Statutory Duties for Governors:

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

Governors:

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

Advice and Training for Governors:

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

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

At the July 2018 Annual Members' Meeting, members voted in favour of a constitutional change, removing West Norfolk Clinical Commissioning Group (WNCCG) as a partner organisation, nominating a governor to sit on the Governors' Council. This change was made with the full agreement of WNCCG that there are many other systems of engagement and liaison between the Trust and its commissioners and that membership of the Governors' Council was therefore not necessary. Furthermore, it was agreed that the CCG's nominated governor could be perceived to have a conflict of interest. Consequently, at 31 March 2019, there were 29 governor seats on the Governors' Council of The Queen Elizabeth Hospital. The Governors' Council is made up as follows:

Sixteen Elected Public Governors

- 9 from West Norfolk
- 2 from Breckland, North Norfolk and the Rest of England
- 3 from Cambridgeshire
- 2 from SE Lincolnshire

Six Elected Staff Governors

- 3 Clinical
- 3 Non-Clinical.

Seven Appointed (Partner) Governors

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

2018/19 Election Report

In January 2019, the Trust held elections in all constituencies: Breckland, North Norfolk and Rest of England, Cambridgeshire, South East Lincolnshire, West Norfolk, Staff Clinical and Staff Non-Clinical.

Governor elections were held in accordance with the election rules set out in the Trust's Constitution, to enable members to elect candidates to the vacancies on the Governors' Council. The election was independently overseen by Electoral Reform Services.

The Cambridgeshire and Staff Clinical constituencies were uncontested and candidates from these areas automatically became governors as follows:

Constituency / Area	Governors to Elect	Contested?	Name	Term
Public Constituency				
Cambridgeshire	1	No	Jenny Brodie	3yrs
Staff Clinical	2	No	Ant Wilson	3yrs

West Norfolk, South East Lincolnshire, Breckland, North Norfolk and the Rest of England (RoE) and Staff Non-Clinical constituencies were contested as detailed:

Constituency / Area	Governors to Elect	Contested? Yes - nominations	Turnout %	Names	Term
Public Constituency					
West Norfolk	4	7	13.2%	Simon Clarke Ann Easton Patrick Kavanagh Kenneth Wicks	3yrs
South East Lincolnshire	2	3	14.6%	Alan Maltby Sue Robinson	1yr 3yrs
Breckland, North Norfolk & RoE	1	2	11.9%	Dale Welch	3yrs
Staff Constituency					
Staff Non-Clinical	2	4	21.7%	Chaz Scholefield Dan Todd	3yrs 3yrs

Meetings of the Governors' Council

The Governors' Council has met formally in public, six times during 2018/19 (including the Annual Members' Meeting) and met at three extraordinary meetings.

The dates and venues for the Governors' Council meetings in 2019 can be found on the QEH website in the Governors' Council section. Alternatively, members can contact the Foundation Trust Office on 01553 613142 or email FT.Membership@qehkl.nhs.uk for details. In response to concerns raised about the effectiveness of the sequencing of the Board and GC meetings and following a review, from November 2018 Governors' Council meetings will follow (no more than a week later) Public Board meeting sequencing.

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

Committees of the Governors' Council

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

The Membership and Communications Committee oversees member and public engagement and during 2018/19 has undertaken:

- Development and delivery of the Membership Strategy, to support engagement and communication with the members and wider public.
- Membership recruitment - In 2018/19, the Committee continued to work to increase the public membership and to address some areas of under-representation in the public membership profile, through targeted recruitment. Once again successful collaboration with the College of West Anglia has enabled wider representation from younger people. Regular membership recruitment took place within the Trust's Outpatient Department.
- Communication / engagement - To assist in communicating with members and the wider public, the Committee has nominated members to participate on the editorial panel of the Trust's newsletter, 'Trust Matters' and has developed an engagement strategy, which includes a programme of healthcare events for members. In 2018, two healthcare events were held at the Trust; a Cancer event in May and a Learning Disabilities event in September.

The Nomination and Remuneration Committee – (Non-Executive Director appointments) makes recommendations to the Governors' Council regarding the appointment and remuneration of non-executive directors (NED). The Terms of Reference for this committee have been drawn up in alignment with the Code of Governance and Monitor's 'Your Statutory Duties – A Reference Guide for NHS FT Governors'. The committee making recommendations to the Governors' Council in respect of NED appointments is comprised of governors and the Trust Chairman. The governors' Nomination and Remuneration Committee began the process of recruiting two new Non-Executive Directors which culminated in appointments commencing in May and July. A further recruitment process followed at the end of 2018 (which was temporarily put on hold pending the outcome of the Trust's 2018 CQC inspection and independent Board Review) which on resumption led to an additional Non-Executive Director appointment to commence in April 2019.

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

The Patient Experience Committee has undertaken a wide range of activities throughout 2018/19:

- Nursing interview panel work;
- Involvement in Mock CQC inspections;
- Engagement with Norfolk Healthwatch;
- Liaison with Matrons and leads across all specialties / wards;
- Review of Patient Experience information drawn from a variety of sources;

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

- Relationships and formal liaison with West Norfolk Patient Partnership and affiliated GP Patient Participation Groups;
- Involvement in PLACE (Patient-Led Assessments of the Environment) Inspection and additional ward and department inspections;
- Development of relationships with South East Lincolnshire Patient Participation Groups;
- Governors' Council Meetings and attendance at various Trust Committee meetings;
- Sustainability and Transformation Partnership and Consultation Meeting(s);
- West Norfolk Association Meetings;
- North Cambs Hospital engagement;
- Fenland Health and Care Forum;
- Community Engagement Forums ;
- Surgery Healthcare 'roadshows'

- CQC 'Well-Led' inspection - governor interviews;
- QEH Healthcare Events; and
- Surveys.

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

The Constitution Working Group undertakes periodic review work and makes recommendations, as necessary, regarding proposed amendments to the Trust's Constitution.

Contacting the Governors

Members and the public can contact the governors at FTGovernor@qehkl.nhs.uk or by post at the following address: The Foundation Trust Office, The Queen Elizabeth Hospital King's Lynn NHS FT, Gayton Road, King's Lynn, Norfolk PE30 4ET

The Governors' Council composition in 2018/19 - see note opposite

Constituency	Name	Current Term / Period remaining - Years	Governors' Council Meetings Attendance	Nomination and Remuneration Committee Member	Membership & Communications Committee Member	Patient Experience Committee Member	Business Committee Member
West Norfolk (9)	Robin Broke (re-elected Feb 2016) 3rd term	3/0	3/6	✓			
	Steve Clark (re-elected Feb 2017) 2nd term	3/1	4/6	✓		✓	Chair
	Simon Clarke (elected Feb 2019) 2nd term	3/3	3/6				✓
	Esmé Corner OBE (re-elected Feb 2017) Lead Governor) 3rd term	3/1	5/6	✓	✓	Chair	✓
	Jonathan Dossetor (re-elected Feb 2017) 3rd term	3/1	6/6	✓	Chair	✓	
	Ann Easton (elected Feb 2019) 1st term	3/3	0/0			✓	
	Penny Hipkin (re-elected Feb 2017) 3rd term	3/1	6/6	✓	✓	✓	
	Patrick Kavanagh (elected Feb 2019) 1st term	3/3	0/0		✓	✓	
	Robert Outred (elected Feb 2016) 1st term	3/0	5/6		✓	✓	
	Peter Tasker (elected Feb 2016) 1st term	3/0	5/6			✓	
	Barrie Taylor (re-elected Feb 2017) 3rd term	3/1	6/6			✓	
	Kenneth Wicks (elected Feb 2019) 1st term	3/3	0/0		✓		✓
Cambridgeshire (3)	Jenny Brodie (Feb 2019) 3rd term	3/3	0/0			✓	✓
	Malcolm Bruce (Feb 2017) 1st term	3/3	3/6		✓	✓	
	Betty Lewis (Feb 2017) 3rd term	3/1	5/6		✓	✓	
Breckland, North Norfolk & Rest of England (2)	Clive Monk (Feb 2017) 2nd term	3/1	6/6			✓	✓
	Patricia Tickner (Feb 2017) 1st term	3/1	5/6		✓	✓	
	Dale Welch (elected Feb 2019) 1st term	2/0	0/6			✓	
South East Lincolnshire (2)	June Chadwick (Feb 2017) 1st term	3/3	0/0			✓	
	Aimee Hicks (Feb 2016) 1st term	3/0	0/1			✓	
	Alan Maltby (elected Feb 2019) 1st term	3/0	2/6		✓	✓	
	Sue Robinson (elected Feb 2019) 1st term	3/1	0/0		✓	✓	
Staff Clinical (3)	Mark Abbott (Feb 2016) 1st term	3/3	0/0				
	Julie Calton (re-elected Feb 2017) 2nd term	3/0	0/6	✓		✓	
	Nigel Tarratt (Feb 2016) 2nd term	3/1	5/6		✓	✓	✓
	Anthony Wilson (Feb 2019) 1st term	3/0	6/6			✓	
Staff Non-Clinical (3)	Darren Barber (elected Feb 2016) 1st term	3/3	0/0		✓		
	Sophia Buckingham (elected Feb 2016) 1st term	3/0	4/6				✓
	Dave Coe (re-elected Feb 2017) 3rd term	3/0	5/6	✓			✓
	Chaz Scholefield (elected Feb 2019) 1st term	3/1	5/6		✓		
	Dan Todd (elected Feb 2019) 1st term	3/3	0/0				
Appointed Governors (7)							
BC King's Lynn & West Norfolk*	Paul Kunes – from June 2015		5/6				✓
Breckland	Ian Sherwood – from May 2016		5/6				
College of West Anglia	Ann Compton – From Feb 2017		5/6			✓	
Freebridge Cmty Housing**	Andy Walder – from March 2017		5/6				✓
Norfolk County Council	Sandra Squire – from July 2017		3/6				
	Hilary De Lyon – until Jul 2018		1/1	✓			
West Norfolk CCG***	Jane Evans – from Feb 2017		4/6		✓	✓	
West Norfolk Carers	Paul Dansie – from April 2016		2/6				
UEA	Brigitte Nelson – from April 2014		2/4				

Key: Governors no longer serving on the Governors' Council

*Borough Council of King's Lynn & West Norfolk **Freebridge Community Housing ***West Norfolk Clinical Commissioning Group

Note: Meeting attendance includes the Annual Members' Meeting and excludes Extraordinary Governors' Council meetings.

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

Who can become a Member?

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

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

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

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

Members of staff

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

How do I apply to become a member?

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

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

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

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

The Membership Strategy

We achieved a public membership of 7,662 by the end of 2018/19.

Current Foundation Trust Public Membership

The QEH Public Constituency	Members 31/03/2018	Members 31/03/2019
Gender		
Male	2,997	2,930
Female	4,671	4,732
Constituency		
Breckland, North Norfolk & Rest of England	1,344	1,332
Cambridgeshire	688	698
SE Lincs	582	576
West Norfolk	5,054	5,056
Age		
16-21	932	841
22-29	686	870
30-39	538	559
40-49	632	630
50-59	798	767
60-74	1,874	1,811
75+	1,605	1,607
Not stated	603	577
Ethnicity		
White	7,241	7,223
Mixed	34	36
Asian or Asian British	78	77
Black or Black British	32	37
Other	19	20
Not stated	264	269
Total	**7,668**	**7,662**

Single Oversight Framework

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

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

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

Segmentation

NHS Improvement (NHSI) has placed the Trust in segment 4.This segmentation information is the trust's position as at 21 May 2019. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website. The Trust is in breach of its licence and has monthly Performance Review Meetings (PRMS) with NHSI. For more information see he Annual Governance Statement.

Finance and use of resources

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

Area	Metric	2018/19 scores				2017/18 Scores			
Financial Sustainability	Capital Service capacity	4	4	4	4	4	4	4	4
	Liquidity	4	4	4	4	4	4	4	4
Financial Efficiency	I&E Margin	4	4	4	4	4	4	4	4
Financial Controls	Distance from financial plan	4	4	4	4	4	4	4	4
	Agency Spend	4	4	4	4	3	3	3	3
Overall Scoring		**4**	**4**	**4**	**4**	**4**	**4**	**4**	**4**

Statement of the Chief Executive's responsibilities as the Accounting Officer of The Queen Elizabeth Hospital King's Lynn 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 The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust to prepare for each financial year a statement of accounts in the form, and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust and of its income and expenditure, 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.

Caroline Shaw
Chief Executive
Date: 21 May 2019

Annual Governance Statement

1. Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, 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.

I was appointed as CEO and Accounting Officer of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust in January 2019 and I will use my first Annual Governance Statement to report on 2018/19 and to talk about my plans for strengthening the Trust's system of internal controls going forwards.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust. Also to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

Risk Management

The Medical Director has executive responsibility for the Trust's Risk Management function, with line management responsibility for a Risk and Governance Team which oversees and supports the maintenance of the Trust's Risk Register at all levels of the organisation, and which undertakes Risk training at appropriate levels throughout the Trust for Risk Managers and Handlers. The Risk and Governance Lead (The Deputy Director of Patient Safety) also oversees the Trust's Clinical Audit function, the Trust's compliance with the Duty of Candour, and the management and reporting of Serious Incidents and Never Events.

An executive Risk Committee, currently chaired by the Chief Nurse, meets monthly and reports to the Hospital Management Board. The Risk Committee reviews the Corporate Risk Register's high risks every month and scrutinises all divisional and departmental risk registers on a programmed rolling basis, providing assurance to the Board via the Hospital Management Board and escalating concerns as appropriate.

The capacity of the Risk and Governance Team has recently been enhanced with the appointment of high calibre officers. Supported by NHSI, the Trust has also commissioned work to review and support the development of the Trust's Risk Register, Risk Management Strategy and related systems and processes.

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

The Board of Directors agrees and monitors the Board Assurance Framework and all high scoring risks on the Corporate Risk Register. The Board Assurance Framework sets out the principal risks to the delivery of the Trust's strategic objectives. Each risk has a lead Executive Director and key monitoring committee assigned to it and details of the controls in place to mitigate against the risk. Any gaps in controls are highlighted through this process, allowing management action to be taken. The Board agrees target risk ratings for all strategic risks and assesses residual risk against its key strategic aims once assurance is received that effective internal controls and mitigations are in place. The Board has also articulated its risk appetite for all principal risks monitored through the Board Assurance Framework.

The Internal Audit review of the Board Assurance Framework, undertaken in 2018/19, gave a 'green' assurance rating, providing substantial assurance that the controls upon which the organisation relies to manage the identified risk(s) are suitably designed, consistently applied and operating effectively.

4. The risk and control framework

The Board completed its Corporate Governance Statement in accordance with Licence Condition 4 in 2018 and confirmed statements in relation to:

- the effectiveness of governance structures
- the responsibilities of directors and subcommittees
- reporting lines and accountabilities between the board, its subcommittees and the executive team
- the submission of timely and accurate information to assess risks to compliance with the Trust's licence; and
- the degree and rigour of oversight the Board has over the Trust's performance.

Risks identified include:

- Risk of inconsistent compliance with Trust Policy. Systems are being developed to monitor and encourage compliance e.g. audit
- Consistency of committee effectiveness at divisional level – revised governance arrangements in place from April 2018 and currently under further review
- Financial stability – regular monitoring of recovery and planning activities with Board and Regulator
- The Trust's systems of accountability may not be applied consistently. The Trust has subsequently developed a formal Accountability Framework to ensure appropriate and consistent visibility and accountability in respect of any emerging quality issues. The Trust also has in place a Quality Improvement Plan and Quality Improvement Board to provide additional oversight and management of the Trust's Quality Improvement Plan.
- Workforce:
  - High-Potential staff retention / development and succession planning being put in place
  - Improved recruitment pipeline management process in place
  - International nurse recruitment pipeline – much reduced (especially in Europe). Trust continues to recruit locally, nationally and internationally – developing 'grow your own' arrangements and optimising relationships with universities regarding student nurse training and retention
  - Recruitment agency relationships being optimised to secure appropriate levels of agency nurses and doctors
  - Trust has, and continues, to develop new ways to market the Trust's offerings to attract junior doctors and is optimising its relationship with Health Education East of England
  - Trust is working closely with universities and colleges.

Corporate Objectives and Principal Risks

In September 2018, The Board set out its revised Corporate Objectives as:

- Care that is safe and supported
- Giving our patients the best possible outcomes – involving and explaining effectively
- Provide a patient experience we can be proud of
- Sustain safe births and supported childhoods
- Strengthen our community's well-being throughout life
- Support our patients to age with dignity
- Optimise our use of resources
- Recruit and retain high calibre staff – and develop potential
- Innovate and harness technologies.

Following the articulation of its revised Corporate Objectives, the Board reviewed and re-articulated its principal risks to the delivery of its corporate objectives through the Board Assurance Framework: (numbering below)

1. There is a risk that the Trust may be unable to establish and maintain an appropriate workforce to support the delivery of its objectives, with failures of:
   - Leadership
   - Engagement
   - Capacity
   - Capability.

2. There is a risk that patients may receive sub-optimal care / treatment, with failures in
   - Outcomes
   - Safety
   - Experience.

3. There is a risk that the Trust becomes unsustainable financially and/or clinically, due to failure to:
   - Deliver financially, at pace

– Deliver productivity and efficiencies
– Transform services for the benefit of our patients.

The Board has monitored its position and mitigations in respect of its principal risks throughout 2018/19. In addition, the Board considers all medium to high corporate risks with a residual risk score of between 15 and 25 and their associated mitigations.

In 2019/20, I will be leading a comprehensive programme of staff, patient and stakeholder engagement, which will result in the co-production of a new Corporate Strategy and supporting strategies.

Risk reporting through the Committee Structure

The Board had six committees reporting to it during 2018/19, namely:

- The Quality and Performance Committee
- The Finance and Activity Committee
- The Trust Executive Committee (latterly the Hospital Management Board)
- The Nomination and Remuneration Committee (Executive Director Appointments)
- The Audit Committee
- The Workforce Committee.

The Board has in 2018/19 been alerted to risks identified at the committees, via a Chair's Key Issues reporting methodology. There are plans to review and refine this methodology for effectiveness in 2019/20.

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

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

Risk management training is provided to relevant staff and policies, and related templates are available on the Trust's intranet site.

Due to the current quality, workforce and financial risk profile of the organisation, it is my intention to constitute the Trust's Risk Committee as a committee of the Trust Board under non-executive director chairmanship. It is expected that this will improve Board visibility and oversight of the Trust's corporate risks and will improve risk monitoring, management and mitigation.

Committees reporting to the Board

The Hospital Management Board is chaired by the CEO and the membership in 2018/19 comprised the Executive Team and the Trust's senior medical, nursing and operational leaders and senior managers. The Committee is responsible for the delivery of the Trust's business plans. The Hospital Management Board develops, implements and reviews tactical plans, approves and recommends associated policy and monitors the performance of the organisation against its plans and key performance indicators.

The Hospital Management Board is a key forum for holding teams and colleagues to account for the delivery of plans and operational performance. There are also regular performance review meetings with each key team, with executive oversight of quality, financial, operational and workforce performance and with key issues escalated as appropriate. A Performance and Accountability Framework was introduced in 2018/19 and this will be rolled out through 2019/20, supported by improved governance arrangements.

The Quality and Performance Committee monitors the delivery of the Trust's Quality objectives as reflected in its Quality Strategy and reviews key quality information to provide the Board with assurance that the Trust is delivering effective, safe services and a positive patient experience. The Committee monitors the Trust's performance in delivering services in accordance with key access standards. The Quality and Performance Committee also undertakes detailed 'Quality Enquiries', where concerns have been raised relating to the delivery of quality services in a particular area.

The Finance and Activity Committee monitors and reviews the adequacy of the Trust's financial risk assessments, assumptions, sensitivities, mitigation plans and contingencies. It monitors the Trust's on-going financial position against the Board approved plans, including cost improvement plans, any action plans in place to recover the financial position and the Trust's position in respect of contracting / commissioning. It also considers and reviews the alignment of capacity and activity volumes to financial plans.

The Workforce Committee oversees and monitors the Trust's workforce issues and risks including those relating to recruitment, retention, sickness absence management, education, training and staff satisfaction / engagement. The Workforce Committee also oversees the delivery of the Trust's Workforce Strategy and Workforce Race Equality Standard Action Plan and the development of the Trust's Values and Behaviours Framework.

The Nomination and Remuneration Committee (ED appointments), oversees the recruitment of the executive directors and approves executive appointments.

The Audit Committee

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

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

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

The Trust complies with the NHS Counter Fraud Authority (NHS CFA) Standards for Providers: Fraud, Bribery and Corruption. The Trust takes a positive stance in countering bribery and fraud against the organisation and the NHS in general and actively seeks to ensure that an appropriate, yet proportionate response is taken to allegations of fraud and bribery.

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

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

An assessment against the criteria of the NHS Counter Fraud Authority Self Review Tool (SRT) was undertaken in 2018/19. The outcomes from the assessment have been considered and an action plan has been agreed with management to address areas for improvement.

Seven LCFS referrals were investigated during the year and these included cases of fraud by false representation, working whilst sick, falsification of timesheets, conflicts of interest and mis-use of Trust equipment, amongst other alleged offences.

The Trust has in 2018/19, had one case that has gone to a disciplinary outcome but has had no cases with a criminal conviction.

A revised Anti-Fraud and Bribery policy which includes further sections on Sanctions and Redress, and which is in line with the standard policy promoted by the NHSCFA, was drafted 2018/19 and approved by the Trust's Audit Committee.

The Care Quality Commission (CQC) and Quality Risk

The 2018 CQC Inspection rated the Trust as 'Inadequate' overall. Following the Trust's inspection, it was placed in Special Measures by NHS Improvement, (NHSI) in September 2018.

Following the 2018 CQC inspection, the Trust was rated:

Overall Rating for the Trust ..... Inadequate

- Are Services at this Trust safe?.....Inadequate
- Are Services at this Trust effective?.....Requires Improvement
- Are Services at this Trust caring? ..... Good
- Are services at this Trust responsive? .....Requires Improvement
- Are services at this Trust well led? .....Inadequate

At the time of writing, the Trust is subject to further CQC inspection (March – April 2019). The CQC's report is expected in early summer of 2019.

During the recent inspection in March 2019, the CQC identified significant concerns, relating to:

- Urgent and Emergency Services
- Medicine
- End of Life Care
- Gynaecology.

The Trust is fully compliant with the registration requirements of the Care Quality Commission. However, as a consequence of the findings of the recent CQC inspection, a "Notice was served under Section 31 of the Health and Social Care Act 2008: Urgent notice of decision to impose conditions on registration as a service provider in respect of regulated activities. (18 March 2019)". Additionally, a Warning Notice was served under Section 29A of the Health and Social Care Act 2008. (19 March 2019). The Trust also has a 2018 Section 31 Notice in place in respect of Maternity Services.

The Trust engages openly and transparently with the CQC, responding to queries in a timely fashion and recently responding immediately to the March Section 31 Notice, in line with the CQC's requirements and timeline.

The Trust has in place a comprehensive Quality Improvement Plan, which is managed through five workstreams, covering the findings and recommendations of the 2018 CQC report. As a requirement of the Special Measures regime, the Trust has in place a Quality Programme Board, reporting direct to the Trust Board, which in turn reports to a monthly Oversight and Assurance Group comprising key regulatory bodies, to monitor and support the Trust's improvement progress.

As newly appointed CEO, it is my intention to drive a simplification of the Trust's Quality Improvement methodologies in 2019/20, in order to effect improved grip and control and to address the Trust's quality issues in a sustainable way.

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

Well-Led

The regulatory definition of a 'well-led' organisation is one where the leadership, management and governance of the organisation ensure the delivery of sustainable high-quality person-centred care, support learning and innovation, and promote an open and fair culture.

The 2018 CQC inspection found the Trust to be 'Inadequate' in the 'Well-Led' domain.

In 2018/19, the Governors' Council appointed a new Trust Chairman, who took up his post in November 2018. The Governors also appointed two new non-executive directors in 2018/19, including a new Chair of the Audit Committee.

The Trust has received Well-Led support from NHSI and an independent Board Review was jointly commissioned by the Trust and NHSI in November 2018. The findings of this review have resulted in the development of an improvement plan, which was reported, together with progress to date, to the Board (in public) in January 2019. The Board's Development Programme for 2019/20 will support the Trust in addressing the issues raised by the independent review.

Public and Staff

Public

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

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

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

The Governors' Council reviews quality, operational performance, workforce and financial information and risk as part of its statutory duty to hold the Non-Executive Directors to account for the performance of the Board. The Governors' Council meets six times a year.

The Governors' Council's views have been taken into account in the development of the Trust's Corporate and Quality Strategies.

The Patient Experience and Business Committees of the Governors' Council review detailed quality, performance and financial risk respectively, and report back to the Governors' Council at every meeting.

Governors receive a comprehensive induction on election to the Council and are also invited to participate in 'Governwell' development programmes for governors, delivered by NHS Providers

Staff

Staff are expected to provide safe clinical practice, report incidents and potential hazards, be familiar with the Trust's Risk Management protocols and departmental risk issues, comply with all Trust policies and procedures and take reasonable care of their own safety and the safety of others. The Trust uses a Datix-web system for the reporting of incidents. All reported incidents are reviewed regularly.

Workforce is a key strategic and operational risk for the Trust. It has made significant operational changes, following the 2018 and 2019 CQC inspections, to ensure that staffing levels are safe, particularly on the Trust's wards and in other clinical areas. This has included the closing of escalation capacity and enhanced staffing for the A&E.

The Trust has in place a Workforce Strategy, which is monitored by the Workforce Committee. In addition, skills-mix papers and recommendations are regularly presented to the Trust Board. It is my intention to review the Trust's Workforce and Organisational Development Strategies through alignment with its Corporate and Clinical Strategies. This will include and reflect ongoing work with our strategic partners on system-wide workforce solutions to support improved patient pathways.

The Trust has a well-developed Whistleblowing Policy, which aligns with the national 'Freedom to Speak Up: Whistleblowing Policy' for the NHS and a range of both internal and external arrangements are in place for staff to be able to raise concerns. All Whistleblowing cases are reported to the Board.

In 2018/19, the Trust appointed an independent Freedom to Speak Up Guardian. This important post is supported by a Non-Executive Director. The Freedom to Speak Up Guardian has reported to the Board and reports quarterly to the National Guardian's Office.

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

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

The Trust has agreed its Workforce Race Equality Standard Action Plan and delivery is being monitored by the Workforce Committee.

Developing Workforce Safeguards

In respect of the 'Developing Workforce Safeguards' recommendations, The Trust will continue to use a triangulated approach to continue to make informed, safe and sustainable workforce decisions to ensure we have the right staff, with the right skills, in the right place at the right time. This will be measured by improvements to patient outcomes, people productivity and financial sustainability. This Trust will continue to report, investigate and act on incidents and use patient, carer and staff feedback.

The Board takes feedback received from its patients and its staff very seriously and in 2019/20, will be improving staff and stakeholder engagement and using feedback secured from compliments, complaints, surveys and 'listening' to inform its Corporate and supporting strategies.

The Trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance. All staff at bands 8D and above are required to declare their interests annually and periodically, if their interest changes. As at April 2019, the annual review is taking place.

Sustainable Development

The 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 Adaptation Reporting requirements are complied with.

The Foundation Trust Sustainable Development Management Plan takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Climate Change Act (2008) was introduced to ensure the UK cuts its carbon emissions by 80% by 2050. The 80% target is set against a 1990 baseline and the Act enables the UK to become a low carbon economy.

Carbon reduction schemes undertaken at QEH in 2018/19 include the installation of LED lighting and a high efficiency upgrade to the heating pipework, enabling the Trust to deliver its commitment to the 34% target reduction in carbon emissions by 2020, as required by the Act and so that the Trust is well placed to meet the 50% target reduction by 2025.

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

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

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

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

The Board considered its 'Going Concern' position at its meeting in April 2019 and after consideration of risks and uncertainties agreed that:

> The use of the 'Going Concern' basis is appropriate but there are material uncertainties related to events or conditions that may cast significant doubt about the ability of the Trust to continue as a 'Going Concern'. These are disclosed in the notes of the financial statements.

The Trust reports on the delivery of its financial plans at regular meetings with the Regulator, NHSI.

The Trust has been financially challenged in 2019/20, due in large part to income being below expectations, temporary staffing costs required to maintain safe levels of staffing and a failure to deliver cost improvements in line with its plans.

The Trust understands that the financial challenge for 2019/20 and beyond will be significant and that delivery of its plans, including the Control Total will require considerable levels of Cost Improvement Programme (CIP) delivery, robust controls and transformational ways of working. I have put in place a Performance and Accountability Framework and additional robust reporting, monitoring and support arrangements to drive improved development, ownership and delivery of robust financial plans and to secure improved cost improvement delivery.

The Trust is working strategically with the NHS Norfolk and Waveney Sustainability and Transformation Partnership (STP) and other partners to secure the sustainability of the regional and local healthcare system.

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

- Standing Financial Instructions and Scheme of Delegation
- Financial Management Policy Suite
- Anti-Fraud and Anti-Bribery Policy Suite
- Management of Conflicts of Interest and Gifts, Hospitality and Commercial Sponsorship Policy Executive management of Trust finance and activity plans
- Regulatory reviews of Reference Costs
- Lord Carter review – 'Operational productivity and performance in English NHS acute hospitals' and the 'Model Hospital' toolkit
- Cost Improvement Programme (Quality Impact Assessed)
- Service Line Reporting / Patient-level Information and Costing (PLICs)
- Procurement Strategy (assimilating Lord Carter recommendations)
- 'Getting it Right First Time' (GIRFT) reviews.

The Trust has reported on 'Use of Resources' to the Board in 2018/19 and as at 31 March 2019, is expecting an external 'Use of Resources' assessment early in 2019/20. Due to its current seriously challenged financial position, the Trust will not be able to achieve a 'Use of Resources' assessment of better than 'Requires Improvement'.

Assurance on 'Use of Resources' and financial controls is also provided by Internal and External Audit and by independent and peer reviews.

Through the Internal Audit programme for 2018/19 the Trust has commissioned a range of audits to provide assurance that resources are used economically, efficiently and effectively:

- Payroll – substantial assurance
- Cost Improvement Programmes – partial assurance
- Debtors – (draft) reasonable assurance.

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

6. Information Governance

Information risk is managed through the Information Governance Committee, which reports to the Hospital Management Board. The Trust has nominated an Executive Director to fulfil the role of Senior Information Risk Owner (SIRO) and has assessed compliance with the requirements of the new NHS Digital Data Security and Protection Toolkit. Internal Audit also undertook a review of the systems and processes supporting the Trust's submission. The Trust met the Toolkit's standard for Data Security Awareness Training (95%) on 05 April 2019.

During the year, there has been one serious incident (against three in 2017/18) that required disclosure in relation to personal data. Following an internal investigation and the remedial measures put in place, alongside existing policies and procedures, the Information Commissioner's Office stated that no further action was required.

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

The General Data Protection Regulation (GDPR) came into effect in the UK on 25 May 2018 and the Trust has made sure that it is compliant. This means that our patients' health and care data will carry on being handled securely and in line with the regulations. Specifically, we have ensured that:
- We report serious data security incidents to the Information Commissioner's Office within 72 hours;
- We are more accountable and transparent with how we process personal information; and
- We have a 'legal basis' for processing personal information.

GDPR compliance is a journey, which did not cease on the 25 May 2018 and the Trust will continue to work to ensure that our patient and staff personal information remains confidential and secure.

7. Annual Quality Report

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

The Trust has presented its Quality Report as part of its Annual Report and Accounts based on a range of Quality indicators that were agreed by the Board and which are monitored on a regular basis through Integrated Performance Reports, including Quality and Operational performance. The Governors' Council has selected a local indicator for audit in 2018/19, as required. The Trust's external auditors will for 2018/19 be auditing and providing assurance in respect of the effectiveness of the 4-hour access standard, the 62-day cancer standard and SHMI (Summary Hospital-level Mortality Indicator) data management and reporting methodologies.

The Board of Directors is satisfied that the messages within the Quality Report accurately reflect the information that it has received on a regular basis throughout the year.

The report has been shared with the Trust's commissioners, Governors, Healthwatch and Norfolk Health Overview and Scrutiny Committee, all of whom have been given the opportunity to review the balance of the document and to provide formal comment for publication within the report.

The Board is assured that the Quality Report presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data, after taking assurance from a range of sources, including:
- Comprehensive Policy Suite and methodology to ensure that policies are kept up to date
- Regular implementation update reports on the delivery of the Trust's Quality Strategy, to the Quality and Performance Committee
- External Audit's limited assurance review of the Quality Report and an audit of data
- NHS Digital Data Security and Protection Toolkit
- External benchmarking from Dr Foster
- Regular performance reporting against key performance indicators (KPIs)
- External review of performance information e.g. CCG Clinical Quality Review Meetings (CQRM)
- Commissioning of independent review of data and information e.g. Emergency Pathway review
- Internal Audit - Data Quality – 62 Day Cancer Target 'Amber/Green' (Reasonable Assurance).

The Quality Report development process is led by the Chief Nurse, with support from the informatics team.

8. Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility

for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, Risk Committee, Clinical Governance Committee, Quality and Performance Committee, Finance and Activity Committee and Health and Safety Committee and consequently a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

Internal Audit reviewed the Board Assurance Framework in 2018/19 giving an overall rating of 'Green' (substantial assurance).

During the year, internal audits were conducted in the following areas:
- Charitable Funds – reasonable assurance
- Recruitment – partial assurance
- Payroll - substantial assurance
- Serious Incident (SI) Management – partial assurance
- Doctors' Leave - partial assurance
- Debtors (draft) – reasonable assurance
- Project Authorisation and approval (draft) – reasonable assurance
- Cost Improvements Plans – partial assurance
- IG Risk Governance (draft) – partial assurance
- Complaints and PALS – partial assurance
- Freedom to Speak Up Guardian – reasonable assurance
- Divisional Governance – advisory
- Board Assurance Framework – substantial assurance
- Infection Prevention and Control Management – partial assurance
- Integrated Performance Reporting including Dashboard – reasonable assurance
- Use of Local Guidelines – reasonable assurance.

Management action plans and follow up audits have been agreed to address any risks, control weaknesses and ongoing compliance issues identified in all Internal Audits. The delivery of these actions is monitored by the Audit Committee. Particular focus has and will be given to the partial assurance opinions.

The quality and accuracy of the Trust's data and information, including elective waiting time data is subject to periodic internal validation and external/independent review.

The Head of Internal Audit opinion for 2018/19 is as follows:

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

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

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

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

I take additional assurance from programmed, ad-hoc and commissioned external reviews, inspections and accreditation visits. These external reviews provide me with an independent view and recommendations. In 2018/19 independent reviews have included:

- NHSI – Infection Prevention and Control
- UNICEF – 'Baby Friendly' review
- HEE - Medical and non-medical education
- Emergency Care Improvement Support Team (ECIST) (Review and support)
- 'Getting it Right First Time' (GIRFT) reviews
- HEE review – Obstetrics and Gynaecology
- Cancer Intensive Support Team (Review and support)
- Peer Review - Ward quality assurance visits
- Independent Reviews – e.g. Board Capacity & Risk Management.

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

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

9. Conclusion

I took up my role as CEO and Accounting Officer of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust in January 2019. My AGS review and my broader observations early in my appointment, lead me to conclude that while progress has been made in some areas in 2018/19, there remain significant challenges for the Trust in 2019/20, relating to:

- Embedding and sustaining quality improvements
- Financial delivery, productivity/efficiency and sustainability
- Emergency pathway
- Nurse and medical staffing sustainability
- Cyber-Security
- Leadership and accountability
- Engagement – both internally and externally

The Trust's Internal Audit team has identified seven 'partial assurance' areas and no 'Red' / 'no assurance' findings. In respect of those areas where controls need to be strengthened, I am satisfied that recommendations are being addressed in a timely fashion.

However, this AGS identifies significant control issues relating to the effectiveness of quality and financial management, as reflected in the findings of the 2018 CQC inspection, early feedback following the 2019 inspection and the Trust's current financial position, as reported in this AGS.

I will be working with my team in 2019/20 and beyond, to strengthen the Trust's controls and sources of assurance for the Board, in order to ensure that the Trust can deliver its strategic objectives.

Caroline Shaw
Chief Executive
Date: 21 May 2019

Quality Report 2018/19

Part 1: Statement on Quality

The Trust Board of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust presents its Quality Report for 2018/19. This report provides an account of where we have achieved quality improvements during the year but also describes the challenges that the organisation has faced and identifies where further improvements are required to ensure that we can provide a sustainable, high quality service that meets the needs of all our patients, engenders a supportive working environment for staff and meets the national standards set by regulators.

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

- Responded to the findings on the quality of its services by the Care Quality Commission (CQC);
- Revised and strengthened its structures of governance and accountability within both its clinical services and the organisation as a whole to better focus on promoting quality within our services;
- Identified where quality improvements are required to strengthen assurance on patient safety and experience;
- Delivered its quality priorities for 2018/19 as set out in the Quality Report last year;
- Responded to feedback and information from complaints, PALS enquiries and incidents and from views expressed in patient and staff surveys and online feedback, to ensure that areas for improvement are identified and acted upon and that lessons are learnt and shared throughout the organisation;
- Monitored and improved its clinical practice through participation in clinical audit and research and learning from mortality reviews;
- Performed in relation to its core clinical indicators and CQUIN activity;
- Responded to national drivers for improvement such as the provision of seven day services;
- Developed and set out its quality priorities for 2019/20.

The Trust has experienced an extremely challenging year in which it has sought to maintain its clinical services against a backdrop of ever increasing demand and at the same time acknowledge, own and understand that improvements are required in a number of key areas to deliver the quality of services expected by our patients, the public, external regulators and our staff.

2018 saw the launch of a new Quality Strategy and a complete refresh of the Trust's quality priorities and objectives. These underpinned the direction of travel for 2018/19. It was therefore disappointing that when the Trust was subject to an inspection visit from the CQC in September 2018, it was found wanting in a number of aspects and failed to meet the standards required in relation to the safety, effectiveness and responsiveness of its services and was deemed inadequate in relation to being 'well-led'. The Trust was therefore placed in Special Measures and was subject to a monitoring and supportive framework to enable improvements to be made.

Since that date there have been significant changes in leadership at Trust Board level and as the newly appointed Chief Executive, I and the entire membership of the Trust Board intend to focus on providing the leadership that will enable the organisation to address its shortfalls, restore the confidence of the public and our regulators in our services and meet the expectations of our patients and the staff who deliver our services.

We have begun this journey of improvement with a strengthening of our operational and governance structures to ensure visibility and accountability at all levels and the provision of intensive support to those areas that are most challenged. The Trust Board recognises that to achieve the improvements in quality that we all seek requires the engagement of staff at every level of the organisation. Under the banner of 'Better Together' we have looked to involve staff in developing improvements and ensure that staff feel that they are both listened to and valued for their contribution.

Staff engagement has been encouraged and promoted by changing how their voice is heard, improving communication and acting on their concerns. This has included:

- Increasing the visibility and accessibility of the Chief Executive (CEO) through regular all-staff briefings;
- Creating a fortnightly CEO blog to ensure staff are kept abreast of developments and better use of social media;
- Creating listening events for junior doctors to feedback to the Medical Director;
- Creating 'Who can I tell?' listening events with the Director of Human Resources;
- Providing'Schwartz' rounds (a group reflective practice forum) to discuss particular clinical challenges in a supportive environment;
- Celebrating success with 'Team of the week' and Values awards;

- Chief Executive and Chairman engagement with the Hospital Medical Staff Committee;
- Regular ward visits by the Trust's Chairman;
- Creating a Non-Executive Director shadowing programme;
- Improving the Communications Strategy and publishing a digital weekly staff magazine;
- Creating a 'Change Team' to take forward improvements that is informed by feedback from staff surveys, workshops and focus groups;
- Creating a new Deputy CEO role to focus on culture, staff engagement and strategy.

Keeping patients safe has to be our first and most important priority. Consistency and reliability provides the best environment for patient safety to be assured. Our recent visit from the CQC in March 2019 highlighted that although it is apparent that improvements in the quality of our services have occurred in some areas, in others we are still failing to guarantee basic standards of safety. We are committed to making the required improvements across all services and staff have demonstrated their appetite for making these changes. This commitment is manifest in our new quality objectives for 2019/20, which clearly focus on areas where improvement is required.

Immediate changes to support an improvement in patient safety have included:

- A reduction in inpatient bed numbers;
- Active recruitment overseas and locally for registered nurses and through the QEH Fellows programme, for doctors for 'hard to fill ' vacancies;
- The introduction of the Safecare software to ensure rostering of ward nursing staff is in line with patient acuity;
- GP streaming in the A&E to support the most appropriate access to support for patients and improve emergency access performance;
- Creation of a new assessment zone in the Medical Assessment Unit to facilitate prompt assessment and decision-making;
- Review of nurse documentation to facilitate an improvement in record keeping;
- Roll out of the 'Perfect ward' data capture across all wards to capture real time measurements of the quality of care;
- Introduction of a new multi-professional Learning and Improving Forum to share learning and best practice;
- Introduction of an independent 'Freedom to Speak Up Guardian' and publicising 'how to speak up' to staff concerned about care.

In those services that were subject to the imposition of Section 29A and Section 31 notices under the Heath & Social Care Act 2008 in March of this year we initiated immediate detailed plans to address all the issues identified by the CQC.

