



**The Queen Elizabeth
Hospital King's Lynn**
NHS Foundation Trust

Annual Report and Accounts 2019/20

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Annual Report 2019/20

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What our stakeholders and patients are saying about us

“Staff at the Queen Elizabeth have always cared for their patients as if they were their own family. Now, it’s great to see the whole Trust playing a full role in the wider health and care family - both as an ‘anchor institution’ in West Norfolk and as a vital partner in the acute hospital system across Norfolk and Waveney. As we all work more closely together, we can care for people even more effectively - and we make each organisation stronger.”

Rt Hon Patricia Hewitt,
Chair, Norfolk and Waveney Health and Care Partnership

“The Queen Elizabeth Hospital King’s Lynn has a special place in the heart of West Norfolk and is a vital part of our acute hospital provision across Norfolk and Waveney. Over the past year everyone in the hospital has worked incredibly hard to improve quality and build stronger partnerships. We see the evidence of this in its ongoing improvement journey and in the contributions it makes within our health and care system.”

Melanie Craig
Chief Executive, NHS Norfolk and Waveney NHS Clinical Commissioning Group

“Healthwatch are pleased to report that there has been a substantial sea change in the way in which the Queen Elizabeth is both operating and being managed. We have been invited in to talk to staff, patients and carers on a regular basis and we are a constituent member of a group of stakeholders who work with the hospital to oversee the improvement programme to get the hospital out of ‘special measures’. It was with particular pleasure that we were able to report that patient confidence has increased considerably over the last 6-9 months with ratings for the hospital rising from one star to four and a half stars (out of five). We recognise that the task facing the Management Team is akin to turning a massive tanker around in the Suez Canal but have full confidence that with everyone’s co-operation, all the changes required will happen.

“We look forward to continuing working with staff, patients and carers over the next 12 months which, in the light of COVID-19 is going to prove a very testing time for us all. We would also like to thank the staff who have worked tirelessly in some very extreme circumstances.”

Alex Stewart
Chief Executive, Healthwatch Norfolk

“I have been impressed by the new leadership teams' determination to improve, engage with, value and develop the workforce and communicate and collaborate with the wider community. There is a renewed sense of optimism for the future, including an exciting shared vision to create a School of Nursing in partnership between The College of West Anglia and QEH.”

David Pomfret
Principal/Chief Executive, College of West Anglia

“As a stakeholder, our relationship with the QE Hospital has improved markedly during the last 12 months both strategically and at a Senior Level. During 2019/20 we have formed a good working partnership with regular joint meetings to agree projects such as the ‘Ask LILY’, web-site directory and a ‘Home from Hospital’ initiative. We look forward to expanding our joint working to new areas.”

Cllr Elizabeth Nockolds

Cabinet Member for Culture, Heritage and Health,
King’s Lynn and West Norfolk Borough Council

“Over the past 12 months, we have continued to develop a positive and proactive working relationship with The Queen Elizabeth Hospital. Our joint working has led to progress in prevention work out in the community and the District Direct project, which helps to get people back into their own homes quickly and safely. This has reduced the length of stay in hospital, which is better for the individual and the hospital. By working closely together, we can identify areas where we can make a difference, and with early intervention we can reduce costs for both organisations and improve outcomes for patients and residents. The QEH is a key working partner for the borough council and together we will continue to seek opportunities to maintain and improve the services available to the residents of West Norfolk.”

Lorraine Gore

Chief Executive, King’s Lynn and West Norfolk Borough Council

“Since being elected, I have been impressed by the dedication and commitment shown by QEH leadership and staff to drive improvements for patients. The team spirit and passion I’ve seen comes through as everyone continues the journey to take the hospital out of special measures. There’s still more to do but I’m proud to help champion their efforts locally and in Westminster.”

James Wild

MP for North West Norfolk

“In the past year the Governors of the Queen Elizabeth FT Hospital have established a much-improved working relationship with the Trust Board and have been especially impressed with the work ethic and the drive for improvement demonstrated by the new Executive Team.

Communications have improved significantly and Governors feel more involved and valued.

The leadership team have managed the recent extreme circumstances associated with the COVID-19 pandemic by leading from the front. Looking forward, strategic planning for the next five years is at an advanced stage and demonstrates vision and an ambition to establish the very best small rural District General Hospital. We look forward to working with the Board in 2020/21 to the betterment of patient and staff experience.”

Esmé Corner OBE

Lead Governor

"The past few months have seen incredibly testing times for the NHS and have pushed to the limit all operational and clinical procedures within hospitals. I have been so impressed at the way staff at the Queen Elizabeth Hospital have adapted to these changes, despite the overwhelming presence of Covid-19. Across the hospital, from porters to cleaners, nurses to consultants, I have received reports of immense kindness, professionalism and tremendous spirit. Staff should be incredibly proud of the work they do and I would like to take this opportunity to thank everyone for their work. You have all made tremendous sacrifices and we have all had to alter the way we work. This has been a steep learning curve for everyone and hopefully if any positive can be taken from the past few months is that we have the ability to change and adapt. The Queen Elizabeth Hospital had embarked on an improvement programme long before the arrival of Covid-19, with great ambitions to transform the hospital. In discussions with the leadership team, I know they were determined to take on board the observations of staff, patients and external organisations in order to deliver a quality health care system. Looking ahead, there will still be many challenges, not least with the continuing presence of the pandemic, but the Queen Elizabeth Hospital has demonstrated tremendous resilience in the face of a devastating adversary, you should all be very proud.

Liz Truss

MP for South West Norfolk

Patient quotes

"Went for a cystoscopy today and was extremely terrified about having it done. All the staff in the department went out of their way to make this appointment comfortable for me. Thank you once again for your time and patience with me."

Posted on Care Opinion website

"I have spent nearly three weeks in both West Raynham and Elm wards. I have received nothing but excellent care and friendliness from everybody in both wards. They have all shown dedication and humour (very important) at all times. I will praise the QEH to everyone when I leave."

Patient feedback through the Friends and Family Test

"Lovely staff, however, arrived for my daughter's follow-up appointment only to be told it had been cancelled. Couldn't be seen so completely wasted trip."

Feedback from Paediatric Clinic patient's parent through the Friends and Family Test

"I have witnessed excellent practice and poor practice, ie; cancer patient waiting three hours for pain relief. On the whole staff have been kind but definitely problems with communication between staff and patients and other departments such as Radiology."

Necton Ward patient feedback through the Friends and Family Test

Overview

This overview gives readers a short summary that provides them with enough 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 Chief Executive and Chairman

Welcome to the 2019/20 Annual Report for the Queen Elizabeth Hospital (QEH) King's Lynn NHS Foundation Trust.

This section of the report is intended to give an overview of how we did against the priorities we set ourselves for 2019/20 and describe our areas of focus for the year to come, reflecting the Trust's new strategy and the direction of travel for the wider health and social care system in Norfolk and Waveney.

April 2019 to March 2020 has been a year of further progress for QEH, with a relentless focus across the Trust on the improvements required of us from our 2019 Care Quality Commission (CQC) report. Remaining in 'special measures' and with a rating of 'inadequate' we have very clear quality improvement plans and a high-calibre, experienced Trust Board now in place to take us forward.

We have embraced all the CQC recommendations and now in our second year at the Trust, have seen more foundations laid as we continue our journey of improvement so that we can deliver sustainable improvements for our patients, their families and our staff. Over the past year and through our response to the COVID-19 pandemic, we have seen the determination and commitment from Team QEH to strive to consistently deliver safe and compassionate care for our patients.

Notwithstanding our challenges and the work still to do, which we describe in more detail below, we have come a long way, with demonstrable progress in many areas to report. We have improved patient safety and the quality of care for our patients. This includes improving cleanliness and infection control standards, as evidenced by our Infection Prevention and Control rating from NHS Improvement/England at the end of 2019 when we moved from 'red' to 'amber'; reflecting colleagues' hard work and focus to ensure we continue to raise the standards for our patients and their families.

Through the development of a new strategy and with the support of 40 ward-based champions, we are improving end of life care for our patients and their families and further changes made to strengthen bereavement support for families during COVID-19 will become the way we do things moving forward.

Following an inspection by NHS Improvement/England at the end of 2019, our Maternity Services were removed from the national Maternity Safety Improvement Programme delivered by NHSI, recognising that the necessary improvements in care governance and leadership had been made. We were delighted earlier this year to be chosen as Charity of the

Year by the Lynn News with a fundraising appeal for a new Maternity Bereavement Suite at QEH now well under way and receiving superb support from our local community.