It is important that we not only recognise where quality improvements are needed but also celebrate those services where the quality of provision is good and improvements have been delivered. During 2018/19 some of our services have been recognised for their achievements and we have met specific high quality clinical outcomes:

- Evaluation of our Stroke Services as best in region and the 6th best in England;
- On-going recognition as a Venous Thromboembolism Exemplar Site due to consistent good practice;
- Halving the number of Clostridium Difficile cases (C.Diff) during the last year from 48 to 22 cases;
- Reduction in the annual number of inpatient falls and maintaining <5 falls per 1000 bed days for nine months of the year;
- Introduction of the 23-hour Surgical Enhanced Recovery Unit to facilitate the management of the elective care pathway and improve patient experience;
- Achieving an overall downward trend in hospital-acquired pressure ulcers since July 2018;
- Meeting and exceeding the targets on the Cancer pathway for diagnostics, 2 week wait and 31 day treatment;
- Meeting the elective waiting list size target at year end;
- Achieving a 10% increase in recruitment of patients (1062 patients) to take part in research ethics committee-approved clinical research studies;
- Strong patient experience scores from the Friends and Family Test;
- Exceeding our CQUIN targets for improving services for patients who attend the A&E with mental health needs;
- The Trust's Cancer research team winning the CREST award this year for Cancer Research Excellence in Surgical Techniques.

There continues to be an investment in our infrastructure to provide the best environment for care and a positive patient experience. There has been further work undertaken as part of the Estates Strategy and in this last year the Trust has seen:

- Modifications to the heating mains pipework to significantly reduce heating costs and the Trust's carbon footprint;
- Upgrades of lighting to highly efficient LED lighting;
- Refurbishment of hospital wards in supporting the 'Deep Cleaning' programme;
- Completion of car parking improvements to create 117 additional spaces to relieve site congestion;
- Upgrading and improving fire detection and compartmentation;
- Commencement of a 5 year rolling programme to replace and upgrade the roof and upgrade ten wards;
- Upgrades to external footpaths;
- Children's environmental issues.

Issues arising from our PLACE inspection (Patient Led Assessments of the Care Environment) will be encompassed in our Estates Strategy and developmental plans for improvement.

The new Quality Strategy launched in 2018 identified 8 Quality Priorities for the Trust to provide a framework against which we would set quality objectives for the year. The Quality Priorities embraced a range of service provision and care that encompassed the varying aspects of quality in terms of patient safety, patient experience and effectiveness of service:

1. Prioritising with our partners, care for our frail and vulnerable patients, including those approaching the end of their lives;
2. Securing safe levels of staff with the right skills;
3. Evidencing effective learning and improved practice from errors and experiences;
4. Keeping patients and their carers well-informed;
5. Delivering a high-quality care experience for pregnant women and their babies;
6. Delivering consistently effective infection control;
7. Embedding consistent and rigorous attention to documentation and record keeping;
8. Ensuring with our partners that patients are treated and cared for in the most appropriate setting.

In 2018/19 we set ourselves an ambitious set of quality objectives to support implementation of these priorities and to ensure sustainability going forward. These included:

- Improve patient and family experience in end of life (EoL) care;
- Improve communication with patients who have a sensory impairment such as deafness or visual impairment;
- Introduction of NEWS (National Early Warning Score);
- Ensure improvements in infection prevention and control within the Trust;
- Ensure improvements in Medicines Management – focusing on the use of anti-coagulants;
- Improve the quality of perinatal care for women;
- Implement a quality improvement programme to support better nutrition and hydration in patients;
- Enhance learning from deaths in people with a learning disability to support improvements in care;
- Undertake an improvement programme to support better documentation and record-keeping;
- Improve understanding of the Mental Capacity Act (MCA) 2005 amongst staff and how it can support improvements in the quality of care for the patient and their carers.

Whilst improvements have been noted in relation to each of these objectives it is only in the use of anti-coagulants that full assurance can be given that the objective is fully delivered. The others will remain as challenges to take forward into the coming year in addition to our new quality objectives for 2019/20. These new objectives all pick up on elements of care where the CQC found failings and so will support the delivery of improvements in practice and care:

- To improve the experience of patients and families at end of life;
- To ensure that discharge arrangements are clearly and timely communicated to the patient and his/her family;
- To reduce avoidable harm by improving the recognition and management of the deteriorating patient;
- To review and identify safe and sustainable ward staffing levels and skill mix together with a plan of delivery;
- To reduce the number of inpatients experiencing a fall resulting in moderate / severe harm;
- To improve responsiveness to complaints within the Clinical Business Units (CBU).

In response to the CQC report and the application of Special Measures we have put in place a Quality Programme Board to oversee the delivery of a comprehensive Quality Improvement Plan. The governance and operational structure is outlined within this report but comprises five work streams, each led by a member of the Trust Board, to ensure overall delivery of the plan.

The Trust Board and I recognise that our staff are central to delivering safe and high quality services for our patients and their families and therefore to successfully deliver our improvement plan. Our commitment to staff is not only in terms of improving engagement but is also about investing in our staff. To this end we will be supporting and developing our staff by:

- Focusing on recruitment to vacant registered nursing posts to build a strong substantive workforce through overseas recruitment, automatic recruitment on completion of student nurse training and development of nursing associates;
- Introduction of a Legacy Nurse role to support and develop newly qualified staff;
- Delivery of learning packages to clinical teams facilitated by the GMC and NMC;
- Increasing support to staff to improve health and well-being;
- Implementation of a wider Organisational Development plan to support development and succession planning;
- Continuing to work in partnership with our trade unions to provide Lifelong Learning opportunities.

In focusing on improving the quality of services we provide it is vital that we continue to value the importance of the quality of patient and carer experience. This year has seen initiatives to improve communication with patients and visitors affected by sensory disabilities, increased provision for carers needing to stay overnight with a vulnerable patient and improvements to the waiting period before going to theatre for an operation through changes to procedure and better communication.

We continue to value the contribution and commitment made to the Trust by the Volunteers, the League of Friends and other partnership organisations that support the delivery of high quality services and work with us to make improvements. This year has seen the extension of the Carer café service to the West Newton and West Raynham wards by West Norfolk Carers, a number of initiatives such as the Pharmacy runners provided by Volunteers and support from voluntary organisations to deliver special events such as the week of activities in May 2018 for Dementia Awareness Week and the celebration of Mental Health Awareness Day.

We remain committed to the work being undertaken as part of the Sustainability Transformation Plan to ensure more effective, cost efficient and streamlined services for our patients. Partnership working with other NHS providers has led to improvements in the quality of services provided to patients and in March this year we saw the opening of the new Midwifery Community Hub at North Cambridgeshire Hospital, a new facility refurbished by Cambridge and Peterborough Clinical Commissioning Group and Cambridge Community Services but staffed by midwives from our Trust.

The Trust Board and I recognise that the organisation will continue to face a number of challenges over the coming year but looking ahead we intend to:

- Focus on working with our staff to deliver the Quality Improvement Plan;
- Support and develop our staff to secure effective leadership capability, capacity and engagement;
- Respond positively to the recommendations of the CQC when their report on their 'Well-led' inspection visit is finalised;
- Deliver our quality objectives as part of our improvement plan;
- Continue to focus on strategies to reduce and prevent patient harm in all our services;
- Listen and learn from our patients, our staff and from all feedback;
- Maintain a real commitment to recruitment and retention and address the challenges of maintaining safe staffing in a changing environment.

Together during this coming year we are aiming to achieve improvements in patient safety and the quality of our services; ensure that our staff are engaged and feel valued for what they do and in achieving these objectives move towards both clinical and financial stability.

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

Caroline Shaw
Chief Executive
Date: 21 May 2019


DO NOT ENTER
Hotel Services Assistant

1.1 How the Trust Board monitors Quality

In 2018/19 the Trust has continued to embed and keep under review, its Quality Governance Structure (see Governance Structure on the next page), with clear accountabilities at all levels of the organisation from divisional level right through to the Board via Board committees, including the Quality and Performance Committee. Assurance and Quality risk is communicated across the Governance Structure, using the Committee Chair's Assurance methodology. The Board monitors quality performance at every meeting through its review of key quality metrics including patient satisfaction, hospital acquired infection, falls, pressure ulcers, serious incidents and mortality. Exception reports are prepared for the Board at every meeting to alert directors to any areas of concern and facilitate monitoring of plans in place to address those issues. In addition to the executive Medical Director and Chief Nurse, the Board includes non-executive directors with clinical backgrounds. This Board skill-mix enhances the Board's scrutiny and challenge in respect of quality-related issues.

The Quality and Performance Committee has monitored the delivery of the Trust's Quality Strategy.

Other in-year work to facilitate the Board's visibility of the Trust's delivery of quality services has included:

- Mortality Surveillance Group reporting to the Quality and Performance Committee;
- All new Serious Incidents / Never Events reported to directors, immediately;
- 'Learning from avoidable deaths' – reporting to the Quality and Performance Committee;
- In-depth 'Quality Enquiries' at the Quality & Performance Committee;
- 'Freedom to Speak-Up Guardian' – reporting to the Board and the National Guardian's Office;
- Independent, regulatory and peer reviews in key quality areas – reporting to the Board via the Board Assurance Framework, which also provides assurance on a comprehensive range of quality areas;
- 'Patient Stories' reporting to the Board at every public meeting;
- '15 steps' methodology enhanced and embedded for all non-executive directors, who undertake a programme of visits across clinical and non-clinical areas of the Trust.

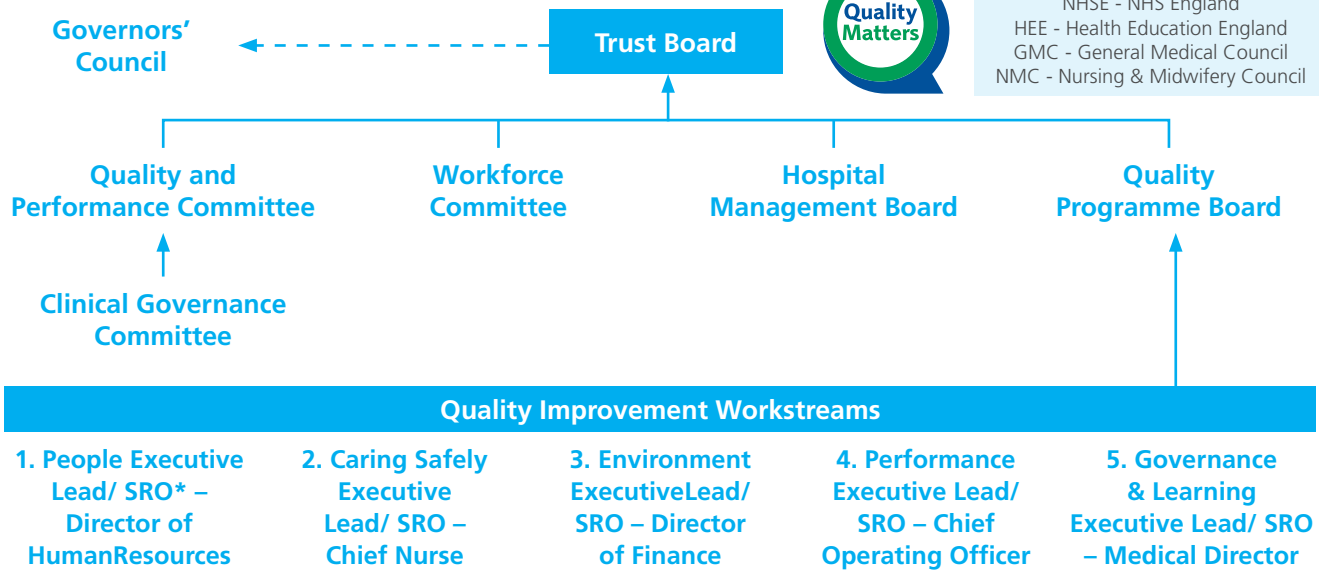
The Trust was subject to a CQC Inspection in 2018. Significant quality concerns and an overall rating of 'Inadequate' resulted in the Trust being placed in 'Special Measures' by NHS Improvement (NHSI), in September 2018.

A requirement of the 'Special Measures' regime is the establishment of a Quality Programme Board, to monitor and provide assurance on progress in the delivery of a Quality Improvement Plan to address the findings of the CQC Inspection. The Quality Programme Board reports to the Trust Board, which in turn reports externally to the Oversight and Assurance Group, chaired in 2018/19 by NHSI and latterly by NHSE (East of England). The Oversight and Assurance Group meets monthly and comprises regulators and commissioners. The group monitors, scrutinises and supports the Trust's Quality Improvement plans. The reporting model is set out below:

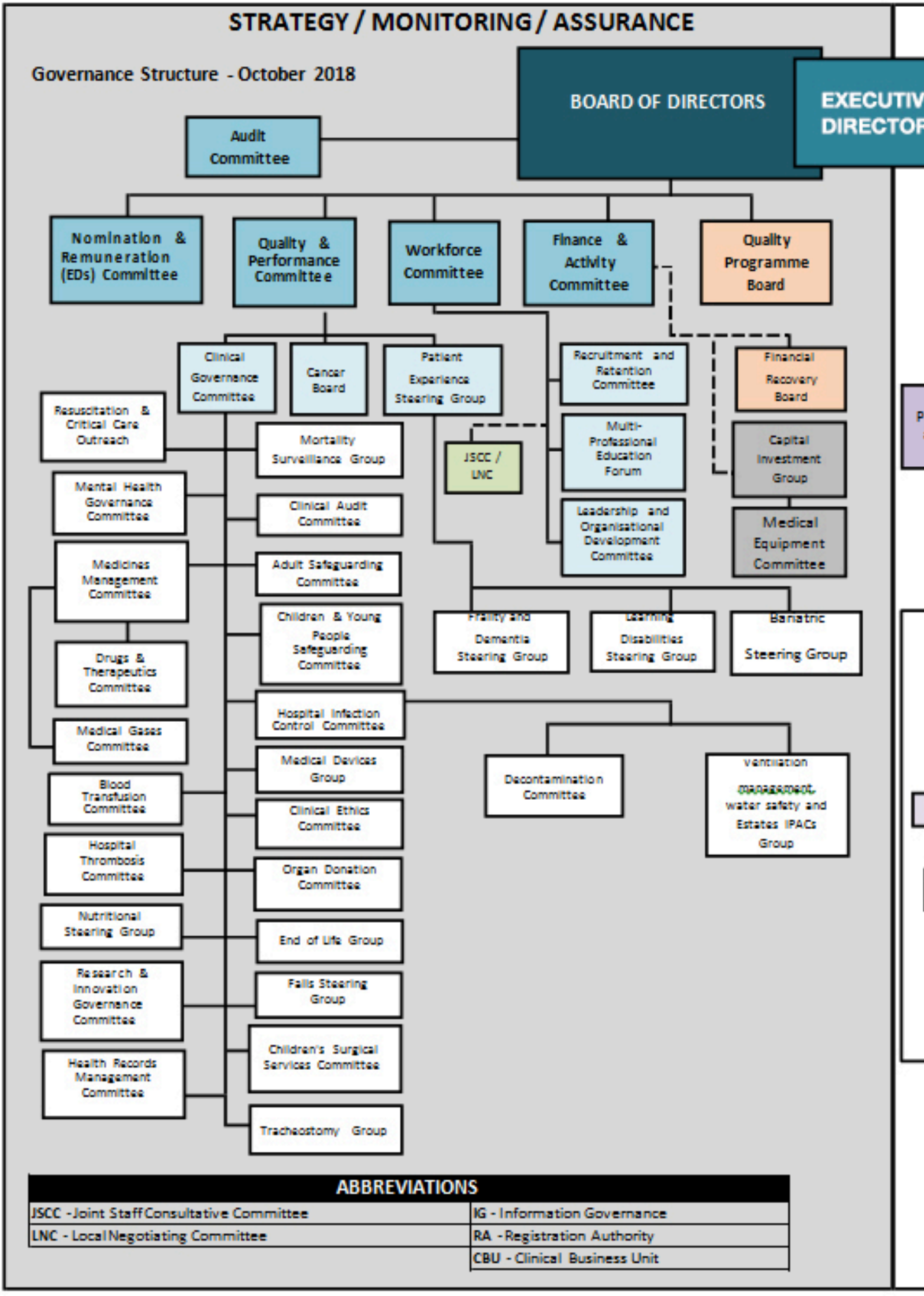
Quality Governance Structure

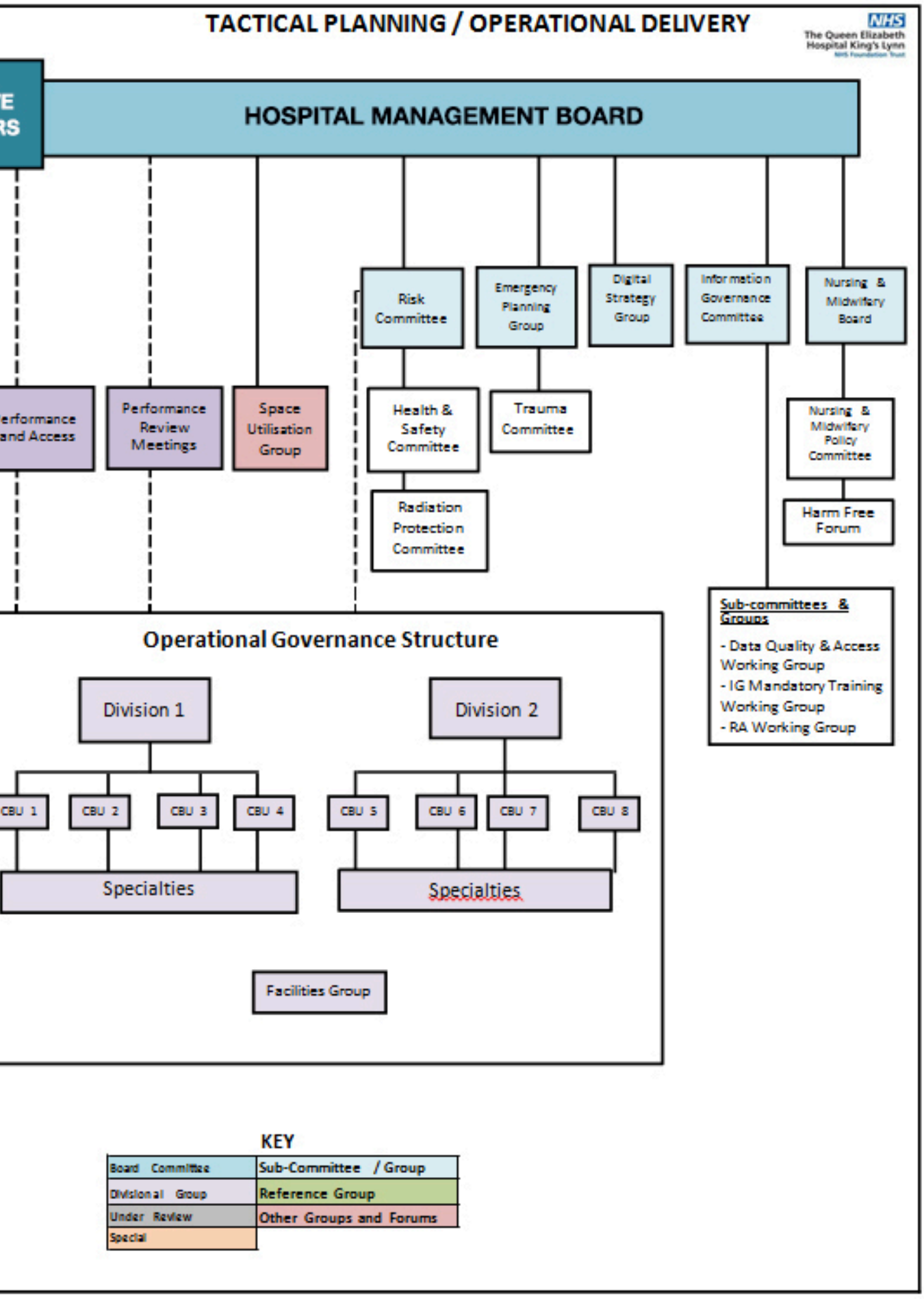
Oversight & Assurance Group
(including NHSI, CQC, CCG, NHSE, HEE, GMC / NMC)*

***Glossary of terms:**
SRO - Senior Reporting Officer
NHSI - NHS Improvement
CQC - Care Quality Commission
CCG - Clinical Commissioning Group
NHSE - NHS England
HEE - Health Education England
GMC - General Medical Council
NMC - Nursing & Midwifery Council



1.2 Governance Structure of The Queen Elizabeth Hospital King's Lynn




TACTICAL PLANNING / OPERATIONAL DELIVERY
NHS
The Queen Elizabeth Hospital King's Lynn
HOSPITAL MANAGEMENT BOARD
Risk Committee
Emergency Planning Group
Digital Strategy Group
Information Governance Committee
Nursing & Midwifery Board
Performance and Access
Performance Review Meetings
Space Utilisation Group
Health & Safety Committee
Trauma Committee
Radiation Protection Committee
Nursing & Midwifery Policy Committee
Harm Free Forum
Sub-committees & Groups
- Data Quality & Access Working Group
- IG Mandatory Training Working Group
- RA Working Group
Operational Governance Structure
Division 1
Division 2
CBU 1
CBU 2
CBU 3
CBU 4
CBU 5
CBU 6
CBU 7
CBU 8
Specialties
Specialties
Facilities Group
KEY
Board Committee
Sub-Committee / Group
Divisional Group
Reference Group
Under Review
Other Groups and Forums
Special

1.3 Incident Reporting and Never Events

Overall reporting of incidents on the Datix system increased by 18% during the past 12 months when compared with the previous year and represents an increase of 37% since 2016-17. This is detailed in the table below:

Table 1: Total Reported incidents

Financial Year	Total Incidents reported	Percentage of Incidents where significant harm has occurred
2016-17	7047	0.72%
2017-18	8288	1.04%
2018-19	9696	1.4%

This shows the willingness of our staff to report patient safety incidents on the Trust's reporting system. The information reported allows the central incident team to map and analyse incidents across the Trust and also down to pathway specific levels.

A daily incident report is generated and is intended to act as a tool for senior staff to augment and stimulate incident awareness and to enable discussion in the safety huddles which have been implemented throughout the clinical areas. New learning and improving posters convey lessons learned from a range of sources to enable staff and the public to be informed about what is happening across the Trust.

Incidents with Harm

The Trust incident reporting system requires staff to report incidents which occur that result in harm to patients. The number of such incidents reported in 2018-19 represents an increase of 18% on the previous year:

Table 2: Harm Incidents reported 2017/18

	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018
Total	95	94	103	101	124	111	110	164	116	109	118	121
											Total 17/18	**1366**

Table 3: Harm Incidents reported 2018/19

	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2018	Feb 2019	Mar 2019
Total	118	131	105	151	136	171	127	119	126	151	137	151
											Total 18/19	**1623**

How do we know this increased reporting doesn't represent a picture that the Trust is causing more harm? Although it is not possible to completely refute this argument, we do know from intelligence that following proactive initiatives across the year to provide clear education about reporting incidents effectively and the building of an open and honest reporting culture, we should expect to see an upturn in reporting of incidents at the Trust. There is more recognition by staff of what can be considered an incident or risk and these are now more likely to be reported.

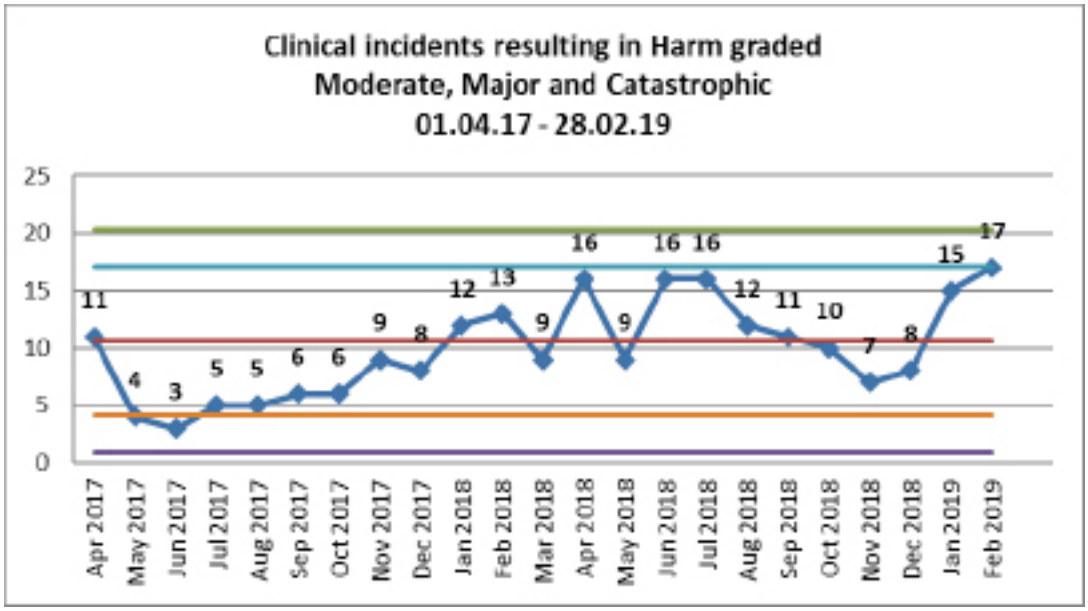
We can also benchmark with other trusts and the latest CQC insight reports shows the Trust is now in the top 50% for incident reporting per 1000 bed days, which is a positive position. This provides assurance that incident reporting has improved and that staff are willing to speak up and report openly. There are still further improvements the Trust will seek to make to ensure that it maximises the potential for reporting, particularly in non-conformity reporting, which helps drive further quality improvement and patient safety.

One of the key observations of the most recent CQC report was to understand if incidents were being graded appropriately. This has been actively built into staff training on incident reporting. Across the organisation the

reporting and appropriate recognition of harm is challenged and we always ensure that staff are encouraged to use the highest feasible descriptor of harm. An incident may be downgraded following a robust quality assurance review at the Trust's weekly Incident Review panel but we actively encourage high reporting so that we limit the potential for incidents to be under-reported for the level of harm caused.

In line with the increase in reporting, it should also be viewed as a positive improvement that more incidents with harm are being graded as significant (Moderate, Major and Catastrophic) as this suggests that they are being effectively recognised.

Graph 1: Reported harms



One specific area of concern which was highlighted by the CQC report related to the reporting of the severity of harm in Maternity services. An intensive period of education took place during the late summer and autumn of 2018 aimed at improving the volume and accuracy of reporting incidents with the correct severity in the Women's and Children's Division (Clinical Business Unit 4). This included the provision of a (not-exhaustive) trigger list of incidents with examples of the expected severity to report. Reporting is now consistently in-line with expected reporting of severity of incidents. The local trend has now demonstrated an upward trend of recognising and reporting incidents with harm and a greater reliability in accurately classifying and reporting severity of harm.

Serious Incidents and Never Events

The Trust declared a total of 1 Never Event and 48 Serious Incidents in 2018/19. This included a number of operational performance breaches which the Trust must now declare as serious incidents under the NHS contract (such as patients breaching 12 hours care in A&E). The Trust undertakes a root cause analysis investigation into all serious incidents and generates significant learning from these incidents to inform both local and system-wide actions to improve safety. Examples of this are the implementation of a transfer protocol to facilitate safer transfers of patients in urgent care areas; enhanced care for patients with a heightened risk of falling and the adoption of a new risk assessment tool for patients requiring care and support with mental health conditions.

Since October 2018 serious incidents in Maternity services which fulfil criteria specified by the 'Each Baby counts' criteria are referred to the Healthcare Safety Investigation Branch (HSIB) for investigation. The HSIB will provide an independent investigation and the Trust will be given specific actions to inform quality improvement within the Maternity services as a result of their report.

Incidents classified as 'Near-Miss and No-Harm'

Staff have also been encouraged to recognise where the organisation is not meeting its quality expectations and report this as near-miss and no-harm incidents. As the tables overleaf demonstrate, there is a greater recognition and reporting of this type of incident. There is an upward trend of 16% on the previous financial year:

Table 4: Near-miss and No-Harm Incidents 2017/18

	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018
Total	450	530	540	584	522	494	549	587	596	617	713	740
											Total 17/18	**6922**

Table 5: Near-Miss and No-Harm Incidents reported 2018/19

	Apr 2018	May 2018	Jun 2018	Jul 2018	Aug 2018	Sep 2018	Oct 2018	Nov 2018	Dec 2018	Jan 2018	Feb 2019	Mar 2019
Total	653	764	629	764	682	605	669	703	552	705	638	709
											Total 18/19	**8073**

Duty of Candour

The Trust has put in place systems and processes to ensure compliance with the requirements associated with Duty of Candour (contained in regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). The Duty of Candour policy was re-issued in October 2018 and includes clear reference to lines of accountability and responsibility for ensuring that compliance is maintained within the Trust's Clinical Business Units.

A compliance report for all incidents for which Duty of Candour is applicable is maintained and updated by the Risk and Governance department. The report is reviewed weekly at the Incident Review panel and reported to the Clinical Governance Committee and the Quality and Performance Committee on a monthly basis.

There has been a sustained improvement with compliance as the process becomes better embedded in practice. The current overall Trust compliance in quarter 3 with Duty of Candour is 88.0% and is expected to improve and further exceed the target of 95.0% once all quarter 4 incidents have been investigated and shared with the patients involved. Compliance with the target of 95% was demonstrated at the end of the previous year (2017/18).

Patient Safety Initiatives

Safety huddles have been implemented across the organisation. The safety huddle is an important mechanism for allowing staff to gain situational awareness of safety issues affecting patient care in the clinical area. A daily report is provided to the teams to enable them to discuss incidents which occurred in their areas and convey important patient safety messages which affect Trust-wide business. The safety huddle is an important and vital mechanism for engaging staff and driving a patient safety focused culture.

Patient Safety learning events which focused on key topics of understanding Safety 1 / Safety 2 systems and the NHS Improvement's 'Just culture tool' were delivered during the autumn led by the Trust's Deputy Director of Patient Safety. During the spring the Trust has delivered workshops on the Duty of Candour and Human Factors led by Human Factors' consultant, Dr Jane Carthey.

We have also held two Patient Safety Conferences during 2018/19; the first of which took place on Thursday 12 April 2018. The Trust was delighted to welcome key external guest speakers including Mr James Titcombe OBE, who gave a personal account of patient safety, Mr Tim Cooper (former Head of Hospital Inspections with the Care Quality Commission) and Dr Alex Carter of Imperial College; all of whom set the context for a wide range of key patient safety topics throughout the day and shared their expertise.

More recently on Friday 29 March 2019, the Trust held its second Patient Safety Conference focused on the theme of 'Mortality and Learning from Deaths'. Once again we were proud to welcome external keynote speakers: Dr Josephine Ocloo, a patient representative member of the National Board of Learning from Deaths at NHS England; Mr Jes Fry, Coroner's Officer of Her Majesty's Coroner's Office for Norfolk and Mr Matthew Parry from the Dr Foster organisation, Telstra. Additionally there were some wonderful, informative and exceptionally high quality presentations from the Trust's own expert staff on their specialist areas. Planning has already started for the Trust's third patient safety conference.

Future work

Work will continue to encourage a reporting culture and to promote the value of safety huddles as a vehicle for improving patient safety. There is scope to roll out the concept of safety huddles to other ancillary and non-clinical areas and amongst other staffing groups.

A business case and funding has been agreed for a new risk management software platform which will offer us greater insight and flexibility in how we are informed by, and learn from, incidents reported within the organisation. We will host engagement sessions to ensure that the users of the risk management system find the experience positive, functional and worthwhile.

As we develop reporting mechanisms such as the new software system, we will seek to educate, engage and encourage greater reporting, particularly where we are not meeting expected quality standards. This will be augmented by training and regular bulletins to share learning from incidents.

The new reporting system provides further opportunities for development in the future such as patient-based incident reporting, mobile-based reporting and greater integration with information arising through other channels such as complaints. These all require greater exploration before implementation.

We also intend to begin to record positive safety events and 'learning from excellence', where we capture and share when we exceed current quality standards, to enable that quality improvement to benefit the whole organisation.

The NHS is expected to grow its reporting taxonomy throughout 2019 with the introduction of the PSIMS Project (Patient Safety Incident Management System). This project will provide a new service that will replace the two existing systems, the National Reporting and Learning System (NRLS) and Strategic Executive Information System (STEIS), using innovative technology to support more and better learning, so the NHS can continue to improve the safety of care that it delivers for patients. We will adopt this as soon as we are able to so that we can ensure that we meet the new reporting standards and are able to make the new taxonomy reporting work to improve patient safety within the Trust.

1.4 Complaints and Compliments

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

The PALS Department is continuously seeking to improve the service it provides and sets itself high standards, such as ensuring that all telephone calls and emails are acknowledged within the same working day. This is measured (along with other aspects of the service) with the 'Rate our Service' Survey Monkey, which is included on all emails and on a compliment slip when information is provided in person.

The PALS Department continues to promote its service by featuring on the front page of the Trust's internet site, regularly visiting the wards, occupying an accessible location in the main entrance and having a prominent position on one of the Trust's newer initiatives, bedside placemats. The placemats are located on nearly all inpatient bed tables and provide guidance, contact details and information for patients and relatives. The Trust has also acquired screen advertising via televisions that are positioned outside the PALS Department and in other public areas around the hospital. The screens advertise the role of PALS and how to contact the department.

Presentations continue to be given promoting both the PALS role and that of the Complaints Team. These are facilitated by members of the Complaints Team presenting at the Trust's induction on a monthly basis to all new staff and continuing to be involved with the education sessions for groups of nurses and medical teams. New staff members are guided on the need to try and resolve issues as an when they arise, to endeavour to ensure that a high level of patient experience is achieved and also to minimise the number of formal complaints received.

The subject codes used with the PALS Department continue to be reviewed and were amended in 2018/19 to ensure that information is being appropriately logged. It is expected that during the next financial year, more subject codes will continue to be developed to limit the use of the code, 'general information', so that more helpful

information can be drawn from the recorded data on contacts. Although use of this code has been reduced this year it remains the largest category. During this last year 4,678 PALS contacts were logged (excluding compliments):

PALS by Sub-subject (primary)	
General Information	664
Travel Expenses	217
Enquiry	198
Complaints Procedure	194
Access to Health Records	154
Department Details	153
Discharge Arrangements	146
Cancellation	126
Sign Post to another NHS Trust	124
Clinical Care	120
Waiting List In-Patients	117
Parking Fine	113
General Enquires	109
Sign Post to another Organisation	108
Staff Attitude	103

During the period from 1 April 2018 to 31 March 2019, the Trust received 422 formal complaints, which is an increase of 16% (361) when compared to 2017/18.

Local Resolution Meetings are offered as soon as a complaint is received to try and encourage complainants to come and speak with the senior staff involved in the patient's care as it is known that this is a much more beneficial way of resolving complainants' concerns. This financial year 90 meetings have been held. As a result of any complaint, follow up actions are identified and undertaken and specific learning is shared to try and prevent a recurrence of the problem. This includes sharing the outcome of complaints at relevant governance and clinical service line meetings to ensure that all staff share in the learning and not just those directly involved in the complaint.

Close relationships are maintained with the Legal Services and Risk Management Departments. The Complaints Team has the opportunity to raise any concerns that may be serious in nature with the Incident Risk Panel which meets on a weekly basis. The relevant data is also shared with the Patient Experience Committee and Patient & Carer Experience Steering Group and is additionally summarised and included in the monthly report produced by the Patient Experience and Public Involvement Lead for the Service Performance and Quality Review Group meeting with the commissioners.

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

The Complaints Team also continues to use the KO41a codes established by Hospital and Community Health Services Complaints (HSCIC) which has allowed for much more robust information to be obtained. The use of KO41a codes is recorded in a quarterly report submitted to HSCIC. The top themes are listed below and although staff attitude and communication issues continue to feature, this year delays in treatment and diagnosis have become the key causes for complaint:

Complaints by Sub-subject (primary)	
Delay or failure in treatment or procedure	32
Delay or failure to diagnose (inc e.g. missed fracture)	27
Communication with patient	19
Discharge Arrangements (inc lack of or poor planning)	19
Attitude of Medical Staff	19
Discharged too early	17
Attitude of Nursing Staff/midwives	13
Appointment Cancellations	12
Inappropriate treatment	11

DatixWEB continues to be used as an administration tool. The system provides a learning tool for all areas, with some areas moving to a completely paperless complaints process. The Trust's average response rate to complaints has decreased this financial year, achieving a rate of 54% of complaints responded to within the set timeframe (64% in 2017/18 and 88% in 2016/17). The complaints process was revised in April 2018 to incorporate the lead investigator conducting a courtesy call to complainant and the Executive Team reviewing all formal complaint responses prior to the letters being signed by the Chief Executive. The Divisions are given 18 working days to respond to formal complaints to allow time for the Executive review to take place and for appropriate amendments to be made.

The compliance with responses being completed and received by the Complaints Department within the set timeframes has decreased. As a result, there are weekly meetings with the Complaints Manager and the Divisional teams as well as weekly Executive Escalation Meetings with the Clinical Triumvirate and Complaints Manager to review all open formal complaints. Training sessions for all staff involved in complaint responses are currently being rolled out across the Trust.

The way in which complaints are received continues to show an increase in the use of the internet:

Complaints by Method	
Email	267
Letter	107
Complaint Form	32
Via PALS	8
Ward Visit	4
Telephone	3
Window Enquiry	1
Staff Attitude	103

Along with the introduction of the PALS survey, the Complaints Team has continued to send satisfaction questionnaires to complainants one month following completion of the complaint.

Although a pre-paid envelope is included to make it easier for complainants to respond, there has been a very low response rate within the financial year making the data non-comparable with the previous year. Therefore, the current system was reviewed and it has been agreed that from April 2019 the Trust will trial sending 'Survey Monkey' questionnaires via email as this is the most popular method that complainants use to submit complaints and communicate with the Complaints Department. This will be reviewed within the first quarter to assess if this helps to improve the response rate. Paper surveys will be used in conjunction with this system when appropriate.

The department continues to manage the process of reimbursing patients' travel expenses on a daily basis and the team processed 839 claims overall, equating to an average of 70 claims a month.

On occasion there are times when despite our best efforts we are unable to resolve a complaint at a local level and the complainant remains dissatisfied. When this occurs, the complainant may seek guidance from the Parliamentary and Health Service Ombudsman (PSHO) to ask for an independent investigation into their complaint and financial redress. During this financial year, seven complaints were referred to the PHSO. Five cases are currently under investigation and we are awaiting the outcome of the process. A complaint which was investigated by the PHSO during 2016/17 has now been closed and was not upheld. One case was reviewed by the PHSO but the decision was not to investigate and the case was closed. In one further case the PHSO identified that the local resolution process was not followed but it was identified that the complaint had not been formally raised with the Trust. However, the PHSO have requested a retrospective investigation and response via local resolution to assist with their case and this also involves other organisations.

Along with feedback and concerns which are shared with the department concerned, the PALS team also log any compliments which are shared with them, whether it is made in person, by email or by way of a card sent directly to the ward. When a compliment holds identifiable information, such as an address, the Chief Executive sends a personal thank you. In 2018/19 the Trust recorded 1904 compliments and this represents an increase in comparison with 2017/18 when 1858 compliments were received:

Part 2 – Priorities for Improvement

2.1 Quality Improvement Priorities for 2018/19

In 2018 the Trust Board developed and agreed its Vision and Corporate Strategy for the Trust. To support the implementation of this strategy and its associated corporate objectives, a number of supporting strategies were developed, one of which was a new Quality Strategy to cover the next three years. The Quality Strategy incorporated information and ideas from stakeholder engagement events and analysis of information on the quality of our services taken from data, audits and external reports such as the 2018 CQC Inspection findings. Our resultant Quality Strategy sets out a pathway of quality improvement based on a set of overarching quality priorities, underpinned by in-year quality objectives, which are designed to drive forward quality improvements on a continuous basis whilst still maintaining flexibility and responsiveness to any challenges to quality improvement that occur during the life of the strategy. We ratified our Quality Strategy in December 2018 and identified that our key quality priorities for improvement would be:

	Quality Priorities
1	Prioritising with our partners, care for our frail and vulnerable patients, including those approaching the end of their lives
2	Securing safe levels of staff with the right skills
3	Evidencing effective learning and improved practice from errors and experiences
4	Keeping patients and their carers well-informed
5	Delivering a high-quality care experience for pregnant women and their babies
6	Delivering consistently effective infection control
7	Embedding consistent and rigorous attention to documentation and record keeping
8	Ensuring with our partners that patients are treated and cared for in the most appropriate setting

Our quality objectives for 2018/19 focused on delivering these priorities across the key domains of quality improvement. These were informed by the views of our governors, commissioners and partner organisations and from comments and concerns arising from patient feedback. The quality priorities and in-year objectives were shared locally and with the public via the Trust's internet.

2.2 Quality objectives for 2018/19 for delivering quality improvement:

Objective	Actions	Outcome Measure
	Patient Experience	
1. Improve patient and family experience in end of life (EoL) care.	Local actions led by EoL Steering Group and Palliative Care team.	Reduction in EoL- related complaints. Improved rating using the End of Life Quality Assessment tool, which measures achievement against the NICE End of Life Quality Standards.
2. Improve communication with patients who have a sensory impairment such as deafness or visual impairment.	Programme of training and awareness-raising amongst staff in collaboration with local voluntary groups. Focus on improving the management of hearing aids with inpatients and the more widespread usage of hearing loops.	Positive feedback via FFT, PALS and NHS Website' comments. Reduction in complaints.

Objective	Actions	Outcome Measure
Patient Safety		
1. Introduction of NEWS2 (National Early Warning Score)	Trust-wide programme of training to support the introduction of NEWS2 with changes to accompanying written guidance and patients' clinical observation charts.	Development of programme to introduce NEWS2 presented to the Clinical Governance Committee with clear dates for training and trust-wide implementation. Audit of practice following implementation.
2. Ensure improvements in infection control within the Trust.	Review, implement and monitor cleaning standards in all clinical areas. Fully implement Matron's Charter.	Sustained improvements in audits of practice. Reduction in hospital-acquired infections.
3. Ensure improvements in Medicines Management – focus on the use of anti-coagulants.	Put in place measures to improve assessment of risk and prescribing practice.	No failures in practice identified during root cause analyses of incidents of Venous Thromboembolism (VTE). Reduction in VTE's and recorded complications from the use of anti-coagulants.
Effectiveness		
1. Improve the quality of perinatal care.	Develop a joint clinic involving midwives, obstetricians and psychiatrists.	Development plan in place by end of Q1. Clinic in place and seeing patients by Q3. Identify and monitor key outcome measures for mother and baby.
2. Implement a quality improvement programme to support better nutrition and hydration in patients.	Review Food and Drink Strategy and set new objectives for 2018/19.	New objectives in place by end of Q1. Quarterly reports to Quality & Safety committee demonstrating progress in meeting objectives. Objectives delivered by end of Q4.
3. Enhance learning from deaths in people with a learning disability to support improvements in care.	Review and revise processes for ensuring that all deaths in people with a learning disability are identified and referred to the LeDeR programme (Learning Disability Mortality Review). Internally examine every death of a person with a learning disability and involve the Learning Disability Liaison nurse in the review.	Full compliance with reporting to LeDeR – reported to the Quality & Safety committee quarterly. Results of all internal investigations to be made available to the LD Steering Group and any learning shared across the organisation via Divisional Governance structure.