Our staff survey results have improved, indicating staff morale and experience is improving. A new staff engagement programme is now in place which is focussing on three key areas in response to staff feedback, which are culture and learning, reward and recognition and health and wellbeing. We were the only Trust in the region to improve in every area in the 2019 national staff survey – but still have some way to go to create the right culture and one where we consistently learn from complaints, incidents and feedback from our patients and their families. We will continue our work to encourage staff to speak up with concerns and feedback, and our new Freedom to Speak Up Champions who represent staff across the Trust, will be instrumental in taking this work forward with our Freedom to Speak Up Guardian.

At 5%, against a target of 4.3%, we recorded one of the lowest nurse vacancy rates on record at the end of 2019, which is a record for QEH and one of the lowest in the country. Our time to recruit has reduced by a third – from over 100 days to 62.5 days; thanks to the efforts of our HR team.

We have made good progress when it comes to investing in our staff, with 35 colleagues completing the Quality Improvement and Service Redesign training and 30 more staff began their QSIR training at the start of 2020. We have launched a new Clinical Director development programme and have strengthened development opportunities for our leaders, including via our band seven leadership development programme. We have been named the regional hub for the Institute of Healthcare Management programme for middle managers, a professional standards programme is in place for our ward teams and we are running a development programme for our matrons.

Our Integrated Quality Improvement Programme (IQIP) has two main areas of focus: ensuring we provide safe, effective care for our patients and a positive working environment for our staff; and ensuring it is delivered in accordance with all regulatory requirements.

A huge amount work during 2019/20 meant that during the first quarter of 2020/21 we were in a position to apply for conditions on our Women and Children's Division (specifically in Maternity) to be lifted and this is now being considered. This follows the lifting of Trust-wide General Medical Council conditions, previously put in place amid concerns about the standards of training we were providing to some of our junior doctors. Further information on our IQIP progress is available on page 12.

With regard to wider performance, we are seeing a number of encouraging results and areas of excellence, including our orthopaedic team being in the top 13 in the country for treatment of hip fractures and our stroke service out performing many other hospitals for timely treatment.

We had one case of Methicillin-resistant Staphylococcus aureus (MRSA) bacteraemia, compared to two the previous year. We continue to do all we can to reduce hospital-acquired infections, though we did see an increase in Clostridium difficile cases (45 versus 22 the previous year). We have delivered strong performance across the cancer 31-day diagnostic to treatment target and cancer screening and did not have any patients waiting longer than 52 weeks for their treatment.

However, 2019/20 has been a challenging year with pressures across emergency and cancer pathways. The Trust achieved five of the seven targets but did not achieve the 62-day wait

target where we have been consistently below the national standard. We also need to do further work to reduce the number of falls and consistently complete timely VTE assessments to ensure the safety of our patients. Please see our annual Quality Report for further information.

The Trust has had another year of exceptional demand on its emergency services, with a 2.48% growth in Emergency Department attendances in 2019/20 compared to 2018/19. Achievement of the national four-hour emergency access standard has been a challenge. We admitted, discharged or transferred just 79.32% of patients against a national target of 95% from our Emergency Department within four-hours of their arrival. This compares to 82.51% the previous year. Innovative models of care have been introduced to support flow through our hospital, including Same Day Emergency Care. We continue to work with our health and care partners across the system, to help inform demand management and admission avoidance schemes that may help to control demand on our Emergency Department as well as to minimise delays in discharging patients to appropriate care settings. This will remain a focus going into 2020/21.

We are developing a strong reputation for research and innovation. We have recruited 924 patients into 59 different clinical trials in 2019/20 and we have the fastest clinical trial set-up time in the region.

We introduced electronic requesting for radiology services across the Trust and for pathology in many areas during 2019/20. We also introduced electronic filing for pathology across all areas in December 2019 and will be looking to introduce electronic referrals between teams and vetting of new referrals.

Thanks to the efforts of staff across the Trust, we have achieved our financial plan for the year and record levels of efficiency savings. We reported a year-end deficit of £2.226m, which was £51K better than our planned deficit and having achieved our plan we were awarded an additional £2.276m of Financial Recovery Funding taking our reported financial performance to a surplus position of £50k. Within this financial position we had achieved £6.4m savings that was £365K more than we had planned for.

We have also invested £17.4m capital over the past year to further improve the environment and our facilities for our patients and staff. This includes building an expanded Emergency Department, providing a new Same Day Emergency Care facility, making much-needed improvements to our Discharge Lounge and creating a decant ward as part of our refurbishment of Feltwell ward.

We have also been able to invest in medical and radiology equipment and made a start to the significant investment required to digitise our hospital. Our new antenatal facilities at the North Cambridgeshire site in Wisbech are ensuring women are cared for in a safer and more comfortable environment.

We developed robust plans to deal with the impact of COVID-19, including planning for our bed (capacity), people and equipment requirements. We worked closely with local system and national partner agencies (including Public Health England and NHSI/E to ensure our patients, public and staff remained safe.

Many positive changes which were implemented at an accelerated pace during COVID-19 – including the digitisation of our hospital, with more than 80% of outpatient appointments transferring to phone and video consultations – will continue beyond the pandemic.

We will also continue plans to implement a new Radiology Information System, E-Prescribing and E-Observations and an electronic bed management system, as well as working towards a system solution for a single Electronic Patient Record.

While it is important to recognise our progress in so many areas, we have much more work to do to consistently deliver safe and compassionate care to our patients and their families. While fewer patients have complained about their care (388 versus 421 last year) and we have significantly improved how we manage complaints to ensure more timely and better-quality responses, too many concerns raised by our patients feature shortcomings in the fundamentals of care and poor staff attitude and behaviour.

The other areas of improvement required going into 2020/21 include sickness absence, appraisal and mandatory training rates.

Over the past six months we have engaged extensively and listened to the views of our patients, Governors, staff, members and partners, as we have developed our new five-year Corporate Strategy, setting a very clear vision for the future. Our strategy is aligned to the long-term strategy for the Norfolk and Waveney health and care system, which we continue to play a full and active part in. We are committed to working even more closely with Norfolk and Waveney health and care partners to deliver QEH's strategy and contribute to the delivery of the system's Long-Term Plan and the Hospital Services Strategy which is being developed in partnership with the James Paget and the Norfolk and Norwich Hospitals.

Looking ahead, we know where we need to focus our efforts to build on our recent improvements. These are described in full in our new strategy and include:

Quality

- To consistently provide safe and compassionate care for our patients and their families
- Modernising our Hospital (estate, digital infrastructure and medical equipment) to support the delivery of optimal care. This will include responding to the next phase of COVID-19 and beyond.

Engagement

- Strengthening staff engagement to create an open culture with trust at the centre
- Working with patients and system partners to improve patient pathways and ensure future financial and clinical sustainability

Healthy Lives

- Supporting our patients to improve health and clinical outcomes
- Maximising opportunities for our staff to achieve their true potential so that we deliver outstanding care

Full details of the milestones and deliverables we have agreed for 2020/21 are available in our Annual Plan and Corporate Strategy.

Thank you to our 4,000-plus Team QEH staff (3,282 whole time equivalents), alongside volunteers, Governors, members, our local community and our partners for their support throughout the year. We look forward to celebrating our 40th anniversary in 2020 with our local community and staff later in the year. We also look forward to working with you in the

year to come as we move into the next chapter of our journey of improvement and continue to work together, committed to ensuring our patients and their families consistently receive the safe and high-quality care they deserve.



Professor Steve Barnett – Chairman

Wednesday 24 June 2020



Caroline Shaw – Chief Executive

Wednesday 24 June 2020

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. Our lead commissioner is Norfolk and Waveney Clinical Commissioning Group.

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

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

- Pathology
- Ophthalmology
- Orthopaedics

In addition, the hospital has a renal dialysis unit, which is an outreach unit of the nephrology service in Cambridge.

*Our oncology service is supplemented by additional facilities in Cambridge and thoracic and plastic surgery services are provided by Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH).

* Urology transferred to NNUH on 1 March 2020. NNUH are the lead provider subcontracting services to QEH. Services continue to be delivered from our site.

A brief history of the Foundation Trust

We were authorised as a Foundation Trust in 2011 and have 439 core beds, 18 core wards and serve a population of around 331,000 people in three counties of Norfolk, Cambridgeshire and Lincolnshire.

Our 4,000-plus workforce (3,282 whole-time equivalents) is committed to working with partners to deliver safe, high-quality care.

We have seven main operating theatres, including two fully integrated endoscopic theatres; a dedicated West Norfolk Breast Unit; and the midwife-led Waterlily Unit which provides expectant mothers with greater choice.

In 2019/20:

- 70,381 patients attended our Emergency Department (1,708 more than 2018/19)
- We treated 49642 Elective and Non-Elective inpatients (41,080 in 2018/19)
- 41,313 day-case procedures (1,307 more than 2018/19)
- 109,165 New outpatient attendances and 274,508 follow-up attendances
- 2,004 babies were born at our hospitals

We were placed in 'special measures' in June 2015 after a Care Quality Commission (CQC) inspection in May and a Rapid Response Review (RRR) in August of that year.

Following a further inspection in June 2015 we came out of 'special measures' but this improvement was not sustained and following an inspection in September 2018 we were rated 'inadequate.'

In March 2019, the CQC returned to carry out an inspection of our core services. This resulted in Section 31 and Section 29A warning notices placing conditions on our registration as a provider of healthcare. These notices required immediate action and we are now being monitored closely through the Trust Board with support from our commissioners and regulators.

In July 2019, the CQC rated us as 'inadequate' overall and gave the following ratings in the five domains:

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

The CQC recommended that we be placed back in 'special measures' by NHS Improvement and we are expecting the inspectors to return to QEH before the end of 2020, which we will embrace as an opportunity to share our clear progress.

Our Integrated Quality Improvement Plan

Our Integrated Quality Improvement Programme (IQIP) reflects our pledge to deliver high-quality, patient-centred, integrated care for our community.

It has been produced with input from staff and stakeholders and, as well as responding to recommendations from our regulators and the CQC, it outlines our longer-term ambitions to be recognised for the care we provide and the way we help staff to continually develop throughout their careers so that they are proud to say they work for QEH.

Our Quality Improvement Programme has two main areas of focus.

We are committed to:

- Ensuring the provision of safe, effective care for our patients and a positive working environment for our staff
- Ensuring the care we provide is delivered in accordance with all regulatory requirements

We will achieve these through:

- Investment and improvement in leadership development – Board and senior management-level
- Communications, engagement and culture change - with a particular focus on improving engagement with our staff
- Governance — developing an overarching scheme of clinical and corporate governance
- Recruitment, retention and workforce utilisation
- Improving the Emergency Department environment and layout
- Closer working with external partners
- Reviewing and improving our programmes of medical education

Of the total 206 actions within our Integrated Quality Improvement Plan (IQIP) – a combination of Conditions, Must and Should Do actions, 106 (51%) have been approved for closure. One hundred actions remain outstanding. We are currently reviewing progress in light of COVID-19.

Our IQIP sits alongside the findings of the CQC's inspection and gives us a clear road map for our ongoing improvement journey.

The General Medical Council (GMC) raised specific concerns about the standards of training in obstetrics and gynaecology and imposed three conditions across the whole trust after a visit in April 2019. These conditions required us:

- To provide an established, visible and trusted process to support and encourage trainees to raise concerns
- To improve the culture of the trust, in particular around tackling unacceptable behaviours
- To establish an effective educational governance system with a clear line of accountability to the Trust Board

A comprehensive improvement plan was agreed with Health Education England and we have had monthly monitoring returns and bimonthly visits from the GMC and HEE to meet with

trainers and trainees to monitor our progress since then. The huge amount of work through 2019/20 resulted in the conditions being lifted in April 2020. In his letter to us, the GMC's Medical Director and Director of Education and Standards, Professor Colin Melville said we had provided evidence of continued improvement, through our improvement plan and regular meetings with trainees. A GMC visit in March demonstrated a department (obstetrics and gynaecology) which had completely turned around and demonstrates examples of good practice.

Our Corporate Objectives

Following our 2019 CQC inspection, we agreed three main priorities and eight strategic priorities with the aim of addressing the concerns which were described in our CQC report and feedback. These align with the Trust's priorities which were agreed and shared with our patients, staff and stakeholders during 2019/20. Below is a summary of how we did.

Strategic priority	2019/20 progress	
1. Safe and Compassionate Care	1. Safe and Compassionate Care	<p>End of Life Care</p> <ul style="list-style-type: none"> • Introduction of the new Individualised Plan of Care (IPOC) – March 2020 • Adopted the ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) process – a personalised process to create and record a plan containing care preference and appropriate clinical recommendations for a person’s clinical care in the event of a future emergency. • New End of Life Care Strategy (2020-2025) launched and becoming embedded across the organisation • New Palliative Care Locum Consultant confirmed • Completed 30/60/90-day Quality Improvement Programme with NHSI/E - 6 small ward-based project in place. • Registered for the third round of the National Audit of the Care at End of Life (NACEL) - audit period: 1 April- 31 May 2020 • Recruited 40 ward-based End of Life Care Champions and six Medical Champions <p>Management of the deteriorating patient</p> <ul style="list-style-type: none"> • More than 300 staff trained as “Readers” of ReSPECT Form • ReSPECT training included in trust Induction and Clinical Skills Training Days.
	2. Leadership and Management	<ul style="list-style-type: none"> • Achieved ambitious target to establish a fully substantive Trust Board and Executive Team within 12 months, bringing experience and stability to QEH • Chairman has taken the Non-Executive Director (NED) contingent of the Board to the maximum allowed by the Constitution (Seven plus the Chairman • 12-month Board Development Programme supported by Fiona Reed Associates has been approved and signed off by Board and is aligned to leadership training and strategic priorities • Divisional Leadership Team Development Programme (also delivered by Fiona Reed Associates) – Building the leadership capacity of the Divisional structure have been booked and will run summer-autumn 2020 • Mandatory band seven Leadership Development Programme launched with the first three full cohorts of staff with 70 staff in total. PRACTICE are delivering a high-quality innovative, interactive leadership programme. Planning for next cohort under way • Customer service/professional standards programme started on our base wards, led by one of our senior nurses, with support from our Improvement Director, commenced early 2020 • A bespoke matron development programme has launched on the new Matron Standards, with

		<p>clear actions, milestones and outcome measures (this includes Back to the Floor Fridays for Matrons which started at the end of February 2020)</p> <ul style="list-style-type: none"> • First Clinical Director development session held March 2020 • First Institute of Healthcare Management leadership session for Bands 5s and 6s planned for 2020 with sessions to continue over a 12-month period • Quality Service Improvement and Redesign Training for Cohort 2 – with support from buddy Trust Sherwood Forest Hospitals NHS Foundation Trust – took place in March 2020 and will continue beyond COVID-19
	3. Governance Assurance	<ul style="list-style-type: none"> • Implementation of the new Governance Structure ongoing; and includes two cycles of newly-established subgroups and sub Board committees completed • Focus on developing terms of reference and reporting schedules for executive lead committees, including convening new subgroups • Revised Board Assurance Framework to be developed to align with the new strategic objectives in the Trust's new Corporate Strategy to launch June 2020 • Intensive support to Clinical Audit Team to oversee recovery plans secured • Progress remains on track for clearing backlog of historic Serious Incidents • Risk recovery plan on track and improved arrangements for oversight through to Executive Assurance and Risk Group in place
	4. Emergency Department	<ul style="list-style-type: none"> • Decision to reconfigure the Emergency Department footprint in response to CQC feedback • Phases one and two completed facilitating the development of a new main entrance lobby. Enabling works started for phase two
2. Improving staff engagement	5. Culture and Engagement	<ul style="list-style-type: none"> • Trust-level action plan with six priority areas in response to staff survey results • Meetings with Divisions and Corporate Leads under way to develop action plans in response to 2019 staff survey results • New staff ideas scheme launched • Health and wellbeing programme developed - with focus on mental, physical and financial health • Working with partners, including King's Lynn and West Norfolk Borough Council, on staff offers – local gyms, fitness classes