Objective	Actions	Outcome Measure
	Build and sustain excellence	
1. Undertake an improvement programme to support better documentation and note-keeping.	Develop and implement a programme of training with all levels of medical and nursing staff to support best practice in line with Royal Colleges' and Regulatory Bodies' standards.	Weekly audits of patients' health records provide evidence of improvements in practice.
2. Improve understanding of the Mental Capacity Act (MCA) 2005 amongst staff and how it can support improvements in the quality of care for the patient.	Develop and implement a programme of training with all levels of medical and nursing staff to support best practice in the use of the Mental Capacity Act 2005 within health care practice.	Staff in all clinical areas are able to explain when and how to use the MCA 2005 within their health care practice. Audits of patients' health records provide evidence of use in practice.

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

A Quality Improvement Implementation Programme was devised that clearly identified the key actions required to deliver our priorities and the performance metrics by which delivery would be measured. These were monitored on a continuous basis by the identified leads for each objective and reported to the Trust Board via summary implementation reports to the Quality & Performance Committee.

The Trust's management and governance structure provided a framework for implementing change locally, monitoring progress and identifying any risks on delivery. Assurance on delivery and achievement was supported by the governance reporting systems and through Board review of the Board Assurance Framework

2.3 How have we delivered on our objectives:

Domain	Patient Experience
Objectives	
1. Improve patient and family experience in end of life (EoL) care. **Quality Priority 1 & 4**	The Trust has received 30 EoL related complaints since April 2018, compared to 32 for the same period the year before, therefore showing only a marginal improvement. When EoL care at the QEH was examined in relation to the National Institute for Clinical Excellence's (NICE) EoL Quality Standards several major points emerged: Identification of patients at the EoL: patients at the EoL should be identified on a point prevalence basis and reported to the EoL Care Facilitator. The Information Team have agreed to provide a daily list of EoL patients on each ward. This commenced recently and is progressing. We have now started a joint palliative care multi-disciplinary team (MDT) in collaboration with Norfolk Community Health and Care NHS Foundation Trust (NCH&C), chaired by Dr Blackburn, the palliative care consultant from the community. We have also started a trial on two wards (Stanhoe/ Tilney) in which the EoL Care Facilitator attends a weekly MDT meeting to help staff to recognise when patients are approaching EoL and supporting with difficult conversations.

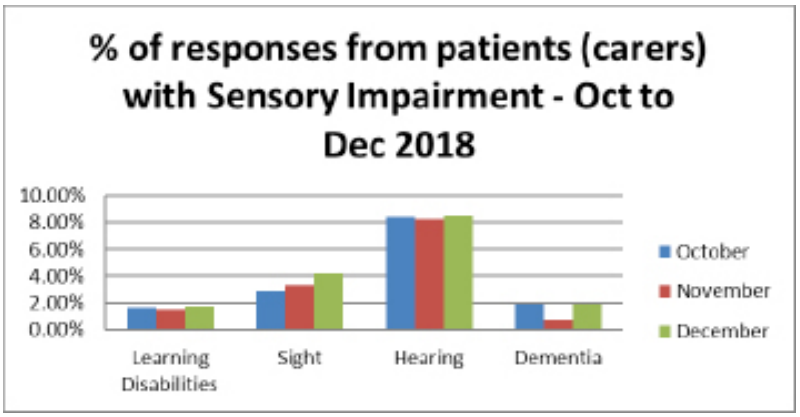
Domain	Patient Experience
	Communication: Work has commenced involving both the Medical Director and the Associate Medical Directors in relation to conversations at the end of life. Courses via Macmillan have been offered to support staff and at EoL study days, there is a feature on breaking bad news. NCH&C have rolled out a course to improve communication and the recognition of EoL patients. Individualised plans of care (IPOC) at EoL: A plan was rolled out initially to implement this approach but it met with limited success as feedback from wards suggested the plans were too lengthy. This is now under revision to produce a more condensed format and once ratified at the EoL Steering Group, we will roll this out again to the ward areas. Patient experience: 200 questionnaires were sent out to families but generated a poor response rate. We are currently looking at a project via the Norfolk and Norwich University Hospital NHS Foundation Trust to gain feedback county-wide from all acute trusts. Workforce Training: The Trust is now offering two Palliative Care study days/year. A member of the EoL team now attends all medical and nursing inductions and the Mortality & Morbidity meetings within Divisions. Additional work is required to move the Trust towards having full assurance that this objective has been fully delivered.
2. Improve communication with patients who have a sensory impairment such as deafness or visual impairment. **Quality Priority 1 & 4**	A programme of training and awareness training commenced as part of the Trust's induction programme in March 2019. A report reviewed the experiences that people with sensory impairment have reported at the Trust between October-December 2018. The information was obtained from the Friends and Family Test. The table below shows the total number of responses collected from patients and their representatives (e.g. carers or family members), the number collected from patients with sensory impairment and the percentage this represents over the three months - October to December 2018. Sensory impairment is defined as those patients who self-define as having learning disabilities, sight loss, hearing loss, and dementia. The number of responses for each type of impairment remained fairly static across the quarter. The only outstanding action required, which we are undertaking is to evaluate the training and continue the collaborative work with external organisations to further enhance our patients' experience.

	Oct	% of tot resp	Nov	% of tot resp	Dec	% of tot resp	Quarterly
All	4260		4264		3388		
Learning Disabilities	71	1.66%	65	1.52%	58	1.71%	1.63%
Sight Loss	120	2.81%	141	3.30%	142	4.19%	3.38%
Hearing Loss	359	8.43%	351	8.23%	287	8.47%	8.36%
Dementia	81	1.90%	80	1.87%	64	1.89%	1.88%

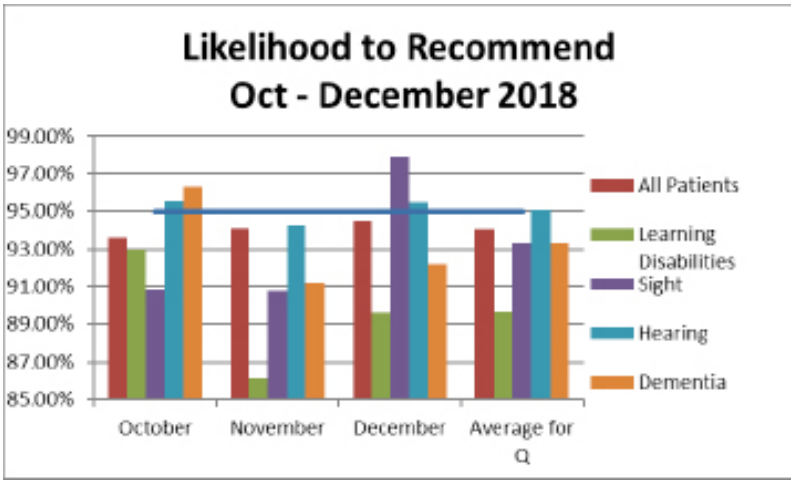
*% of tot resp - % of total responses

Domain	Patient Experience

The number of responses for each type of impairment remained fairly static across the quarter. The only outstanding action required which we are undertaking is to evaluate the training and continue the collaborative work with external organisations to further enhance our patients' experience.



As part of the Friends and Family Test patients are asked how likely they are to recommend the care they have received. The following chart shows how likely patients with a sensory impairment are to recommend our hospital when compared against the Trust's target and in relation to the response of the general population:



The responses from patients with learning disabilities or their representatives show the worst likelihood to recommend across the general population and all other areas of sensory impairment currently collected by the Trust. Across the quarter less than 90% of patients/carers recommended their experience.

This offers partial assurance, which should move to full assurance once the training is embedded and further audits demonstrate changes to practice. This reflects feedback through other routes such as the Learning Disability Steering Group, where families have expressed their anxiety prior to a hospital admission and perceived concerns about outcomes of care.

The Trust can record partial assurance in relation to the work undertaken with other patient groups with sensory impairment but clearly further training for staff is required to embed those changes in practice that will provide the reassurance and responsive approach required to support the families of patients with a learning disability.

Domain	Patient Safety
Objectives	
1. Introduction of NEWS2 **Quality Priority 3**	We introduced NEWS2 into the Trust in November 2018 and it is now fully embedded. An audit undertaken to assess the effectiveness of this implementation indicated the following: • The initial training provided in preparation of the Trust changing from EWSS to NEWS2 'captured' over 600 Nursing/Physio/OT staff and approx. 200 medical staff; • All NEWS2 training is recorded on ESR; • NEWS2 is taught on induction and mandatory training as a refresher; • Students and Health Care Assistants are taught NEWS2 by the NVQ (National Vocational Qualification) team; • Medical staff are required to provide evidence of training to the medical secretary in the Education Centre. Online training is preferred by the medical teams but there are plans for training to be commenced to teach the doctors at the point when they change over jobs. • NEWS2 is referred to in Basic Life Support training but only in reference due to timings. • The audit overall demonstrated that compliance was good but with some variables. The main issue of note was that the doctors needed to prescribe oxygen and this is being addressed by the Medical Director. This offers assurance that the NEWS2 process is in place but ongoing audits will be required to ensure that this process continues to be fully embedded.
2. Ensure improvements in infection control within the Trust. **Quality Priority 6**	Cleaning standards have been developed and all Credits for Cleaning audits (C4C) are completed monthly and this is reported at the Hospital Infection Prevention & Control committee and at monthly performance review meetings. Daily red, amber and green (RAG) rating is in place and this is reported to NHS Improvement (NHSI). All areas have cleaning schedules clearly displayed and signing folders that are checked by the domestic supervisor. The Matron's Charter has been fully implemented by the matron team, and a recent NHSI inspection in relation to infection prevention & control, indicated that the matron's role fully embraces and meets the charter.

Domain	Effectiveness
Objectives	
1. Improve the quality of perinatal care. **Quality Priority 5**	We are working within the Local Midwifery System (LMS) to put in place an honorary contract for the perinatal lead for mental health across the LMS. In addition a joint role to support vulnerable women is being progressed with Norfolk & Suffolk NHS Foundation Trust. However, as proposals are still in the development stage, it is not possible to obtain full assurance that this objective is being met. The Division will be working with the Medical Director to develop metrics that will allow assessment of progress and time scales.
2. Implement a quality improvement programme to support better nutrition and hydration in patients. **Quality Priority 3 & 8**	The Nutrition and Hydration Strategy for 2018-2021 was launched in April 2018 following the successful delivery of objectives set out in the Food and Drink Strategy 2015-2018. The strategy focuses on three key areas: 1) Patient nutrition and hydration 2) Healthier eating across the Trust 3) Sustainable food and catering services The key focus for 2018-2019 has been: • The implementation of International Dysphagia Diet Standardisation Initiative (IDDSI) within the Trust following a Patient Safety Alert in April 2018 around safer modification of food and drink. Extensive work has been carried out in collaboration with the Speech and Language, Nutrition and Dietetics and Catering departments. This has involved reviewing all patient menus and adapting menu choices according to the new guidelines. By the end of March 2019 we will also have seen the use of thickening agents changed to a new product to comply with the new IDDSI guidelines; this has involved a significant amount of training at ward level for nursing staff. • Reviewing the completion of 'MUST' nutrition screening by undertaking an audit against agreed standards. This saw a completion rate of 65.7% on admission (down from 79% in 2016) with a 73% accuracy for completion. Work is planned in for 2019/20 to address these findings. • Quarterly reports on progress have been submitted and presented to the Clinical Governance Committee. These results offer only partial assurance and will require continued work to be undertaken in 2019 / 2020.
3. Enhance learning from deaths in people with a learning disability to support improvements in care. **Quality Priority 1 & 3**	The Learning Disability Liaison nurses have identified patients with a learning disability through contact during visits to the hospital. These patients have been annotated on our patient administration system (Patient Centre) using a special alert flag. In addition, a report is generated by Information Services which highlights when any patient, previously identified as having a Learning Disability (LD), attends the A&E or is admitted into the hospital. This report is used to facilitate a visit from the LD team and will also identify if a LD patient dies whilst in our care. We also report on deaths with an ICD10 'F' code denoting a mental health condition. The LD liaison nurses report any LD death via the portal as and when they are made aware of the death.

Domain	Effectiveness
Objectives	
	We find that although clinicians are very good at documenting the reason for an emergency admission the information on LD can sometimes not be clear, so the alert ensures that the LD team is made aware and can support the patient and his/her family. We are currently involving the LD nurses in undertaking a retrospective mortality review of the health records of the patients we have submitted to the LeDeR programme to determine whether there is any learning we need to implement prior to the LeDeR review. Following the retrospective notes review, we will ensure that any learning is shared across the organisation. We are arranging a 'Learning from Deaths' conference on 29 March 2019 where outcomes from LeDeR investigations will be shared more widely within the Trust. This is ongoing work and offers only assurance for the work undertaken to date, but ongoing work is required to ensure that the learning is embedded into practice.
Domain	**Build and sustain excellence**
Objectives	
1. Undertake an improvement programme to support better documentation and note-keeping. **Quality Priority 7**	Following a recent consultation regarding the existing medical clerking proforma, the Consultants and Doctors in training felt the documents needed to be modified to match the current requirements of the service. One of our acute medicine consultants took the initiative to modify the clerking proforma following feedback from various clinical colleagues to achieve a more practical and useful booklet. This has been approved by the Health Records Committee. Informal feedback from various medical colleagues and doctors in training has been positive and encouraging. An audit of the medical clerking proforma will be completed by the end of quarter one and will be presented in the specialty clinical governance meeting. A programme of weekly audits of patient's health records is planned to be undertaken once the use of the proforma is established in daily practice. Record keeping was incorporated into the Quality Improvement Plan (QIP) and included the development of new Nursing Assessment documentation for Adult In-patients. This document was developed in collaboration with nursing staff and following formal ratification through the appropriate committees was launched on 17 December 2018, supported by training for staff. This remains open as a quality improvement action as it is important the evaluation of this documentation is carried out and the impact of the changes in both documents is measured both in terms of functional improvements and quality of documentation. A formal audit programme is being developed and the results of this will be triangulated with evidence from the Quality Assurance Visits. In the meantime monthly auditing of elements of the nursing documentation is being captured within the Perfect Ward Technology and results shared with staff. This provides partial assurance as the embedding and assessment of the impact of this on practice is still to be formally evaluated.

Domain	Build and sustain excellence
Objectives	
2. Improve understanding of the Mental Capacity Act 2005 amongst staff and how it can support improvements in the quality of care for the patient. **Quality Priority 1 & 7**	To support the Trust's commitment to improving the knowledge and application of the Mental Capacity Act (MCA) amongst staff we firstly began by undertaking a review of the Trust policy. Following this we developed MCA guidance in the form of a booklet that was provided to staff via their salary slips. We have also strengthened the governance arrangements to provide a greater level of oversight and assurance with MCA now sitting with the Trust's Adult Safeguarding Lead. To support the existing training in place a review has been undertaken of the MCA workbook to ensure that it continues to provide staff with the underpinning information they require to apply the Act in the clinical setting. Alongside this we have begun delivering two hour bespoke MCA training sessions which are open to all staff and are planned for the rest of this year. E-learning packages are currently being explored to further strengthen this. From February 2019 the Mental Health Liaison Team and Safeguarding Lead will begin delivering the MCA audit plan, an audit that will have a ward and Trust-wide focus. Findings from this audit programme will provide a steer for future training requirements. We are currently developing a focused Trust-wide awareness campaign to include hub promotion/screensavers and have already provided staff with lanyard cards to help support their clinical practice. This is the Trust's current compliance with MCA training. MCA and Deprivation of Liberty Safeguards (DoLS) are now recorded separately to support a greater level of scrutiny of the data captured and to allow us to focus training into specific areas of knowledge and practice. This update provides partial assurance of changes in practice, but ongoing work to embed and assess changes in practice is required before full assurance can be gained.

Governors' Quality Priority

In 2018/19, the Trust's external auditors audited the 4-hour access and 62-day cancer standards as mandated indicators for audit. These are reported elsewhere within this report.

In March 2019, The Governors' Council selected a local indicator for audit, in accordance with the external audit requirement. This year, the strong recommendation from NHSI was that the Governors should select SHMI (Summary Hospital-level Mortality Indicator) as their locally selected indicator. The Trust's Governors' Council resolved that SHMI would be their locally selected indicator for 2019/20. The Governors selected no further indicators for audit this year.

Part 3: Key Priority Performance

3.1 Delivering Safe Care

3.1.1 Reducing and Eliminating Healthcare Associated Infections

The Trust has a strategy for Infection Prevention and Control with objectives based on the Code of Practice within the Health and Social Care Act 2008 (updated 2015). This provides the standards on the prevention and control of infections with related guidance from the Department of Health and is used by the Care Quality Commission as a measure of standards.

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

Management Structure for Infection Prevention & Control

The Trust has in place a structure for the prevention and control of infections led by the Director of Infection Prevention and Control, supported by an Infection Prevention and Control Team (IP&C team) and monitored by an Infection Prevention & Control committee that meets on a bi-monthly basis.

Trajectory for (Methicillin Resistant Staphylococcus Aureus) MRSA and Clostridium difficile

MRSA bloodstream infections (target = zero)

There have been two avoidable MRSA blood stream infections for the year 2018/19 associated with the Trust.

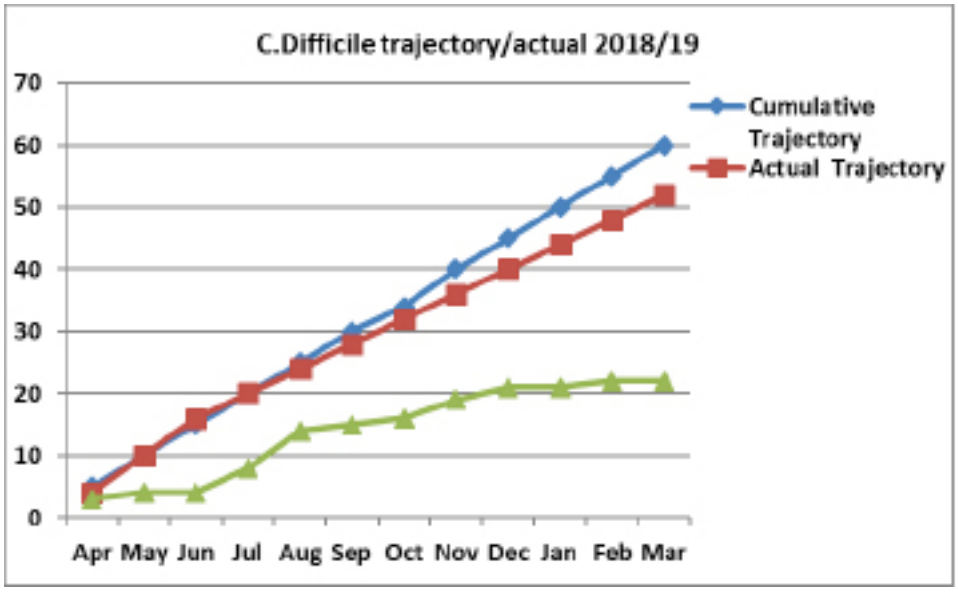
Both cases were reviewed by a multidisciplinary team and an action plan compiled to address practice issues identified.

Screening rates for MRSA on admission and weekly are now maintained at 95% across the Trust.

Clostridium difficile Infection – CDI (Objective = <52)

The CDI objective for 2018/19 was to achieve less than 52 Trust apportioned cases. The annual incidence of CDI was 22 cases with 5 cases identified as incurring no lapses in care at the post-infection review.

Improved cleaning regimes have resulted in a significant reduction in the number of cases from the previous year.

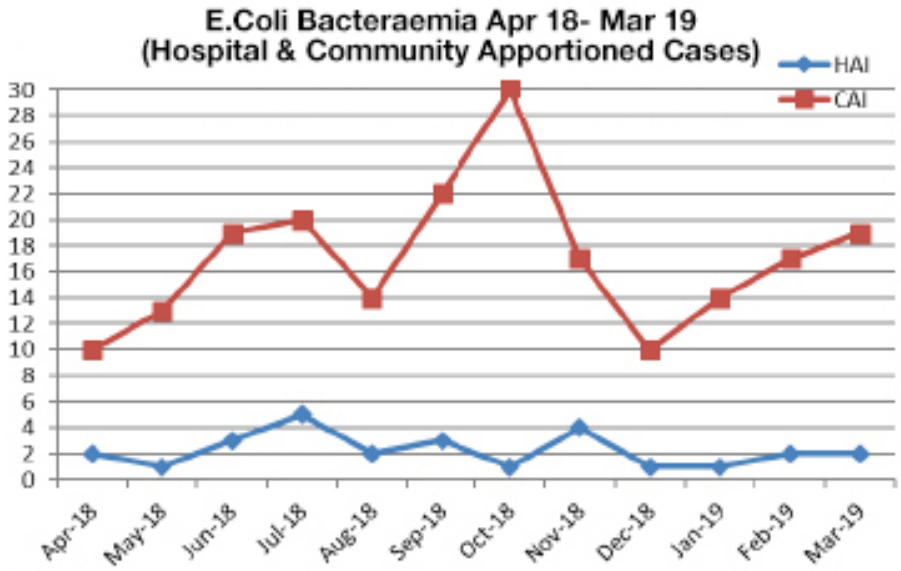


Challenges this year

Gram Negative Blood Stream Infections (GNBSI) – following the launch of the Secretary of State for Health's ambition to reduce Gram-negative BSIs by 50% by 2021, the Trust has continued to work collaboratively across the health economy to achieve this ambition.

One of the continued priorities has been Escherichia coli BSIs, which represent 55% of all Gram-negative BSIs. Preventing BSIs is anticipated to have a major impact on reducing the rise in antibiotic resistance through reducing the need to prescribe antimicrobials.

The IP&C team continue to work with CCG colleagues to identify causes of GNBSI, both those that are community and hospital-acquired:



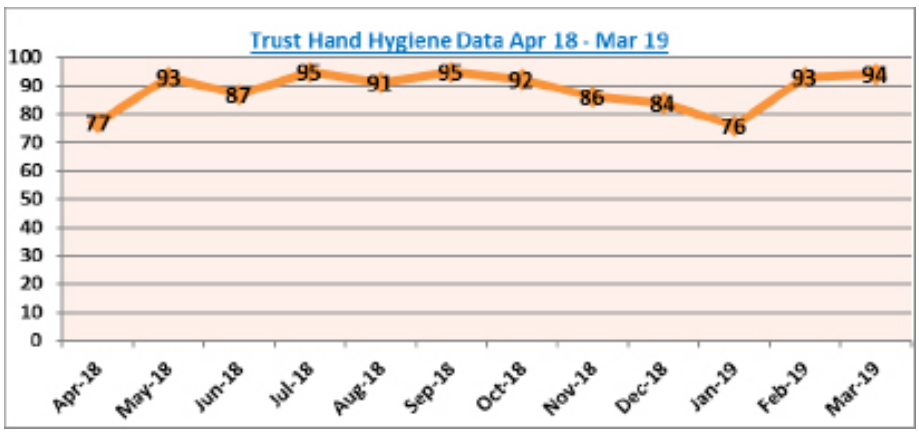
Influenza – This has been a challenge and since December 2018, there have been 248 laboratory confirmed cases of Influenza; one Influenza B the rest Influenza A. This has been the predominant strain this year. The Trust successfully managed two outbreaks involving more than one ward and the management of patients kept the outbreak contained.

Anti-viral treatment was prescribed to patients meeting the criteria defined in the Public Health England (PHE) guidance for those symptomatic as well as prophylaxis treatment for those in the high risk groups.

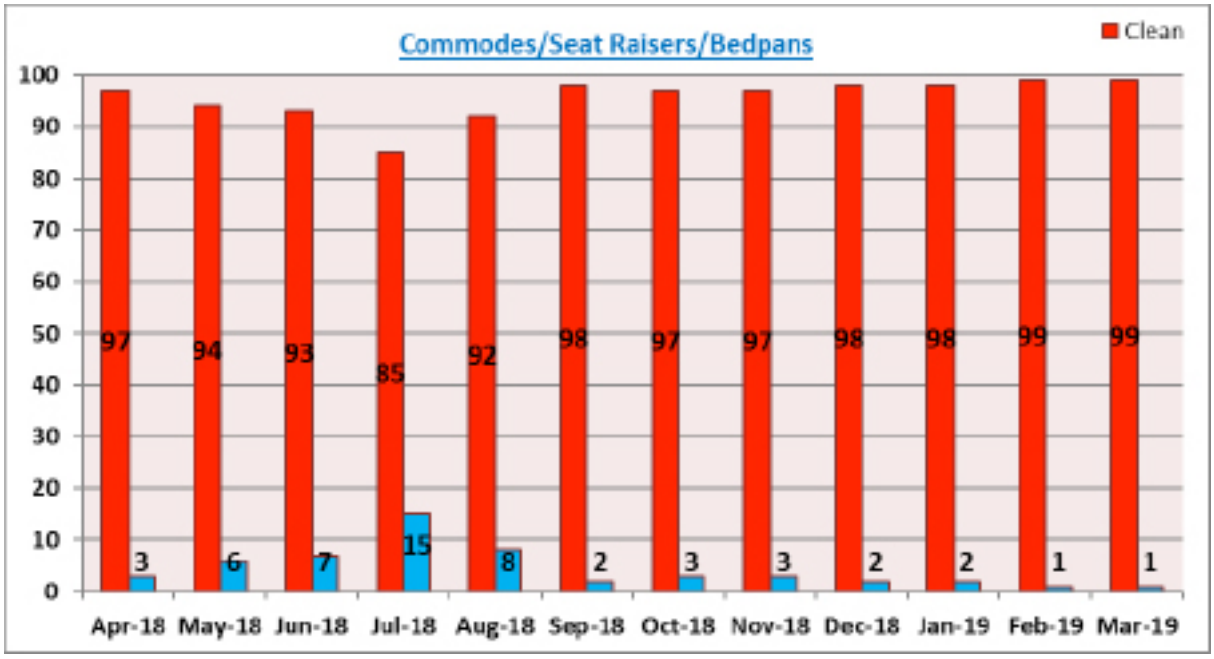
Reports from PHE indicated that the influenza vaccine was very effective and resulted in milder presentation in symptomatic patients.

Audits

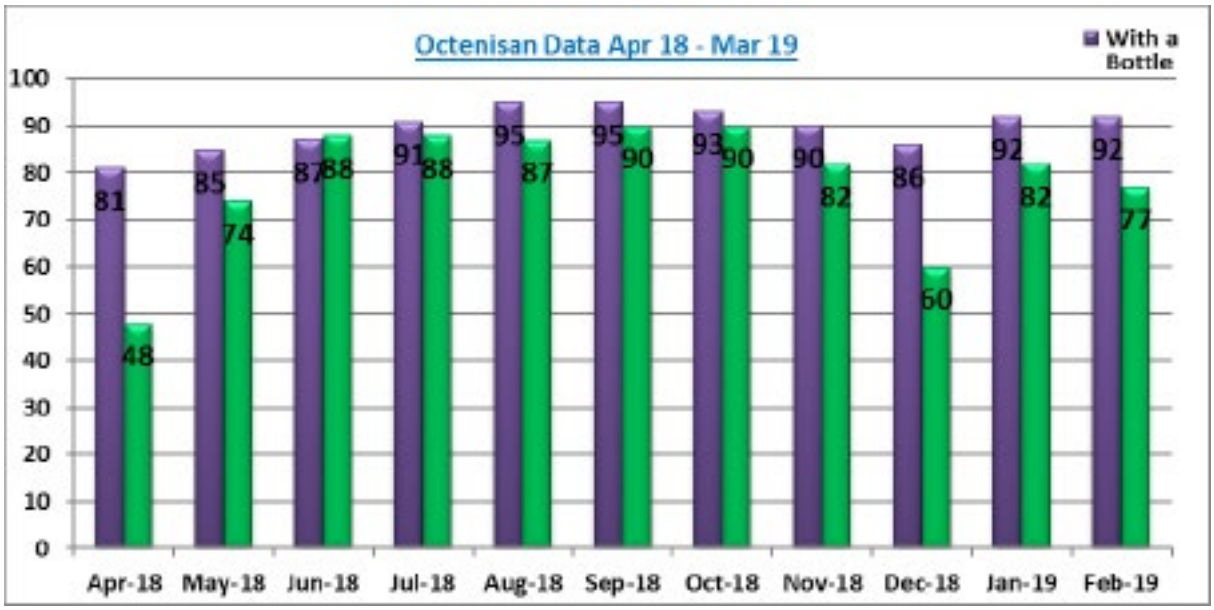
Hand Hygiene – The team has undertaken weekly audits on all inpatient wards (excluding Women's & Children's) – monitoring compliance via High Impact Interventions (HII) and also in outpatient areas. These results have been reported on the weekly Quality dashboard:



Commode/Toilet Raisers/Bedpan – The team has undertaken weekly audits on all inpatient wards (excluding Women's & Children's) and this has been reported on the weekly Quality dashboard. The monthly compliance figures are as follows:



Octenisan Compliance – Since November 2016 when Octenisan body wash was introduced across the Trust, the team has undertaken monthly audits on the use of this product. There is ongoing education into the use of this product and where audits highlight areas of poor compliance, these are targeted with further education.



Completion of Stool Charts – Since January 2017 the IP&C team has audited the compliance with documentation on stool charts. It is a Trust standard that all inpatients have a stool chart and that this is completed daily.

Annual Audits

Urinary catheter audit 2018

This audit was conducted to ascertain current compliance with best practice.

A Quality Premium for the Clinical Commissioning Groups was launched in 2016/17, for a 10% reduction in gram negative blood stream infections (GNBSIs) with an overall plan of a 50% reduction by March 2020. This was in response to Lord O'Neill's challenge to strengthen infection prevention and control (IPC) and in-line with

the Secretary of State for Health's ambition to reduce gram-negative GNBSIs by 50% by 2021. When a GNBSI is identified, a review of each case is undertaken and is reported via the Public Health England Healthcare Infection Data System. The information inputted into the system to help identify the possible source infection and any related themes, identifying areas that require targeting such as urinary catheter management.

The IP&C team carried out the data collection for the audit over 4 days: the 16, 17, 18 and 19 June 2018. All inpatients on all wards were checked for the presence of an indwelling urinary catheter. Those with a catheter-in-situ were assessed using a recognised audit tool which looked at whether:

- There was the correct insertion sticker in the patient's health record;
- There was detailed documentation providing evidence of the catheter insertion details and use of aseptic non-touch technique (ANTT);
- There was a valid reason as to why the catheter was required and if there was a documented review date;
- There was evidence of the use of a Catheter Passport.

The data was analysed and a report formulated by the IP&C team. In total 414 inpatients were visited during the audit and 88 patients were found to have a urinary catheter. This represents (21%) of the Trust's inpatients, which is a 2% decrease from 2017. None of the 88 catheterised patients had a catheter passport.

Overall the audit concluded that catheter care represented an area of high concern as compliance was variable for all measurable audit criteria with some areas of high compliance (catheter looks clean) through to a complete absence of compliance (use of catheter passport).

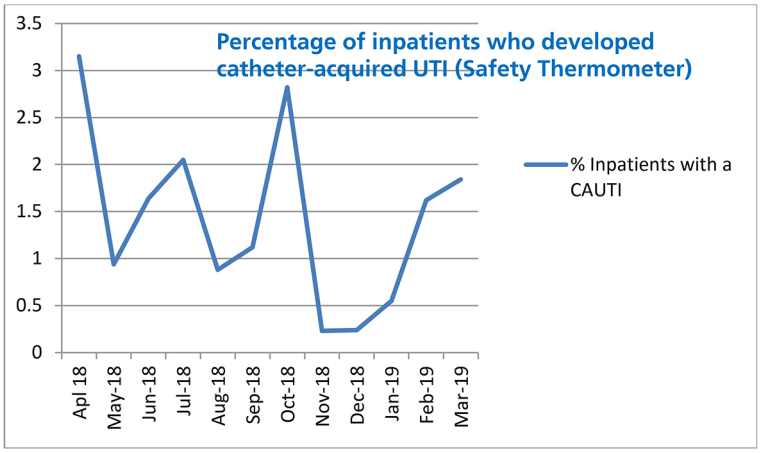
Just over half of the catheters that were audited had a sticker insertion record (63%), compared to 74% in 2017. There was very poor documentation on the review date of catheters (16%) and this showed no improvement since 2017 when it was also 16%. It was not possible to ascertain when or where the catheter was inserted which could lead to a longer duration of the device being in situ, presenting an infection risk and pain and discomfort for the patient.

Audit criteria	Best Practice Standard	Standard Achieved	Variance from Standard
Sticker insertion recorded in health record	100%	63%	-37
Detailed documentation about insertion of catheter if inserted whilst an inpatient	100%	38%	-62
Clerked in health record from A+E if admitted with a urinary catheter	100%	58%	-42
Documented review date	100%	16%	-84
Valid reason why catheter is needed	100%	76%	-24
In-date expiry sticker	100%	42%	-58
Catheter looks clean	100%	98%	-2
Documented evidence on catheter care	100%	30%	-70
Evidence of a Catheter Passport	100%	0%	-100

Urinary tract infections are the second largest source of healthcare associated infections at 19.7% and HII reports have shown that 60% of these are related to catheter insertion (Department of Health Act 2006).

The Catheter Passport was implemented in the Trust in 2012 and the aim was to complete one following insertion of a urinary catheter both within the hospital and in the community. It provides a record of insertion and details such as reason for insertion, process used and type/size of catheter. In addition, it provides clear instructions regarding the management of the device including: review date and evidence of any interventions required such as flushes, bag changes and patient preference. It also provides data of any previously catheter-acquired infections which could include E-Coli and other gram negative organisms, including resistant strains. Unfortunately the data collected this year has shown no improvement on the 2017 data.

Data obtained from the Safety Thermometer collection each month demonstrates that the proportion of patients with an indwelling urinary catheter who develop a catheter-acquired infection varies between 0.23 and 3.15% of inpatients with a mean average of 0.99%:



Although this suggests that the majority of patients with an indwelling urinary catheter do not develop an infection there is clearly room for improvement in terms of reducing overall incidence and improving reliability and consistency of catheter management.

Urinary catheter management is a key intervention in the prevention of catheter-acquired UTIs, and the prevention of gram negative infections is an area that will require a renewed focus in 2019/20 in order to achieve the required reductions in infection.

Training and Education

The IP&C team undertake training for all staff at the Trust using workbooks and teaching sessions. Staff receive ad hoc education in clinical environments or where a particular training need is identified. Compliance with mandatory and induction training is monitored by the training department and each individual's level of compliance is addressed via appraisal. Maintaining full compliance with mandatory training remains a challenge for some staff due to clinical commitments and requires further focus during 2019/20. Each Clinical Business Unit is being required to develop a trajectory for improvement and new initiatives, such as e-learning packages, are being implemented where appropriate.

Data up to 31 Mar 2019	Infection Control (Core Subject)		
Staff Group	In post	Attended	%
Add Prof Scientific and Technic	117	99	84.62
Additional Clinical Services	814	655	80.47
Administrative and Clerical	659	659	100.00
Allied Health Professionals	177	143	80.79
Estates and Ancillary	443	426	96.16
Healthcare Scientists	29	23	79.31
Medical and Dental	294	196	66.67
Medical and Dental - in training	122	101	82.79
Nursing and Midwifery Registered	889	720	80.99
(Total) Headcount requiring training	3544	3022	85.27
Clinical	2442	1937	79.32
Non-clinical	1102	1085	98.46

Results and Surveillance

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

Results on Norovirus and Influenza are also imported to ICNET. The IP&C team request Norovirus testing when required within the Trust as part of an assessment of patients presenting with symptoms of diarrhoea and vomiting. The IP&C team monitor bays and wards, advising on patient flow, assessing the level of risk and deciding when bay or ward closures are advised.

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

3.1.2 Reducing avoidable mortality

Learning from Deaths

In March 2017, the National Quality Board (NQB) introduced new guidance for NHS providers on how they should learn from the deaths of people in their care. Monitoring overall hospital mortality data is recommended as it can indicate where there are problems with the quality of care. Several indicators are used nationally, including the Hospital Standardised Mortality Ratio (HSMR) and the Summary Hospital Mortality Indicator (SHMI):

HSMR: Hospital Standardised Mortality Ratio

This is the Dr Foster indicator and it:

- Is widely reported;
- Considers risk of death based on diagnosis at first episode of care;
- Is adjusted for palliative care;
- Does not include deaths after discharge;
- Is based on 56 diagnosis groups representing 80% of hospital deaths.

SHMI: Summary Hospital Mortality Indicator

This was devised to replace other indicators and has become the 'national standard' it:

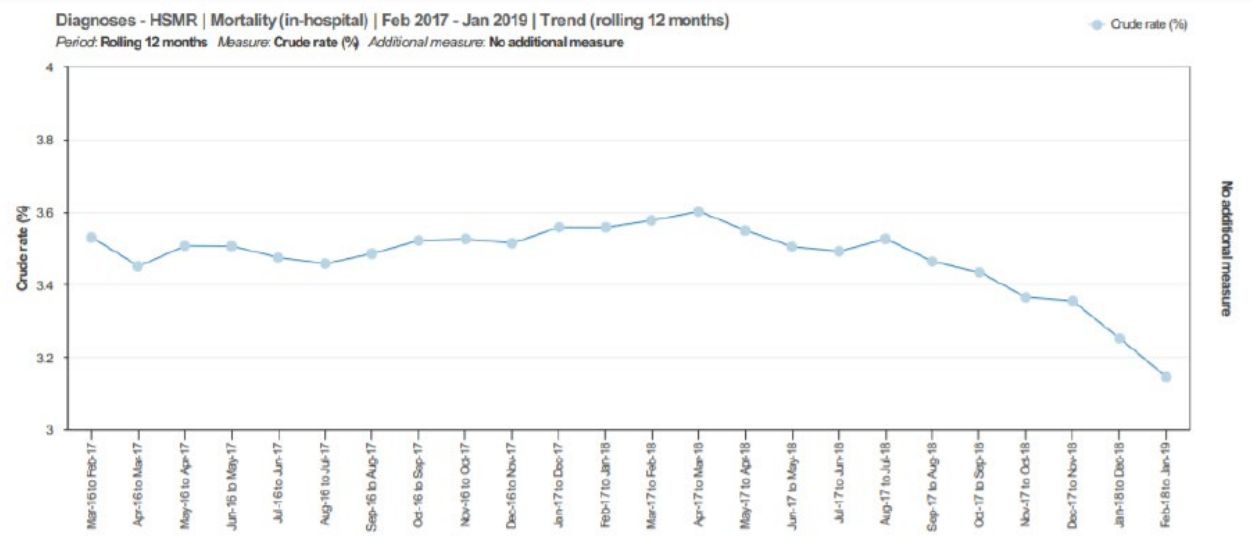
- Is available to the public on the NHS Choices website;
- Considers risk of death based on diagnosis at first episode of care;
- Includes deaths within 30 days of discharge;
- Has a rolling 12 month average, updated quarterly and is published 6 months in arrears.

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

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

The following graph shows the HSMR trend from January 2017 to December 2018. Data is published three months in arrears and the last quarter is as yet unavailable:

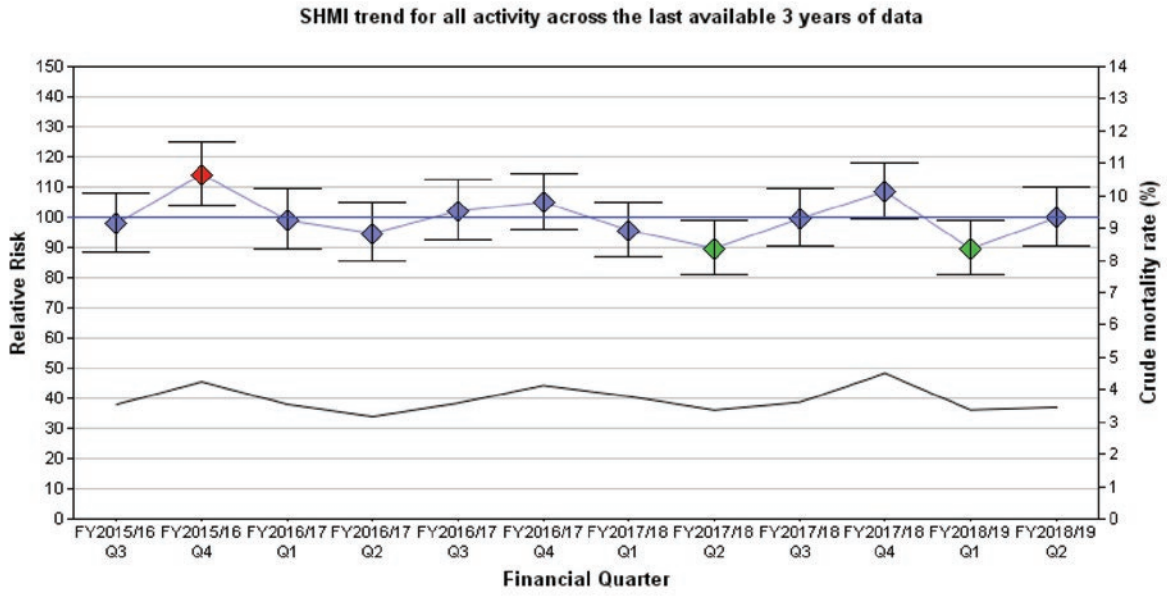
Fig 1.2 HSMR Crude rate Trend (Rolling 12 months)



The HSMR for the period from January 2018 – December 2018 was in the as expected range as follows:

Indicator	QEH (expected range)
Overall HSMR	102.5 (98.8 – 108.2)
Weekday	98.8 (94.9 – 109.8)
Weekend	113.6 (92.8 – 118.3)

In addition, the Board also monitors the SHMI. The data for the SHMI is published six months in arrears and for the period from October 2017 – September 2018 the SHMI was 0.9956. This is within the as expected range:



Mortality Surveillance Group

The Mortality Surveillance Group is chaired by the Medical Director. The group meets monthly and reviews data from a number of sources, including Dr Foster. It monitors the HSMR, SHMI and diagnostic groups falling outside the expected range. The group also monitors high risk groups.