		<ul style="list-style-type: none"> • Introducing Long Service Awards – event planned for September 2020 • Team QEH 2020 Awards launched • Recruitment of 14 new Freedom to Speak Up Champions across QEH • Plans to relaunch and realign culture change programme
	6. Recruitment, Retention and Workforce utilisation	<ul style="list-style-type: none"> • Reduction in vacancy rate from 14.77% in June 2019 to 10.69% in January 2020 • High-profile recruitment campaign • Streamlined recruitment processes and closer working with managers • Development opportunities, including the Band 7 Leadership programme, Institute of Healthcare Management programme for middle managers, readiness into education programme and QSIR training • Successful recruitment to additional posts including QEH Fellows/10 physician associates/ 36 Trainee Nursing Associates • Successful internal transfers and movement from bank to substantive appointments • Offer of employment made for students qualifying in February 2020
	7. Medical Education	<p>Health Education England (HEE)/General Medical Council (GMC) action plan progress</p> <ul style="list-style-type: none"> • All GMC conditions have now been lifted May 2020 • Extensive multi-disciplinary work undertaken to address the culture across the trust to improve its educational environment • New appointments to roles of Director of Medical Education, Deputy Director of Medical Education and Clinical tutor for staff and associate specialists and locally employed doctors made • Cultural workshops undertaken with the support of General Medical Council (GMC), Nursing and Midwifery Council (NMC), Health Education England (HEE) and NHSE to address specific concerns in obstetrics and gynaecology. • Regular junior doctors’ forum and medical director briefings with weekly meetings with director of medical education, deputy medical director and medical director instated • Fatigue and facilities charter improvements made to doctors’ mess and British Medical Association staff and associate specialists charter signed • New Division of Women and Children created and new Clinical Director and educational leads appointed for obstetrics and gynaecology • Governance structure of the Trust revised with introduction of a new Education, Research and Innovation Committee to oversee education

		<ul style="list-style-type: none"> External review of education and training commissioned with HEE to assess capacity and requirements of trust to become an outstanding place to work and to learn <p>Medicine and Obstetrics and Gynaecology</p> <ul style="list-style-type: none"> Six weekly reporting to HEE and two monthly on-site meetings with the trainees have now been stood down due to the reported improvements in teaching, rotas, induction and culture These departments remain in enhanced monitoring with visits reduced to once every three months
<p>3. Meeting our financial plan and efficiency requirements</p>	<p>8. Close working with external partners</p>	<ul style="list-style-type: none"> Extensive external stakeholder engagement and feedback regarding development of our new five-year Corporate Strategy, which will launch internally and externally in June 2020 Attendance at Norfolk Health Overview and Scrutiny Committee to update on CQC progress, winter, performance, strategy development Strengthened engagement with West Norfolk stakeholders to influence local priorities, including: <ul style="list-style-type: none"> West Norfolk Strategic Partnership Board Borough Council Executive to Executive meetings, and King’s Lynn Town Deal Board West Norfolk Local Delivery Group Lobbying local politicians regarding requirement for significant national capital to modernise QEH Strengthened relationships with the local and regional media Strong and active involvement in the Norfolk and Waveney Sustainability and Transformation Partnership (STP) – including STP Executive meeting, Hospital Services Strategy, Acute Services Integration, Clinical Care and Transformation Group, Capital Planning and digital developments

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 May 2020 and after consideration of risks and uncertainties agreed that:

The use of the 'Going Concern' basis is appropriate.

Performance analysis: Our finances

Overview of 2019/20 financial performance

In 2019/20, we set a deficit budget of £25.5m. This was in line with the control total of £25.9m deficit set for us by NHS Improvement, excluding Provider Sustainability Funding (PSF), Financial Recovery Fund (FRF) and Marginal Relief Emergency Tariff funding (MRET) and predicated on the delivery of a £6.0m Cost Improvement Programme (CIP). Delivery of the plan would secure access to £23.2m of PSF, FRF and MRET funding, driving a reported deficit of £2.3m.

We delivered an actual deficit of £25k. This deficit position included an additional element of £2,276k of Financial Recovery Funding as the Trust had achieved its financial performance objectives. This deficit also included the impact of certain items that the Trust is not performance managed against and when adjusting for those items, the Trust delivered a surplus of £50k. Within this financial position we had achieved £6.4m savings that was £365K more than we had planned for.

There was a financial impact of the COVID-19 pandemic, resulting in additional spend during the year and a loss of income. This is reflected in our financial statements and we have received additional support from the Department of Health and Social Care (DHSC) to match our costs.

We spent £17.4m on capital projects during the year. This was funded by our own internally-generated resources, a loan from the DHSC and from Public Dividend Capital (PDC). We did exceed our initial planned value of capital expenditure; however, this was driven by new funding awarded during the year to support investment into Urgent and Emergency Care capital schemes. The key elements of our capital programme were:

- Addressing backlog maintenance and investment within critical infrastructure
- Expanding and improving our Ambulatory Emergency Care (AEC); discharge facilities; and creating a decant ward as part of investment in Feltwell ward
- Investing in IT
- Investing in new and replacement medical equipment

Performance against our financial plan

We delivered a £0.1m surplus for the year including PSF, FRF and MRET funding (£25.5m deficit excluding these sources of funding) against the original planned deficit of £2.3m, including PSF.

Our final year-end position included the following (excluding the impact of donated assets):

- Total income £239.4m actual; a net positive movement from plan of £15.6m. This includes an additional £2.3m of FRF as a result of delivering our original plan and central funding of £5.8m for additional employer pension contributions following an increase in rate to 6.3%
- Total expenditure £238.3m actual; which was £14.4m over plan and includes the impact of increases in employers pension contributions, investment into international nursing recruitment of £1.8m and payroll costs exceeding planned levels by £8.8m
- There was an increase of £0.850m following the revaluation of our assets
- Cost Improvement Programme delivered £6.4m against a £6m target
- Capital expenditure £17.4m against a capital plan of £16.6m
- Cash balance £14.2m closing cash balance against a plan of £3.2m following the drawdown of our capital loan (£8.4m) and receipt of PDC (£4.7m)

Balance Sheet

Cash: We ended the year with a cash balance of £14.2m. We received capital loan funding of £8.8m and £4.8m of Public Dividend Capital to fund Urgent and Emergency Care schemes, an Electronic Prescribing system and IT projects.

Non-current assets: The value of our non-current assets (including property, plant and equipment and intangible assets) increased by £11.9m mainly as a result of:

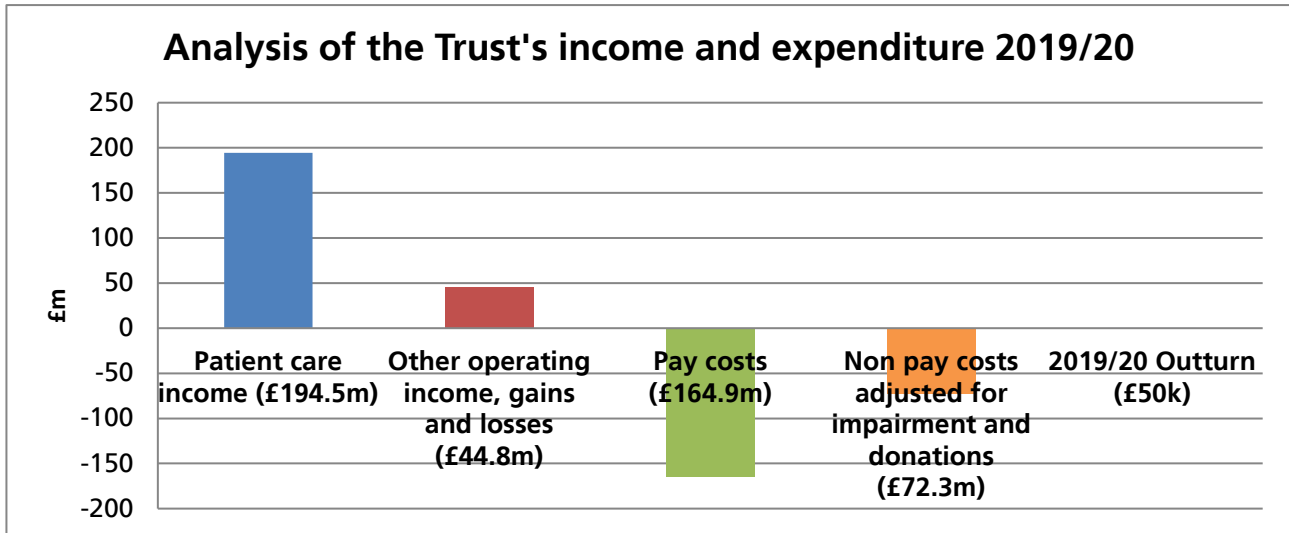
- £17.5m total net additions; plus
- £2.0m upward revaluation; less
- £6.3m depreciation

Receivables: Our receivables (current and non-current) have increased by £7.5m driven by an increase in contract receivables from NHS and Department and Health and Social Care (DHSC) bodies

Payables: Our payables (current and non-current) have increased by £92.3m due to the planned conversion of our existing interim revenue and capital loans to Public Dividend Capital (PDC) in 2020/21. The revenue and capital loans within current payables will be repaid when the Trust receives the PDC in 2020.

Taxpayers' equity: This represents the methods of funding our assets and liabilities. The main component of our taxpayers' equity is PDC which increased by £4.8m from the previous year. Our retained earnings reduced by £01m due to our impairment following an asset revaluation exercise. Our revaluation reserve balance increased by £0.85m due to the net asset revaluation.

Key Financial Indicators

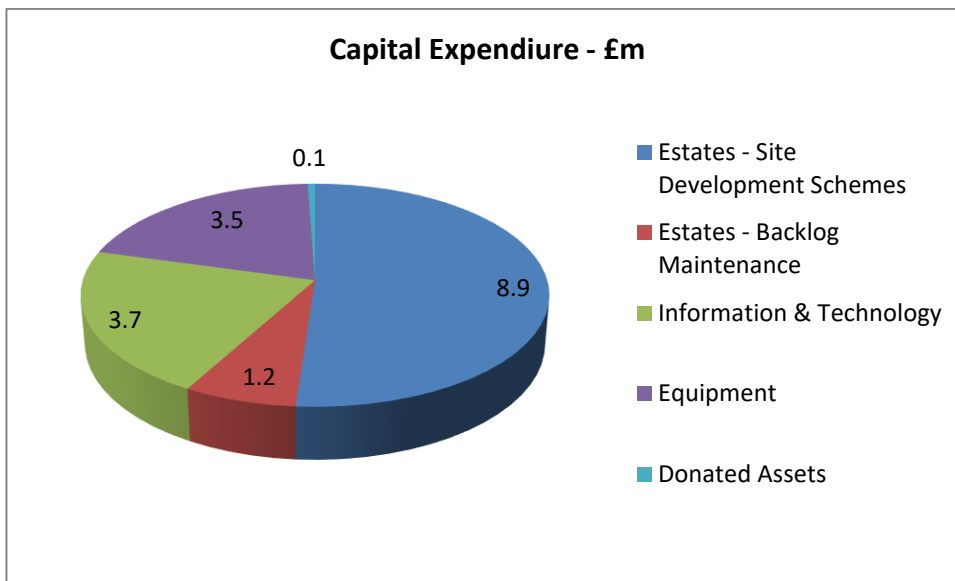


Income: We received £239.4m of income which is a £50.8m increase from the £188.6m we received in 2018/19.

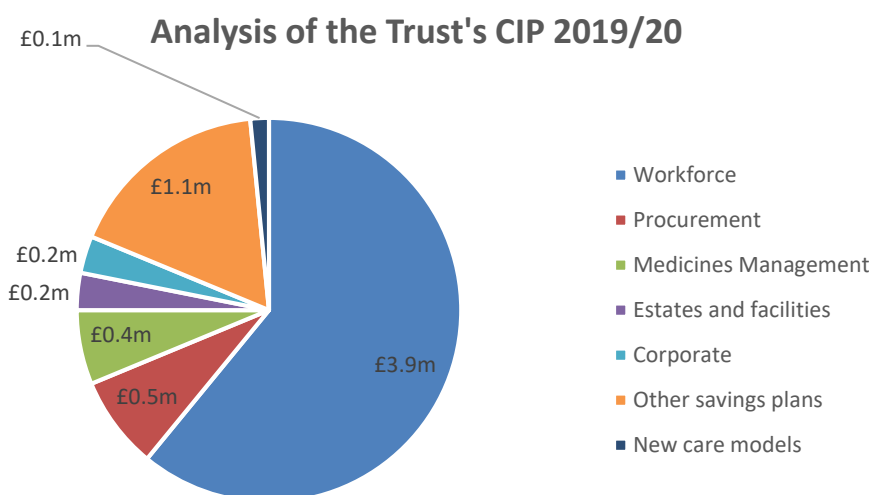
Pay expenditure by staff group: We spent £164.9m on staff costs, which is a £12.3m increase over the 2018/19 total of £152.6m. £7.9m of this increase is due to substantive staff costs, £5.7m relating to increased employer pension contributions. There was a £1.2m decrease in the costs relating to bank staff and agency spend.

Non-pay expenditure: We incurred £72.3m of non-pay expenditure, which was a £2.2m increase over the 2018/19 total of £70.1m.

Capital expenditure: Our capital expenditure was £17.4m, a £12.5 increase on the 2018/19 total of £4.9m. A breakdown of that spend is shown in the chart below.



Our efficiency programme: We delivered £6.4m against our £6m Cost Improvement Programme (CIP) in 2019/2020. The programme focused on reducing costs through focusing on our workforce model, whilst maintaining high quality patient services. A breakdown of the CIP achieved is shown in the chart below.



Financial planning for 2020/21

As a response to the COVID-19 pandemic, NHS England and Improvement suspended the operational planning process for 2020/21 until further notice and set amended financial arrangements for the NHS until at least to the end of October 2020. The financial arrangements put in place have been designed to support us to deliver a break-even position for these months through moving to a block payment arrangement with commissioners, reimbursement of COVID-19 specific costs and top-up payments, if required, to bridge any remaining gap between our income and expenditure.

We remain committed to using our resources productively to maximise patient benefit. In particular, we have improved our financial discipline and increased our grip and control on all areas of what we spend our money on.

We have placed greater controls on our agency workforce spend and as a proportion of our overall pay bill this fell below 10% for the first time in more than three years. This was achieved by being better at recruiting to our substantive workforce through different initiatives including a successful overseas nurse recruitment programme. As a result, we have ended the year with one of the lowest nurse vacancy rates in the country and the lowest ever rate for QEH (at 5%), helping us to provide better quality care for our patients and reduce reliance on agency spend. We also achieved £1m savings through renegotiating contracts and reducing spend on supplies across all our clinical and administration teams.

We will continue with this discipline, build upon it and with the use of benchmarking tools like the Model Hospital and the Getting it Right First Time (GIRFT) reviews will drive the efficiency programme and generate ideas to support the level of transformation required to secure a financially sustainable position.

Our Charity

The net assets of the QEH Charity for 2019/20 were £3.58m compared to £1.86m the previous year; an increase of 92.4%. This is as a result of total incoming resources for the year increasing to £2,296,000 in 2019/20 (£451,000 in 2018/19) – primarily the result of a large legacy of £1.6m in the year. Spending increased from £303,000 in 2018/19 to £553,000 in 2019/20.

We spent £114,000 on new building projects and refurbishments aiming to provide more comfortable surroundings for patients and staff. From these:

£36,000 has been spent on new recliner chairs for the Chemotherapy Room

£24,000 has been spent on garden works and architect fees for the Wellbeing Centre

£23,000 has been spent to refurbish the log cabin

In 2019/20, the Charitable Fund has spent £118,000 on medical and surgical equipment. Items include:

- Manikins (£17,000) and My Kit Check (£12,000) for the Resuscitation Department
- Syringe pumps and blood bank fridge for the Cancer Unit (£13,000)
- Orthopaedic instruments (£15,000)
- Bilirubinometers (£12,000)
- Ophthalmology Department used their charitable fund to buy additional equipment to enable mobile working and tonometers (£11,000)
- Sure Monitors and four scoop stretchers from the Falls Appeal fund (£8,000)
- Linear probes for the breast Care Unit (£8,000)

A further £108,000 of charitable funds has been used to support nursing staff courses, conferences, symposiums and staff welfare activities.

£69,000 of funds have been used to support and improve patient welfare. This has been used to buy wheelchairs, patient engagement projects, and Christmas presents for patients and the St John library subscription fee.