Following concerns raised nationally into premature deaths of people with a learning disability, all deaths in this group are reviewed and information is submitted via a national portal for independent review.

This year our HSMR has been within the expected range. Our crude death rate is also in line with our local peers. The Trust is reassured by our SHMI data which does not include an adjustment for palliative care and has stayed within the expected range.

A 'Learning from Deaths' conference was held in March 2019 to ensure that learning from deaths is shared on a wider scale throughout the Trust.

End of Life

Our Trust's End of Life team and Steering group, which includes local partner organisations, has continued to focus this year on the early recognition of patients at the end of life and improving communication between the medical teams and patients/families. Fast track discharges have continued to be an issue, with several nursing homes de-registering as nursing homes and no longer accepting end of life patients. We have lost the use of the equivalent of three vacant hospital beds in the last year due to delays in patients being either able to go home or to other care facilities (1098 bed days lost), most importantly this has affected patient choice for those patients involved.

Close collaborative efforts have continued throughout the year between our End of Life team, the Specialist Palliative Care Team at Norfolk Community Health and Care NHS Foundation Trust and NHS Improvement leading to:

- The creation of a Palliative Care Multi-Disciplinary Team (MDT) with a Palliative Care consultant as the Chair;
- A continued focus on delivering the six ambitions of Care;
- Two trial wards receiving increased palliative care attendance at their MDT meetings to support early decision-making and support with difficult conversations;
- Attendance of the End of Life Care Facilitator at surgical and medical Mortality & Morbidity meetings;
- Increased input from the Palliative Care consultant from Tapping House (Hospice), undertaking four sessions a week at our Trust;
- A complete overhaul of our intranet page for Palliative and End of Life care, which now features a library and a resource page for all staff to access;
- End of Life study days taking place twice a year, as well as quarterly link nurse meetings (one link nurse per Clinical Business Unit);
- The provision of a quarterly End of Life newsletter which updates all members of the Trust about new projects and initiatives and provides other departments with an opportunity to share updates on End of Life matters;
- Our End of Life Care Facilitator contributing to teaching days for doctors during Foundation Year 1 and 2 and on the Clinical Trainee programme, as well as contributing to mandatory training sessions for those senior clinicians in substantive positions;
- An e-learning programme being made available via our Electronic Staff Record system that enables staff to meet their mandatory training requirements.

3.1.3 Reducing the number of patients experiencing harm as a result of hospital acquired pressure ulcers

The standardised practice encompassed in the ASKINS bundle (a care model for pressure ulcer prevention) continues to keep pressure ulcer prevention at the forefront of our minds and provides a methodology for us to strive to maintain and improve current standards.

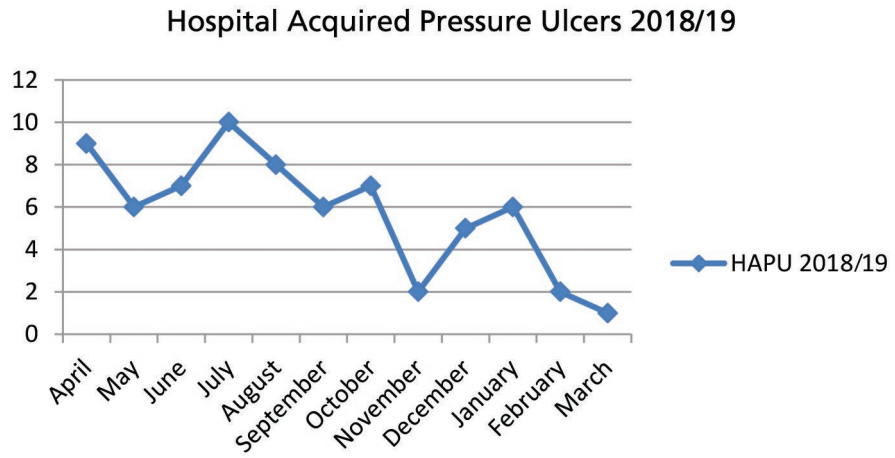
The number of pressure ulcer incidents is one of the monthly quality indicators that the ward managers and matrons collect each month. An ASKINS checklist is completed for all hospital acquired pressure ulcers (HAPU) and results are discussed face to face with the ward manager or nurse-in-charge at the time of completion and sent to each ward manager and matron electronically. This helps to identify where specific training should be focused.

Table 1 and Chart 1 show the number of incidents in 2018/19. This represents a 28% increase in incidents compared to 2017/18 with a peak in July 2018 in which ten incidents were recorded followed by a general declining trajectory during the last six months of the year with only one incident recorded in March 2019. The increase in incidence in July 2018 reflected the national picture and occurred during a sustained period of hot weather. A local review of practice took place and this resulted in changes to mandatory training and education to facilitate improvements in practice.

Table 1. Pressure ulcer incidents 2018/19

Month	2018/19	2017/18
April	9	5
May	6	3
June	7	1
July	10	6
August	8	5
September	6	5
October	7	8
November	2	6
December	5	3
January	6	5
February	2	4
March	1	3
Totals	69	54

Chart 1 Pressure ulcer incidents 2018/19



New NHSI 2018 guidance

Implementation of new national guidance commenced at the beginning of Quarter 4. This has introduced changes in categorisation and reporting of pressure ulcers. As well as the previous categories 1-4, the following categories can also be reported from January 2019: unstageable, deep tissue injury (DTI), medical device related pressure ulcers (MDRPU) and moisture associated skin damage (MASD). DTI and MDRPU incidents had already been included within our existing reporting procedure and so are reflected in the incident report for 2018/19, but MASD incidents are recorded separately and do not form part of the monthly incident report.

Education/training

The SaIINTS link group, which is a collaboration of four link groups, continues but as a closed Facebook group. We decided to move to this model of training due to the low numbers of staff able to leave the wards to attend face to face meetings. New information, study days and guidance are shared on the forum. In addition the following training is being provided:

- Mandatory training – From December 2018, the Tissue Viability Nurses recommenced delivering pressure ulcer prevention training as part of mandatory training. Due to the increase in the number of incidents, a booklet based on the new guidance was developed and disseminated to all nursing staff (registered/non-registered). Throughout 2019, 29 sessions have been booked to take place;
- Induction – 12 sessions per year. Booklets are also disseminated at these sessions;
- Preceptorship;
- Nursing auxiliary training – monthly;
- Student nurses' induction;
- Ward-focused training – this has reduced greatly due to the direct patient workload within the Tissue Viability team;
- Bespoke placements for students and Trust staff.

Expert Leadership

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

- Collection of Safety Thermometer data on a monthly basis by the audit team and validated by one of the Tissue Viability Nurses;
- Weekly reporting of HAPU data to the Board by the Chief Nurse;
- Providing a daily ward presence – Tissue Viability Nurses and Matrons;
- Authorisation process for the use of Nimbus 3 mattresses;
- Evaluation of prevention equipment – a Total Bed Management steering group is in progress to aid implementation of new beds and mattresses;
- Provision of a Dressings' formulary – appropriate dressings/ creams in ward stock for prevention/ management of skin damage/ wounds (including pressure ulcers). The leads for Tissue Viability and Procurement from our Trust are working with those from the Norfolk & Norwich University Hospital NHS Foundation Trust and James Paget University Hospital NHS Foundation Trust and with the NHS Supply Chain in order to make savings across the Sustainability and Transformation Partnership (STP).

Avoidable v Unavoidable pressure ulcers

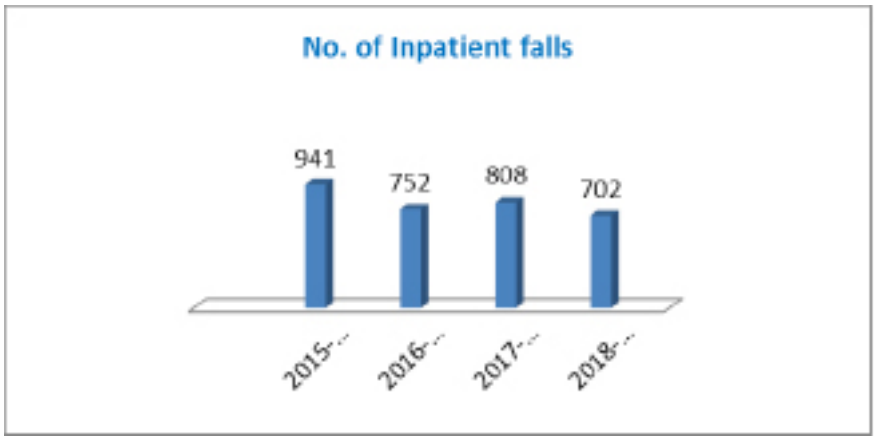
Following the new NHSI 2018 guidance, the terms avoidable/unavoidable are no longer used to describe pressure ulcers and instead the focus during the investigations is on identifying good practice and learning:

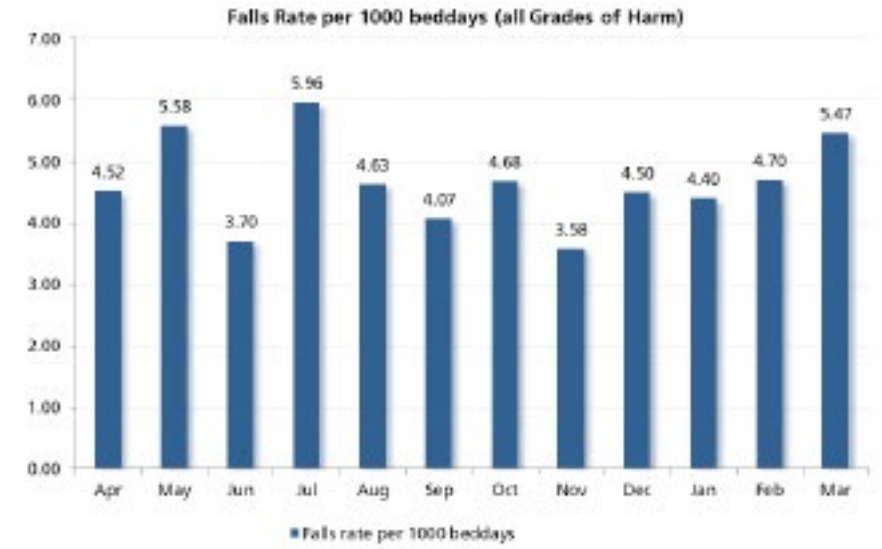
- All category 2-4, unstageable and DTI (including MDRPU) hospital-acquired pressure ulcers are reported via Datix;
- The Tissue Viability Nurse sees the patient within 48 hours following a reported incident to assess and complete the review using the ASKINS criteria. This is sent to the appropriate ward manager/matron and the Risk & Governance department. The document is also uploaded to Datix;
- For category 3 and above, the Tissue Viability Nurses then request a full Root Cause Analysis (RCA) from the ward manager, which includes an action plan for learning. If 'new' learning is identified, the RCA will be reported on STEIS (the national Strategic Executive Information System) and the RCA shared with the Clinical Commissioning Group;
- The general themes and identified learning highlighted in investigations suggests that the main issues involved in the development of hospital-acquired pressure ulcers continues to be:
  – Inaccurate risk assessment leading to inappropriate use of equipment.
  – Lack of documented evidence regarding regular repositioning.

Extra focus has been directed at these issues during training sessions.

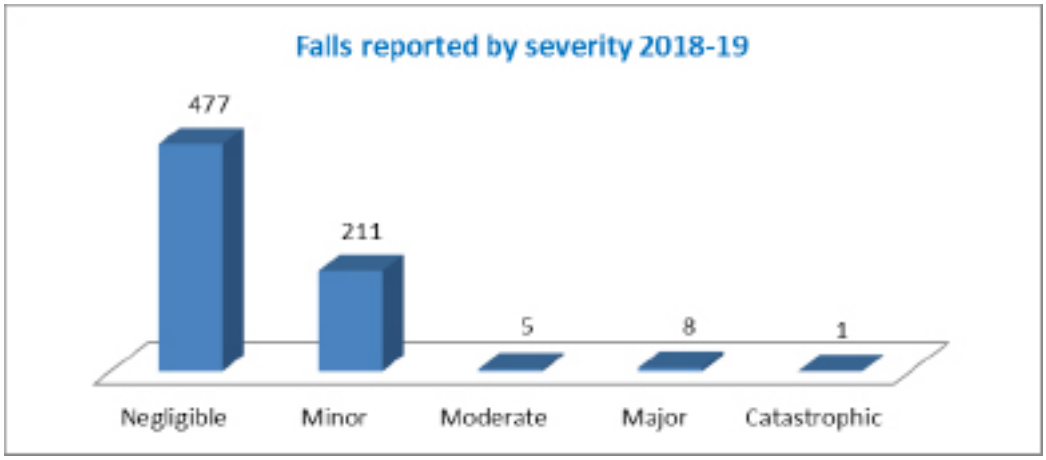
3.1.4 Reducing the number of patients experiencing harm as a result of a fall in hospital

The Trust has continued to monitor its performance against an agreed benchmark which we set in 2015, committing us to a falls rate per 1000 beds days of <5 for all adult inpatients. This target was met in nine of the last 12 months with an overall downward trajectory in the number of adult inpatient falls recorded compared with the previous year. Last year we saw the lowest falls rate in a 12 month period for four years:





However, alongside this welcome reduction in inpatient falls the Trust saw an increase in falls that resulted in moderate or catastrophic harm in 2018/19; with a number of these incidents occurring in the last quarter of the year:



We have continued to robustly review and investigate falls that result in harm, benchmarking ourselves against similar organisations.

The focus for falls prevention and management in the Trust is to minimise patient falls, drive improvements in safety and quality and always strive for a positive patient experience. We actively promote a safe care environment, where patients are protected from avoidable harm.

Prevention and risk management

We attribute much of the success in reducing the overall fall rate to the introduction of the post of Falls Co-ordinator. This is a substantive post introduced to the Trust in 2016. The Falls Co-ordinator is supported by the Lead Nurse for Older People and has led and driven a number of falls work streams in which we have robustly reviewed many elements of care to ensure that we fully recognise and address all aspects of falls' prevention and management across the organisation. In the last 12 months this has included:

- A further review of the falls' prevention care plan, which is used with individual patients, has been tailored to take account of learning from incidents and to continue to strengthen holistic patient assessment using a multifactorial approach;
- A strengthening of the incident reporting pathway to ensure we fully validate the falls data captured so that we are able to completely understand our current position, have a concise understanding of the incident concerned and the information to support further investigation. Lastly, so that we can gain insight into the issues that should be included in further workforce development programmes on falls' prevention and management;
- A strengthening of the use of assistive technology across the Trust. These devices in conjunction with a robust care plan and risk assessment to support individualised plans of care that promote independence but maximise patient safety.

As in the previous year, we held a further Falls summit this year, which was open to all staff and was supported by a range of expert clinician speakers covering a range of falls-related topics. We plan to hold a further summit in the autumn of 2019.

Education/training

A substantial element of work this year has focused on raising awareness and training in falls prevention and ensuring that the steps to mitigate risk in the clinical area are successfully implemented. This has been through mandatory and bespoke training sessions for all staff.

A continued focus has also been on recognising the intrinsic link in some patients between falls prevention and the need for a higher level of supervision and support due to the patient being at risk of harming themselves or others. This work has led to a strengthened assessment and documentation process allowing for a greater level of mitigation to be undertaken. We have also sought advice and support from other providers and visited another trust to understand how they approach this element of patient care and safety.

Much work has been undertaken and will continue this year in conjunction with the manual handling team, in developing new systems of work to support staff to provide safe care to patients who have fallen, with suspected harm. This work stream will see new manual handling equipment introduced to clinical areas in 2019.

We have begun to join work streams with the newly appointed Osteoporosis Specialist Nurse in the Trust, exploring ways to identify at risk patients, developing pathways to access the on-site Dexa scanner, exploring preventative prescribing for patients and working with our community partners to promote integrated working and seamless pathways of care.

The Trust also committed in January of this year to join a 12 month national falls' audit programme (NAIF) which focuses on adult inpatient falls that result in harm. It is anticipated that this audit will offer an additional body of evidence and may give us a greater understanding of why patients fall in hospital and provide an opportunity to strengthen our safeguards in preventing unintended and unexpected harm.

Expert Leadership

The Falls Co-ordinator has been developing a group of ward based clinical staff to be 'falls champions' and has already delivered a number of additional training sessions for this group. Falls champions are identified key workers in their clinical areas that have received a higher level of training and development in falls prevention and management and can therefore provide immediate ward level support, guidance and resources to staff and patients.

Key issues and priorities for improvement

In the next 12 months we will be focusing on work streams that complete the composite review of the post-fall protocols and the development of new working practices for patients who fall with suspected harm. We will be looking to undertake a peer review with another trust in the Eastern Region, which will provide both trusts with an external review of their falls service and provide assurance on our current strategy. We also plan to further explore the period immediately after a person has fallen, looking to potentially adopt elements of the 'swarm'

multi-disciplinary team approach to falls prevention. The essential 'falls champion' role will be further strengthened with additional training and development for champions.

3.2 Listening To Patients

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

Patient and public involvement is integral to how the hospital plans and improves its services. In 2018/ 19 the Trust actively engaged with patients, their carers and members of the public so that they could contribute to improving the quality of services that we provide.

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

- Acting on comments and feedback received as part of the Friends and Family test;
- Using learning from compliments, complaints, national surveys and online comments and feedback to enhance the quality of the services we offer our patients;
- Ensuring that our environment is appropriate for clinical care and a positive patient experience.

Measuring and reporting patient experience

We sought to capture patient and carer experience through a number of different methods including:

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

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

Friends and Family Test (FFT)

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

Hosting events

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

The Hospital also held a week of activities in May 2018 to support Dementia Awareness Week, welcoming members of the public and staff to enjoy different activities including a sing-a-long, bingo and craft workshops. A cake sale raised funds to support activities for our patients on West Newton Ward. Mental Health Awareness Day was celebrated in the hospital front entrance with a virtual cycle tour of the North Norfolk Coast to promote the benefits of exercise and raise funds for West Norfolk Mind. Local organisations supporting mental health had stands to share

information and promote well-being including Lynn Sport, West Norfolk Befrienders, West Norfolk Carers, Change Grow Live (alcohol and drug dependency voluntary provider) as well as organisations to support our staff including Occupational Health and our Chaplaincy team.

In addition, we host a number of 'cafés' every week including a twice weekly café run by West Norfolk Carers and another run by King's Lynn and West Norfolk Borough Council's Careline, which offers advice about housing, benefits and information available via the Ask Lily website and advice line. West Norfolk Carers also take their 'Carers' Cafés' to the patients and carers on West Newton Ward and West Raynham Ward to support carers who wouldn't normally enter the hospital via the front entrance nor be aware of the availability of this support – these are available twice monthly on each ward with referrals available outside these times.

Public and Partnership engagement

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

Our Governors also attended meetings organised by other statutory bodies to understand how changes in the NHS are likely to affect our patients, to raise concerns and learn more about the processes. These meetings have included NHS Providers East Yorkshire/East of England Governors' Regional Workshop, Norfolk and Waveney STP event for Chairs, Lay Members, Governors and Non-Executive Directors, Healthwatch Norfolk STP Meeting.

Two of our Governors attended (and presented at) a recent Hospital Catering Association 'Enhancing the Dining Experience' meeting to review and improve how and what food is provided to our patients.

Governor members of the Patient Experience Committee have also undertaken a wide range of other supportive activities throughout 2018/19 including:

- Panel members for Nurse Interviews;
- Involvement in Mock CQC Inspections;
- Involvement in PLACE (Patient-Led Assessments of the Environment) Inspection and additional ward and department inspections;
- Liaison with Matrons and Leads across all specialties / wards;
- Attendance at various Trust Committee meetings;

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

- Development of relationships with South East Lincolnshire Patient Participation Groups;
- North Cambridgeshire Hospital engagement
- Community Engagement Forums ;
- Surgery Healthcare 'roadshows'
- CQC governors interviews;
- QEH Healthcare Events; and
- Surveys

Patient Stories at Board Meetings

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

- The experience of a patient being cared for in A&E, Addenbrookes and West Raynham Ward following a haemorrhagic stroke;

- A presentation from the Chair of Downham Dementia Support Association which consisted of three vignettes of different hospital experiences of patients with dementia and those who care for them;
- A patient's experience of bowel cancer surgery whilst caring for and supporting her husband with Alzheimer's disease and hearing loss;
- Feedback from the children of an elderly lady with vascular dementia who experienced a number of ward moves during her hospital stay which led to disorientation of the patient, delirium and poor continuity of care between teams;
- Positive feedback from a patient who received care within the Breast Care service and noted excellent team work, empathy and compassion.

National Patient Surveys

During April 2018 to March 2019 we took part in the following National Patient Surveys:

- National Adult Inpatients Survey 2018 – results to be published later in 2019 (preliminary feedback received from contractor February 2019);
- National Cancer Patients Experience Survey 2018 – results to be published later in 2019;
- National Maternity Survey 2019 – results to be published later in 2019;
- National Children and Young Persons Survey 2018 – publication to be confirmed;
- National Urgent and Emergency Care Survey 2018 – results to be published later in 2019.

There were three surveys published between April 2018 and March 2019 relating to the experience of patients during 2017 – National Cancer Survey (2017), National Maternity Survey (2017) and National Inpatient Survey (2017).

There were a number of positive aspects reported in the National Cancer Survey. These included two questions which were scored (positively) outside the expected range – patient involvement in decisions about care and treatment and receiving understandable answers to important questions from the Clinical Nurse Specialists. The Trust also witnessed significant improvement over three years in relation to the confidence and trust in all ward nurses. Two areas relating to privacy and dignity highlighted in the 2016 survey showed improvement and are now in line with national averages. One area requires significant improvement and this relates to communication to the patient about the effectiveness of radiotherapy treatment.

The National Maternity Survey (2017) highlighted some key improvements made over the previous 12 months in relation to the experience of patients. There were two areas in which the Trust performed significantly better than others: those patients needing to attend during labour and birth were able to get a member of staff to help for a reasonable time during labour and birth and mothers were treated with dignity and respect. Being treated with dignity and respect is the most important aspect of the birth experience for mothers and 100% of our mothers told us that they were.

The National Inpatient Survey (2017) highlighted a less positive experience for patients, although privacy in the A&E was significantly better than other Trusts. Other areas where the Trust performed well relate to privacy on the ward, mixed sex accommodation, hospital food (both quality and choice) and having enough support from health and social care professionals at discharge. There were a number of areas in which the Trust was significantly worse than other Trusts, most notably in relation to noise at night and discharge arrangements.

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

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

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

- Patient placemats continue to be rolled out to all inpatient and day case wards to provide patients with information essential to their stay;
- Carer's Cards are being rolled out across the Trust to support those unpaid carers who provide emotional and personal support to patients, especially those with dementia, delirium and learning disabilities;
- Provision of vending machines, a water fountain, magazines and better access to a television to improve the waiting area experience for patients in the A&E;
- Surgical wards have been given access to the theatre management system so that patients can be kept better informed about the status of their surgical procedure;
- The availability of medication to the wards and the Discharge Lounge has been facilitated by the recruitment of volunteers to act as Pharmacy runners to work specifically to deliver medication from the Pharmacy to different areas of the hospital;
- Patients highlighted that whilst waiting for surgery, particularly when it is very hot and they are nil by mouth, it is very uncomfortable. The Anaesthetists have reiterated the message that patients can have 50ml of water per hour whilst waiting for surgery (unless otherwise advised);
- Improvements have been made to the continuity of care for maternity patients through the development of a specialist pathway to ensure that patients see the same team of obstetricians;
- Unpaid family carers can now stay with their loved one overnight as the Trust has purchased six foldaway beds. This supports patients and carers to normalise the hospital experience especially if the patient has a learning disability, dementia or is particularly worried about their hospital stay;
- Patients at risk of falls are not moved between wards after 10pm and not placed into a side room (to ensure full oversight);
- As part of improvements to the discharge process on Castleacre ward (postnatal care), group bath and bottle feeding demonstrations have been implemented;
- Improvements have been made to ensure the smooth management of prescriptions within the Pharmacy department and to meet the expectations of both staff and patients by processing prescriptions in order of arrival;
- Access to support on West Newton and West Raynham wards has been improved through the introduction of twice monthly 'Carer's Cafés' on the wards by West Norfolk Carers.

Communicating learning locally within wards and departments

- Wards and departments receive a monthly ward poster detailing number of surveys completed, likelihood to recommend and a selection of comments made by patients;
- All room for improvement comments are returned to area leads for action and support provided to make changes if required;
- A monthly report from our FFT Service Provider is made available electronically to senior staff across the Trust;
- All NHS website / Patient Opinion comments and the response we have made are distributed to lead staff in the areas concerned;
- Whole hospital improvements are promoted via a range of posters (learning and improving boards) and information screens across the Trust;
- Improvements are discussed at sessions for clinical staff in mandatory training and through development courses;
- Quality Meetings involving ward managers and matrons and led by an Associate Chief Nurse are held to provide a forum for sharing learning;
- Actions taken in response to patient feedback is shared across the Trust to other areas experiencing similar problems;
- Governors and the Public and Patient Experience Lead have been involved in recent ward assurance and mock CQC inspections which has resulted in shared learning across wards to improve both staff and patient experience.

PLACE (Patient-Led Assessments of the Care Environment) inspections

The annual PLACE report was published in August 2018. The report followed a two day inspection visit involving ten wards, four outpatient areas, the A&E, communal areas within the Trust and the environment outside the hospital building. The report focused on a range of issues from the patient's perspective and involved an inspection team comprising Trust staff, plus external inspectors from the Governing Body and Healthwatch. The inspection criteria and the areas inspected had changed from 2017 so comparisons with previous findings were difficult. However, the overall picture suggested a lower level of compliance with this year's inspection criteria and the scores within each parameter were lower than the national average:

	Cleaning	Food score	Privacy, dignity & well-being	Condition, appearance & maintenance	Dementia	Disability
QEH	97.53%	83.05%	67.86%	87.22%	70.14%	71.51%
National average	98.5%	90.2%	84.2%	94.3%	78.9%	84.3%

Action has been taken to address some of these shortfalls including improving signage within the wards and re-arranging seating in waiting areas. Trust-wide issues will be incorporated into the Trust's overall improvement plans.

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

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

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

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

Key Issues	Lessons Identified	Actions
Patients felt they were not listened to during labour and were not provided with appropriate support.	Women should be listened to during labour and their concerns addressed promptly.	Ward Manager of the midwifery-led birthing unit arranged a teaching event for midwives at which the main subject was the latent phase of labour and how to prepare women for this time and ensure effective communication.
Patients and their relatives felt they were not fully informed regarding discharge arrangements.	Discharge arrangements to be discussed and clearly communicated with patients and families and ensure that they understand the plans made for when the patient is due to leave the hospital.	The wards involved now have a Multi-Disciplinary Team (MDT) meeting each day to evaluate the status of each patient from the perspective of all the parties involved, before any decision about discharge is shared with the patients. The effectiveness of this will be determined in the coming months. Discharge planning training is ongoing Trust-wide.

Key Issues	Lessons Identified	Actions
Patients delayed at time of discharge whilst awaiting medication to take home.	To continue improvements to streamline and speed up the discharge process for patients and to improve patient flow.	Improvements to discharge process are on-going including the use of the Pharmacy robot to streamline and quicken the process and the provision of 'Pharmacy runners' to take medication to the wards.
Patients are not advised of waiting time to be seen by Clinical Psychology or advised where to access support in the meantime.	To ensure that patients referred to the Clinical Psychology team from other organisations are informed of waiting times.	Clinical Psychology Department is working with stakeholders to provide a website for patients to be referred to on how to access self-help resources while they are waiting for their appointment and so ensure they are provided with support and reassurance.
Delay in provision of care for patients requiring 1:1 support.	Ensure appropriate support available for patients requiring 1:1 care.	As an organisation, we recognised that there is a greater need for this enhanced role and as from 24 September 2018, there is now an enhanced care team to help support ward teams in the care of patients requiring 1:1 care.

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

Sometimes patients and carers speak with the Patient Advice and Liaison Service (PALS) to raise suggestions rather than complaints. These suggestions vary and have included ways to improve the car park and the automated reminder service for appointments and posters in ward areas to identify what each colour uniform means to assist patient and visitors in identifying staff.

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

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

Estates 2019/20

The Trust has continued to invest in the Estate in working to improve the overall patient experience with the following projects:

- Modifications to the heating mains pipework to significantly reduce heating costs and the Trust's carbon footprint;
- Upgrades of lighting to highly efficient LED lighting;
- Refurbishment of hospital wards in supporting the Deep Cleaning programme;
- Completion of car parking improvements to create 117 additional spaces to relieve site congestion;
- Upgrading and improving fire detection and compartmentation;
- Commencement of a five-year rolling programme to replace and upgrade the roof and upgrade 10 wards;
- Upgrades to external footpaths.

In the new financial year of 2019/20 we are looking at undertaking the following improvement initiatives:

- Progressing refurbishment of the hospital roof;
- Refurbishment of hospital street corridors and toilet facilities;
- Upgrade to Theatre ventilation systems;
- Replacement of Autoclaves in the Sterile Services Department;
- Upgrading the electrical infrastructure to the Main Kitchen;
- Further upgrades of lighting to highly efficient LED lighting;
- Investing in our communities with the appointment of apprentices to the trades' staff teams;
- Further developing the Trust's sustainability agenda, through investment in carbon management and staff development opportunities.

3.3 Supporting our staff

Our aim is to deliver high quality patient care provided by a workforce that is not only highly skilled and competent, but one that is engaged and feels valued by the organisation. Patient experience is often mirrored in the experience of staff, so it is vital that staff feel supported and valued in their roles.

We want to be an employer of choice, attracting and retaining quality staff and at the same time ensuring that we support and develop their individual potential to create a sustainable workforce that is flexible, engaged with new developments and able to meet the challenges of the changing healthcare environment of the future. We are developing a 'people strategy' to ensure we have the right staff with the right skills in the right place at the right time.

Staff Development

The Trust is embarking on a journey in which it will support and develop new roles and individualised career pathways. This will include increasing engagement with a range of schools, colleges and the local community and services to offer pre-employment and volunteering opportunities to attract a diverse workforce from the local community.

The new roles will seek to ensure that the Trust is able to attract individuals to hard-to-recruit-to posts and in conjunction with focused recruitment plans, will contribute to the planned reduction in agency spend.

The 'Talent for Care' programme supports the workforce to grow and develop the skills needed to excel in service delivery. The Trust offers a substantial range of learning routes including pre-employment, volunteering, apprenticeships and student placements leading to pre-professional and professional careers in all clinical and non-clinical areas of the Trust. The Trust is developing its staff through offering supported learning and professional development opportunities. In addition, flexible routes are being developed for other professions such as Nursing, Occupational Therapy and Physiotherapy. A leadership development programme will be established for all leaders in the organisation, including a bespoke Board Development programme. The Trust will be developing a new talent map to support its succession plans to determine the relevant leadership development required.

In terms of medical education, the Trust works with Health Education England (HEE), the Postgraduate Deanery, the Medical Director, Norwich Medical School and The University of East Anglia (UEA) to ensure that medical education at postgraduate and undergraduate level delivers high quality training and education, resulting in positive experiences and feedback. The Trust will continue to develop and explore how new roles and new ways of working will support the delivery of the Trust's strategy and ensure safe levels of staffing. This includes developing Physician Associates, Nurse Specialists, Assistant Practitioners and Nurse Associate roles. The Trust's aim is to cover not only ongoing hard to fill vacancies, but also to prepare for any future shortages through introducing new ways of working and the introduction of new posts.

The Trust continues to work in strong partnership with HEE, UEA and other universities to support and lead the educational development of nursing, midwifery and allied health professional students to offer quality clinical learning. The Education and Practice Development Team work closely across all disciplines, to increase inter-professional learning and development opportunities.

The Trust will work with partner organisations to secure the benefits from national and regional systems and continue to develop electronic systems to support more streamlined working, aiming to reduce manual paper processes. The Trust is developing a culture in which the Trust can transform its services and meet the wider health and social care agenda in the Sustainability Transformation Plans by equipping managers with strong transformational leadership skills to positively engage staff in service changes, development and delivery both internally and across the system.

Lifelong learning is a partnership programme between the Trust and our recognised trade unions. It aims to give staff learning opportunities to help with confidence and encourage access to personal development. The opportunities do not necessarily relate to work, with classes including well-being activities such as pilates, yoga, dancing and sewing, as well as continuing support for dementia awareness, mindfulness and mental health first aid.

Trust Values

Our staff, patients and parents have developed a set of values, 'Better Together @ Team QEH'. These are the values that should characterise all that we do, and our behaviours with our patients and families and each other. Our values are that we:

- Act Well;
- Listen Well;
- Care Well.

These values are extremely important to us and we expect everyone who works at the Trust in any capacity, including employees, bank staff, contractors, agency staff, people who hold honorary contracts, students and volunteers, will share and uphold our values. Each value is underpinned by behavioural standards and employees are expected to display these behaviours at all times.

The Trust also expects that everyone who works at the Trust shall act in such a manner as to justify public trust and confidence and to uphold and enhance the good standing and reputation of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust. Individuals must at all times carry out their duties with due regard to the Trust's Equality at Work Policy.

Our values define who we are. They encompass what we believe and how we will work together to achieve our objectives.

Recognition Awards

We believe that it is important for members of TeamQEH to be recognised when they go above and beyond their duties and so in February 2019 the Trust launched 'Living Our Values' awards. In addition, the Trust has also developed a Team of the Week award.

Staff Engagement

The Trust recognises that by developing an engaged, enabled and empowered workforce, which is well-led and supported, the Trust can ensure its staff benefit from a positive work experience and would recommend the Trust as a place to work and receive care. Staff engagement is one of the top three priorities for the Trust to concentrate on improving in 2019 and beyond. The Trust's pledge to do so is encouraging staff to be committed to their organisation's goals and values, motivated to contribute to organisational success and will enhance their own sense of job satisfaction.

The Trust is an active participant in the NHS Improvement Change Programme and is currently undertaking the Phase 1 diagnostic part of this work to improve the culture of the Trust and increase staff engagement.

Staff engagement is supported by a comprehensive internal communications programme which includes a weekly electronic round-up of current news, the publication of a relaunched staff magazine called 'In The Know' and a 'Better Together' fortnightly blog from the Chief Executive.

The Trust has developed a 'Listening Forum' with the Chief Executive and Chairman of the Trust which is open to all staff for them to provide feedback on the key issues and to have the opportunity to ask any questions of the Chief Executive and Chairman.

Staff are kept up-to-date on a range of performance and finance issues affecting our Trust through both the integrated performance report which is shared with staff and also through regular email correspondence on the key issues. Where there are issues affecting particular staff groups, including service changes, we will consult with staff and hold regular meetings with those staff groups and staff-side representatives, as appropriate.

Staff Survey

The Staff Opinion Survey provides an opportunity for staff to provide feedback on their experience of working in our Trust and provides evidence of where things are going well and where there are potential areas for improvement.

Staff participation with the NHS staff survey is not compulsory, although staff are strongly encouraged to use the opportunity to give their opinions and views about the organisation in which they work.

The following key areas are included in the staff survey questionnaire:

- Staff engagement and involvement including job satisfaction;
- Leadership and management;
- Equality and Diversity;
- Appraisal and support for development;
- Raising Concerns;
- Errors and Incidents ;
- Staff Health and Well-being;
- Working patterns;
- Patient care and experience;
- Violence, harassment and bullying.

The response rate to the survey was 44%, which was 2% lower than in the previous year. The following table highlights the top and bottom five ranking scores.

Top Five Ranking Scores	Score	Bottom Five Ranking Scores	Score
Staff reported errors and near misses	93%	Staff state that communication between senior management and staff is ineffective	49%
Staff know how to report errors and near misses	94%	Staff state senior managers do not include staff in making important decisions	52%
Staff reported that user experience is collated	91%	Staff state that the Trust acts on concerns raised by service users / patients	58%
Staff feel trusted to do their role	91%	Staff state that the Trust acts on concerns raised by service users / patients	43%
Staff have had an appraisal	7.7	Staff feel the organisation does not value their work	33%

The table below presents the results of significance testing conducted on this year's theme scores and those from last year. It details the organisation's theme scores for both years and the numbers of responses each of these are based on and whether there has been a change between the two years results:

Theme	2016 Scores	2016 Benchmark	2017 Scores	2017 Benchmark	2018 Scores	2018 Benchmark
Equality, Diversity and Inclusion	9.0	9.2	8.9	9.1	8.7	9.1
Health and Well-being	6.1	6.1	6.0	6.0	5.7	5.9
Immediate managers	6.5	6.7	6.5	6.7	6.4	6.7
Morale					5.7	6.1
Quality of Appraisal	4.9	5.3	4.9	5.3	4.8	5.4
Quality of Care	7.7	7.6	7.5	7.5	7.1	7.4
Safe Environment – Bullying and Harassment	7.8	8.0	7.7	8.0	7.6	7.9
Safe environment – Violence	9.2	9.4	9.2	9.4	9.2	9.4
Safety Culture	6.5	6.6	6.4	6.6	6.0	6.6
Staff Engagement	7.0	7.0	6.9	7.0	6.5	7.0

A Trust-wide action plan has been developed to address the areas of concern within the staff survey which includes the following key actions:

- Implementing Trust wide 'ask and act'IPOC sessions;
- Introducing staff recognition awards;
- Developing a leadership development plan for the organisation which includes leadership skills, behaviours framework, underpinned by leadership training needs analysis and NHSi cultural diagnostic work;
- All leaders will undergo a 360˚ appraisal within the next 12 months;
- Improved staff engagement;
- Roll out of #bettertogether@teamQEH;
- Providing opportunities for managers to feedback;
- Audit of quality of appraisals.

In addition to the Trust-wide action plan, all the Divisional Triumvirates and Corporate leads have been asked to identify their top five areas that they intend to focus on. As a result, a structured and deliverable programme of work and action plan will be developed by 1 May 2019 that will address the results of the staff survey at both Trust-wide and Divisional/ Corporate level. The performance action plan will be monitored through the Trust performance review process and the Workforce Committee will receive quarterly updates on progress against this action plan.

Staff Friends and Family Test (SFFT)

The Trust is committed to improving the engagement of staff with the Staff Friends and Family Test, as it provides a valuable marker of how staff feel about their own role in the organisation and the quality of the service they are providing to patients. The SFFT comprises two key questions with an option to provide additional comment:

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

Analysis of staff feedback from SFFT and other routes suggests a need to strengthen staff engagement and support and developments are already in place with further actions planned for the coming year:

- Open discussion sessions with the Chief Executive;
- #bettertogether weekly blog by the Chief Executive;
- Schwartz rounds to provide support and an opportunity to discuss concerns;
- Behavioural framework to emphasise to all what are acceptable and expected behaviours within the work environment;
- Opportunities for life-long learning;
- 'Who can I tell' and 'Ask & Act' sessions;
- Reward and recognition awards.

The Trust will continue to focus in 2019/20 on improving participation in the Staff Friends and Family Test and most importantly on engaging with staff to ensure they feel able to recommend the Trust to others in terms of the service that they provide and as a place to work.

3.3.1 Addressing Rota Gaps

Medical Staffing

The Medical Staffing Team assumed responsibility for permanent Medical Recruitment in May 2018 and in October 2018 took on the Medical Locum recruitment with a new member of staff joining the team. In May 2018 the vacancy rate for Medical Staff was 20.3%, but by March 2019 the vacancy rate has improved and is now 5.42%. In March 2018 we looked to innovatively fill the number of junior doctor vacancies in Division 2 and we advertised for QEH Fellows. The aim was to try to recruit doctors for these gaps and we hoped to be able to rotate them through the Division. We have recruited 35 QEH Fellows in Medicine and now have two in Division 1. We have developed a tailored 'on boarding programme' and provide these doctors with an e-portfolio, an appraiser and access to training. The Medical Staffing team initially advertised nationally and worked with a recruitment agency to source these doctors, but as recruitment has progressed the Fellows themselves are recommending the Trust as a place to work and we are now able to fill all posts either by advertising or through personal recommendation.

Rota gaps

Short term rota gaps are filled by the QEH Fellows, whereas immediate gaps caused by sickness etc. are posted on Locum's Nest, an App based system which posts vacancies to any doctor who has signed up to the system. Where this is not successful, bank or agency doctors are used. We currently do not have a system to monitor the number of unfilled shifts but work is in progress to introduce a system which will give this management information to the team.

3.3.2 Freedom to Speak Up

The Trust Board of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust commits to the further development of its patient safety culture so that people who have concerns about patient safety know how to 'speak up', and where:

- People feel confident to speak up;
- People feel safe to speak up;
- Concerns are investigated;
- Speaking up makes a difference;
- Concerns are well-received.

The Trust has both a Whistleblowing policy and a Freedom to Speak Up policy, which in combination, aim to ensure that staff are encouraged and supported in speaking up, particularly over matters of patient care, patient safety or bullying and harassment. The policies also endeavour to ensure that staff do not suffer detriment by speaking up.

Several different ways of whistleblowing or speaking up are outlined and provided by the Trust to enable staff to raise issues, when normal lines of communication are not experienced by staff as working appropriately. Firstly staff can contact the Freedom to Speak Up Guardian directly by phone or email, details of which are widely publicised. Secondly, there is a whistleblowing hotline where staff can leave a message, which will be picked up confidentially by a member of the Communications and Engagement Team. Thirdly, where the emphasis is more on risk and risk management, staff can contact the Risk and Governance team or register their concerns, which could include near misses as well as actual risks, on the Datix system. Fourthly, any matters of safeguarding children or adults can be reported through line management or via any of the above routes as a matter of urgency.

The Freedom to Speak Up Guardian has been appointed by the Trust Board to work independently. In so doing the expectation is that the Freedom to Speak Up Guardian should be readily available to front line staff, provide support and guidance as required, and work in partnership with the management of the hospital.

In 2018/19, 11 cases have been referred to the Freedom to Speak Up Guardian. One has resulted in an external investigation, another in an internal investigation and a third has resulted in an external review. Patient Safety has been the main concern which has been raised by staff and the Freedom to Speak Up Guardian has provided advice and support to staff, particularly those who felt that they had suffered detriment as a result of speaking up.

Open Culture

Speaking Up is not just a matter concerning individual members of staff. The whole culture of the hospital is crucial – an open culture needs to be created, where staff can raise issues, be consulted about issues, and managers listen to and work with staff, especially if concerns are raised.

The Trust has successfully tackled the issue raised by the Care Quality Commission in 2018 in relation to staff awareness about how to speak up – in December 2018, 70% of 151 staff surveyed from a wide cross section of the hospital, knew who the Guardian was and 82% said they knew how to get in touch. Work is now ongoing to raise the quality of leadership and ensure positive responses by managers and senior managers in the hospital to Speaking Up. The Board, through the Workforce Committee, is promoting an action plan on improving the openness of the culture of the hospital through training, workshops and bringing in external examples of best practice.

3.4 Quality priorities for improvement 2019/20

Our Quality Strategy 2018-2021 set out a new three year programme of quality improvement that focused on key quality priorities for improvement supported by an ambitious set of in-year objectives. Those objectives outlined for 2018/19 were only partially delivered in the year and, as they continue to be seen as valuable measures of quality improvement, they will be carried forward as ongoing into 2019/20, but built upon by a further set of objectives that reflect the concerns highlighted by the CQC as outlined in the following tables:

Quality Objectives 2019/20

Objective	Actions	Outcome measure
	Patient Experience	
To improve the experience of patients and families at end of life.	• To identify senior palliative care medical staff to lead improvements in palliative care in the Trust within the next 6 months; • All patients recognised as approaching end of life to have an individualised end of life care plan in place; (IPOC) • Review staff education to include the following topics: - Recognition of End of Life - Nuts & Bolts - Sage & Thyme - Syringe Driver • Review opportunities regarding the most appropriate place and environment for patients at End of Life.	• 40% reduction in complaints and concerns related to end of life; • Evidence of attendance at staff education sessions; • Retrospective audit in quarter 2 of 30 patients who have died in quarter 1 excluding sudden deaths – - >90% care plans in place - Medication administered within 30 mins of reported symptoms - Support for families recorded.
To ensure that discharge arrangements are clearly and timely communicated to the patient and his/her family.	• To review and clearly identify discharge arrangements in patient health record, including that the discharge arrangements have been communicated to patient and/or family; • To develop guidance for junior doctors to be given at induction on best practice in relation to facilitating discharge & ensuring a good experience for the patient and his/her family.	• 10% reduction in comments on Friends & Family feedback about problems with communication on discharge and • 10% reduction in complaints in relation to communication of discharge arrangements.
	Patient Safety	
To reduce avoidable harm by improving the recognition and management of the deteriorating patient.	• Incorporate NEWS 2 training for all new starters during induction and for existing staff within mandatory training; • Introduce new trust-wide transfer/handover SBAR tool by end of July 19; • Implement guide for assessing requirement for a patient escort during transfer in all areas by end of May 19; • Ensure safety huddles are implemented on all wards daily & patients of concern to be highlighted within huddles by end of July 2019; • Audit compliance with NEWS2 & escalation process within 'Perfect ward' by end of Sep 19; • Post 2222 national audit review to be communicated to Divisional ACNs & AMDs from quarter 2; • Implement trust wide the 'Stop the Clock' campaign prior to transfer.	• 50% reduction in incidents related to patient deterioration omissions during transfer between clinical areas; • Trust-wide transfer /handover SBAR tool implemented in all clinical areas; • Patient escort guide implemented; • Compliance with the provision of ward safety huddles to be confirmed by matrons as part of their daily ward checks; • Compliance audit of NEWS2 & escalation process incorporated into 'Perfect ward'; • Post 2222 national audit reviews communicated to Divisional ACNs & AMDs; • Stop the Clock campaign implemented by end of July 19.

Objective	Actions	Outcome measure
	Patient Safety	
To reduce the number of inpatients experiencing a fall resulting in moderate / severe harm.	• All patients to have their risk of falling assessed on admission using a multi-factorial assessment; • Individualised falls care plan which includes requirement for cohorting, supervision, or use of assistive technology if appropriate; • Consistently share information & agreed plan of care on all at risk patients during the ward safety huddles; • Strengthen the 'falls champion' roles in clinical areas with a bespoke training programme; • Falls Summit to be held in autumn 2019; • Peer review to be facilitated in quarter 2 to share learning and provide external assurance on current practice within the Trust; • Take part in national NAIF audit programme to facilitate learning; • Review Post-fall protocol.	• 20% reduction in falls with harm over 2018/19; • Falls Summit delivered in quarter 3; • Post-fall protocol reviewed and implemented in quarter 2; • Report on Peer review to be reviewed by Quality & Performance Committee in quarter 3; • Root cause analyses on all falls with harm will demonstrate that in >90% of incidents the patient will have evidence of a multifactorial assessment, a care plan and evidence of implementation; • Compliance with NAIF audit submission.
	Effectiveness	
To improve responsiveness to complaints within the Clinical Business Units (CBU).	• Review of complaints process to streamline clinical oversight and sign off at Divisional and Corporate level; • Responding to complaints and ensuring learning/ changes to practice within the CBU as a result of complaints to be a key CBU performance indicator for 2019-2020; • Progressive target improvements in response times throughout 2019/20.	• Revised complaints process and agreed sign off to be in place by end of June 2019; • Response rates to improve progressively and to be consistently: - > 50% by end of quarter 2 - > 70% by end of December 2019 - > 80% by end of March 2020 • Progress to be monitored monthly at Hospital Management Board.

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

Part 4: Statements of Assurance from the Board

Review of services

During 2018/19 the Trust provided and/or sub-contracted 45 NHS services. The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust has reviewed all the data available to them on the quality of care in 100% of these NHS services.

The income generated by the relevant health services reviewed in 2018/19 represents 100% of the total income generated from the provision of relevant health services by The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust for 2018/19.

4.1 Participation in Clinical Research

The number of patients in 2018/2019 receiving relevant health services provided or sub-contracted by The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust that were recruited between 1 April 2018 and 31 March 2019 to participate in research approved by a research ethics committee was 1062.

This included 1007 patients recruited to NIHR portfolio studies and 55 patients recruited to non-portfolio studies. In 2018/19 the Trust actively recruited to 47 NIHR portfolio (National Institute for Health Research) and 10 non-portfolio clinical research studies. New departments which are research active this year are the dialysis suite and paediatric injuries and emergencies.

This represents a further increase of more than 10% in recruitment on the previous year and reflects both the result of new approaches championed by the Research Department and the Trust's increased focus and support of improvements in health care and outcomes for patients through encouraging all clinicians, whenever possible, to offer participation in all the research studies that are applicable to our patients. We have embedded research into all aspects of patient care – from the first letters to the patient, which mention research, to our clinical teams providing more in-depth information about the opportunities to participate in innovative and cutting edge research trials.

The Trust's Cancer research team has won the CREST award this year for Cancer Research Excellence in Surgical Techniques, as well as eight awards for cancer research excellence from the NIHR Clinical Research Network.

4.2 Participation in Clinical Audits and National Confidential Enquiries

During the reporting period 2018/19, the Trust engaged in 57 National Clinical Audits and five National Confidential Enquiries covering the relevant health services that The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust provides. During that period The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust participated in 95% of the National Clinical Audits and Patient Outcomes Programme (NCAPOP) and 100% of the National Confidential Enquiries which it was eligible to participate in. In addition, the Trust participated in a further five National Audits (Non-NCAPOP) recommended by Healthcare Quality Improvement Partnership (HQIP).

National Clinical Audits 2018/19

The National Clinical Audits and National Confidential Enquiries that The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust was eligible to participate in and for which data collection was completed during 2018/19 are listed as follows, alongside the percentage of cases submitted as a percentage of the number of registered cases required by the terms of that audit or enquiry:

Audit Title	Participation	% of cases submitted
Acute		
Case Mix Programme - Adult Critical Care (ICNARC) (CMP)	Yes	TBC%
National Emergency Laparotomy Audit (NELA)	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	TBC%
Trauma Audit Research Network (TARN)	Yes	66%
Consultant Sign Off (RCEM)	No	0%
Severe Sepsis and Septic Shock (RCEM)	No	0%
Asthma Care in A&Es (RCEM)	No	0%
SHOT review	Yes	100%
Cancer		
National Bowel Cancer Audit (NBOCAP)	Yes	100%
National Lung Cancer Audit (NCLA)	Yes	100%
National Oesophago-gastric Cancer audit (NOGCA)	Yes	100%

Audit Title	Participation	% of cases submitted
National Oesophago-gastric Cancer audit (NOGCA)	Yes	100%
Prostate Cancer (Urology)	Yes	TBC
Head and Neck Cancer Audit	Service is carried out in tertiary care settings	
CT Head turnaround times	Yes	100%
Cardiology		
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	47%
Cardiac Arrest Audit (NCAA)	Yes	Requested%
Heart Failure	Yes	46%
Diabetes		
National Diabetes Audit	No	Trust software not compatible
National Diabetes Foot Audit	Yes	95%
National Diabetes in Pregnancy (NPID)	Yes	100%
National Diabetes Inpatient Audit (NADIA)	No	0%
Surgery		
Elective surgery (National PROMs Programme)	Yes	100%
National Obstetric Anaesthesia Database (NOAD)	No	0%
Nephrectomy Audit (BAUS)	Yes	100%
Surgical Site Infection (SSI)	Yes	100%
UK Registry of Endocrine and Thyroid Surgery (UKRETS)	Yes	80%
Vascular surgery (VSGBI Vascular Surgery Database)	Service is carried out in tertiary care settings	
Other		
Pain in Children	Yes	Waiting for National report
Fractured Neck of Femur	Yes	TBC%
National Audit for Rheumatoid and Early Inflammatory Arthritis	Audit not collecting data 2018/19	
National Audit of Dementia	Yes	100%
Inflammatory Bowel Disease	No	
National Comparative Audit of Blood Transfusion	Yes	100%
National COPD Audit Programme (BTS): Emergency use of Oxygen	Yes	98%
Adult Asthma (BTS)	No	0%
Procedural Sedation in Adults	Yes	100%
Renal Replacement Therapy	Service is carried out in tertiary care settings	
LeDeR Programme (HQIP)	Unavailable to Trust for 2018/19	

A number of the national audits are rolling audits and the final submission date for data for 2018/19 falls outside the publication date for this report and so affects percentage of cases submitted.

National Confidential Enquiries 2018/19

Audit Title	Participation	Eligible Number	Actual Submissions
Perioperative Diabetes	Yes	8	4 (50%)
Pulmonary Embolism	Yes	4	In progress
Acute Bowel Obstruction	Yes	7	In Progress
Long Term Ventilation	Yes	Waiting for the case numbers	
Cancer in Children Teens and Young Adults	Yes	We had no eligible numbers for this study	

National Audits – Actions and Outcomes

The reports of three national clinical audits that the Trust participated in were published between 1 April 2018 and the 31 March 2019. A brief overview of the national findings are outlined as follows with both national recommendations and where appropriate local findings and follow up actions:

National Lung Cancer Audit (NLCA) – This is an annual audit looking at the outcome for patients diagnosed with lung cancer. The data relate to patients diagnosed with lung cancer who underwent surgical operations during the period between 1 January and 31 December 2016.

National findings:

- The number of annual lung cancer operations has increased with good short-term survival;
- The number of minimally-invasive (VATS - video assisted thoracic surgery) operations has exceeded 50% for the first time. This procedure is associated with lower morbidity, a shorter length of stay in hospital and has a faster recovery time;
- A total of 6,343 resections for lung cancer were reported, an increase of 6.9% on the previous year (5,842 of which were for non-small-cell lung cancer (NSCLC) or carcinoid). Between 2015 and 2018, lung cancer resections have risen by 29.7% from 4,892;
- The majority (93%) of surgery for lung cancer is performed for NSCLC although resection of carcinoid tumours is increasing, from 226 operations in 2014 to 422 in this year's report (2016 data). This is an 87% increase over only 2 years, suggesting a change in the management of these relatively rarer tumours;
- More than 77% of all resections for lung cancer were lobectomy procedures. Only 277 pneumonectomy operations were performed, 4% of overall activity;
- 81% of resections were for stage one or two lung cancer, while 12.9% (819 cases) were for stage IIIA disease. There was no cancer stage recorded for 1.9% (121 cases);
- A total of 98.2% of patients (6,228 of 6,343 resections) were alive 30 days after surgery a comparative figure to that reported in LCCOP 2017.

Recommendations:

There is no formal action plan in place relating to this audit data. Findings and examples of good practice were discussed at the lung cancer specialty meeting and any actions to improve the pathway will be managed through the specialty meetings.

National Bowel Cancer Audit (NBOCA)

NBOCA 2018 looked at care pathways and outcomes of treatment:

National findings:

- Patient referral pathways remain unchanged with the majority of patients referred via their GPs (54%);
- 23% of patients eligible to participate in the National Bowel Cancer Screening Programme (60-74 years old) were referred from screening, but considerable geographical variation (17% to 29%) exists;
- 63% of patients underwent curative treatment, with 93% undergoing major resection and 7% falling in to the 'too little cancer' category;
- 90 day mortality improved for both elective (2.9% ↓ 2.0%) and elective (16.3% ↓ 11.5%);
- Reduction in deaths in hospital from 46.2% (2011) to 34.6% (2016).

Local issues:
- Challenges with local data submissions have been addressed and data submission has risen to 94% of eligible cases. Further work is required to improve data completeness.

Recommendations / Actions:
- Efforts should continue to increase public awareness of the symptoms and signs of bowel cancer so that it is diagnosed earlier;
- Further work should be carried out to better describe and understand the geographical variation in chemotherapy administration and the management of emergency presentations.

Chronic Pain on Inpatient Pain Service (CHIPS) – To identify referral channels and numbers of referrals to acute inpatient pain services for the management of exacerbations of chronic pain, acute post-surgical pain issues for chronic pain and compare with the best practice standards. The Faculty of Pain Medicine core standards for acute pain state that Acute Pain Services (APS) must be able to provide specialist pain management services for complex pain, including acute neuropathic pain, opiate tolerance and acute on chronic pain.

Audit took place over three months from 7 April – 7 June 2018.

National findings are yet to be published.

Local Findings:
- 40 inpatients referred to APS and followed up;
- Referral channels identified - referred from general surgery, orthopaedics, gynaecology, critical care and medicine with medicine being the predominant specialty – 55% of referrals (22/40);
- Primary assessment of pain – only 25% undertaken by a clinician with chronic pain experience;
- Limitations noted – patients excluded over weekends, not all eligible patients referred and patchy APS service during some weeks.

Recommendations / Follow up action:
- Push towards integrated pathways/services;
- Consider developing transitional outpatient pain clinics;
- Training and education for clinicians on pain management;
- Follow up plan to prevent revolving door admissions – GP/pain clinic;
- Improve management of opioid epidemic;
- Consider expanding APS service.

Local Clinical Audit

The reports of 142 local clinical audits were reviewed by the provider in 2018/19. A selection of these audits is outlined below and the Trust has taken, or intends to take, the following actions to improve the quality of healthcare provided:

Care of the Elderly – An audit looking at compliance with delirium screening and cognitive assessment on admission for people aged 65 and above in accordance with local clinical guidelines. People aged 65 and older are at higher risk of developing delirium (NICE clinical guideline 103) so screening for delirium and cognition should be done on admission to ensure early identification and management and so reduce associated morbidity and mortality and length of stay.

Findings:
- Evidence that 5.7% were screened for delirium and 48.2% received an assessment of cognition on admission in clerking documentation;
- Evidence that 4.7% were screened for both delirium and received an assessment of cognition.

F**ollow up action**:
- Share findings with all relevant clinical staff to make them aware of current shortfall in delirium screening and cognitive assessment in people at risk;
- Review of documentation to highlight the requirement to complete these sections on admission;
- Education & training for junior doctors about the use of the 4AT test (rapid easy screening tool for delirium);
- Frequent re-auditing to monitor and maintain good practice.

General surgery – Completion of VTE prophylaxis in general surgical patients. To determine the percentage completion of the VTE assessment sheet and subsections in the general surgery clerking documents and identify if there are discrepancies between this and what is prescribed on the drug chart. Moreover, to identify the proportion of patients on the general surgery wards prescribed thromboembolic stockings who then wore them.

Findings:
- 8/25 clerking documents and 8/25 drug charts had VTE prophylaxis fully completed;
- Key features missing; 60% of VTE risk factors on clerking sheet incomplete and 68% of bleeding risk factors on drug chart incomplete.

Follow up action:
- A presentation on completion of VTE prophylaxis was provided to all junior doctors newly entering the department in July 2018 as part of the induction programme (highlighting the key findings of the audit);
- Modification of the existing general surgery clerking document to include an additional two boxes in the VTE risk factor and bleeding risk factor sections entitled 'No risk factors identified' to improve evaluation of whether an assessment had been completed or not;
- Discussion with nursing staff who administer thromboembolic deterrent stockings (TEDS) to patients as to the reason why some patients do not have TEDS despite having a prescription for them. Look to utilise this information to support obtaining improved documentation of the reason for their omission and to encourage increased compliance in the use of TEDS by patients where a reason for omission is not identified.

Obstetrics & Gynaecology – An audit looking at Induction of Labour – In 2004 and 2005 one in every five deliveries in the UK was induced, this figure included those induced for medical reasons. When labour was induced using pharmacological methods (whether or not surgical induction was also attempted), fewer than two thirds of women gave birth without further intervention, with about 15% having instrumental births and 22% having emergency caesarean sections.

However, according to the HES (Hospital episode statistics), the proportion of deliveries where labour was induced has increased from 20.4 per cent in 2007-08 to 32.6 per cent in 2017-18.

A retrospective audit of inductions of labour was undertaken during July to September 2018 and to compare local data with that from the national HES data. 75 cases were audited.

Findings:
- Local induction of labour rate was 21.5%, which is in line with national trends;
- The majority of indications for induction were appropriate with the top three reasons being reduced fetal movement (19 cases), tailing growth / <10th centile in 16 cases, post-maturity (18 cases);
- Decision-maker was Consultant (49%), Middle-grade (30%) and Midwife (20%);
- 82% received a medical review prior to augmentation with syntocinon (NICE guidance recommends 100%);
- Outcome of labour - Vaginal delivery rate (74%), caesarean section rate 25% (3 category1) and instrumental delivery rate 12%, post-partum haemorrhage rate (9.5%). The caesarean section rate was lower than for those who went into labour spontaneously.

Follow up action:
- A yearly in-depth audit to assess whether standards are being maintained;
- Obstetric review to be done in 100% of the women being started on syntocinon augmentation.

Liaison services – Audit of Mental Health Act detention papers 2017-2018. This audit set out to review the health records of all patients who have been detained under the Mental Health Act 1983 (2007), hereafter described as the Act, at The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust during the period 2017/2018. The aim of the review was to establish if the legal frame work of the Act was followed and clearly documented in the patients' health records and to determine whether the level of compliance with the statutory process has been maintained and/or improved. This information will then be utilised to look at what improvements may be required to improve compliance in the future.

Findings:
The audit demonstrated an improvement on the previous year in terms of the conversion rate of Section 5.2 detentions to Section 2 following a psychiatric assessment, which suggests more appropriate application of the Act and the provision of information to patients on their rights. Some issues remain in relation to copies of documents being appropriately filed within the patient's health record and in the Legal Office and in the process of accessing assessment and treatment, with delays in obtaining a psychiatric assessment and a mental health acute bed when required:

- In 12/13 cases the detention was fully documented;
- 100% of cases had the correct spelling of the patient's name, the hospital name and address on all paperwork;
- 71% of Section 5.2 detentions were converted to Section 2;
- Average time for referral to psychiatric assessment was 19.8 hours;
- Copies not always in the patients' health records but all Section 2 detentions had been notified to the Legal Office;
- 46% of patients were admitted solely for mental health issues (reduction of 16% on 2016/17);
- 54% of patients were known to mental health services so should have been aware of how to access help elsewhere;
- 92% of patients received information on their rights either verbally or in the form of a leaflet (79% in 2016/17) but only 69% of relatives (53% in 2016/17);
- Wait for a mental health bed varied from one to over 11 days.

Follow up action:
- Re-development of audit proforma to better capture completeness of data collection;
- Provide a programme of training for frontline staff on mental illness, the use of the Act and the requirements of the process of detention;
- Training for Site Practitioners in terms of use of the checklists and their responsibility in the process as the designated manager on behalf of the Trust;
- Ensure that patients waiting for mental health beds are treated as delayed discharges and reported to the Clinical Commissioning Group as such;
- Re-audit in 12 months.

Patient Experience/Satisfaction
In addition to the Friends and Family Test feedback cards, specialties have participated in the following four patient experience or patient satisfaction (service evaluation) studies in 2018/19:
- General Surgery – Breast Care service;
- Dermatology – Regional skin cancer pathway;
- General Surgery – Colorectal Outpatient care;
- General Surgery – Stoma Care service;
- General Surgery – Endoscopy service.

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

4.3 Seven Day Hospital Services
NHS Improvement required acute provider trusts to assess their progress in implementing the priority clinical standards for seven day hospital services, utilising the Seven Day Hospital Services Board Assurance Framework. The Framework concentrated on achieving greater than 90% compliance on the four priority clinical standards which focus on ensuring that patients have access seven days a week to:

- Clinical Standard 2 – First consultant review within 14 hours;
- Clinical Standard 5 – Consultant-directed diagnostics;
- Clinical Standard 6 – Consultant-led interventions;
- Clinical Standard 8 – On-going consultant-directed review.

In accordance with requirements the Trust undertook a self-assessment in February 2019 utilising audit data obtained during March/April 2018. Assurance was provided that greater than 90% compliance was achieved for both Clinical Standard 2 and 5 although it was acknowledged that Echocardiography and Magnetic Resonance Imaging are not available at weekends at the Trust.

Clinical Standard 6 was not met as the Trust is not able to offer Interventional Radiology or Cardiac Pacing at the weekend.

Clinical Standard 8 was not met. Overall the Trust achieved 88% compliance but this comprised 92% compliance during the week, dropping to 76% compliance during the weekend. The standard was met in emergency admission areas where there is sufficient consultant presence to support the delivery of twice daily ward rounds for high dependency patients and once daily ward rounds for all other patients.

A further self-assessment will take place in June 2019.

4.4 Commissioning for Quality and Innovation (CQUIN)

A proportion of the income received by The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between The Queen Elizabeth Hospital, King's Lynn, and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework. The monetary total for income in 2019/20 conditional on achieving these quality improvement and innovation goals and the monetary total for the associated payments in 2018/19 are yet to be published:

Acute		Specialist	
2017/18	£3,473,982.00	2017/18	4 (50%)
	£3,101,920.10 (Achieved)		£181,556.00 (Achieved)
2018/19	£3,632,335.00 Available	2018/19	£186,555.00 Available
2019/20	Not Available		Not Available

Further details of the agreed goals for 2019/20 and for the following 12 month period are available electronically at www.qehkl.nhs.uk and included within this document.

4.5 Care Quality Commission

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is 'Inadequate'. The last CQC inspection was in September 2018.

The Trust was formally rated:

Overall Rating for the Trust	Inadequate
Are Services at this Trust safe?	Inadequate
Are Services at this Trust effective?	Requires Improvement
Are Services at this Trust caring?	Good
Are Services at this Trust responsive?	Requires Improvement
Are Services at this Trust well-led	Inadequate

Following the publication of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust's CQC report in September 2018, the Trust was placed in Special Measures by NHS Improvement, with the appointment of an Improvement Director. The inspection report detailed the actions the Trust 'Must' take to comply with its legal obligations and actions it 'Should' take to comply with a minor breach that did not justify regulatory action, to prevent it failing to comply with legal requirements in the future. There were 94 Must and Should actions in total which were aligned to the regulated activity detailed below:

- Regulation 5 HSCA (RA) Regulations 2014 – Fit and proper persons: directors;
- Regulation 12 HSCA (RA) Regulations 2014 – Safe care and treatment;
- Regulation 13 HSCA (RA) Regulations 2014 – Safeguarding service users from abuse and improper treatment;
  Regulation 17 HSCA (RA) Regulations 2014 – Good governance;
- Regulation 18 HSCA (RA) Regulations 2014 – Staffing;
- Regulation 20 HSCA (RA) Regulations 2014 – Duty of Candour.

To support the delivery of the Must and Should actions, a Quality Improvement Programme was established in line with Special Measures reporting and governance arrangements and a Quality Improvement Plan (QIP) developed detailing the actions required to deliver the improvements.

The QIP, was themed and divided into five workstreams, each with its own Executive Lead, accountable for the delivery of the required improvement actions. The Musts and Shoulds were aligned to the respective workstreams and duplicate actions themed.

Quality Improvement Programme (QIP)

Based on the five workstreams, a 'high level' Quality Improvement Plan (QIP) was developed detailing 285 actions. The plan also included the May 2018 Section 29A Warning Notice relating to Maternity Services and the Section 31 Maternity Services Enforcement Notice issued in July 2018. Due to the submission timeframe stipulated by the CQC, the QIP was developed without the wider involvement of Trust staff.

A governance structure was established to support the delivery of the QIP which included a newly formed Quality Programme Board (QPB) in September 2018 chaired by the Chief Executive. Membership included all other Executive Directors and one Non-Executive Director. Once established the QPB met monthly and was an operational group responsible for overseeing, driving and monitoring the delivery of the QIP. The QPB reported monthly to the Trust Board to provide assurance concerning progress and risks to the successful delivery of the QIP and related actions. The QPB was also responsible for agreeing the transfer of items discharged from the QIP process to the Trust's 'Business as Usual' management and governance structure, to ensure associated improvements and learning are embedded, and support the ongoing development and improvement of the Trust on a sustainable basis.

A QIP Evidence Assurance Group was established in January 2019, whose membership included Trust staff, patient and CCG representatives. This group is responsible for reviewing the evidence of proposed completed actions and applying a 'check and challenge' approach to gaining assurance that actions have been effectively completed and there is evidence of sustained improvement.

While the Trust is in 'Special Measures' the QPB also reports monthly to the Oversight and Assurance Group (OAG) represented by external stakeholders and regulators and chaired by NHSI. The first OAG meeting was held on 31st October 2018.

Quality Improvement Plan

To support the delivery of the QIP, an additional resource was secured in November 2018 in the form of three Interim Improvement Project Managers (IPMs) who were aligned to specific workstreams. The IPMs joined the newly appointed Associate Director of Quality Improvement forming a Quality Improvement Team, with three, 18 month substantive appointments being secured during this time to replace the interim IPMS. Their role is to support both the delivery of improvement actions within the QIP and the Trust's longer term development of a quality improvement strategy to generate and support a culture of improvement.

In view of the scale of the QIP, the IPMs have been required to focus on the development of the Quality Improvement Programme, its reporting arrangements with more recently, the start of dedicated support for specific improvement projects.

The CQC carried out an unannounced inspection of Maternity Services in December 2018 to review progress against the Section 31 and Section 29A enforcement notices, publishing its findings in March 2019. The CQC did not rate the service at this time, but identified key areas of early improvement considering the conditions, particularly in relation to leadership, culture and pathways of care. However, the CQC report recognised these early improvements now need to become embedded and sustained.

The Trust received its 2019 re-inspection Provider Information Request in February 2019 and was informed the CQC would be carrying out an announced three day inspection in March 2019 of seven core services plus one additional service.

Core Service Inspection:
- Urgent and Emergency Care;
- Surgery;
- Medicine;
- Maternity;
- End of Life Care;
- Outpatients;
- Children and Young People;
- Gynaecology.

Significant concerns were found during and after the inspection in relation to the following services:
- Urgent and Emergency Care;
- Medicine;
- End of Life Care;
- Gynaecology.

Notice was served under Section 31 of the Health and Social Care Act 2008 on 18 March 2019, imposing eight conditions on the Trust's registration as a service provider.

A warning notice was served under Section 29A of the Health and Social Care Act 2008 on 19 March 2019.

Section 31
A&E – Conditions 1-7
- A lack of risk assessments for patients presenting with mental health concerns;
- A lack of environmental risk assessments in areas where patient with mental health concerns are cared for;
- A lack of process in place to identify and escalate patients at risk of deterioration upon arrival;
- A lack of streaming / triage/ timely clinical assessment of patients throughout the department;
- A lack of exclusion criteria and oversight of several areas to identify, escalate and take action if patients deteriorate;
- Staffing concerns.

Gynaecology – Condition 8
- A backlog of patients waiting for results post treatment / investigation.

At the time of writing this report, immediate improvement actions have been put in place to ensure the consistent safety of patients within the A&E and Gynaecology services, with further improvement actions having been agreed and established with the involvement of the respective teams.

Section 29A
This Warning Notice identified eight areas of concern that require significant improvement:
- Poor standards of documentation and lack of individualised care plan and use of (IPOC); for patients at the end of life;
- Issues with recognition, recording and escalation of deteriorating patients and patients at the end life;
- Inconsistent understanding of MCA/ DoLS by staff;
- Lack of safeguarding process;
- Lack of security in relation to COSHH;
- Lack of dignity and respect from staff to patients;
- Lack of leadership and ownership for EoL care;
- Lack of management oversight and assurance in relation to the risks identified during the inspection.

Following a number of immediate actions put in place, the Trust responded to the CQC regarding the Section 29A by 30 April 2019.

Well-Led Inspection
The CQC carried out the Well-Led element of their inspection between the 9 and 11 April 2019. It is anticipated the Trust will receive a draft copy of the CQC's findings in June 2019.

Review of the Quality Improvement Programme

Following the March 2019 inspection of core services and the subsequent Enforcement Notices, it has been agreed to carry out a full review of the Quality Improvement Plan (QIP) and Quality Improvement Programme. There is a recognition that the plan and programme are too complex and need to be simplified to accurately reflect progress, identify risks and ensure effective delivery of the required improvements. 'Must' and 'Should Do' actions need to be prioritised through a risk assessment process and there is a need to reduce the administration element of the plan to ensure resources are used more effectively in the delivery of the plan.

There is a recognition that staff were not effectively involved in the development of the QIP and this has impacted on ownership and delivery of the required improvements. It is therefore essential that improvement actions and solutions to address concerns identified as part of the 2019 CQC inspection must be developed with, and owned by, our staff.

4.6 Secondary User Services (SUS)

The Trust submitted records throughout 2018/19 to the Secondary User Services for inclusion in the Hospital Episodes Statistics which are included in the latest published data. As of January 2019, SUS data which included the patient's valid NHS number was:

- Inpatient GP practices 100% NHS number 99.8%
- Outpatient GP practices 100% NHS number 99.9%
- Emergency Dept GP practices 100% NHS number 99.2%

4.7 Data Security and Protection Toolkit Assessment Report

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (RCX) Data Security and Protection Toolkit Assessment Report overall score for 2018/19 was 'Standards not met' with an action plan in place to be fully compliant by 31/08/2019.

4.8 Clinical Coding Error Rate

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust was not subject to a Payment by Results (PbR) clinical coding inpatient quality audit during the reporting period by our regulators because audits are now being targeted on trusts with a higher error rate. The Trust completed internal coding audit reviews for evidence for the Information Governance Toolkit. These audits did not reveal any particular areas of concern. However, the results are based on 200 notes for each audit out of 106,832 notes coded each year so the results should not be extrapolated further than the actual sample.

Accuracy	Percentage achieved
Primary diagnoses	93.50%
Secondary diagnoses	90.04%
Primary procedures	90.35%
Secondary procedures	89.61%

4.9 Data Quality

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

- Continue monitoring data quality via SUS submission dashboards;
- Change the data quality forum to meet on a weekly basis to investigate and correct data quality issues in a timelier manner;
- Carry out regular audits on the recording of data across the Trust;
- Use exception reports to highlight areas of potential concern.

4.10 Reporting Against Core Indicators

Indicator	Summary Hospital-Level Mortality Indicator (SHMI) SHMI is a hospital-level indicator which measures whether mortality associated with a stay in hospital was in line with expectations. SHMI is the ratio of observed deaths in a Trust over a period of time divided by the expected number given the characteristics of patients treated by the Trust. SHMI is not an absolute measure of quality but it is a useful indicator to help Trusts understand mortality rates across every service provided during the reporting period. A lower score score indicates better performance.					
The data made available to the Trust by the Information Centre with regard to:	**Reporting period**	**QEHKL score**	**National average**	**Highest score**	**Lowest score**	**Banding**
	Oct 15 – Sep 16	1.0138	1	1.0642	0.9653	2
	Oct 16 – Sep 17	0.9797	1	1.0267	0.9344	2
	Oct 17 – Sep 18	0.9956	1	1.0430	0.9498	2
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust for the reporting period (the palliative care indicator is a contextual indicator)						
	Oct 15 – Sep 16	10.8	NA			
	Oct 16 – Sep 17	11.1	NA			
	Oct 17 – Sep 18	14.3	NA			

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

- The Trust is banded as a '2' which is 'as expected' mortality. This correlates with information gained from local clinical quality meetings.

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

- Recruitment of nursing staff to vacant and new posts and daily monitoring of staffing levels to ensure minimum ratios were achieved across the Trust;
- Continued monitoring and investigations of mortality through the Mortality Surveillance Group;
- Improved pathways for emergency admissions including the Ambulatory Emergency Care unit, GP streamlining 'Hot clinics' and GP referral pathways for advice;
- Further use of the 'care bundles' approach to standardise early treatment of emergency conditions;
- Continued emphasis on routine harm prevention including sustained rates of risk assessment for venous thromboembolism, falls and nutritional status and compliance with routine measures of infection control.

Indicator	Patient reported outcome measures Total Hip Replacement				
The data made available to the Trust by digital.nhs.uk	Reporting score	QEHKL score	National average	Highest score 95%	Lowest score 95%
Total Hip Replacement Oxford Hip Score	2014/15	21.07	21.43	20.30	22.58
	2015/16	21.80	21.60	20.38	22.83
	2016/17	20.08	21.38	20.12	22.64
	2017/18	22.37	22.2	23.51	20.90
	2018/19	NA	NA	NA	NA
Indicator	**Patient reported outcome measures Total Knee Replacement**				
The data made available to the Trust by digital.nhs.uk	Reporting score	QEHKL score	National average	Highest score 95%	Lowest score 95%
Total Knee Replacement Oxford Knee Score	2014/15	16.59	16.11	14.79	17.43
	2015/16	15.11	16.36	15.04	17.69
	2016/17	16.68	16.57	15.01	17.77
	2017/18	16.83	17.10	18.82	15.38
	2018/19	NA	NA	NA	NA

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

- Results are monitored and reviewed as part of the quality schedule agreed with local commissioners;
- NA indicates where numbers are so low statistically analysis cannot be performed;
- Data for varicose vein and groin hernia operations will no longer be available.

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

- The monitoring of PROMs is undertaken within Information Services as well as within the Clinical Business Unit.

Indicator	**Re-admission Rates** The percentage of patients readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.				
The data made available to the Trust by the Information Centre with regard to:	**Reporting score**	**QEHKL score**	**National average**	**Highest score**	**Lowest score**
Percentage of patients aged (i) 0 to 15;	2014/15	10.48%	8.40%	NA	NA
	2015/16	11.70%	NA	NA	NA
	2016/17	10.86%	NA	NA	NA
	2017/18	10.63%	8.90%*	NA	NA
	2018/19	11.77%	9.00%*	NA	NA
And (ii) 16 or Over	2014/15	8.02%	8.00%	NA	NA
	2015/16	7.90%	NA	NA	NA
	2016/17	8.59%	NA	NA	NA
	2017/18	9.24%	8.30%*	NA	NA
	2018/19	8.98%	8.60%*	NA	NA

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

- Re-admission rates are monitored monthly at Divisional and Board level;
- Data is provided from both NHS England and Dr Foster.

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

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

*Based on Dr Foster – 2018/19 National Average only based on period Apr 18 to Jan 19 only as this was the most recent period available on Dr Foster as at mid May 2019.

Indicator	The Trust's score with regard to its responsiveness to the personal needs of its patients during the reporting period. This indicator which is based on data from the National Inpatient Survey, forms part of the NHS Outcome Framework.		
The data made available to the Trust by the Information Centre with regard to the overall patient survey score *2017/18 calculation methodology changed. Results not comparable with previous years. 2016/17 amended to show comparison in ( )	**Reporting period**	**QEHKL score**	**England**
	2014/15	76.4	76.9
	2015/16	77.7	77.3
	2016/17	75.9	76.7 (78.0)
	2017/18	75.5	78.4
	2018/19	NA	NA

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

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

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

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

Indicator	Staff Friends and Family Test				
The data made available to the Trust by the Information Centre with regard to:	**Reporting score**	**QEHKL score**	**National average**	**Highest score**	**Lowest score**
The percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends	2014/15	52	67	89	38
	2015/16	76	79	96	58
	2016/17	72	80	98	44
	2017/18 Q2 Snapshot	74	80	100	43
	2017/18 Q4 Snapshot	68	80	100	36
	2018/19 Q1 Snapshot	67	81	98	53
	2018/19 Q2 Snapshot	62	81	100	39
	2018/19 Q4 Snapshot	62	N/A	N/A	N/A
	2018/19	63.9	N/A	N/A	N/A

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

- Responses to the Trust Staff Friends and Family Test are independently reviewed.

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

- Providing regular open discussion sessions with the Chief Executive to provide an opportunity for staff to be provided information on key matters such as the performance of the Trust and to feedback on their thoughts and comments and to ask questions;
- The Executive team have 'buddy' areas that they visit and ensure opportunities to gain feedback from staff and to answer queries.
- Staff behaviour workshops were held to understand from staff expectations regarding behaviours towards them and their experiences. Following the analysis of feedback from the workshops and other surveys including the Staff FFT a new behavioural framework has been developed that will be launched in May 2018.
- Developing and 'growing our own' staff to fill registered and unregistered nursing roles and continuing with successful international nurse recruitment, further cohorts are planned,
- The development and implementation of Life Long Learning yoga and Pilates classes for staff and promoting other benefits such as the Staff Gym
- Reward and recognition – Monthly Values in Action staff awards, long service awards
- Communication via the 'Friday Round-Up' trust wide staff communication email and the 'Knowledge' weekly magazine to improve communication and ensure that staff are well informed of key issues in the organisation;
- 'Who Can I Tell' sessions held with staff, further sessions planned for May / June 2019;
- 'Ask and Act' sessions in place for staff to attend;
- Schwartz rounds implemented across the Trust on a monthly basis;
- New Chief Executive blog #bettertogether has been launched.

Indicator	Patient Friends and Family Test Accident and Emergency				
The data made available to the Trust by NHS England FFT Data Pages	Reporting Period*	QEHKL Score	National Average	Highest Score	Lowest Score
The percentage of patients during the reporting period who would recommend the Trust to Friends and Family	March 2015	92	87	99	58
	March 2016	90	84	99	49
	March 2017	91	87	100	46
	March 2018	90	84	100	64
	March 2019	91	NA	NA	NA

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

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

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

- Ensuring feedback is available monthly to all senior staff to cascade to colleagues across the Trust;
- Sharing feedback with patients and the public through ward noticeboards, Trust information screens and additionally to staff through regular internal communications methods, including a weekly digital staff magazine;
- Reviewing negative feedback, sharing with colleagues and providing an action plan to resolve issues highlighted by patients if appropriate;
- Monitoring feedback following changes to ensure that impact has been positive by reviewing both positive and negative feedback;
- Sharing actions between areas;
- Triangulating FFT feedback with Complaints, PALS, NHS website, Twitter, Google reviewing national surveys and other forms of feedback, monthly reporting internally and externally to the organisation (to Commissioners);
- Incorporating aspects of the FFT at all patient experience training for staff from induction through to clinical mandatory training sessions;
- Improving learning through the introduction of Learning and Improving boards to every staff clinical area so that improvements can be discussed at handover and the development of a monthly forum to share improvements but also to discuss concerns.

* (annual information not available hence March of each year used as snapshot)

Indicator	Patient Friends and Family Test Inpatients				
The data made available to the Trust by NHS England FFT Data Pages	Reporting Period*	QEHKL Score	National Average	Highest Score	Lowest Score
The percentage of patients during the reporting period who would recommend the Trust to Friends and Family	March 2015	91	95	100	78
	March 2016	95	96	100	72
	March 2017	96	96	100	82
	March 2018	95	96	100	81
	March 2019	96	NA	NA	NA

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

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

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

- Ensuring feedback is available monthly to all senior staff to cascade to colleagues across the Trust;
- Sharing feedback with patients and the public through ward noticeboards, Trust information screens and additionally to staff through regular Trust-wide internal communications methods, including a weekly digital staff magazine;
- Reviewing negative feedback, sharing with colleagues and providing an action plan to resolve issues highlighted by patients if appropriate;
- Monitoring feedback following changes to ensure positive impact has been by reviewing both positive and negative feedback;
- Sharing actions between areas;
- Triangulating FFT feedback with Complaints, PALS, NHS website, Twitter, Google Review, national surveys and other forms of feedback and reporting internally and externally to the organisation (to Commissioners) monthly;
- Incorporating aspects of the FFT at all patient experience training for staff from induction through to clinical mandatory training sessions;
- Introduced Learning and Improving boards to every staff clinical area so that improvements can be discussed at handover and a monthly forum started to share improvements but also to discuss concerns.