Performance analysis: Our care

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

At a glance

Operational performance	18/19	19/20	Increase / decrease	% change
Emergency attendances	68673	70381	1708	2.48%
Emergency admissions	26466	30668	4202	15.87%
Patients waiting longer than four hours from arrival in ED to admission, transfer, discharge	82.51	79.32	-3.19	-4.02%
Day case	40,006	41,313	1307	3.26%
Electives	5,001	4,563	-438	-8.75%
New outpatient attends	76,216	73,769	-2447	-3.21%
Follow up outpatient attends	173,275	172,000	-1275	-0.73

Quality Measure (%)	18/19	19/20 *to February	Increase / decrease	19/20 Target
Patients waiting < 62-days from 2ww referral to treatment for all screening cancers	100	97.14	-2.86	90
Patients waiting < 14-days from 2ww referral to date 1 st seen	95.32	94.66	-0.66	93
Patients waiting < 14-days from 2ww referral to date 1 st seen for breast symptomatic patients	91.67	84.69	-6.98	93

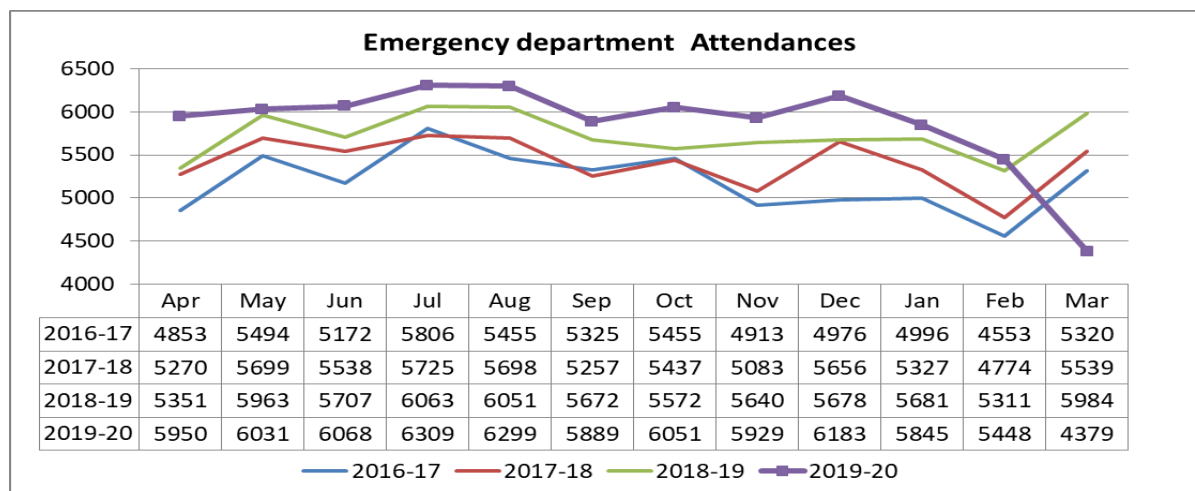
Quality Measure (%)	18/19	19/20 *to February	Increase / decrease	19/20 Target
Patients waiting < 62-days from 2ww referral to treatment for all cancers	81.74	67.98	-13.76	85%
Patients waiting < 31-days from diagnosis to first treatment for all cancers	97.50	97.92	0.42	96%
Patients waiting < 31-days for subsequent treatments for all cancers - surgery	99.43	96.36	3.07	94%
Patients waiting < 31-days for subsequent treatments for all cancers – drug treatment	99.71	99.59	0.12	98%

Four-hour emergency access target

There has been a Trust-wide focus and determination to improve the experience of our emergency patients and flow in and through our Emergency Department (ED) and out of our hospitals. We have reduced discharge delays and the number of long stay patients and did work with our wards to improve internal processes and redesign in 2019/20.

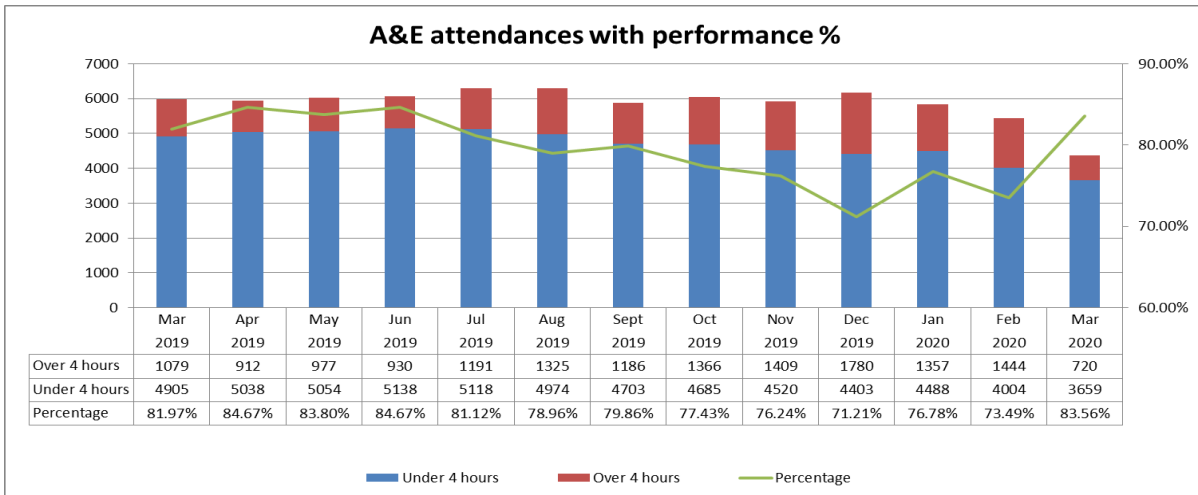
Despite all of this hard work, we admitted, discharged or transferred just 79.3% of patients from our ED within four-hours of their arrival against the 95% national standard (compared to 82.48% the previous year).

Year	Attendances	Breaches	Performance %	Variance from prev year	Growth %	Previous Year attendances
16/17	62318	5832	90.6%	2415	3.88%	59903
17/18	65003	9409	85.5%	2685	4.13%	62318
18/19	68673	12028	82.5%	3670	5.34%	65003
19/20	70381	14597	79.3%	1709	2.43%	68672



A number of factors are having a detrimental impact on performance and include: the department was not designed to accommodate the volume of attendances we are now experiencing (2.48% increase in ED attendances and a 15.9% overall increase in emergency admissions compared to 2018/19); high number of patients waiting in our ED for a hospital bed; and insufficient staffing to manage the heightened demand and deal with the high number of patients waiting for a hospital bed.

Against this challenging backdrop we have seen fluctuations in performance against achievement of the four-hour target in year;



AE Attendances	2019 04	2019 05	2019 06	2019 07	2019 08	2019 09	2019 10	2019 11	2019 12	2020 01	2020 02	2020 03
Month	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Total Attendances	5950	6031	6068	6309	6299	5889	6051	5929	6183	5845	5448	4379
Under 4 hours	5038	5054	5138	5118	4974	4703	4685	4520	4403	4488	4004	3659
Over 4 hours	912	977	930	1191	1325	1186	1366	1409	1780	1357	1444	720
Performance	84.7%	83.8%	84.7%	81.1%	79.0%	79.9%	77.4%	76.2%	71.2%	76.8%	73.5%	83.6%

Innovative models of care have been introduced to support flow within the hospital, including the implementation of Same Day Emergency Care as well as the expansion of the Discharge Lounge to accept patients requiring stretcher patients.

Performance and improvement plans for urgent and emergency care continue to be overseen by the West System Operational Resilience and Transformation Group, chaired by our Chief Operating Officer and attended by leaders from across health and social care in West Norfolk. Significant work is being done across the system to seek to streamline patient flow across emergency care pathways. Improving performance against the emergency access standard remains one of our top priorities as we head into 2020/21.

We continue to work with our partners to help inform demand management/admission avoidance schemes that may help to control demand on our ED, as well as minimise delays in discharging patients to appropriate care settings. This includes a focus on implementation of Discharge to Assess supported by the further development of the integrated Discharge Team.

Case study

Improving emergency and urgent access to care without needing to admit patients

We are seeing more emergency patients with the opening of our Same Day Emergency Care (SDEC) unit, which opened to extend the Ambulatory Emergency Care (AEC) unit. It will provide same day care for patients who would otherwise have been admitted overnight.

The AEC unit, which treated emergency day case patients who didn't require bedded care, could previously care for up to 40 patients, but with the new SDEC this has expanded capacity to potentially see another 25 patients a day.

The SDEC unit is fully equipped with monitors that can measure heart rate and blood pressure, along with Point of Care Testing equipment, which analyses blood samples and gives results within 20 minutes.

The opening hours for the unit are 8.30am-12.30am, Monday to Friday and 9am-7pm on Saturdays and Sundays.

The Acute Medical team has recognised the specific needs of our population and the increased number of patients that can be seen, treated and discharged on the same day.