* (annual information not available hence March of each year used as snapshot)

Indicator	Patient safety incidents and the percentage that resulted in severe harm or death.				
The data made available to the Trust by the Information Centre with regard to:	**Reporting period**	**QEHKL**	**National average acute (non-specialist) Trusts**	**Highest Score**	**Lowest Score**
The number and rate of patient safety incidents reported within the Trust during the reporting period	**Based on 1000 bed days**				
	April 2016 – September 2016	37.90	34.74	71.81	21.15
	October 2016 – March 2017	35.31	40.14	68.97	23.13
	April 2017 – September2017	33.59	42.84	111.69	23.47
	October 2017 – March 2018	42.64	42.50	124.0	24.19
	April 2018 – September 2018	42.37	44.5	107.4	13.1
The % of such patient safety incidents that resulted in severe harm or death during the reporting period	**Based on 1000 bed days**				
	April 2016 – September 2016	0.7	0.6	0.9	0
	September 2016	0.7	0.4	2.1	0
	October 2016 – March 2017	0.3	0.4	1.5	0
	April 2017 – September 2017	0.2	0.2	0.8	0
	October 2017 – March 2018	0.2	0.2	0.6	0
	April 2018 – September 2018	0.2	0.2	0.6	0

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

- The Trust has actively promoted an open culture and encouraged the reporting of incidents to ensure lessons are learnt. This has also positively influenced the reporting rate. The QEH will continue to promote a positive reporting culture measured against the national benchmark and align its strategies to learn from best practice methods.

Examples of the safety improvements and risk reduction strategies put in place this year include:

- The team has focused on compliance and working with divisions on the governance agenda;
- The team has worked with external consultants to improve the quality of Root Cause Analysis reports and Risk Management;
- The Trust has held two patient safety conferences and Patient Safety Learning events and presentations;
- We are preparing for the change to using the PSIMS reporting system over the next year.

Indicator	Patients admitted to hospital who were risk assessed for venous thromboembolism				
The data made available to the Trust by the Information Centre with regard to:	Reporting Period	QEHKL Score	National Average	Highest Score	Lowest Score
The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	2014/15	97.51%	96%	100%	79%
	2015/16	97.49%	95.53%	100%	78%
	2016/17	97.78%	95.53%	100%	63%
	2017/18	97.10%	95.23%	100%	67%
	2018/19	97.41% (up to end of Mar 2019	95.65% (up to end of Dec 2019	100% (up to end of Dec 2019	55% (up to end of Dec 2019

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

- The coding team check that all admitted patients have been risk assessed;
- There was a small loss of data in Jan/Feb 2018 due to the switch from paper to electronic record-keeping in the Ambulatory Emergency Care;
- The data is shared monthly with clinical teams and reviewed and monitored through the specialty governance meetings

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

- Achieving on-going recognition as a Venous Thromboembolism Exemplar Site due to consistent good practice;
- Undertaking a Root Cause Analysis (RCA) on all patients diagnosed with VTE following hospital admission in previous 3 months continues to identify Hospital Associated Thrombosis (HAT). During 2017/18 74 cases were identified as requiring a RCA, of which 6 (8.1%) were not risk assessed. 25 cases (33.8%) were potentially preventable and required completion of section 4 of the RCA. Of these, 22 were not given thromboprophylaxis but in accordance with the Trust guidelines. All cases were fully investigated and action plans monitored. Teaching was carried out when required;
- Use of compression hosiery – All staff providing compression hosiery received training from the hosiery company in accordance with NICE guidelines: 'Patients eligible for compression hosiery must be measured by a trained person'. This is an on-going programme;
- FFT has consistently been 100% that our service would be recommended to family & friends.

The QEHKL percentages above represent the full YTD position taken from our internal performance monitoring file. In the case of 2018/19 this includes the period up to an including the end of Mar 2019.

The QEHKL 2017/18 figure has been amended from 97.05% as provided last year to 97.10%. The 97.05% figure was correct but was only based on the period up to end of Feb 2018, and the 2017/18 figure of 97.10% now represents the full years position 9i.e up to end of March 2018).

The National Average percentages are taken from the last available quarterly snapshot using the link below. The latest in this instance Is up to end of Quarter 3 18/19, i.e Dec 2018.

https://improvement.nhs.uk/resources/venous-thromboembolism-vte-risk-assessment-201819/

Indicator	Clostridium difficile infection rate				
The data made available to the Trust by the Information Centre with regard to:	**Reporting Period**	**QEHKL Score**	**National Average**	**Highest Score**	**Lowest Score**
The number of reported cases per 100,000 bed days amongst patients aged 2 or over during the period	2014/15	28.3	15	62.6	0
	2015/16	27.6	14.9	67.2	0
	2016/17	15.2	13.2	82.7	0
	2017/18	32.4	13.2	91	0
	2018/19	15.3	*NA	*NA	*NA

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

- The accuracy of data is thoroughly checked by the infection prevention and control team and crossed checked with the laboratory (external assurance) prior to submission.

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

- Addressing outbreaks and periods of increased incidence promptly undertaking measure to reduce any further transmission;
- As part of outbreak plan undertaking a multi-agency Trust walk round with feedback to identify and action areas of concern;
- Implemented a robust action plan to implement on going measures to prevent any further transmission;
- Reviewed standards, methods and assurance of cleaning across the Trust;
- Targeted education on areas/wards of high incidence of C difficile;
- Undertaken training on use of sporicidal wipes for use by clinical staff across the Trust;
- A robust audit programme including Hand hygiene, PPE usage, isolation and environmental cleaning;
- Antibiotic stewardship and engagement with wider community.

Indicator	Maximum 6 Week Wait for Diagnostics				
The data made available to the Trust by the Information Centre with regard to:	**Reporting Period**	**QEHKL Score**	**National Average**	**Highest Score**	**Lowest Score**
Performance against the operational standard of less than 1% of patients waiting six weeks or longer for a Diagnostic Test, from time of Referral.	2014/15	0.64%	1.54%	34.6%	0.0%
	2015/16	0.34%	1.74%	60.0%	0.0%
	2016/17	0.25%	1.06%	52.3%	0.0%
	2017/18	2.45%	2.10% *	33.0% *	0.0%*
	2018/19	0.37%	2.5%**	58.1%**	0.0%**

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

DEXA
The deterioration in the Diagnostic waiting times has primarily been driven by the introduction of the DEXA scanning service that was commissioned at the Trust from 1st September 2017. The handover from the original Provider did not highlight a number of issues which were inherent within the service. Since taking the service on, the Trust has been proactively working to resolve these issues. The main reasons for the breaches have been down to service capacity, machine down time and there being no dedicated administrative support for the service.

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

DEXA
The Trust has implemented a number of remedial actions to resolve these issues which include now running the service for 3 days a week rather than only 2, and putting in place dedicated administrative support for the service. The Trust therefore expects to have the DEXA backlog cleared and to be achieving the required standard by the end of May 2018.

* These figures for 17/18 have been revised. At the time they were based on Feb 2018 data as March was not available. The figures now shown represent the position as at end of March 2018.

** National Average, Highest Score and Lowest Score % Totals are based on Mar 2019.

We do not use the full YY/YYs performance, as each month's performance is a snapshot against a waiting list total at month end, and not a cumulative total.

Part 5 Other Information

5.1 National, Local And System-Wide CQUINS

Priority 1

1a - Health & Well-Being

Why do we need to improve?

In 2015 Public Health England estimated the cost of sickness absence to the NHS at £2.4bn. Work in the NHS can often be physically, emotionally and psychologically demanding, providing NHS services 24 hours a day, 365 days per year. There is an opportunity for the NHS as an employer to impact positively on staff overall health, well-being and happiness.

Staff retention rates are shown to improve when staff feel their employer cares about their health and well-being, which in turn leads to improved team cohesion and better working environments.

The NHS health and well-being review, led by Dr Steven Boorman, and NICE guidance have outlined the link between staff health and well-being and patient care, including improvements in safety, efficiency and patient experience. This is the second year of this improvement programme.

Aim and goal

To improve in three specific areas:

1a Improving support across musculoskeletal, mental health and physical activities
1b Healthy food for NHS staff, visitors and patients
1c Improving uptake of flu vaccinations by frontline healthcare workers
1a Improving support across musculoskeletal, mental health and physical activities

What did we do to improve our performance?

Building on the initiatives introduced in Year 1, the Trust has introduced a number of approaches in 2018/19 to promote physical and mental well-being and to build up resilience to prevent problems occurring.

In Year 1, an intranet portal 'Just For You' was produced as a central resource point for information on staff health and well-being initiatives. During 2018/19 further developments took place and a comprehensive 'Be Well' intranet site was created and the original 'Just for You' site concentrated on providing information about financial benefits and advice. The 'Be Well' site acts a portal to a range of support, advice and information on benefits and services for staff.

The launch of the website was accompanied by a full communications programme including articles in the Knowledge, posters throughout the Trust and a screensaver promoting the site.

Well-being forms part of the initial health assessment undertaken when new employees join the Trust and information on how to access services is provided at induction.

The Trust has introduced monthly Schwartz Rounds, which is an evidence-based programme to support the emotional demands on healthcare workers and promote resilience. Staff are able to reflect on aspects of their work in a safe environment and re-focus on the important emotional drivers that support the provision of good teamwork and excellent patient care.

In addition, staff have access to the Mental Health Well-being Service, which works in partnership with NHS and Voluntary organisations in the Norfolk and Waveney area,

to provide telephone-based treatments, workshops, stress management guidance, computer-based therapy, one-to-one support and access to community-based support and mental first aid. This is supplemented by access to a range of self-help guides on matters such as relationship issues, financial and legal problems.

The Occupational Health Nurse Advisors can also refer staff for a 1:1 session with the Lead Nurse for Liaison Services at the hospital for support and advice on dealing with stress and managing low mood.

The Trust employs a staff physiotherapist to provide dedicated support to staff and to act largely in a preventative capacity, advising individuals and departments on how to reduce the risk of musculoskeletal injuries occurring within their practice and work environments. Staff returning to work following a musculoskeletal injury see the physiotherapist as part of the return to work process and can be advised on any restrictions to practice or modifications to their work environment as required.

How we monitored and reported progress

Data has been collected throughout the year on the number of staff participating in each of the initiatives together with staff feedback.

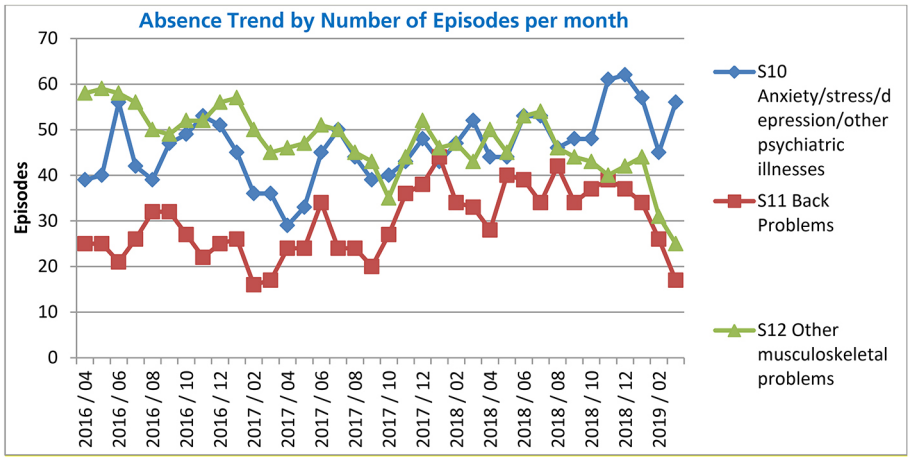
Outcome

Lifelong Learning classes continued throughout 2018/19 and included:

- Yoga sessions;
- Spanish conversation classes;
- Pilates;
- Jazzercise, an aerobic workout incorporating modern dance movements.

Approximately 12–15 members of staff took part in each activity and in 2018/19 115 members actively used the Staff Gym.

166 members of staff were referred to Occupational Health for support with musculoskeletal problems and 132 for support with mental health issues. Support for both groups was made available utilising the Staff Physiotherapist and the various support arrangements for mental health. During Q3 and Q4 an improvement was noted in the number of episodes of absence due to back problems and musculoskeletal issues but the absences due to mental health issues showed no improvement:



Going forward:

In 2019/20, in addition to our current provision we are going to provide three free Pamper sessions for staff during the year in conjunction with the College of West Anglia. This will enable staff to have a short break away from work to de-stress and at the same time provide an opportunity for students to gain practical experience in delivering treatments.

1b - Healthy food for NHS staff, visitors and patients

Why did we need to improve?

The national drive to reduce obesity and the comorbidities associated with obesity such as diabetes, has focused this element of the CQUIN on improving the diet of members of staff, patients and visitors alike by encouraging healthy

eating. The goals laid out in the CQUIN were to:
- Ban the promotion of high fat/ high sugar products;
- Ban the sale of high fat/ high sugar products at the checkout;
- Ban the advertising of high fat/ high sugar products at checkouts;
- Offer more healthy food and drink options.

What did we do to improve our performance?

The Trust has three locations within the hospital which supply food and refreshments to staff, visitors and patients in addition to vending points available throughout the site; these comprise:
- The Hub – the main restaurant open to all on the first floor and operated by the Trust;
- The Costa coffee shop and Amigo shop at the front of the hospital and operated by an external contractor;
- The League of Friends shop at the main entrance of the hospital, run by volunteers within this charity-run facility.

All the three locations have continued to comply with the original four objectives from 2016/17 and these have been visually audited on a monthly basis to ensure compliance with the following requirements:
- No price promotions on sugary drinks or food high in fat;
- No advertising of sugary drinks or food high in fat;
- No promotion of sugary drinks or food high in fat at point of sale in the till area;
- Ensuring healthy options are available, including at night.

Progress has continued to be made and has been built on the achievements delivered in the first two years of this CQUIN and in 2018/19, trusts were additionally required to ensure that:
- 90% of drinks lines stocked must have less than 5g of added sugar per 100ml. In addition to the usual definition of sugar sweetened beverages (SSBs), it also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk-based drinks (with sugar content of over 10grams per 100ml);
- 80% of confectionery and sweets must not exceed 250 kcal;
- At least 75% of pre-packed sandwiches and other savoury pre-packed meals (wraps, salads, pasta salads) available should contain 400kcal (1680 kJ) or less per serving and not exceed 5g saturated fat per 100g.

Outcome

The Hub (staff and visitor restaurant)

Four audits were undertaken in June, September and December 2018 and in March 2019 looking at compliance in relation to the provision of drinks and confectionery.

The Hub was fully compliant with the CQUIN requirements for 2018/19 and remained compliant with those for 2016/17. Progress has included:
- Stopping all price promotions on sugary drinks and foods high in fat;
- Banning all price promotions and offers on any sugary drinks and foods high in fat;
- Removing all unhealthy snacks/crisp etc. from checkout location and replacing with a fruit stand;
- Increasing supply of crudités and vegetable pots by 15% per day and individual fruit pots by 25%;
- Introducing a health options fridge which is working well;
- Including the Salad Bar in the meal deal as the health option and this is proving very popular;
- Reducing the number of confectionary lines;
- Reducing the portion size of the main courses and home-made scones;
- Maintaining staff discount on jacket potatoes and other healthier options;
- Maintaining 100% compliance with drinks below 5g sugar per 100ml;
- Increasing the amount of healthier snacks provided;
- Providing a snack trolley for staff;
- Setting up a Healthy Breakfast Bar and ensuring all cooked breakfast items are oven baked except the eggs and these are cooked on the griddle;
- Extending our Gluten-free range of items;
- Making the decision not to use salt in the production of food for patients and staff/visitors and looking to reduce the sugar content of all our recipes;
- Preparing all sandwiches on site and labelling with allergen content.

Costa Coffee and Amigo Shop

The Costa Coffee and the Amigo shop were fully compliant with the CQUIN requirements for 2018/19 and remained compliant with those for 2016/17. Progress has included:
- Stopping all price promotions on sugary drinks and foods high in fat;

- Banning all price promotions and offers on any sugary drinks / foods high in fat;
- Removing all unhealthy snacks/crisp etc. from checkout location;
- Making all hot drinks with semi-skimmed milk;
- Identifying the calorific value on all prepacked sandwiches with a variety having less than 400 calories;
- Removing chocolate and high fat crisps from meal deals;
- Ensuring all fizzy drinks are low calorie & syrups for drinks are reduced sugar syrups;
- No upselling at the tills (i.e. offering cream/marshmallows on hot chocolate etc);
- Ensuring all meals deals are only available with the less than 400 calorie sandwich.

League of Friends Shop

The League of Friends shop was fully compliant with the CQUIN requirements for 2018/19 and remained compliant with those for 2016/17. Progress has included:

- Stopping all price promotions on sugary drinks and foods high in fat;
- Banning all price promotions and offers on any sugary drinks and foods high in fat;
- Removing all unhealthy snacks/crisp etc. from checkout location;
- Stopping selling the duo bars such as Mars Bars etc;
- Increasing the amount of baked crisps provided and the lower calorie popcorn option;
- Introducing low fat yogurts, fruit pots and salad pots.
- Identifying the calorific value on all prepacked sandwiches with a variety having less than 400 calories.

Vending machines

Throughout the year we have had regular meetings with the commercial company to explain and ensure that all our vending machines must comply with the CQUIN. This was achieved with:

- All public vending machines becoming compliant with the requirement that 90% of drinks lines being stocked having less than 5g of added sugar per 100ml. In addition to the usual definition of SSBs, it also includes energy drinks, fruit juices (with added sugar content of over 5g) and milk-based drinks (with sugar content of over 10g per 100ml);
- 80% of confectionery and sweets not exceeding 250 kcal;
- Introducing a baked crisp.

In-house vending machines now provide healthy options such as salad, fresh fruit, baked crisps and low calorie drinks. The Trust has increased this type of vending to include one facility for the staff area and one for the public on the first floor near the lifts and this is publicised in A&E as an 'out of hours' option.

The provision of a hot vending machine offering healthy meals and snacks 24/7 has proved popular with staff, especially those that work at night. This includes a low calorie option (Weight Watcher meals).

Future plans

To maintain the CQUIN targets and ensure that they become embedded as normal service. We will continue to look at ways of reducing fat and sugar in the fresh cooked food that we produce on site.

1c – Improving uptake of flu vaccinations by frontline healthcare workers

What did we do to improve our performance?

The Trust has worked proactively to move towards 100% uptake of vaccination by all frontline staff. During 2018/19 this has included:

- Provision of daily drop-in clinics;
- Offers of vaccination at all appointments and to any staff who attended the Occupational Health Department;
- 'Flu walk rounds' – these took place on all wards during the day, evening, at night and early in the morning and at the same times at weekends;
- Fantastic support from 'Peer vaccinators';
- Promotion of vaccination and information for all new staff at induction;
- Regular reminders to all frontline staff at departmental / corporate meetings;
- Regular communications to staff via the Communication team;
- Offers of staff incentives (cinema tickets and shopping vouchers);
- Release of a weekly themed video clip by the Communications Department at the start of the flu season.

How we monitored and reported progress

The Occupational Health Department monitored staff uptake on a weekly basis and was supported by Information Services and the Project Management Team. Two sets of statistics were monitored and reported:

ImmForm – this is the system used by the Department of Health, the NHS and Public Health England to record data in relation to uptake against immunisation programmes and incidence of flu-like illness. Statistics are uploaded onto the system monthly throughout the campaign by Occupational Health, as in previous years.

CQUIN data – this local indicator excluded bank staff and staff unavailable to be vaccinated because of either being inactive and not working, or long-term absent.

Outcome

Compliance with the programme this year ensured that the CQUIN target of >75% was met by November 2018 and in February 2019 the percentage of staff vaccinated was as follows:

Accuracy	2016/17 CQUIN	2017/18 CQUIN	2018/19 CQUIN
Percentage of front-line healthcare workers vaccinated for influenza	93.50%	78.6%	81%

This comprised the following breakdown of frontline staff:

Staff Group	Medical	Nursing	AHPs	Support
No. of staff vaccinated	343	753	269	741

Priority 2

Sepsis

Why do we need to improve?

Sepsis is a common and potentially life-threatening condition in which the body's immune system goes into overdrive in response to an infection, setting off a series of reactions that can lead to widespread inflammation, swelling and blood clotting. This can lead to a significant decrease in blood pressure, which can mean the blood supply to vital organs such as the brain, heart and kidneys is reduced – potentially leading to death or long-term disability. Sepsis is recognised as a significant cause of mortality and morbidity in the NHS. The UK Sepsis Trust estimates that in the UK about 147,000 people are admitted to hospital with sepsis every year, 137,000 adults and 10,000 children, and that 30% of the people admitted to hospital with sepsis die; so around 44,100 deaths are attributed to sepsis every year.

Aim and Goal

The aim is to incentivise providers to screen for sepsis in all those patients for whom this is appropriate and rapidly initiate intravenous antibiotics within one hour of presentation for patients who have suspected severe sepsis, Red Flag Sepsis or septic shock and then review antibiotics after 72 hours. This CQUIN covered both the A&E and Inpatient settings.

Part 2a

Timely identification of patients with sepsis in the A&Es and Acute Inpatient settings:

- To determine the percentage of patients who met the criteria for suspected severe sepsis, Red Flag sepsis or septic shock that were screened for sepsis.

Part 2b

Timely treatment of sepsis in the A&Es and Acute Inpatient settings:

- To determine the percentage of patients that having been identified as having sepsis in 2a had treatment with intravenous antibiotics initiated within one hour.

Part 2c
Empiric review of antibiotic prescriptions:
- Antibiotic prescriptions should be reviewed within 72 hours by either:
  - Infection (infectious diseases/ clinical microbiologist) senior doctor
  - Infection pharmacist
  - Senior member of clinical team
- Documentation of antimicrobial prescribing decision (with review date or course length as appropriate);
- Documentation of rationale for continuing use of intravenous antibiotic therapy.

Part 2d
Reduction in antibiotic consumption per 1,000 admissions and proportion of broad spectrum antibiotic use:
- Reduction of 1% or more in total antibiotic consumption against the baseline;
- Reduction of 2% or more in carbapenem;
- Increase the proportion of antibiotic usage (for both inpatients and outpatients) within the Access group of the AWaRe* category to ≥55% of total consumption or increase consumption in this group by 3% from baseline.

What did we do to improve performance?
An increase in the level of training was achieved across the Trust combined with an increase in the clinical support to the audit team.

Posters were produced on a quarterly basis to demonstrate the up-to-date results of the CQUIN analysis and to remind providers of the importance of the 'Sepsis 6'. These have been displayed in all emergency areas in the hospital.

The Sepsis Concise Care Bundle (CCB) was made available electronically as a care plan on EDIS for use in the A&E.

How we monitored and reported progress
The CQUIN for sepsis was reviewed and reported in four parts:

Part 2a
Timely identification of patients with sepsis in the A&Es and Acute Inpatient settings:

An audit of a random sample of 50 sets of patient records coded for sepsis per month was undertaken for (i) patients presenting to the A&E and other units that directly admit emergencies and up to 50 sets of patient records coded for sepsis for (ii) patients from Acute Inpatient settings.

The audit looked to determine the total number of patients presenting to the A&E and other units that directly admit emergencies and those admitted to our Acute Inpatient services that met the criteria of the local protocol and were screened for sepsis.

The A&E and the Inpatient screening element of the CQUIN required an established local protocol that defined which patients required sepsis screening. From 1 November 2018 this Trust aligned its use of local protocols with the national requirement to changeover to the National Early Warning Score 2 (NEWS2).

Part 2b
Timely treatment of sepsis in the A&Es and Acute Inpatient settings:

An audit of a random sample of up to 50 sets of patient records per month was undertaken for patients presenting to the A&E and other units that directly admit emergencies and up to 50 sets of patient records coded for sepsis from Acute Inpatient settings to determine whether:

(i) Where a patient was newly admitted, for whom in the course of their admission, a decision to treat with intravenous antibiotics was made by a competent decision-maker, that these were administered within 60 minutes of the possible identification that the patient had Red Flag Sepsis or Septic Shock.

(ii) Where a patient was an existing inpatient, for whom a decision to treat with intravenous antibiotics, or to change the type of antibiotics previously prescribed, was made by a competent decision-maker, that these were administered within 60 minutes of the possible identification that the patient had Red Flag Sepsis or Septic Shock.

Part 2c:
Antibiotic Review

A local audit of a minimum of 30 patients was undertaken from a representative sample of patients from across all wards at the Trust (adult and paediatric) to determine the number of the antibiotic prescriptions submitted that had evidence of a review having taken place between 24 and 72 hours PLUS a review by an appropriate clinician PLUS a documented rationale for intravenous use.

Oral and intravenous antibiotic prescriptions were included. Eye drops, ear drops, suppositories, nebulisers, etc were not included. Patients should have been on their antibiotic for at least 24 hours.

Part 2d:
Reduction in antibiotic consumption per 1,000 admissions and proportion of antibiotic usage (for both inpatients and outpatients within the ACCESS AWaRe category*)

Antibiotic consumption data was available for commissioners to review via a dedicated website (https://fingertips.phe.org.uk/). Consumption data was obtained via pharmacy records of direct issues to both inpatients and outpatients to measure:

1. Reduction for total antibiotic consumption by 2% against 2017/18 target;
2. Reduction for carbapenems by 3% against 2017/18 target;
3. ACCESS group ≥ 55% of total antibiotic consumption.

The quarterly data totals were then submitted to the commissioners via UNIFY.

Outcome

2a.

Throughout 2018/19, an average of 400 patient records were reviewed on a monthly basis for 2a (i) and an average of 75 patient records were reviewed on a monthly basis for 2a (ii). The results are as follows:

a.i)

Quarter	% of patients who met the local criteria and were screened for Sepsis (Emergency Patients)	
	Target	Actual
1	90%	100%
2	90%	100%
3	90%	100%
4	90%	100%

a.ii)

Quarter	% of patients who met the local criteria and were screened for Sepsis (Acute Inpatients)	
	Target	Actual
1	90%	100%
2	90%	100%
3	90%	100%
4	90%	100%

2b.

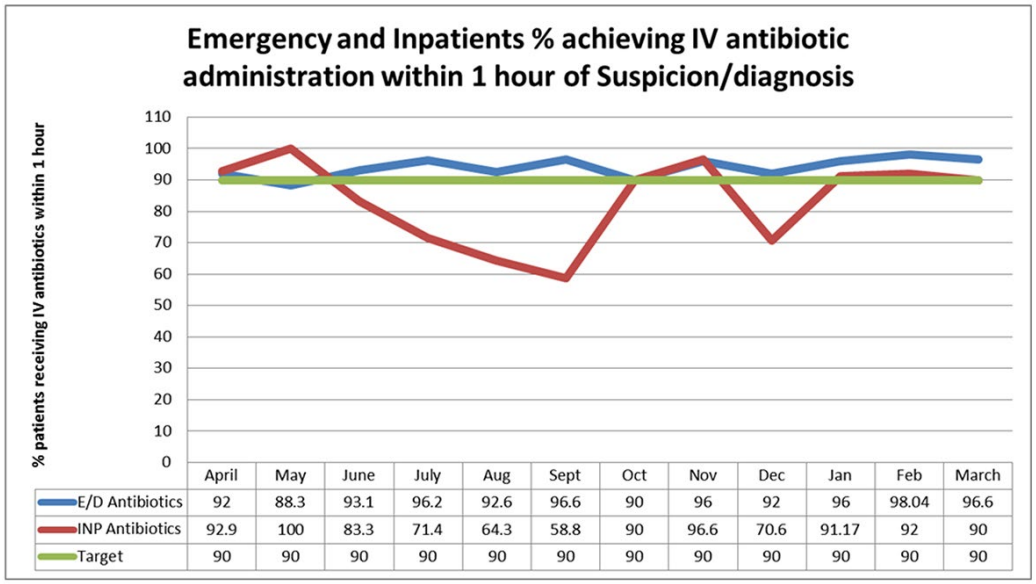
Throughout 2018/19, an average of 400 patient records were reviewed on a monthly basis to achieve the target of 50 consecutive Emergency patients for 2b (i) and an average of 75 inpatient records were reviewed on a monthly basis for 2b (ii). The results are as follows:

b.i)

Quarter	% of patients where antibiotics clearly recorded as GIVEN within 60 minutes of arrival and empiric antibiotics review within 3 days (Emergency patients)	
	Target	Actual
1	90%	90.6%
2	90%	95.2%
3	90%	92.4%
4	90%	96.8%

b.ii)

Quarter	% of patients where antibiotics clearly recorded as GIVEN within 60 minutes of arrival and empiric antibiotics review within 3 days (Acute Inpatients)	
	Target	Actual
1	90%	91.5%
2	90%	64.4%
3	90%	84.3%
4	90%	90.2%

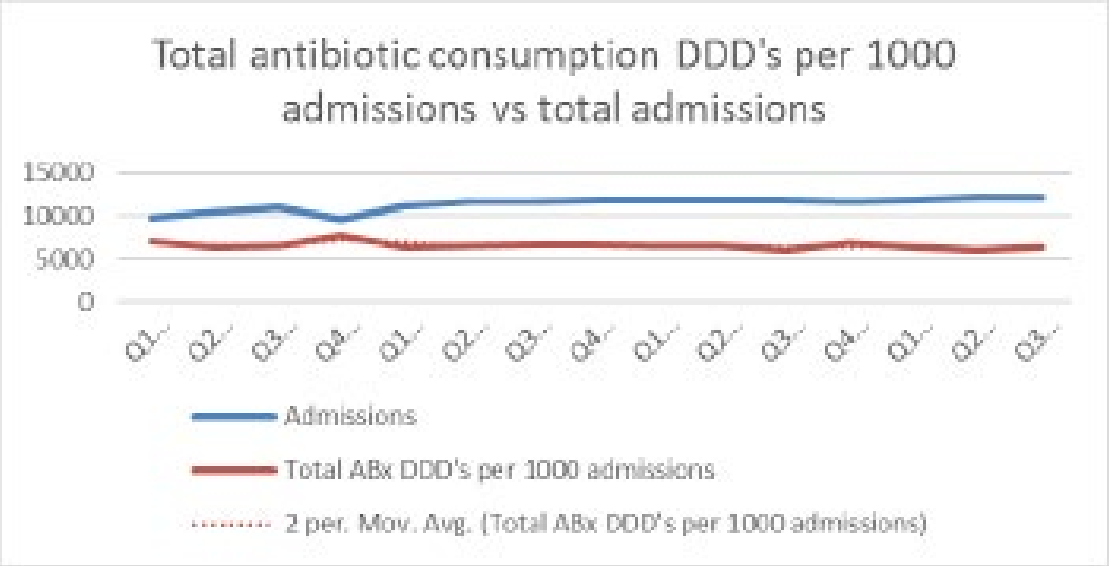


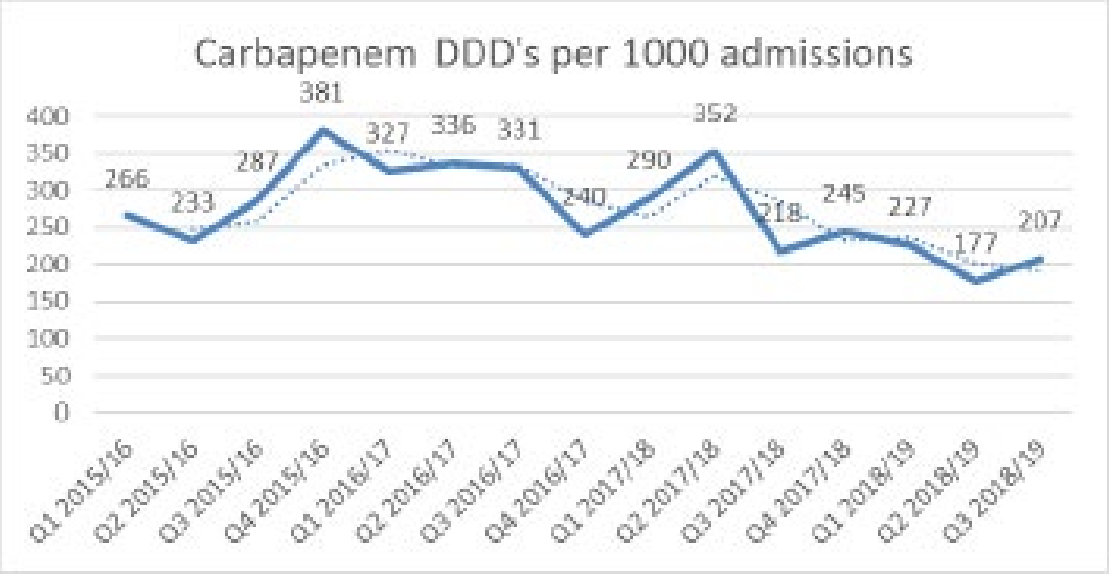
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
E/D Antibiotics	92	88.3	93.1	96.2	92.6	96.6	90	96	92	96	98.04	96.6
INP Antibiotics	92.9	100	83.3	71.4	64.3	58.8	90	96.6	70.6	91.17	92	90
Target	90	90	90	90	90	90	90	90	90	90	90	90

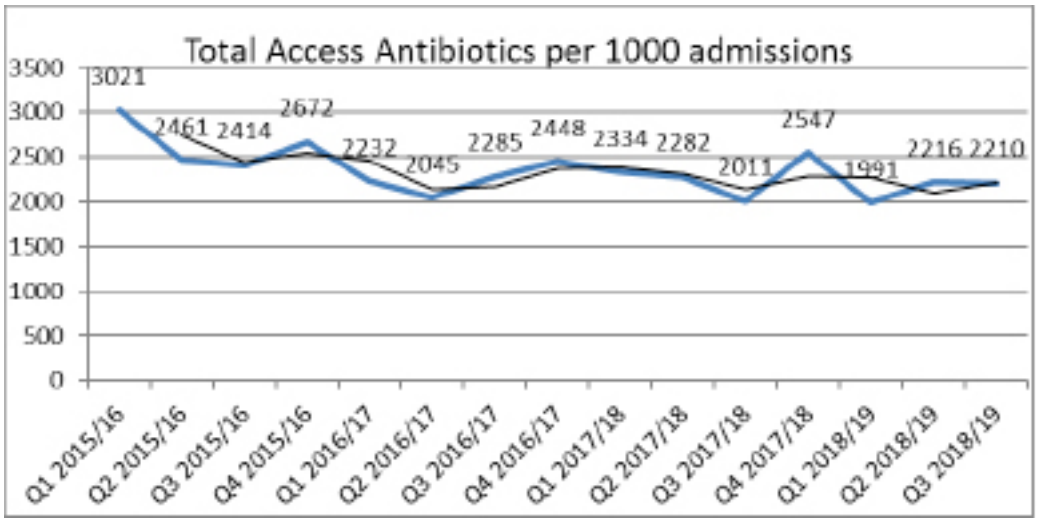
2c:

Quarter	% of antibiotic prescriptions submitted that had evidence of review between 24 and 72 hours PLUS a review by an appropriate clinician and a documented IV rationale	
	Target	Actual
1	25%	34%
2	50%	66%
3	75%	35%
4	90%	42%

2d.







At Q4 of 2018/19 the total consumption of antibiotics is below the consumption levels of the baseline year of 2016 (6788 vs 7174 DDDs per 1000 admissions), although consumption of Carbapenems increased in Q4. It should also be noted that the proportion of ACCESS antibiotics used remains lower than the baseline year, with the target to exceed by at least three percentage points (proportion of ACCESS antibiotics vs total is on average 42% vs target percentage of 55%).

There has been an increase in Trust-wide education raising awareness of Sepsis 6 and the changes to National Early Warning Score (NEWS2). The Nurse Consultant for Critical Care, with the support of the Corporate Practice Development Nurse has, and continues to deliver, a rolling programme of mandatory training covering both NEWS2 and the identification of Sepsis 6 across the Trust using both face to face presentations and via the Electronic Staff Record intranet site. Training is also delivered as part of the ALERT National programme[1] and the SPEED course for all healthcare assistants[2]. Sepsis 6 and NEWS2 is automatically included in all clinical staff induction, including the international nurses. The A&E provides rolling training for all staff on Sepsis 6 and NEWS2.

Concise Sepsis care bundles are available via the electronic EDIS system in the A&E and in sticker format throughout the rest of the Trust.

The Outreach team were involved in collecting some data for the inpatient audits as the team members are able to prescribe first line antibiotics utilising a new patient group direction and act as front line advocates for this group of patients.

This data was made available by the Outreach team to assist in capturing information for the CQUIN, but was limited in nature and was often only available to the audit team very close to the closing dates of each quarter. Following several PDSA cycles (Plan,Do,Study,Act), the audit team, in conjunction with the acute physicians, increased the potential cohort for the audits by identifying inpatients who had undergone a blood culture test during the relevant month. This considerably increased the identification of possible episodes to audit, with the Outreach team data then acting as an additional resource in the run up to the closing dates.

To date the Trust has not consistently achieved the sepsis, antibiotic stewardship and national CQUIN targets for both Inpatient and the A&E throughout the year. The figures for the A&E show some consistency, but there is a wider variance in the inpatient data, demonstrating a slower improvement in ensuring that antibiotics are administered within the requisite 60 mins from the time of diagnosis, and a disappointing reduction in performance in achieving a senior review of the prescription within 72 hours in Q3. During this period there was no antimicrobial pharmacist in post and variable engagement from some senior clinical staff. There were also occasions when antibiotics were given as prescribed but there was no clear 'diagnosis' time in the patient's health record. Inpatient management of sepsis remains a priority for improvement going forward.

In 2019/20 there will be no CQUIN for Sepsis but reporting on Sepsis will remain part of the National Contract. There will need to be an increased focus in ensuring that when inpatients develop a possible sepsis that treatment is commenced within the optimal timeline and that antibiotic prescriptions are both in accordance with recommendations and reviewed in line with best practice.

*ACCESS AWaRe – The World Health Organisation has split antibiotics into three categories in order to fight resistance; access, watch and reserve. The CQUIN aimed to drive improvements in the use of narrow spectrum antibiotics from the 'access' group.

[1]ALERT – The Acute Life-threatening Events—Recognition and Treatment course.
[2]SPEED – A course on recognising the deteriorating patient aimed at unregistered staff.

Priority 4

Improving Services for People with Mental Health Needs Who Present to A&E

Why do we need to improve?

People with mental health are three times more likely to present to an A&E than the general population. More than 1 million presentations are currently recorded as being directly related to mental health. People with known mental ill health are five times more likely to be admitted to acute hospitals and 80% of these emergency admissions are recorded as being primarily for physical reasons. This highlights the need for acute hospitals to be equipped to detect and treat urgent mental health needs that are cited as the primary reason for presentation, as well as improving identification of underlying mental health conditions where the primary presenting reason may be a physical health one.

The QualityWatch study also found that people with mental health had 3.6 times more potentially preventable emergency admissions that those without mental ill-health in 2013/14, and that 'the high levels of emergency care use by people with mental health indicate that they are not having their care well managed and suggest that there are opportunities for planned care (inside and outside of the hospital) to do more. These people are well known to the healthcare system and are having many health encounters'.

Half of A&E attendees present with at least one long term condition (LTC) (Blunt, 2014)[2] while a House of Commons Health Committee (2014) reports the figure to be even higher at 68%. At least 30% of people with LTCs present with co-morbid mental health problems leading to poorer health outcomes (Cimpean and Drake, 2011)[3]. Although psychological factors are likely to be exacerbating symptoms and attendance patterns, this cohort are rarely referred to psychological/mental health services because the reason for presentation is usually to meet medical needs (Blunt 2014).

Acute services generally struggle to identify and manage the needs of individuals with medically unexplained symptoms. The clinical complexity of these individuals often makes medical decision making extremely challenging. A lack of medical diagnosis and clarity in these instances can lead to unnecessary tests, procedures and lengthy admissions detrimentally impacting upon patient flow. Identifying these patients, providing specialist assessment and then co-ordinating appropriate care across all agencies involved is anticipated to reduce unnecessary attendances in this cohort.

Aim and goals

The CQUIN has been designed to encourage collaboration between providers across the care pathway – both acute and mental health providers. It is anticipated that there will be increased collaborative working across care providers (primary care, police, ambulance, substance misuse, social care and voluntary sector).

The aim is to provide a cohort of patients, who have been identified as regularly attending the A&E, with an individually tailored care plan. These plans will ensure that the necessary social, medical and psychological support and interventions are provided in a well-co-ordinated manner, which in turn will reduce unnecessary attendances to the A&E.

1. www.qualitywatch.org.uk/sites/files/qualitywatch/field/field_document/QualityWatch_Mental_ill_health_and_hospital_use_summary.pdf **2.** Blunt, I. (2014) Focus on A&E attendances. Nuffield Trust. www.nuffieldtrust.org.uk/research/focus-on-a-e-attendances **3.** Cimpean, D. and Drake, R. (2011) Treating co-morbid medical conditions and anxiety/depression. *Epidemiology Psychiatric Sciences* 2011;20 (2) 141-50

In 2017/18, a baseline was taken in the first quarter of the year with the aim for end of Year 1 to have reduced attendances by the identified cohort by 20%. Year 1 (2017/18) focused on improving the understanding of the complex needs of the cohort of patients and also on improving the quality of the coding of primary and secondary mental health needs in the A&E.

Year 2 (2018/19) sought to maintain the 20% reduction achieved in 2017/18. The aim to reduce overall mental health attendances to the A&E by 10% was removed. Instead the aim was to identify a new cohort of frequent attenders who could benefit from psychosocial interventions (NHS England April 2018). This cohort had to include at least 25-30 people; it did not need to be the most frequent attenders to the A&E and but instead focused on groups of people who experience particular inequalities in accessing services (Annex A CQUIN Indicator Specification 2017/18-2018/19).

What did we do to improve our performance?

Performance was improved through a number of strategies. This included:

- Monthly identification of the relevant cohort of patients via the EDIS system;
- Regular liaison with partner organisations;
- Development of multi-agency care plans. This work was predominantly led by the Clinical Health Psychology Department and was patient-focused and patient-inclusive;
- Improved coding of patients via the EDIS upgrade;
- Regular review against target for the group of cohort patients.

How we monitored and reported progress

Progress has been monitored on a quarterly basis and has been reported via the CQUIN system.

Outcome

In 2017/18 CQUIN Performance showed that there had been a 48% reduction in attendance for the identified cohort of patients. The reduction for this cohort has been maintained at below 20% in 2018/19.

The second cohort of patients has also shown a significant reduction in attendance which was greater than the 20% reduction required to achieve the CQUIN target. (The full data set is not yet available)

Priority 6

Advice And Guidance

Why do we need to improve?

The demand for outpatient appointments keeps growing. Advice and Guidance from a consultant to a GP may help to prevent a patient having to attend the hospital. Advice and guidance is where a GP asks a consultant specialist a question regarding a patient through e-Referral. If the consultant believes the patient still needs to be seen, the advice request can be converted to a referral.

Advice and Guidance may include:

- Virtual review of test results (Electrocardiogram, blood tests) and advice on next steps required;
- Supply of a suggested treatment or management plan to the GP (which may include carrying out further investigations in Primary Care);
- Direct booking of diagnostic tests (e.g. Endoscopy);
- Advice on the appropriate clinic referral (reducing re-directed appointments).

Aim and goals

Prevent unnecessary hospital attendances and provide the patient with timely, appropriate care.

What did we do to improve our performance?

The CQUIN standard was to ensure that Advice and Guidance services were operational for specialties covering at least 75% of total GP referrals, and provide a response for 80% within 48 hours.

How we monitored and reported progress

Requests for advice and guidance are actioned daily. An email is sent to the owning clinician to request input. If a response is not received within 24 hours a reminder is sent. Responses are recorded in e-Referral. A spreadsheet has been maintained of all requests received and responses provided. A quarterly update is provided to the Clinical

Commissioning Group. Some services nominated a specific clinician; this helped improve the timeliness of the responses.

Outcome
We provided advice and guidance for all specialties. The CQUIN target was achieved in Q4. There have been challenges in turning around our responses within 48 hours in those specialties where the Trust relies on a visiting consultant.

Priority 7

STP (Sustainability And Transformation Plans)

Why do we need to improve?
The NHS as a whole is stretched financially and is continually trying to implement better ways of working to improve patient care and stream line processes to ensure value for money. Local health economies have been encouraged to prioritise engagement between Providers and Commissioners to work together to achieve financial balance across the whole health economy by developing Sustainability and Transformation Plans.

Effective organisations are unable to implement the Five Year Forward View and deliver the required productivity savings and care redesign on their own. Only through a system-wide set of innovations will the NHS be sure of being able to deliver the right care, in the right place, with optimal value. Each STP becomes the route map for how the local NHS and its partners convert the Five Year Forward View into reality within the Spending Review envelope. It provides the basis for operational planning and contracting.

This has meant developing new relationships with patients and communities, looking at the totality of health and care when identifying solutions, using social care and wider services to support improved productivity and quality as well as improving people's well-being.

Aim and goals
The Trust Board was required to approve the plan agreed through the STP governance structure and to contribute to STP transformation initiatives; demonstrating commitment, support and full engagement in all the local STP initiatives. This included memorandums of understanding with partnership organisations and governance structures to demonstrate engagement with key stakeholders, patients and the public.

What did we do to improve our performance?
The Trust has been fully engaged with the Sustainability and Transformation Partnership as required by the CQUIN. This has involved representing the hospital and our patients at many events, both clinical and non-clinical, to help set the future direction of health care services across Norfolk. The Trust is leading on a number of work streams such as Estates and procurement and has played an active role in all other areas. The Trust has been actively involved, participating in decision-making, demonstrating delivery of provider-specific actions and has aligned and worked collaboratively with other organisations towards meeting the aims and objectives of the STP.

How we monitored and reported progress
The Trust was required to provide evidence of engagement with the Norfolk and Waveney STP, patients and the public in the form of minutes or other confirmation of regular attendance and participation at the STP Executive Board, the STP Programme/Delivery Board and other relevant meetings.

Outcome
This engagement has been recognised by the CCG and wider STP and the Trust has been awarded full achievement for this CQUIN for the first three quarters of the year. Quarter 4 achievement is yet to be announced.

Priority 9

Preventing Ill Health by Risky Behaviours – Alcohol and Tobacco

Why do we need to improve?

The burden of smoking
Smoking is estimated to cost £13.8bn to society (£2bn on the NHS through hospital admissions, £7.5bn through

lost productivity, £1.1bn in social care). Smoking is England's biggest killer, causing nearly 80,000 premature deaths a year and a heavy toll of illness, 33% of tobacco is consumed by people with mental health problems.[1] Smoking is the single largest cause of health inequalities.[2]

A Cochrane Review[3] shows that smoking cessation interventions are effective for hospitalised patients regardless of admitting diagnosis. Inpatient smoking cessation leads to a reduced rate of wound infections, improved wound healing and increased rate of bone healing. Permanent smoking cessation reduces the risk of heart disease, stroke, cancer and premature death. The quit rates among patients who want to quit and take up a referral to stop smoking services are between 15% and 20%, compared to 3% to 4% amongst those without a referral.[4]

The status quo nationally

Coverage of advice and referral interventions for smokers is patchy. Currently in secondary care, some patients may be asked if they smoke, but not all, and not at every admission, e.g. less than half of smokers admitted to hospital receive very brief advice to stop as an inpatient. For those patients that have been identified as a smoker, this is no guarantee that they will then be given an effective stop smoking intervention and referral to evidence-based smoking cessation support. Currently, only 1.5% of smokers in acute hospital settings go onto make an attempt to quit with stop smoking services.

The financial case

Modelling of the tobacco component of the CQUIN suggests that it could reduce costs through fewer admissions and improved health of smokers and passive smokers; resulting in net savings of £13 per patient referred to stop smoking support and prescribed Nicotine Replacement Therapy each year over 4 years. This is a conservative estimate accounting for the reduced cost of hospital admissions only.

The burden of excessive alcohol consumption

In England, 25% of the adult population (33% of men and 16% of women) consume alcohol at levels above the UK Chief Medical Officer's low-risk guideline and increase their risk of alcohol-related ill health.[5] Alcohol misuse contributes (wholly or partially) to 60 health conditions leading to hospital admission, due either to acute alcohol intoxication or to the toxic effect of alcohol misuse over time. Conditions include cardiovascular conditions, liver disease, cancers, depression and accidental injuries.[6] There are nearly 22,500 alcohol-attributable deaths per year.[7] Out of circa 3.7m admissions[8], 333,000 were admissions where an alcohol-related disease, injury or condition was the primary diagnosis or there was an alcohol-related external cause. These alcohol-related admissions are 32% higher than in 2004/05[8].

Alcohol is estimated to cost the public purse £21bn per annum, of which £3.5bn are costs to the NHS. Around three quarters of the £3.5bn cost to the NHS is incurred by people who are not alcohol dependent, but whose alcohol misuse causes ill health – this is the group for which IBA is the most effective. 'Identification and Brief Advice' (IBA) results in recipients reducing their weekly drinking by about 12%. As the alcohol health risk is dose dependent, reducing regular consumption by any amount reduces the risk of ill health.

The status quo nationally

Currently IBA delivery in secondary care is patchy and nowhere near the optimal large scale delivery required to significantly impact on population health. It is strongest where there are strong 'Making Every Contact Count' (MECC) initiatives that include alcohol IBA and where there are well-resourced alcohol care teams that train other staff.

The financial case

Alcohol identification and brief advice is effective in reducing health risk from drinking in non-dependent drinkers. The successful delivery of the CQUIN is estimated to bring about a reduction of weekly alcohol consumption of 12%, which could result in estimated net savings of £27 per patient receiving alcohol brief advice each year over 4 years, due to fewer alcohol-related hospital admissions due to improvements in morbidity. (NB: these figures are taken from unpublished modelling conducted by Sheffield University using data derived from the latest Cochrane review of brief advice in primary care.[3])

1. www.gov.uk/government/uploads/system/uploads/attachment_data/file/366852/PHE_Priorities.pdf **2.** www.sciencedirect.com/science/article/pii/S0140673606689757 **3.** Rigotti N, Munafo MR, Stead LF. Interventions for smoking cessation in hospitalised patients.Cochrane Database of Systematic Reviews 2007; Issue3.Art.No.:CD001837.DOI:10.1002/14651858.CD001837.pub2 **4.** www.ncsct.co.uk/usr/pub/Briefing%208.pdf **5.** http://digital.nhs.uk/catalogue/PUB16076 **6.** www.hscic.gov.uk/catalogue/PUB13218/HSE2012-Ch6-Alc-cons.pdf **7.** Public Health England (2016), Local Alcohol Profiles for England. Available at: http://fingertips.phe.org.uk/profile/local- alcohol-profiles **8.** Admissions to acute, acute &community and acute specialist providers in 2014/15, excluding maternity and below 18s, based on HES data.

Aim and goals
This CQUIN seeks to help deliver on the objectives set out in the Five Year Forward View (5YFV), particularly around the need for a '…radical upgrade in prevention…' and to be '…incentivising and supporting healthier behaviour'. The proposal also supports delivery against the 5YFV efficiency target by generating a projected national net cost-saving to the NHS over the course of the CQUIN.
T
he CQUIN has been designed to encourage staff to act as health educators with the aim of preventing disease through the adoption of a healthier lifestyle.

In the first quarter of the Year 3, key components had to be completed. These were completing an information systems audit, training staff to deliver brief advice and collecting baseline data.

For the remaining quarters of the year the aim was to improve performance across the indicators.

What did we do to improve our performance?
Performance was improved through a number of strategies. This included:

- Initial training of a group of Champions to support the roll out of the campaign;
- Development of a patient sticker to be included as part of the clerking documentation to support data collection and act as prompt to support patient assessment and education;
- Following review of the documentation sticker, the medical clerking proforma was adapted to include the relevant required information;
- Training has been delivered at every Trust induction and is supported by the development of an electronic training package;
- Patient leaflets have been developed which supply relevant information on reducing and ceasing smoking or drinking habits.

How we monitored and reported progress
Progress has been monitored on a quarterly basis and has been reported via the CQUIN system.

Outcome
CQUIN Performance in 2018/19 achieved the requirements for the three quarters to date. Fourth quarter still awaiting confirmation.

CQUINS - Specialist Contract

Priority 1

Medicines Optimisation

Why do we need to improve?
Optimising the use and management of medicines is a significant and realisable opportunity for the NHS. The Carter Review highlighted that unwarranted variation in use and management of medicines costs the NHS at least £0.8 billion per year which could be re-invested to support sustainable service delivery. This CQUIN was designed to support Trusts and commissioners to realise this benefit through a series of modules that improve productivity and performance related to medicines. The expectation being that the targets and metrics will unify hospital pharmacy transformation programme (HPTP) plans and commissioning intentions to determine national best practice and effective remedial interventions.

Aim and goals
This CQUIN scheme aims to support the procedural and cultural changes required fully to optimise use of medicines commissioned by specialised services. The following priority areas for implementation have been identified nationally by clinical leaders, commissioners, trusts, the Carter Review and the National Audit Office, namely:
- Faster adoption of best value medicines with a particular focus on the uptake of best value generics, biologics and CMU (Commercial Medicines Unit) frameworks as they become available;
- Significantly improved drugs data quality to include dm+d code and all other mandatory fields in the drugs MDS and outcome registries such as SACT (Systemic Anti-Cancer Therapy), as well as to meet the requirements of the ePharmacy and Define agendas;
- The consistent application of lowest cost dispensing channels;
- Submission of costing data to NHSE (NHS England) via a standardized system (Pharmex).

What did we do to improve our performance?

- All relevant drugs were identified in advance of the availability of generics or biosimilars to ensure that switches could be made within the required timescale;
- Where appropriate for safe patient care, supply of medicines via homecare has been used to achieve VAT-efficient supply; the viability of creating a wholly-owned subsidiary is being considered;
- All costing data submitted via Pharmex.

How we monitored and reported progress

All required parameters were monitored via JAC (pharmacy stock control system), and reported as required by NHSE quarterly.

Outcome

Q1: 100% achievement
Q2: 100% achievement
Q3: 100% achievement
Q4: NA

Priority 2

Dental Dashboard

Why do we need to improve?

A Dental Quality Dashboard has been developed nationally in order to capture information to facilitate planning for the new dental pathways. Submission of the dashboard will lead to increased intelligence about activity at a local, regional and national level to support pathway development in line with NHS England's published Commissioning Guides for Commissioning Dental Services.

What did we do to improve performance?

All required information was identified and the data recorded on a monthly basis for the dental specialties provided within the Trust.

How we monitored and reported on progress

All the information on the specified activity was captured on a Quality Dashboard and submitted on a quarterly basis to the Clinical Commissioning Group.

Outcome

The Trust was fully compliant with populating the Dental Quality Dashboard for 2018/19.

Priority 3

Breast Screening

Why do we need to improve?

This local CQUIN was developed to ensure the sustainability of the breast cancer screening programme across Norfolk through the development of a clinical network between the three acute trusts (The Queen Elizabeth Hospital, James Paget University Hospital and the Norfolk and Norwich University Hospital) and to aid business continuity and service development.

Aims and Goals

- Updated Terms of Reference to be agreed by all three Trusts;
- Interval cancer review group for bi-annual review of interval cancers;
- Evidence that the third interval cancer review group has been conducted demonstrating outcome of actions;
- Evidence of network wide training plan;
- Evidence of continued network meetings;
- Enabling consistent achievement of key performance indicators and quality and performance standards in breast screening.

What did we do to improve performance?
- James Paget University Hospital to lead, named individual agreed;
- Interval cancer review group for bi-annual review of interval cancers, first two have been held and attended by all three trusts;
- Agreed plans from the three trusts were submitted for the development of a clinical network and this included the new terms of reference;
- Quarterly meetings of the three trusts;
- Three trusts agreed network objectives and action plan submitted;
- Training plan developed and submitted.

How we monitored and reported progress?
All three trusts have met up on a regular basis to agree aims and objectives and to determine progress.

Outcome
The Trust has participated fully in the development of the network and has met all the requirements of the CQUIN.

Priority 4

Armed Forces

Why do we need to improve?
The Armed Forces Covenant is now included within the NHS Constitution. The Trust Board Armed Forces Champion plays a pivotal role in ensuring the Armed Forces Covenant is applied in clinical practice and across all access pathways. The principle of no disadvantage is understood and upheld in terms of clinical need.

Extract of The Armed Forces Covenant, 'Today and Tomorrow':

The Armed Forces Community should enjoy the same standard of, and access to, healthcare as that received by any other UK citizen in the area they live. They should retain their relative position on any NHS waiting list, if moved around the UK due to the service person being posted.

Veterans receive their healthcare from the NHS, and should receive priority treatment where it relates to a condition which results from their service in the Armed Forces, subject to clinical need. Those injured in the Service, whether physically or mentally, should be cared for in a way which reflects the Nation's moral obligation to them whilst respecting the individual's wishes. For those with concerns about their mental health, where symptoms may not present for some time after leaving Service, they should be able to access services with health professionals who have an understanding of the Armed Forces culture.

What did we do to improve performance?
The Queen Elizabeth Hospital, in conjunction with both the Norfolk and Norwich University Hospital NHS Foundation Trust and the James Paget University Hospital NHS Foundation Trust, collaborated in producing a patient access policy for Norfolk. Provision is made for the armed forces to ensure personnel are not disadvantaged when moving between areas as part of their military commitment.

The Trust has submitted the Silver nomination for the Employer Recognition Standard. The Trust is also part of the Step into Health programme which aims to offer current and former military personnel the opportunity to embark on a second fulfilling career for the benefit of others, in working within hospital. We have created armed forces champions within the hospital to support new members of staff.

Outcome
The Trust will celebrate armed forces day on 28 June 2019. We have signed the Armed Forces covenant to signify our long term commitment to our obligations to military personnel. We have also updated our social media sites to ensure that the support we have in place is publicised.

5.2 Commissioning for Quality and Innovation (CQUIN)

National & Regional CQUINs 2019/20 (Acute Contract)

Goal No.	Description of Goal	Indicator name	National/ Regional Indicator	Indicator value
1a	Achieving 90% of antibiotic prescriptions for lower urinary tract infections (UTI) in older people meeting NICE guidance (NG109) and Public Health England diagnosis of UTI guidance in terms of diagnosis & treatment.	**Antimicrobial resistance**	National	0.125%
1b	Achieving 90% of antibiotic surgical prophylaxis for elective colorectal surgery being a single dose & prescribed in accordance with antibiotic guidance.			
2	Achieving an 80% uptake of flu vaccination by frontline clinical staff.	**Staff flu vaccination**	National	0.125%
3a	Achieving 80% of inpatients admitted to an inpatient ward at least for one night who are screened for both smoking and alcohol use.	**Alcohol & tobacco screening**	National	0.125%
3b	Achieving 90% of identified smokers given brief advice.	**Tobacco brief advice**	National	0.125%
3c	Achieving 90% of identified as drinking above low risk levels given brief advice or offered a specialist referral.	**Alcohol brief advice**	National	0.125%
7	Achieving 80% of older inpatients receiving key falls preventions actions.	**3 High impact interventions to prevent hospital falls**	National	0.125%
11a	Achieving 75% of patients with a confirmed pulmonary embolus being managed in a same day setting where clinically appropriate.	**SDEC* – Pulmonary Embolus**	National	0.125%
11b	Achieving 75% of patients with confirmed atrial fibrillation being managed in a same day setting where clinically appropriate.	**SDEC – Tachycardia with Atrial Fibrillation**	National	0.125%
11c	Achieving 75% of patients with confirmed community acquired pneumonia being managed in a same day setting where clinically appropriate.	**SDEC – Community-acquired pneumonia**	National	0.125%
			Total value	**1.250%**

*SDEC – Same day emergency care

5.3 Trust Performance Against the 2018/19 Risk Assessment Framework

Description	Target	Performance	Achieved Y / N
18 weeks			
Admitted	90.0%	71.11%	**No longer national target**
Non-admitted	95.0%	N/A	**No longer national target**
Incomplete pathways	92.0%	80.87%	**N**
Cancer			
2ww	93.0%	95.32%	**Y**
Breast symptoms 2ww	93.0%	91.67%	**Y**
31 day – Diagnosis to first treatment	96.0%	97.50%	**Y**
Subsequent treatments (31 day) – Drug treatments	98.0%	99.71%	**Y**
Subsequent treatments (31 day) - Surgery	94.0%	99.43%	**Y**
62 day – Waits for first treatment (urgent GP referral)	85.0%	81.74%	**N**
62 day – Waits for first treatment (NHS Cancer Screening referral)	90.0%	96.94%	**Y**
A&E			
Patients seen in < 4 hrs	95%	82.48%	**N**
Clostridium Difficile			
Clostridium Difficile	93.0%	96.20%	**Y**
Total number of cases YTD	52	22	**Y**

Annex 1 – Statements from Commissioners, Local Healthwatch Organisations and Overview and Scrutiny Committees

Norfolk Overview and Scrutiny Committee

The Norfolk Health and Overview and Scrutiny Committee has decided not to comment on any of the Norfolk provider Trusts' Quality Accounts and would like to stress that this should in no way be taken as a negative comment. The Committee has taken the view that it is appropriate for Healthwatch Norfolk to consider the Quality Accounts and comment accordingly.

Healthwatch Norfolk Statement

Healthwatch Norfolk is pleased to comment on the Queen Elizabeth Hospital, King's Lynn Quality Report for 2018/19.

We noted in our review of the 2017/18 report that it was difficult to find one's way around due the structure of the document. We are happy to see that the current year's report is laid out logically and clearly which makes navigation through the various sections much easier even for the lay reader.

However, we would repeat comments made last year to the effect that many of the charts are not legible due to the size of the print and the amount of content, that in some charts legends are missing which makes it difficult to understand and explanations of the content are not always consistent. It may be beneficial to consider including the more complex charts as appendices.

In the main, topics are discussed in plain language at the start of each section before more technical details are introduced. Whilst the report is written for a range of audiences, the needs of the public are properly catered for but there are some acronyms and descriptors which are used and either not explained or only clarified much later (for example "Schwartz Round" which is first used in page 4 but not clarified until page 101). A consistent policy of explaining terms and acronyms at first use or of including a glossary would be helpful.

It is not specified whether the draft document is available in different formats e.g. electronic, hard copy, Braille, other languages.

Preparation of last year's plan had been delayed due to the arrival of a new management team who wished to review the strategy. This year's plan reviews the progress made against those revised priorities set out in the 2017/18 report but is also very much influenced by the CQC inspections in 2018 and 2019.

The Chief Executive's report summarises steps already taken and being taken to improve governance, staff engagement, patient safety and, at the same time, is very explicit in highlighting the fact that only one of the 10 quality objectives set out in the 2017/2018 report had reached the stage where full assurance could be given – this is in the use of anti-coagulants. The others are being carried forward in addition to new objectives formulated for 2019/20.

We are pleased to see that the CEO's report reminds us that whilst there have been many negative events in the past year, there have also been some notable successes which it is important to recognise – 12 examples of successful achievement or high quality clinical outcomes are listed.

We welcome one theme which is emphasised throughout the plans for 2019/20 which is the need to embed changes in a sustainable manner so as to provide assurance that patients. will receive safe care not just in the immediate term but into the future.

The Trust reports that there has been significant rise (18%) in reported incidents including Near-Miss No Harm and those With Harm. This increase is attributed, in the main, to proactive initiatives aimed at encouraging reporting of incidents. Whilst the improved willingness to speak up is of immense value, we would note that it is important to be able to identify any underlying trends in actual harm being caused as well as changes in reporting activity. The report does not explain how this will be achieved.

Priorities for the past year and for 2019/20 are explained clearly and we are pleased to note that each is accompanied by explicit action plans together with detail as to how outcomes will be measured.
Complaints increased by 16% between 2017/18 and 2018/2019. Whilst any increase in complaints is clearly

undesirable, it would perhaps be helpful to put the increase in the context of numbers of patients treated. The Trust is still not in a position to respond to complaints in a timely manner and a streamlined procedure should be in place by the end of June 2019. The year 2018/19 saw responses within the set timeframe reduce to 54% from 64% in 2017/18 and 88% in 2016/17. The Trust aims to achieve > 50% in Quarter 2 2019/20 rising progressively to >80% by the end of March 2020.

Patient safety and clinical quality/effectiveness are covered as part of the Key Priority Performance measures. Action plans and monitoring mechanisms are detailed where improvements are needed. One particular area of high concern is catheter care where audits show significant and wide ranging variances from standard. Improving catheter management is reported as being a key intervention needing renewed focus in 2019/20 as part of the infection control objectives.

Also it was disappointing to see that pressure ulcer incidents in 2018/19 were some 28% higher than the previous year although there was a substantial decline in the latter half of the year, which gives cause for some optimism. On a more positive note we were pleased to see that 2018/19 saw the lowest falls rate for four years – unfortunately accompanied by an increase in those falls resulting in moderate or catastrophic harm. Further work is planned for this area.

The Trust uses a variety of sources to obtain feedback from patients – these include the Friends and Family Test, hosting events such as Cancer and Learning Disability; involvement with public organisations, patient stories at board meetings. In general patient feedback compares favourably with national averages - the main exception being patients with a learning disability where less than 90% would recommend.

The Trust notes that it does use feedback to improve the experience of patients and carers – a list of examples is included in the report. Changes arising from complaints form part of the improvement plan for 2019/20.

PLACE results for 2018 showed the QEH as being just below the national average for cleaning but significantly under in all other areas with the worst being Privacy & Dignity at 67.86% compared to a national figure of 84.2%. The report notes that some of these shortfalls have been addressed directly with others being incorporated into the Trust's overall plans. No further detail is given and it is difficult to track the improvements through into other areas of the document (for example privacy & dignity is not covered explicitly elsewhere).

In the plans for 2018/19 the Trust recognised that improvements were needed in support for staff. This year's plan continues the theme and a large number of measures are listed to improve engagement, personal development and well-being. Staff engagement improvement is one of the top three priorities for 2019.

A recent staff survey (with a 44% response rate) came up with scores which in every category were worse than the previous year and were also lower than benchmark. The Trust has responded to this with a detailed plan aimed at addressing these issues.

The results of the staff survey are mirrored by the Staff FFT figures which are significantly below the national averages and show a deteriorating position over the last five years falling from 76% in 2015/16 who would recommend down to 62% in the 2018/19 quarter 2 snapshot.

The Trust's action plan to address this details a number of steps aimed at improving employees' work experience but also, and more importantly, includes a strong emphasis on ways in which staff can express their concerns directly to Trust executives during open discussion sessions, executive ward visits, workshops etc. We welcome the addition of greater involvement of executives and managers 'on the ground' as our own experience in this area teaches that problems have more impact when encountered live rather than in abstract discussion. We hope that feedback from this programme will form a permanent part of the Board agenda.

It was encouraging to see that through a series of proactive initiatives, since May 2018 medical vacancies have reduced from 20.3% to a current figure of 5.42.

The Trust engaged in 57 National Clinical Audits and 5 National Confidential Enquiries in the past year. A number of areas requiring improvement were noted and action plans detailed.

The Trust reported that their Data Security and Protection Toolkit Assessment report score resulted in 'Standards not met'. There is an action plan in place aimed at being fully compliant by 31/08/2019 but no details are given.

The Trust report against core indicators shows the following areas where performance deteriorated or was below national averages:

- Patient Reported Outcome Measures for Hip and Knee Replacement are given in two tables using the Oxford score system. This is not described so the figures will not mean anything to the lay reader.
- Readmission rates for age 16 and over are slightly over national average figures but in the 0 to 15 group the Trust score is significantly and consistently higher than national data. No explanation is given for this and we feel that it merits some sort of clarification together with a specific action plan if appropriate.
- As already noted Staff FFT results are poor and are around 20% below national averages.
- Clostridium Difficile infection rates are very variable since 2014/15 and are above national figures. Although the 2018/19 outcome is greatly improved, infection control forms a key priority for 2019/20 and the need to embed this in Trust standards is clearly demonstrated by the swings in historic patterns.

Alongside these areas where performance is below expectations it is important to recognise that there are a greater number where the indicators show improvements which are in line with or better than national averages.

In spite of a particularly difficult year the Trust has continued to participate in clinical research and has increased recruitment of patients to take part in approved clinical research by more than 10% compared to the previous year thereby demonstrating its commitment to continued healthcare improvement.

Although monetary totals for participation in CQUINS in 2018/19 have not been published yet, information in the report points to a high level of achievement against the targets including exceeding targets for people with mental health problems who attend A&E. However, sepsis, antibiotic stewardship and national CQUIN targets for Inpatient and then Emergency have not been met on a consistent basis.

The Trust met or exceeded target against its 2018/19 Risk Assessment Framework in seven out of out of 10 categories. It failed to achieve the required level in Incomplete Pathways (80.87% v 92.0%), Cancer – 62-day waits for first treatment (81.31% v 85.0%) and patients seen in less than four hours (82.48% v 95.0%). In each of these three areas performance is lower than the previous year and in addition the 18-week admitted performance for which there is no longer a national target fell from 76.41% to 71.11%. These areas were highlighted in our response to last year's report and it is a matter of concern that failure to meet targets continues, but more importantly that there is year on year deterioration.

The Report confirms the Trust's commitment to working with partners and other organisations involved in the Sustainability & Transformation Plans to continue to bring about improvements in healthcare within the confines of stretched financial resources.

As was noted at the beginning, the 2018/19 Quality Report has been prepared against a backdrop of a series of unsatisfactory outcomes resulting from a number of visits by the CQC. The Quality Report describes the steps being taken to address these matters but does not enter in detail given the sheer volume of improvements that are required. The Trust's own plans for 2019/20 dovetail with the changes arising from the CQC visits.

The Governance Structure tasked with monitoring and providing assurance on delivery of the Quality Improvement Plan is described in reasonable detail. However, no mention is made of the fact that the Oversight and Assurance Group includes Healthwatch and Patient Representation. We believe that it is important for the public to know that as part of the strategy of listening to patients, their voice is also heard in the arena monitoring and scrutinising the Trust's plan to address issues raised by the CQC inspections.

Healthwatch is pleased to see that in spite of historical difficulties, there is a determination to work with all the Trust staff, with regulators, with patients and carers as well as partners and external organisations to bring about longlasting embedded change.

Healthwatch Norfolk is committed to providing as much support and assistance as necessary to help the Trust achieve its aims.

Alex Stewart
Healthwatch Chief Executive
13 May 2019

West Norfolk Clinical Commissioning Group

NHS West Norfolk Commissioning Group (WNCCG), as the co-ordinating commissioner for The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEHKL) has reviewed the 2018/19 Quality Account and confirms it represents a fair and accurate reflection.

WNCCG recognises that the QEHKL had undertaken some ambitious quality improvements in 2018/19 including the success of optimising the use of anti-coagulants within the Trust. This is however against a backdrop of challenges following the CQC inspection in April 2018 which rated the Trust as Inadequate and led to Section 29A letters and a Section 31 notice being issued. Whilst it is recognised that the Trust has made some improvements in some areas, the CCG is concerned that when the CQC returned in March 2019, it was felt there was still a failure to guarantee basic standards of safety.

The CCG recognises the impact of this on frontline staff and welcomes the addition of the Deputy Chief Executive role in the structure to lead on culture and staff engagement at such an important time.

The Trust continues to work collaboratively with a range of stakeholders and has received external support from both NHS I and NHS E during the year. The CCG has, and will continue, to support the Trust through the Senior Performance and Quality Review Group (SPQRG) and Oversight and Assurance Groups. We have also welcomed the opportunity to work with the Trust at Evidence Review meetings.

Quality Priorities 2018/19

Improve patient and family experience in end of life (EoL) care; The CCG recognises from the evidence supplied a marginal improvement was demonstrated and would highlight the need for further tangible improvement.

Improve communication with patients who have a sensory impairment such as deafness or visual impairment; The CCG would agree that only partial assurance can be gained from the evidence and would look for further assurance, particularly how they will ensure people with a Learning Disability have a positive experience of care, once the training is embedded.

Introduction of NEWS2 (National Early Warning Score); The CCG recognises the work undertaken to adopt the NEWS2 process, but requires further assurance that the process is fully embedded in the Trust. The CCG would welcome the audit programme described to gain fuller assurance and would suggest this is cross referenced with any serious incidents relating to failure to escalate.

Ensure improvements in infection control within the Trust; Unfortunately the evidence supplied referencing the domestic staff audit is not legible and the CCG would ask the Trust supply this in a different format. It is noted in the body of the report the successful reduction in Clostridium Difficile cases in 2018/19 which the Trust should be congratulated.

Ensure improvements in Medicines Management – focusing on the use of anti-coagulants; The CCG recognises the excellent work achieved on the use of direct oral anti-coagulants in the Ambulatory Emergency Care Unit and looks forward to seeing this adopted more widely within the Trust.

Improve provision and assurance of safe staffing levels on inpatient wards; The CCG welcomes the recent introduction of the SafeCare software package but due to infancy of the pilot, the CCG lacks assurance on this quality initiative. The CCG would encourage the Trust continue this as a priority for 2019/20.

Improve the quality of perinatal care; The CCG recognises this initiative remains in the development stage and would encourage the Trust continue this as a priority in 2019/20.

Implement a quality improvement programme to support better nutrition and hydration in patients; The CCG recognises some of the work undertaken and would support the Trust statement in suggesting that continued work would need to take place in 2019/20 for assurance to be gained.

Enhance learning from deaths in people with a learning disability to support improvements in care; Whilst the CCG recognises the work undertaken by the LD liaison team, the CCG is not assured that this work has resulted in significant change in the Trust. This is supported by the poor experience of care for people with a learning disability noted earlier and would suggest the Trust continue this work into 2019/20.

Undertake an improvement programme to support better documentation and record-keeping; The CCG recognises this initiative needs further evaluation to understand its impact and therefore assurance cannot be gained. The CCG would welcome this work continue as a priority for 2019/20.

Improve understanding of the Mental Capacity Act (MCA) 2005 amongst staff and how it can support improvements in the quality of care for the patient; The CCG recognises that ongoing work needs to be embedded and assessed before full assurance can be gained and would welcome the continuation of this work for 2019/20.

Quality Priorities 2019/20

The CCGs are in support of the key quality priorities for 2019/20. WNCCG does however recommend that the Trust ensures that those Quality Priorities that were not achieved in 2018/19 are continued. Furthermore, the CCG would ask the Trust to consider another quality priority for inclusion:

- To improve compliance of serious incident investigations in line with the National Standard. We would encourage the Trust to aspire to 100% compliance.

QEHKL 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.

We believe that overall this report highlights some good work by the Trust to improve quality at a difficult time as you work to get out of special measures. The CCG looks forward to continuing to working in a positive and collaborative manner with the Trust to continue improvements in patient care and outcomes during the coming year.

Sarah Jane Ward
Director of Nursing and Quality Assurance – NHS West Norfolk CCG
8 May 2019

Trust Governors

The following represents a composite of the views expressed by the Trust's Governors on the Quality Report 2018/19.

This very comprehensive report has highlighted some of the difficulties the Trust has faced in the last year, and also the action being taken to improve quality. However, the Governors would have liked to see more evidence of how initiatives have had a positive impact on patients and have led to sustained quality improvement.

The Governors would also have liked to see specific reference to the role of the executive and non-executive directors in leading the Trust to a position of sustained improvement.

A high level of clinical incident reporting can be a good sign of an open and learning organisation and this report shows an increase in the last year compared with 2017/18. This is associated; however, with an increase in harm from 1.04% to 1.4%, which is disappointing, although it is possible that a more robust interpretation of incidents may have influenced this trend.

Equally, it is disappointing to see an increase in formal complaints of 16% in the past year and a deterioration in complaint response times.

The Governors' Council welcomes an increase in compliments in the year.

The CQC findings as described in the report are a summary of the shortcomings they reported, and the document does not try to down play the implications of the CQC's assessments. The report shows the effort the Trust is making to remedy these deficiencies and improve the working environment for staff. The Governors hope that the rigour with which the problems are being addressed will satisfy the regulator that sustainable quality improvements have been secured and that this will ultimately lead to the Trust emerging from special measures.

The section on 'Falls' shows how the appointment of a falls co-ordinator and champions on wards has made a difference and resulted in a reduction in falls in the Trust.

The document also shows that the Trust has an excellent record for participating in research and engaging in audits, which bodes well for the future and shows that clinical staff are working to improve the care they deliver and aiming for excellence.

Positive Governor Observations

Governors welcomed:

- Reduction in Serious Incident numbers
- Sustained reduction in pressure ulcers
- The 'Values and Behaviours Framework' initiative – Governors look forward to seeing this impacting positively on the Trust's cultural development
- Focus on Infection Control
- Ward Accreditation Scheme – in which Governors have been involved
- Active nurse recruitment – overseas and locally
- Innovative recruitment offerings to encourage high-calibre interest in hard-to-fill medical vacancies
- Appointment of an independent Freedom to Speak Up Guardian
- The Trust's improved engagement with the Norfolk and Waveney Sustainability and Transformation Partnership

Areas for Improvement, identified by Governors:

- Hydration and nutrition for patients
- Discharge arrangements
- Experience of patients at the end of life and their families
- Improving the involvement / engagement of doctors in 'end of life' discussions
- Recognising the deteriorating patient and escalating appropriately
- Communication and staff attitude (as reflected in Complaints)
- Staff sickness-absence levels
- Access and the experience of patients attending the A&E
- Consistent, high quality management of Sepsis
- Care for people with mental health issues, attending the A&E
- Working relationships with GPs
- Staff engagement and accountability
- Some poor infection controls e.g. catheter care
- Collaborative working with Community Services, after discharge – resulting in the potential for readmission.

The Governors hope and expect that the Trust's outstanding quality issues will be addressed by its Quality Improvement Plans and through delivery of the key Quality Priorities for 2019/20, as set out in this Quality Report.
13 May 2019

Annex 2 – Statement of Directors' responsibilities for the Quality Report

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare quality accounts for each financial year.

Guidance has been issued to NHS Foundation Board of Directors on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Board of Directors should put in place to support 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;
- 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 over the period April 2018 to March 2019
  - feedback from commissioners dated 8 May 2019
  - feedback from governors dated 13 May 2019
  - feedback from local Healthwatch organisations dated 13 May 2019
  - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 7 July 2018
  - national inpatient patient survey, dated June 2018
  - national staff survey, dated February 2019
  - the head of internal audit's annual opinion over the Trust's control environment, dated 7 May 2019
  - CQC quality update - monthly.
- The quality report presents a balanced picture of the NHS Foundation Trust's performance over the period covered;
- The performance information in the quality report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- The quality report has been prepared in accordance with NHS Improvement's annual reporting guidance which incorporates the detailed requirements for quality reports 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.

NB: sign and date in any colour ink except black

.....Date .....Chairman

.....Date .....Chief Executive

Independent auditor's report to the Council of Governors of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust to perform an independent assurance engagement in respect of The Queen Elizabeth Hospital King's Lynn 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 13 May 2019;
- feedback from governors, dated 13 May 2019;
- feedback from local Healthwatch organisations, dated 13 May 2019;
- feedback from Overview and Scrutiny Committee, dated 13 May 2019;
- 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 13 September 2-18;
- the 2018/19 Head of Internal Audit's annual opinion over the trust's control environment, dated [DD] 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 The Queen Elizabeth Hospital King's Lynn 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 The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 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
Chartered Accountants
Botanic House, 100 Hills Road, Cambridge CB2 1AR

22 May 2019

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Financial Report 2018/19

Foreword To The Accounts

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

These accounts for the year ended 31 March 2019, have been prepared by the Board of Directors of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust in accordance with paragraphs 24 and 25 of schedule 7 to the National Health Service Act 2006.

Caroline Shaw
Chief Executive
Date: 21 May 2019

Statement of the Chief Executive's Responsibilities as the Accounting Officer of The Queen Elizabeth Hospital King's Lynn 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 th e NHS Act 2006, has given Accounts Directions which require The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health Group Accounting Manual and 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;
- ensure the use of public funds complies with the relevant legislation, delegated authorities and guidance;
- confirm the that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy; and
- prepare the financial statements on a going concern basis.

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

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

Caroline Shaw
Chief Executive
Date: 21 May 2019

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Independent auditor's report

to the Council of Governors of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion is unmodified

We have audited the financial statements of The Queen Elizabeth Hospital King's Lynn 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 2019 and the Department of Health and Social Care Group Accounting Manual 2019.

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	£3.36m (2017/18:£1.90m) 2% (2017/18: 1%) of total operating income.	
Risks of material misstatement		**vs 2017/18**
Recurring risks	Recognition of NHS and non-NHS income	◄►
	Valuation of land and buildings	◄►
	Going concern	◄►
	New: Fraudulent 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 £35.8 million before impairments against a revised deficit of £37.6 million (planned £15.8 million deficit). The Trust's financial plans for 2019/20 show a forecast deficit position of £2.6 million. This includes cost savings of £5.4 million and also includes an assumption of further DHSC support of £23.3 million for the financial year. 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 of £120.0 million, or any new ones which are received during 2019/20. 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: – **Accounting transparency:** we assessed the completeness and accuracy of the matters covered in the going concern disclosure by reviewing the results of 2018/19 against plan in addition to reviewing the 2019/20 plan submitted to NHS Improvement.

3. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. Going concern is a significant key audit matter and is described in section 2 of our report. We summarise below, the key audit matters, in decreasing order of audit significance, in arriving at our audit opinion above together with our key audit procedures to address those matters and our findings ("our results") from those procedures in order that the Trust's governors as a body may better understand the process by which we arrived at our audit opinion. These matters were addressed, and our findings are based on procedures undertaken, in the context of, and solely for the purpose of, our audit of the financial statements as a whole, and in forming our opinion thereon, and consequently are incidental to that opinion, and we do not provide a separate opinion on these matters.

	The risk	Our response
Recognition and estimation of NHS and non-NHS Income (Income: £189 million; 2017/18: £186 million) *Refer to pages 196 to 205 (accounting policy) and pages 205 to 207 (financial disclosures).*	**Subjective estimate:** The Trust earned £189 million of operating income in 2018/19, of which £170 million was patient income from NHS bodies. The two largest sources are NHS England (£14 million) and Clinical Commissioning Groups (£154 million). There is a risk that the Trust recognises income to which they are not entitled and that cannot be supported by actual activity levels undertaken during the year. Insufficient provision may be made for potential penalties or fines levied by the commissioners, especially where agreement has not been reached on disputed sums during the year. An agreement of balances exercise is undertaken between all NHS bodies to agree the value of transactions during the year and the amounts owed at the year end. 'Mismatch' reports are available setting out discrepancies between the submitted balances. Operating income also includes £18 million earned from activities other than delivering patient care. The largest items for the Trust are Education and Training (£4 million) and Other Contract Income (£6 million). There is a risk that the Trust recognises income to which it is not entitled and that could 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 material mismatches we sought explanations and supporting evidence to verify the Trust's entitlement to the receivable; — **Test of detail:** we obtained copies of the signed contracts in place for the largest CCG commissioners and NHS England. For a sample of contracts, we reconciled the income per the contract to actual income recognised in the year and agreed variances to source documentation; — **Test of detail:** we agreed a sample of items relating to other income activities to source documentation and agreed their treatment. — **Test of detail:** we assessed the Trust's assumptions behind the provision and the application of IFRS 9 for the 2018/19 and 2017/18 periods.