Winter planning 2019/20

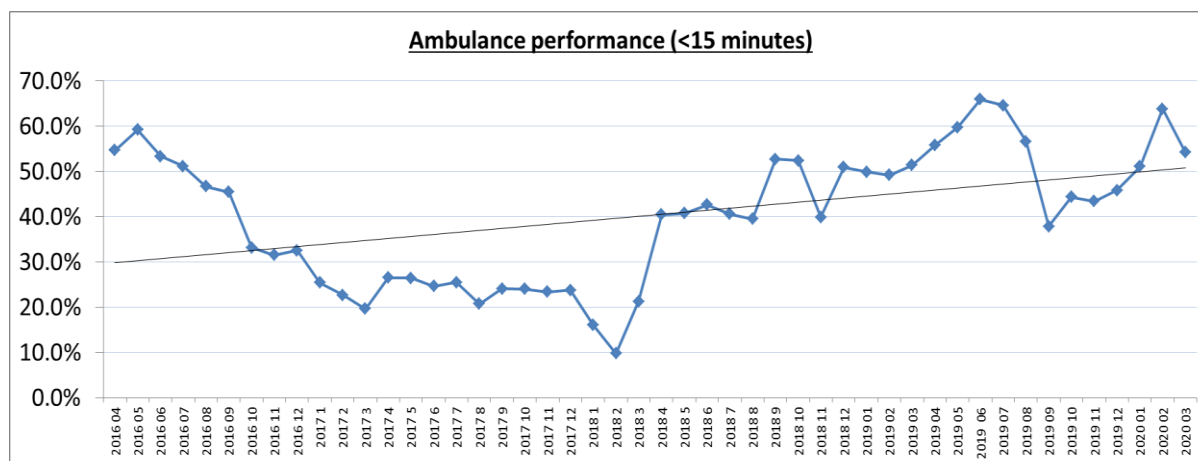
The system's strengthened winter plan, learning from 2019/20, included:

- Redesigning the ED footprint to enhance the ambulance offload area to support a reduction in handover delays
- Implementing a robust Same Day Emergency Care model
- Implementing the Surgical Enhanced Recovery Unit to facilitate elective flow within the organisation
- Developing a dedicated winter ward within the organisation supported by robust governance mechanisms to enable effective management and use
- Developing the Discharge Lounge to enable stretcher patients to be accommodated to support earlier discharge flow from the inpatient wards
- Partnership working with commissioner and community colleagues to further embed Discharge to Assess supported by refocusing on the priority of reducing long-stay patients
- Flu campaign and infection prevention (71.88% frontline staff vaccinated for flu, compared to 80% the previous year)
- Focus on staff health and wellbeing
- Joined-up, system and NHS-wide public-facing communications campaign encouraging appropriate use of services.

Ambulance handover

Intrinsically linked to the emergency access standard (above), is our ability to receive patients from ambulances. This target, known as the handover waiting time, shows the amount of time the ambulance and crew have had to wait with the patient before the Emergency Department was able to accept the patient. The standard expected is that a patient is handed over within 15 minutes.

While there have been fluctuations in performance historically, we have seen an improvement in ambulance handovers of more than 15 minutes over recent years due to a range of actions which have been taken.



Ambulance	2019 04	2019 05	2019 06	2019 07	2019 08	2019 09	2019 10	2019 11	2019 12	2020 01	2020 02	2020 03
Cohorts	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
0 - 15 Minutes	1001	1126	1250	1188	1117	680	821	830	950	1012	1180	910
15 - 30 Minutes	474	428	372	391	453	623	482	500	546	486	402	483
30 - 1 Hour	164	180	150	150	214	232	284	307	260	245	166	147
1 - 2 Hours	115	98	95	87	123	158	198	210	207	142	81	93
2 Hours +	41	53	28	23	66	104	66	66	110	95	20	44
Grand Total	1795	1885	1895	1839	1973	1797	1851	1913	2073	1980	1849	1677

We have worked with East of England Ambulance Service (EEAST) to reduce the length and number of ambulance handover delays, including an expansion of handover capacity and embedding a handover SOP (Standard Operating Procedure) and a protocol for ambulance crews to present directly to Same Day Emergency Care to reduce pressures within our Emergency Department. We remain committed to improving this position and delivering a better patient experience.

Cancer access targets

Our cancer services receive in excess of 800 two-week wait referrals per month. The Trust achieved five of the seven national cancer targets in 2019/20. We have consistently delivered against the:

- Cancer two-week wait
- 31-day decision to treat to treatment
- 31-day subsequent for drug and surgery cancer treatments; and
- 62-day screening standards

Our performance against the 62-day standard has been below the national standard and remains a key area of focus going into 2020/21. We recognise a number of reasons for this and significant work has been carried out to ensure we are delivering timely care for our patients. This work includes significant engagement and support from the national cancer Intensive Support Team.

Cancer Services have continued to focus on the 62-day backlog reduction and embedding escalation processes within operational teams to minimise breaches and roll-overs from one month to the next. In addition, improvements in clinical pathways have been made such as the introduction of the Lower GI (Gastro-intestinal) straight-to-test initiative in January 2020 and Gynaecology one-stop clinics, which were introduced in March 2020.

Through dedicated and focused work of staff across our tumour sites, we have plans in place and hope to recover performance against the cancer constitutional standards in 2020/21.

Cancer Performance

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
2 week wait	81.05%	91.94%	95.88%	96.70%	96.22%	97.13%	97.10%	96.69%	95.97%	97.10%	96.83%	
31 day	96.12%	93.16%	100.00%	97.25%	98.13%	97.89%	99.21%	99.17%	100.00%	98.06%	98.15%	
62 day	70.90%	63.69%	81.12%	75.19%	63.89%	70.63%	62.56%	64.14%	74.77%	65.13%	60.43%	

*cancer performance for March 20 will be available on the 6th May

Eighteen-week Referral to Treatment standard (RTT)

With regard to performance against the 92% national standard, historically we have achieved a total performance of:

- March 2020 – 79.29%
- March 2019 – 79.82%
- March 2018 – 81.05%
- March 2017 – 92.38%
- March 2016 – 92.05%

Nationally, in 2019/20 there was a move away from achieving 92% of patients being seen and treated in 18 weeks. The Trust target was to achieve a total waiting list of 14,191 at the end of March 2020.

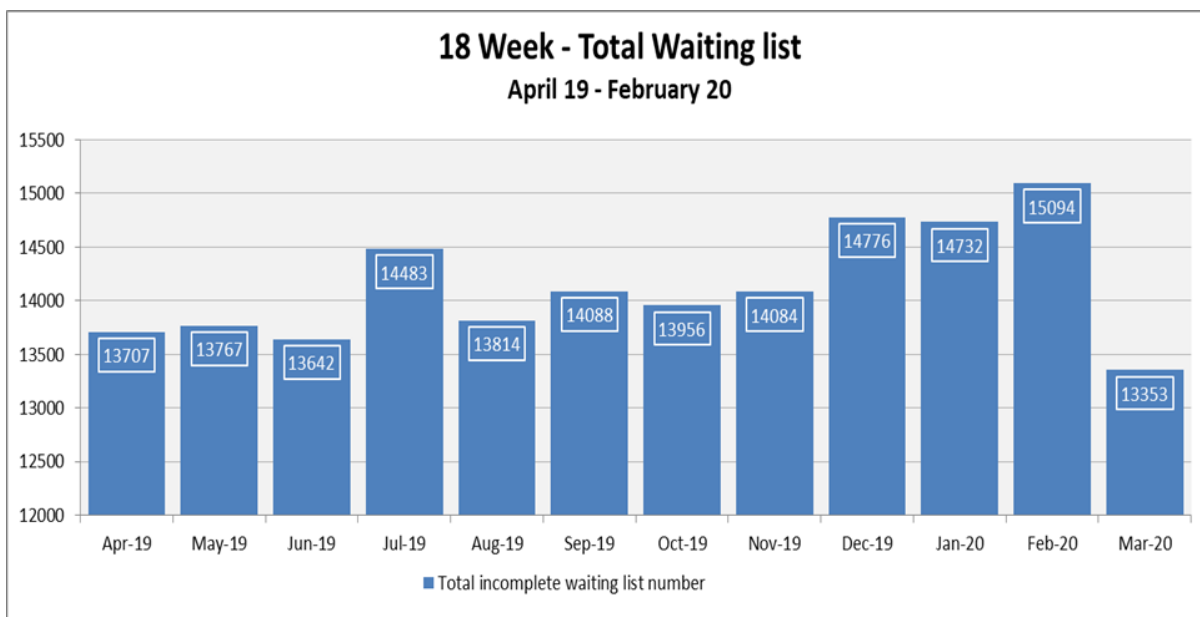
RTT - Incomplete

	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
Total incomplete waiting list number	13707	13767	13642	14483	13814	14088	13956	14084	14776	14732	15094	13353
Patients waiting under 18 weeks	11023	11365	11155	11752	11147	11218	11038	11004	11291	11300	11505	10587
Patients waiting 18 weeks and over	2684	2402	2487	2731	2667	2870	2918	3080	3485	3432	3589	2766
% Performance	80.42%	82.55%	81.77%	81.14%	80.69%	79.63%	79.09%	78.13%	76.41%	76.70%	76.22%	79.29%

While we did not achieve the 92% standard in 2019/20, the target associated with waiting list size was achieved. Please note, this was due in part to the transfer of Urology services to NNUH as lead provider in March 2020.