3. Key audit matters: our assessment of risks of material misstatement

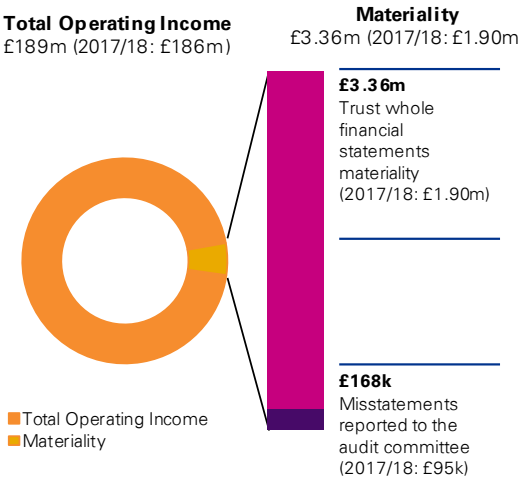
	The risk	Our response
Valuation of land and buildings (£64 million; 2017/18: £68 million) *Refer to pages 196 to 205 (accounting policy) and pages 212 to 215 (financial disclosures).*	**Subjective valuation:** Land and buildings are required to be held at fair value. As hospital buildings are specialised assets and there is not an active market for them they are valued on the basis of the cost to replace them with an equivalent asset. The appropriate valuation of land and buildings relies on: the expertise of the valuer and the accuracy of records provided to the valuer to prepare the valuation. The Trust had a full valuation undertaken at 1 April 2014 which was incorporated into the 2014/15 accounts. An interim desktop valuation was performed as at the 1 April 2016 with an indexation exercise performed for the 31 March 2019 year end. There is a risk that land and buildings values are materially misstated, therefore our work focused on whether the basis of valuation as at 31 March 2019 was appropriate. 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: — **Impairment Indicators:** inspecting Board meeting minutes to identify any changes in the use or indicators of impairment to the Trust's land and/or buildings, which could lead to a change in the valuation. — **Assessing valuer's credentials**: we assessed the scope, qualifications and experience of the valuer and the overall methodology of the valuation performed to identify whether the approach was in line with industry practice and the valuer was appropriately experienced and qualified to undertake the valuation; — **Benchmarking assumptions**: comparing the valuer's assumptions to externally derived data in relation to the indices used and the market conditions cited.
Fraudulent expenditure recognition Accruals £12.0 m (2017/18: £12.0 m), Provisions £0.3 m (2017/18: £0.5 m) *Refer to pages 196 to 205 (accounting policy) and pages 218 to 221 (financial disclosures).*	**Effect of irregularities:** - There is a risk that the Trust may seek to improve it's financial position from the manipulation of expenditure recognition (for instance by deferring expenditure to a later period or through the understatement of liabilities at year end). - We consider the risk to specifically relate to accruals and provisions, as they represent the key mechanism for management to manipulate year-end outturn. - These areas can also be a key area of judgement, especially where there is a dispute with commissioners	Our procedures included: — **Segregation of duties:** we have considered the application of appropriate segregation of duties in the accounts payable process (i.e. the approval of purchase orders and invoices for payment) between those responsible for delivering services and those preparing the financial statements (Finance Team) which helps to prevent fraudulent manipulation of expenditure; — **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 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.

4. Our application of materiality

Materiality for the Trust financial statements as a whole was set at £3.36 million (2017/18: £1.90 million), determined with reference to a benchmark of total operating income (of which it represents approximately 2% (2017/18: 1%). We consider operating income to be more stable than a surplus- or deficit-related benchmark.

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.2m million (2017/18:(£0.2 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 performed at the Trust's headquarters in King's Lynn.



5. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 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.

6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 62, 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 their 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

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REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

— any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.

— any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

Our conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources is qualified.

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

Qualified Conclusion

As a result of the matters outlined in the basis for adverse conclusion paragraph below, we are unable to satisfy ourselves that, in all significant respects that The Queen Elizabeth Hospital King's Lynn 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 has been in breach of its license with Monitor since April 2013. Following an inspection by the Care Quality Commission (CQC) in September 2018, the Trust was rated as "Inadequate" and has been placed back into special measures as a result. Follow up inspections have not shown sufficient progress against this rating.

In the current year the Trust has incurred a deficit of £35.8 million. The original plan for the year was a deficit of £15.8 million, revised in Q3 of 2018/19 to £37.6 million.

The ongoing breach of licence conditions, inadequate CQC rating, and deterioration in the Trust's finances against plan is evidence of a weakness in arrangements for effective planning and deployment of resources and in the governance arrangements in place for monitoring performance.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources .

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

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 overleaf together with the findings from the work we carried out on each area.

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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 the NHSi exposes the Trust to operational and financial challenges in terms of financial sustainability.	Our work included: • Reviewing the Trust's performance against its agreed target year-end outturn and CIP target at year-end; • Reviewing management's forecast to determine whether an improvement in run rate is expected to be achieved in the short term, and if so, whether the underlying assumptions are reasonable; • Reviewing the correspondence with NHS Improvement where they confirmed support through providing further funding. **Our findings on this risk area:** • The Trust has incurred a deficit of £35.8 million against an revised control total of £37.6 million deficit; • The Trust has prepared a financial strategy setting out its plans and initiatives to improve its financial position. • The latest CQC report (September 2018) was rated "Inadequate". • The Trust is reliant on further cash support from NHS Improvement in order to meet its liabilities and continue to provide healthcare services. • We concluded that these issues highlighted weaknesses in the Trust's arrangements to plan its finances effectively to support the sustainable delivery of strategic priorities and maintain its statutory functions.
CQC Rating	In September 2018, the Trust was placed back into special measures after being rated inadequate by the CQC. In forming our value for money opinion in 2018/19 we have considered progress against the following areas: - The results of the regulator's findings and the Trust's action plan.	Our work included: • Review of the latest CQC reports and also any up to date correspondence with the CQC. • Reviewed the CQC Use of Resources assessment report from September 2018 in relation to the Trust. **Our findings on this risk area:** The latest CQC inspection rated the Trust as "inadequate" and as a result was put in to special measures. Therefore, we have qualified the value for money 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 The Queen Elizabeth Hospital King's Lynn 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.

Stephanie Beavis
for and on behalf of KPMG LLP (Statutory Auditor)

Chartered Accountants
Botanic House
100 Hills Road
Cambridge
CB2 1AR

28 May 2019

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Statement of Comprehensive Income and Expenditure

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	170,396	168,020
Other operating income	3.4	18,214	18,385
Operating expenses	4, 5	(222,666)	(204,909)
Operating surplus/(deficit) from continuing operations		**(34,056)**	**(18,504)**
Finance income	8.1	45	17
Finance expenses	8	(1,812)	(1,454)
PDC dividends payable		-	-
Net finance costs		**(1,767)**	**(1,437)**
Other gains / (losses)	9	(5)	(72)
Surplus / (deficit) for the year		**(35,828)**	**(20,013)**

All income and expenditure is derived from continuing operations.
The notes on pages 196 to 226 form part of these accounts.

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	10	503	605
Property, plant and equipment	11	83,325	85,180
Receivables	14	1,044	998
Total non-current assets		**84,872**	**86,873**
Current assets			
Inventories	13	2,102	2,191
Current Liabilities	14	13,935	9,887
Cash and cash equivalents	15	4,402	5,633
Total current assets		**20,439**	**17,711**
Current assets			
Trade and other payables	16	(24,608)	(24,252)
Borrowings	18	(42,169)	(1,393)
Provisions	20	(134)	(194)
Other liabilities	17	(604)	(301)
Total current liabilities		**(67,515)**	**(26,140)**
Total assets less current liabilities		**37,796**	**78,354**
Non-current liabilities			
Borrowings	18	(78,067)	(82,443)
Provisions	20	(228)	(321)
Other liabilities	17	(533)	(538)
Total non-current liabilities		**(78,828)**	**(83,302)**
Total assets employed		**(41,032)**	**(4,948)**
Financed by			
Public dividend capital		52,690	52,319
Revaluation reserve		11,614	11,614
Income and expenditure reserve		(105,336)	(68,881)
Total taxpayers' equity		**(41,032)**	**(4,948)**

The notes on pages 196 to 226 form part of these accounts.

The financial statements on pages 190 to 226 were approved by the Board on 21 May 2019 and signed on its behalf by:

Caroline Shaw
Chief Executive
Date: 21 May 2019

Statement of Changes in Equity for the Year Ended 31 March 2019

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**52,319**	**11,614**	**(68,881)**	**(4,948)**
Impact of implementing IFRS 15 on 1 April 2018	-	-	(627)	**(627)**
Surplus/(deficit) for the year	-	-	(35,828)	**(35,828)**
Public dividend capital received	371	-	-	**371**
Taxpayers' equity at 31 March 2019	**52,690**	**11,614**	**(105,336)**	**(41,032)**

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**52,160**	**11,614**	**(48,868)**	**14,906**
Surplus/(deficit) for the year	-	-	(20,013)	**(20,013)**
Public dividend capital received	159	-	-	**159**
Taxpayers' equity at 31 March 2018	**52,319**	**11,614**	**(68,881)**	**(4,948)**

The accompanying notes form part of these financial statements:

Information on Reserves

Public Dividend Capital

Public Dividend Capital (PDC) is a type of public equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may be issued to trusts by the Department of Health and Social Care. A charge, the cost of capital used by the Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation Reserve

Increases in asset values arising from revalutations are recognised in the revaluation reserve, except where, and to the extent that, they reserve impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Statement of Cash Flows

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(34,056)	(18,504)
Non-cash income and expense:			
Depreciation and amortisation	4.1	6,809	6,389
Income recognised in respect of capital donations	3.4	(155)	(92)
(Increase) / decrease in receivables and other assets		(4,721)	(1,386)
(Increase) / decrease in inventories		89	175
Increase / (decrease) in payables and other liabilities		271	3,714
Increase / (decrease) in provisions		(154)	(67)
Net cash generated from / (used in) operating activities		**(31,917)**	**(9,771)**
Cash flows from investing activities			
Interest received		45	17
Purchase of intangible assets		(21)	(357)
Purchase of property, plant, equipment and investment property		(4,197)	(4,597)
Sales of property, plant, equipment and investment property		6	33
Net cash generated from / (used in) investing activities		**(4,167)**	**(4,904)**
Cash flows from financing activities			
Public dividend capital received		371	159
Movement on loans from the Department of Health and Social Care		36,296	17,452
Capital element of finance lease rental payments		(90)	(89)
Interest on loans		(1,704)	(1,398)
Other interest		(11)	-
Interest paid on finance lease liabilities		(9)	(10)
PDC dividend (paid) / refunded		-	280
Net cash generated from / (used in) financing activities		**34,853**	**16,394**
Increase / (decrease) in cash and cash equivalents		**(1,231)**	**1,719**
Cash and cash equivalents at 1 April - brought forward		**5,633**	**3,914**
Cash and cash equivalents at 31 March	15.1	**4,402**	**5,633**

Where relevant prior year analysis has been adjusted to be on a consistent basis with the current year.

The accompanying notes form part of these financial statements:

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NOTES TO THE ACCOUNTS

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

Going Concern

International Accounting Standard (IAS) 1 requires management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. The financial statements should be prepared on a going concern basis unless management intends, or has no alternative but, to apply to the Secretary of State for the Trust's dissolution without the transfer of its services to another public sector entity.

The Trust's financial plan for 2019/20 has been approved by the Board following discussion with the Regulator and a comprehensive planning process. Cost savings of £5.4m (2%) have been included in the plan along with investments to maintain and enhance patient care. The plan includes the receipt of Provider Sustainability Funding, Marginal Rate Emergency Tariff and Financial Recovery Funding as the Trust is planning to deliver the control total deficit.

As a consequence the Trust will require additional external funding from the Department of Health and Social Care (DHSC). The DHSC is expected to confirm the level of cash support (capital and revenue) that will be available to the Trust for the year. 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.

The Directors have fully considered the principle of 'Going Concern' and have concluded that there is a reasonable expectation that the Trust will have access to adequate cash resources to continue in operational existence for the foreseeable future. For this reason they continue to adopt the going concern basis in preparing the accounts. 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.

DHSC Guidance

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. hese have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.2 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.3 Going concern

These accounts have been prepared on a 'Going Concern' basis.

Note 1.4 Critical judgements in applying accounting policies

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The Trust's management has made the following critical judgments in applying the Trust's accounting policies:

Valuation of Land and Buildings

The most significant estimate within the accounts is the value of land and building. The interim valuation for 2016/17 was performed by professional Chartered Surveyors Boshier and Company on the basis of market value as at 1 April 2016. Boshier and Company has extensive knowledge of the physical estate and market factors, is independent to the Trust and certified by the Royal Institute of Chartered Surveyors. The value does not take into account potential future changes in market value which cannot be predicted with any certainty.

It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period. On the basis of existing knowledge, outcomes within the next financial year that are different from the assumption around the valuation of our land, property, plant and equipment could require a material adjustment to the carrying amount of the asset or liability recorded in note 11.

Untaken annual leave

Under Trust policy with respect to annual leave, staff are not allowed to carry over any holiday days into the following financial year. The Trust does have a financial liability for any annual leave earned by staff but not taken as at 31 March 2019 in respect of those staff who are on maternity leave, long-term sickness leave or suspended. The estimated costs of untaken annual leave as at 31 March 2019 was £322,770, (31 March 2018 £322,770).

Provisions

Assumptions around the timing of cash flows relating to provisions are based on information from the NHS Pensions Agency and internal opinion in the Trust.

Non-Consolidation of Charitable Funds

IFRS10 requires production of consolidated accounts where there is a parent/subsidiary relationship. IFRS10 defines a subsidiary as 'an entity...that is controlled by another entity. Control is the power to govern the financial and operating policies of an entity so as to obtain benefits from its activities.' The Trust is Corporate Trustee of the Charitable Fund and meets the definition of control.

Materiality is an overriding consideration in preparation of the accounts. The International Accounting Standards Board (IASB) states that "Information is material if its omission or misstatement could influence the economic decisions of users taken on the basis of the financial statements".

The net assets of the Charitable Fund amount to about 4% of the Trust net assets. Charitable fund income is about 0.3% of Trust income. The Directors therefore consider that the significant amount of work which would be necessary to consolidate the accounts of the Charitable Fund with those of the

Trust is not justified on the grounds of materiality.

Note 1.4.1 Key sources of estimation and uncertainty

The preparation of the financial information in conformity with IFRS requires management to make judgements, estimates and assumptions that affect the application of policies and the reported amounts of income and expenses and of assets and liabilities. The estimates and assumptions are based on historical experience and other factors that are believed to be reasonable under all the circumstances.

Actual results may vary from these estimates. The estimates and assumptions are reviewed on an ongoing basis.

Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods. The estimates and judgements that have had a significant effect on the amounts recognised in the financial statements are outlined below.

Note 1.4.2 Income estimates

In measuring income for the year, management has taken account of all available information. Income estimates that have been made have been based on actual information related to the financial year.

Included in the income figure is an estimate for partial spells, i.e. patients undergoing treatment that is only partially complete at twelve midnight on 31 March. The number of partial spells for each specialty is taken and multiplied by

the average specialty price and adjusted for the proportion of the spell which belongs to the current year.

Note 1.4.3 Expense accruals
In estimating expenses that have not yet been charged for, management have made a realistic assessment based on costs actually incurred in the year to date, with a view to ensuring that no material items have been omitted.

Note 1.4.4 Provisions
In accordance with the stated policy on provisions, management have used best estimates of the expenditure required to settle the obligations concerned, applying HM Treasury's discount rate as stated, as appropriate. Management have also taken into account all available information for disputes and possible outcomes.

Note 1.5 Income
Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.6 Expenditure on employee benefits

Note 1.6.1 Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Note 1.6.2 Pension costs

NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers' pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

Note 1.7 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.

Note 1.8 Property, plant and equipment

Note 1.8.1 Recognition
Property, plant and equipment is capitalised where:
- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably.
- the item has a cost of at least £5,000;

or

- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under singlemanagerial control;

or

- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Note 1.8.2 Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at fair value.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of valuation less any subsequent accumulated depreciation and impairment losses.

Revaluations are performed every 5 years and reviewed with sufficient regularity in between to ensure carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost

The Trust conducted an interim valuation of land and buildings as at 1 April 2016. The valuation was performed by Boshier and Company Chartered Surveyors.

Properties in the course of construction for service administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Note 1.8.3 Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above.

The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Note 1.8.4 Depreciation

Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction contract are not depreciated until the asset is brought into use.

Note 1.8.5 Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a

revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Note 1.8.6 Transferring revaluation surplus to retained earnings

The depreciable amount of a revalued asset is based upon its revalued amount, not its cost. The depreciation charge for each period is recognised as an expense in the profit and loss.

However, the revaluation surplus may be transferred directly to retained earnings as the surplus is realised. Realisation of the surplus may occur through the use (and depreciation) of the asset or upon its disposal.

Where the Trust disposes of the asset, the whole of the revaluation reserve is transferred. Other than this no transfer of any part of the revaluation reserve will take place.

Note 1.8.7 Impairments

In accordance with the DH GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.8.8 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual
- and customary for such sales;
- the sale must be highly probable ie:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower end of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.8.9 Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case,

the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.9 Intangible assets

Note 1.9.1 Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Note 1.9.2 Software
Software which is integral to the operation of hardware e.g. an operating system is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Note 1.9.3 Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Note 1.9.4 Amortisation
Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.10 Revenue government and other grants
Government grants are grants from Government bodies other than income from Care Commissioning Groups or NHS Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

Note 1.11 Inventories
Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the weighted average cost method.

Note 1.12 Financial instruments and financial liabilities

Note 1.12.1 Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of nonfinancial items (such as goods or services), or that are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described above/below.

Note 1.12.2 De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.12.3 Classification and measurement

Financial assets are categorised as either available for sale, at fair value through income and expenditure, loans and receivables or held to maturity.

Note 1.12.4 Financial assets and financial liabilities at 'fair value through income and expenditure'

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the Statement of Comprehensive Income.

Note 1.12.5 Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS debtors, accrued income and 'other debtors'.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Note 1.12.6 Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Note 1.12.7 Determination of fair value

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health and Social Care, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

Note 1.12.8 Impairment of financial assets

At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

Note 1.13 Leases

Note 1.13.1 Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Note 1.13.2 Operating leases
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Note 1.13.3 Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.14 Provisions
The NHS Foundation Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation.
Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Note 1.14.1 Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims.
Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed in note 19.1 but it is not recognised in the Trust's accounts.

Note 1.14.2 Non-clinical risk pooling
The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.15 Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital used by the NHS foundation trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash

balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.16 Value Added Tax

Most of the activities of the NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.17 Corporation Tax

The Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly in relation to specified activities of a Foundation Trust (s519 (3) to (8) ICTA 1988). None of the Trust's activities in the period are subject to corporation tax liability.

Note 1.18 Foreign Exchange

The functional and presentational currencies of the trust are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Note 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 NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 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 NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.21 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19

Note 1.22 Accounting standards that have been issued but have not yet been adopted

The DH GAM does not require the following Standards and Interpretations to be applied in 2018/19.
These standards are still subject to HM Treasury FReM adoption,

- IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRS 17 Insurance Contracts - Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
- IFRIC 23 Uncertainty over Income Tax Treatments - Application required for accounting periods beginning on or after 1 January 2019,
- IFRS 14 Regulatory Deferral Accounts – Applies to first time adopters of IFRS after 1 January 2016 – therefore not applicable to DHSC group bodies

Note 2 Segmental reporting

Under the definitions of operating segments contained within International Financial Reporting Standard 8, the Trust has a single operating segment where the revenues are derived from the provision of healthcare services.

The products and services provided to external customers are identified in notes 3.1 and 3.2 below under the headings "Income from activities patient care" and "Other operating income". All revenues from external customers are derived from within the UK, and all non-current assets are located in the UK. Revenues from transactions with entities under the control of the UK Government amount to £169.592m (2017/18 £179,782m), and are reported within the single healthcare segment

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1

Note 3.1 Income from patient care activities (by nature)	2018/19 £000	2017/18 £000
Acute services		
Elective income	29,513	28,299
Non elective income	67,322	65,294
First outpatient income	12,744	12,498
Follow up outpatient income	14,960	15,028
A&E income	8,995	8,645
High cost drugs income from commissioners (excluding passthrough costs)	11,795	11,170
Other NHS clinical income	22,133	26,423
All services		
Private patient income	64	72
Agenda for Change pay award central funding	2,223	–
Other clinical income	647	591
Total income from activities	**170,396**	**168,020**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2018/19 £000	2017/18 £000
NHS England	13,938	14,918
Clinical commissioning groups	153,463	150,458
Department of Health and Social Care	2,223	–
Other NHS providers	10	10
NHS other	–	210
Non-NHS: private patients	64	72
Non-NHS: overseas patients (chargeable to patient)	24	56
Injury cost recovery scheme	647	539
Non NHS: other	27	1730
Total income from activities	**170,396**	**168,020**
Of which:		
Related to continuing operations	170,396	168,020

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2018/19 £000	2017/18 £000
Income recognised this year	24	56
Cash payments received in-year	24	56
Amounts written off in-year	6	-

Note 3.4 Other operating income

	2018/19 £000	2017/18 £000
Other operating income from contracts with customers:		
Research and development (contract)	635	697
Education and training (excluding notional apprenticeship levy income)	6,288	6,219
Non-patient care services to other bodies	4,154	4,411
Provider sustainability / sustainability and transformation fund income (PSF/ STF)	1,221	1,405
Other contract income	5,761	5,561
Receipt of capital grants and donations	155	92
Total other operating income	**18,214**	**18,385**
Of which:		
Related to continuing operations	18,214	18,385

****Analysis of other operating income: Other**

	2018/19	2017/18
	£000	£000
Car parking Income	1,658	1,350
Catering	664	603
Pharmacy sales	49	56
Property rental (not lessee income)	394	172
Staff accommodation rental	12	–
Estates recharges	363	–
IT recharges	46	–
Staff contribution to employee benefit schemes	20	–
Clinical tests	2,361	2,586
Clinical excellence awards	194	214
Other income generation schemes	–	793
Other income not already covered	–	(213)
	5,761	**5,561**

Note 3.5 Sustainability and transformation fund income

STF - incentive scheme - general distribution	-	1,405
PSF - incentive scheme - general distribution	1,221	-

Note 3.6 Additional information on revenue from contracts with customers recognised in the period

	2018/19
	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	5
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	-

Note 3.7 Transaction price allocated to remaining performance obligations

	31 March 2019
	£000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	
within one year	643
Total revenue allocated to remaining performance obligations	**643**

Note 4 Operating Expenses

Note 4.1 Operating expenses

	2018/19	2017/18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	5,663	4,713
Purchase of healthcare from non-NHS and non-DHSC	3,199	794
Staff and executive directors costs	152,582	142,559
Remuneration of non-executive directors	122	120
Supplies and services - clinical (excluding drugs costs)	14,861	15,019
Supplies and services - general	3,138	2,890
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	16,739	15,922
Inventories written down	91	–
Consultancy costs	766	282
Establishment	2,115	1,473
Premises	6,272	5,912
Transport (including patient travel)	1,047	1,157
Depreciation on property, plant and equipment	6,686	6,310
Amortisation on intangible assets	123	79
Movement in credit loss allowance: contract receivables / contract assets	287	61
Change in provisions discount rate(s)	10	6
Audit fees payable to the external auditor		
Audit services - statutory audit	55	55
Other auditor remuneration (external auditor only)	9	11
Internal audit costs	110	122
Clinical negligence	5,759	4,885
Insurance	111	96
Education and training	464	445
Rentals under operating leases	548	545
Car parking & security	49	73
Hospitality	44	33
Losses, ex gratia & special payments	6	25
Other services, eg external payroll	84	105
Other	1,726	1,218
Total	**222,666**	**204,909**
Of which:		
Related to continuing operations	222,666	204,909

In addition the external auditor audits The Queen Elizabeth Hospital Charitable Fund and the fee is £5,820 (2017/18 £5,820)

Note 4.2 Other auditor remuneration

	2018/19	2017/18
	£000	£000
Other auditor remuneration paid to the external auditor:		
2. Audit-related assurance services	9	11
Total	**9**	**11**

Note 4.3 Limitation on auditor's liability
The limitation on auditor's liability for external audit work is £1m (2017/18: £1m).

Note 5 Employee benefits

Note 5.1 Employee benefits

	2018/19	2017/18
	£000	£000
Salaries and wages	112,634	105,686
Social security costs	11,192	9,880
Apprenticeship levy	539	505
Employer's contributions to NHS pensions	12,437	11,639
Temporary staff (including agency)	16,037	15,032
Total staff costs	**152,839**	**142,742**
Of which:		
Costs capitalised as part of assets	251	183

Note 5.2 Retirements due to ill-health
During 2018/19 there were 3 early retirements from the trust agreed on the grounds of ill health (2 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £13k (£121k in 2017/18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 6 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:

Note 7 Operating Leases
This note discloses costs and commitments incurred in operating lease arrangements where The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust is the lessee.

	2018/19	2017/18
	£000	£000
Operating lease expense		
Minimum lease payments	548	545
Total	**548**	**545**

	31 March 2019 £000	31 March 2018 £000
Future minimum lease payments due:		
- not later than one year;	138	373
- later than one year and not later than five years;	502	3
- later than five years.	125	-
Total	**765**	**376**

Note 8 Finance

This note discloses costs and commitments incurred in operating lease arrangements where The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust is the lessee.

Note 8.1 Finance income

Finance income represents interest received on assets and investments in the period.

	2018/19 £000	2017/18 £000
Interest on bank accounts	45	17
Total	**45**	**17**

Note 8.2 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2018/19 £000	2017/18 £000
Interest expense:		
Loans from the Department of Health and Social Care	1,798	1,444
Finance leases	2	10
Total	**1,800**	**1,454**
Unwinding of discount on provisions	1	–
Other finance costs	11	–
Total finance costs	**1,812**	**1,454**

Note 8.3 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

No interest was incurred in either 2018/19 nor 2017/18 in respect of late payment of commercial debts.

Note 9 Other losses

	2018/19 £000	2017/18 £000
Losses on disposal of assets	(5)	(72)
Total other losses	**(5)**	**(72)**

Note 10 Intangible Assets

Note 10.1 Intangible assets - 2018/19

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	930	930
Additions	21	21
Valuation / gross cost at 31 March 2019	**951**	**951**
Amortisation at 1 April 2018 - brought forward	325	325
Provided during the year	123	123
Amortisation at 31 March 2019	**448**	**448**
Net book value at 31 March 2019	503	503
Net book value at 1 April 2018	605	605

Note 10.2 Intangible assets - 2017/18

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	573	573
Additions	357	357
Valuation / gross cost at 31 March 2018	**930**	**930**
Amortisation at 1 April 2017 - brought forward	246	246
Provided during the year	79	79
Amortisation at 31 March 2018	**325**	**325**
Net book value at 31 March 2018	605	605
Net book value at 1 April 2017	327	327

Note 11.1 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	4,610	73,099	2,461	29,062	177	18,001	679	128,089
Additions	-	-	4,663	144	-	35	-	4,842
Reclassifications	-	1,532	(4,227)	2,141	-	554	-	-
Disposals / de-recognition	-	-	-	(325)	-	-	-	(325)
Valuation/gross cost at 31 March 2019	**4,610**	**74,631**	**2,897**	**31,022**	**177**	**18,590**	**679**	**132,606**
Valuation/gross cost at 1 April 2018 - brought forward	-	12,009	-	18,006	163	12,207	524	42,909
Additions	-	3,221	-	1,948	5	1,493	19	6,686
Reclassifications	-	-	-	(314)	-	-	-	(314)
Accumulated depreciation at 31 March 2019	**-**	**15,230**	**-**	**19,640**	**168**	**13,700**	**543**	**49,281**
Net book value at 31 March 2019	4,610	59,401	2,897	11,382	9	4,890	136	83,325
Net book value at 1 April 2018	4,610	61,090	2,461	11,056	14	5,794	155	85,180

Note 11.2 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	4,610	64,628	4,406	29,229	430	18,107	678	122,088
Prior period adjustments	-	6,514	-	(1,807)	(253)	(1,318)	1	3,137
Valuation / gross cost at 1 April 2017 - restated	**4,610**	**71,142**	**4,406**	**27,422**	**177**	**16,789**	**679**	**125,225**
Additions	-	-	3,609	103	-	5	-	3,717
Reclassifications	-	1,957	(5,554)	2,390	-	1,207	-	-
Disposals / de-recognition	-	-	-	(853)	-	-	-	(853)
Valuation/gross cost at 31 March 2018	**4,610**	**73,099**	**2,461**	**29,062**	**177**	**18,001**	**679**	**128,089**
Accumulated depreciation at 1 April 2017 - as previously stated	-	2,410	-	18,719	408	12,174	499	34,210
Prior period adjustments	-	6,514	-	(1,807)	(253)	(1,318)	1	3,137
Accumulated depreciation at 1 April 2017 - restated	-	8,924	-	16,912	155	10,856	500	37,347
Provided during the year	**-**	**3,085**	**-**	**1,842**	**8**	**1,351**	**24**	**6,310**
Disposals / de-recognition	**-**	**-**	**-**	**(748)**	**-**	**-**	**-**	**(748)**
Accumulated depreciation at 31 March 2018	**-**	**12,009**	**-**	**18,006**	**163**	**12,207**	**524**	**42,909**
Net book value at 31 March 2018	4,610	61,090	2,461	11,056	14	5,794	155	85,180
Net book value at 1 April 2017	4,610	62,218	4,406	10,510	22	5,933	179	87,878

Note 11.3 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019								
Owned - purchased	4,610	55,552	2,897	10,850	9	4,863	122	**78,903**
Owned - donated	-	3,849	-	532	-	27	14	**4,422**
NBV total at 31 March 2019	**4,610**	**59,401**	**2,897**	**11,382**	**9**	**4,890**	**136**	**83,325**

Note 11.4 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018								
Owned - purchased	4,610	57,050	2,461	10,548	14	5,785	139	**80,607**
Finance leased	-	-	-	19	-	-	-	**19**
Owned - donated	**-**	**4,040**	**-**	**489**	**-**	**9**	**16**	**4,554**
NBV total at 31 March 2018	**4,610**	**61,090**	**2,461**	**11,056**	**14**	**5,794**	**155**	**85,180**

Note 11.5 Economic life of purchased intangible assets

	Min life Years	Max life Years
Software	7	7

Note 11.6 Economic life of Property, Plant and Equipment

	Min life Years	Max life Years
Buildings excluding dwellings	15	80
Plant and machinery	5	15
Transport equipment	7	7
Information Technology	5	8
Furniture and fittings	5	15

Note 12 Donations of property, plant and equipment

	2018/19 £000
Medical equipment	136
Software	19
	155

Note 13 Inventories

	31 March 2019 £000	31 March 2018 £000
Drugs	741	861
Consumables	1,340	1,239
Energy	21	91
Total inventories	**2,102**	**2,191**
Of which:		
Held at fair value less costs to sell	–	–

Inventories recognised in expenses for the year were £30,070k (2017/18: £29,226k).
Write-down of inventories recognised as expenses for the year were £91k (2017/18: £0k).

Note 14 Trade Receivables

Note 14.1 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Contract receivables*	13,049	
Trade receivables*		4,922
Accrued income*		3,443
Allowance for impaired contract receivables / assets*	(1,298)	
Allowance for other impaired receivables	-	(1,011)
Prepayments (non-PFI)	1,363	1,481
VAT receivable	170	346
Other receivables	651	706
Total current trade and other receivables	**13,935**	**9,887**
Non-current		
Other receivables	1,044	998
Total non-current trade and other receivables	**1,044**	**998**
Of which receivables from NHS and DHSC group bodies:		
Current	12,488	7,506
Non-current	-	-

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 14.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 April 2018 - brought forward		–
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	1,011	(1,011)
New allowances arising	287	–
Allowances as at 31 March 2019	**1,298**	**(1,011)**

Note 14.3 Credit Quality of Financial Assets 2017/18

	31 March 2019 £000	31 March 2018 £000 (restated)
Ageing of impaired financial assets		
0-30 days	76	14
30-60 days	25	55
60-90 days	106	24
90-180 days	113	183
Over 180 days	978	734
	1,298	**1,010**
Ageing of non-impaired financial assets		
0-30 days	7,319	2,614
30-60 days	518	(282)
60-90 days	252	288
90-180 days	278	296
Over 180 days	2,068	2,053
	10,435	**4,969**

Note 15 Cash and cash equivalents

Note 15.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2018/19 £000	2017/18 £000
At 1 April	**5,633**	**3,914**
Net change in year	(1,231)	1,719
At 31 March	**4,402**	**5,633**
Broken down into:		
Cash at commercial banks and in hand	29	82
Cash with the Government Banking Service	4,373	5,551
Total cash and cash equivalents as in SoFP	**4,402**	**5,633**
Total cash and cash equivalents as in SoCF	**4,402**	**5,633**

The trust held no cash or cash equivalents which relate to monies held by the Trust on behalf of patients or other parties at 31 March 2019 (31 March 2018 nil)

Note 16 Trade and other payables

Note 16.1 Trade and other payables

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	6,843	7,136
Capital payables	1,107	617
Accruals	11,923	12,090
Social security costs	1,599	1,421
Other taxes payable	1,421	1,305
Accrued interest on loans*		107
Other payables	1,715	1,576
Total current trade and other payables	**24,608**	**24,252**
Of which payables from NHS and DHSC group bodies:		
Current	4,501	6,961
Non-current	–	–

**Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note . IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 16.2 Early retirements in NHS payables above

There are no payables amounts in relation to early retirements at 31 March 2019 (31 March 2018 nil)

Note 17 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	604	301
Total other current liabilities	**604**	**301**
Non-current		
Deferred income: contract liabilities	533	538
Total other non-current liabilities	**533**	**538**

Note 18 Borrowings

Note 18.1 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Loans from the Department of Health and Social Care	42,169	1,303
Obligations under finance leases	-	90
Total current borrowings	**42,169**	**1,393**
Non-current		
Loans from the Department of Health and Social Care	78,067	82,443
Total non-current borrowings	**78,067**	**82,443**

Note 18.2 Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	Finance leases £000	Total £000
Carrying value at 1 April 2018	**83,746**	**90**	**83,836**
Cash movements:			
Financing cash flows - payments and receipts of principal	36,296	(90)	**36,206**
Financing cash flows - payments of interest	(1,704)	(9)	**(1,713)**
Non-cash movements:			
Impact of implementing IFRS 9 on 1 April 2018	100	7	**107**
Application of effective interest rate	1,798	2	**1,800**
Carrying value at 31 March 2019	**120,236**	**-**	**120,236**

Note 18.3 Analysis of Loans with Department of Health and Social Care

The Trust has 26 loans outstanding with the Department of Health, the details of which are contained in the table below:

	Loan Value £000	Term (Years)	Expiring	
Normal Capital Investment Loan	450	10	2020/21	2-5
Normal Capital Investment Loan	1,054	10	2021/22	2-5
Interim Capital Loan	734	15	2029/30	>5
Interim Revenue Loan	16,800	5	2019/20	<1
Revolving working capital facilities	17,630	5	2019/20	<1
Interim Revenue Loan	15,625	5	2020/21	2-5
Interim Capital Loan	5,152	13	2028/29	>5
Interim Revenue Loan	1,000	3	2019/20	<1
Interim Revenue Loan	2,468	3	2019/20	<1
Interim Revenue Loan	2,775	3	2019/20	<1
Interim Revenue Loan	1,540	3	2020/21	2-5
Interim Revenue Loan	1,615	3	2020/21	2-5
Interim Revenue Loan	1,546	3	2020/21	2-5
Interim Revenue Loan	3,485	3	2020/21	2-5
Interim Revenue Loan	5,443	3	2020/21	2-5
Interim Revenue Loan	5,126	3	2020/21	2-5
Interim Revenue Loan	1,752	3	2021/22	2-5
Interim Revenue Loan	2,500	3	2021/22	2-5
Interim Revenue Loan	1,000	3	2021/22	2-5
Interim Revenue Loan	5,450	3	2021/22	2-5
Interim Revenue Loan	3,000	3	2021/22	2-5
Interim Revenue Loan	2,300	3	2021/22	2-5
Interim Revenue Loan	1,080	3	2021/22	2-5
Interim Revenue Loan	6,070	3	2021/22	2-5
Interim Revenue Loan	3,000	3	2021/22	2-5
Interim Revenue Loan	11,448	3	2021/22	2-5
	120,043			

Note 19 Finance leases

Note 19 The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust as a lessee

Obligations under finance leases where The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust is the lessee.

	31 March 2019	31 March 2018
	£000	£000
Gross lease liabilities	**–**	**90**
of which liabilities are due:		
- not later than one year;	–	90
Finance charges allocated to future periods	–	–
Net lease liabilities	**–**	**90**
of which payable:		
- not later than one year;	–	90

Note 20 Provisions for liabilities and charges

Note 20.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits*	Other	Total
	£000	£000	£000	£000
At 1 April 2018	**90**	**266**	**159**	**515**
Change in the discount rate	(1)	11	0	**10**
Arising during the year	31		64	**95**
Utilised during the year	(14)	(27)	(55)	**(91)**
Reversed unused	(15)	(88)	(65)	**(168)**
Unwinding of discount	-	1	-	**1**
At 31 March 2019	**91**	**168**	**103**	**362**
Expected timing of cash flows:				
- not later than one year;	15	16	103	**134**
- later than one year and not later than five years;	49	64	-	**113**
- later than five years.	27	88	-	**115**
Total	**91**	**168**	**103**	**362**

Note 20.2 Clinical negligence liabilities

At 31 March 2019, £94,729k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (31 March 2018: £76,924k).

Note 21 Contractual capital commitments

	31 March 2019	31 March 2018
	£000	£000
Property, plant and equipment	817	1,088
Total	**817**	**1,088**

Note 22 Financial Instruments

Note 22.1 Carrying values of financial assets

IFRS 9 Financial Instruments is applied retrospectively 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	Total book value
	£000	£000
Carrying values of financial assets as at 31 March 2019 under IFRS 9		
Trade and other receivables excluding non financial assets	12,159	**12,159**
Cash and cash equivalents at bank and in hand	4,402	**4,402**
Total at 31 March 2019	**16,561**	**16,561**

	Loans and receivables	Total book value
	£000	£000
Carrying values of financial assets as at 31 March 2018 under IAS 39		
Loans and Receivables	8,006	**8,006**
Cash and cash equivalents at bank and in hand	5,633	**5,633**
Total at 31 March 2019	**13,639**	**13,639**

Note 22.2 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied retrospectively 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	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS		
Loans from the Department of Health and Social Care	120,236	**120,236**
Trade and other payables excluding non financial liabilities	19,041	**19,041**
Total at 31 March 2019	**139,277**	**139,277**

	Other financial liabilities	Total book value
	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39		
Loans from the Department of Health and Social Care	83,746	**83,746**
Obligations under finance leases	90	**90**
Trade and other payables excluding non financial liabilities	20,611	**20,611**
Total at 31 March 2018	**104,447**	**104,447**

Note 22.3 Maturity of financial liabilities

	31 March 2019	31 March 2018
	£000	£000
In one year or less	61,210	22,004
In more than one year but not more than two years	35,533	41,976
In more than two years but not more than five years	39,560	36,911
In more than five years	2,974	3,556
Total	**139,277**	**104,447**

Note 23 Losses and special payments

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	3	-	2	-
Fruitless payments	12	127	30	14
Bad debts and claims abandoned	5	7	346	4
Total losses	**20**	**134**	**378**	**18**
Special payments				
Compensation under court order or legally binding arbitration award	–	-	3	9
Ex-gratia payments	24	54	35	64
Total special payments	**24**	**54**	**38**	**73**
Total losses and special payments	**44**	**188**	**416**	**90**
Compensation payments received		**–**		**–**

Note 24 Revaluation Reserve

There was no movement in the Revaluation Reserve in 2018/19 or 2017/18

Note 25 Application of IFRS

Note 25.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

The was no material impact to the Trust following initial application of IFRS 9

Note 25.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

The impact of initial application of IFRS 15 resulted in £627k adjustment to opening reserves.

Note 26 Related Parties

	Receivables		Payables	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Other NHS Bodies	12,488	7,506	4,440	6,804
Other Government bodies including:				
Local Authorities	231	378	3,086	2,784
Department of Health	-	-	-	-
Charitable Funds	15	6	-	-
Total	**12,734**	**7,890**	**7,526**	**9,588**

	Income		Expenditure	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Other NHS Bodies	181,010	179,676	14,049	12,353
Other Government bodies including:				
Local Authorities	43	106	25,051	22,869
Department of Health and Social Care	2,243	-	-	-
Charitable Funds	303	452	-	-
Total	**183,599**	**180,234**	**39,100**	**35,222**

List of Related Parties:

- Department of Health and Social Care
- HM Revenue & Customs
- Care Quality Commission
- NHS Business Service Authority
- NHS Pension Scheme
- NHS England
- NHS Commissioning Board
- NHS Blood & Transplant
- NHS North Norfolk CCG
- NHS South Norfolk CCG
- NHS West Norfolk CCG
- NHS Norwich CCG
- NHS Cambridgeshire & Peterborough CCG
- NHS Lincolnshire East CCG
- NHS South Lincolnshire CCG
- NHS West Suffolk CCG
- NHS Litigation Authority
- Health Education England
- Cambridgeshire University Hospital NHS Foundation Trust
- Cambridgeshire Community Services NHS Trust
- Cambridge & Peterborough NHS Foundation Trust
- Norfolk and Norwich University NHS Foundation Trust
- North West Anglian NHS Foundation Trust
- East of England Ambulance Service NHS Trust
- Kings Lynn and West Norfolk Borough Council

The Trust received revenue and capital payments amounting to £303,213 (£452,131 2017/18), as disclosed above, from The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust Charitable Fund, the Trustees for which make up the Trust Board. A copy of The Queen Elizabeth King's Lynn NHS Trust Charitable Fund Accounts can be obtained on request (01553 613981).

The Trust conducted transactions with other Health Authorities and NHS bodies, which individually are not regarded as material, during the normal course of the Trust's activities.

Note 27 Financial risk management

International Financial Reporting Standard 7 and International Accounting Standard 32 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Foundation Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the NHS Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Foundation Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Foundation Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trusts internal auditors.

Currency Risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2019 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity Risk

The Trust's operating costs are incurred under contracts with primary care Trusts, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.