Pressures in demand for emergency care continues to impact on routine elective activity with capacity managed on a day-by-day basis. We continue to have specialty pressure points and patients waiting longer than we would wish. We are proactively managing our waiting lists and work at a service-level to ensure effective management of patients waiting for elective care. With the exception of those patients choosing to wait, by the end of 2019/20 we have eliminated all other 52-week wait patients.

We have focused on reducing the 18-week RTT elective waiting list with detailed demand and capacity modelling completed for each specialty area as well as agreed trajectories for delivery. However, there has been a significant impact as a result of winter bed pressures in quarter three and quarter four of 2019/20 resulting in an increase in the number of patients waiting more than 18-weeks. This position will be exacerbated by the impact of COVID-19.



Participation in clinical research

We recruited 924 of our patients to take part in approved research during 2019/20.

This includes 668 patients recruited to National Institute of Health Research (NIHR) portfolio studies and 256 patients recruited to non-portfolio studies. In 2019/20 we actively recruited to 47 NIHR portfolio and 12 non-portfolio clinical research studies.

This is a slight decrease on the previous year, reflecting our focus on randomised control trials, which are more resource intensive. Highlights of the year include successfully completing our first-in-human study for a pre-CE marked device, and our first commercially sponsored trial, where the Chief Investigator is a member of our staff.

The strong team effort reflects both the result of new approaches championed by the Research Department and our increased focus and support of improvements in health care and outcomes for patients by encouraging all clinicians, whenever possible, to offer participation in all the research studies that are applicable to our patients.

We have embedded research into all aspects of patient care – from the first letters to them, which mention research to our clinical teams providing more in-depth information about the opportunities to participate in innovative and cutting-edge trials.

Case Study

Trialling safer prostate biopsies

The Trust was invited to take part in its First “first in human study” during 2019/20. This involved using a new medical device called a “CamProbe” for transperineal prostate biopsies.

Prostate cancer is the most common male malignant cancer and a leading cause of mortality. The diagnosis is based on a transrectal ultrasound guided biopsy of the prostate under local anaesthesia. This method passes a needle through the bowel wall, which inevitably allows bacteria to enter the urinary system and the blood stream. A significant number of patients will develop infections, despite prophylactic antibiotics.

The new device we trialled passes through the perineum thus avoiding the bowel and has an integrated method for delivering local anaesthesia. The primary aim was to assess the safety of the device as a method of acquiring prostate biopsy samples. We measured the incidence of infection at seven and 30 days after biopsy. We also gathered patients’ experiences based on pain scores, and impact on urinary and sexual function.

Our data is now being analysed and we hope that it will lead to this device being approved for medical use (CE marked) and then into clinical applications.

Accountability Report 2019/20

Directors' Report

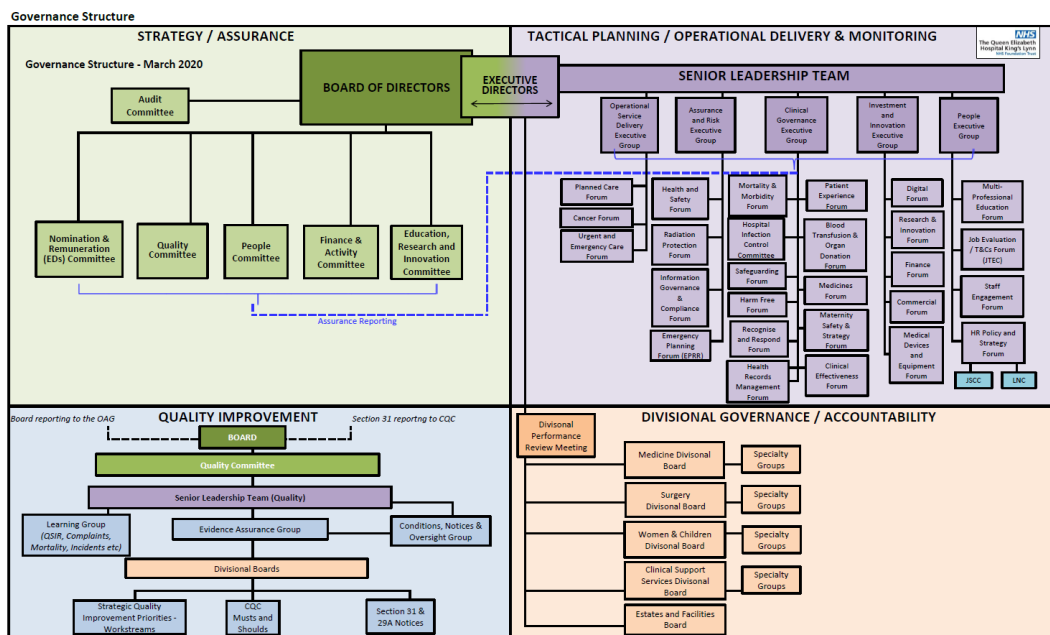
How our hospital is governed

What is a Foundation Trust?

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

- 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

Queen Elizabeth Hospital Governance Structure



Our Board

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust Board Non-Executive Directors

Professor Steve Barnett, Trust Chairman

Steve has more than three decades of experience working in senior NHS positions. Steve was previously Chair at West Hertfordshire Hospitals NHS Trust for three years, during which time the hospital was removed from special measures. 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.

Alan Brown, Non-Executive Director, Vice Chairman and Senior Independent 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 three years, initially at Hinchingsbrooke Health and Care NHS Trust and, more recently, at North West Anglia NHS Foundation Trust. Alan moved to Norfolk in 2016 and continued to work, part-time, as a partner in a consultancy company until July 2019. Alan is Chair of the Trust's Charitable Fund Committee.

Dr Ian Mack, Non-Executive Director

Dr Ian Mack worked in the NHS as a doctor in West Norfolk for most of his working life. He came to the Queen Elizabeth Hospital King's Lynn as a House Physician in 1985. He was a GP in West Norfolk between 1992 and 2017 and held a number of senior roles on NHS Boards in Norfolk, leading clinical improvements particularly for services supporting older people. He was Chair of West Norfolk CCG for four and a half years until his retirement as a GP. Ian is Chair of the Trust's Quality Committee.

Simon Roberts, Non-Executive Director

Simon is an experienced business leader and adviser having worked substantively and as a consultant/adviser in the NHS and private healthcare markets, holding Executive leadership positions in both. He has worked extensively for, and across, NHS England on system and commissioning transformation, including leading major change and transition programmes providing strategic oversight and direct support. Simon is Chair of the Trust's People Committee.

Graham Ward, Non-Executive Director

Graham is a chartered accountant who has more than 35 years of experience in senior financial and commercial roles within the accountancy profession, industry, higher education and management consultancy. He has extensive NHS Non-Executive Director experience, including being a Non-Executive Director at Sherwood Forest Hospitals NHS Foundation Trust, where he also chairs the Audit Committee. Graham is Chair of the Trust's Finance and Activity Committee.

David Dickinson, Non-Executive Director

Following retirement from the post of Director of Resources at Newark and Sherwood District Council in Nottinghamshire, David moved to 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.

Jackie Schneider, Non-Executive Director

Jackie is a Registered Nurse and has worked in the NHS for over four decades, across a broad and varied range of clinical environments, in both clinical and senior clinical leadership positions. She retired in 2018 having been the Registered Nurse on the governing body of North Norfolk Clinical Commissioning Group for six years. At county level, Jackie also held lead roles in quality agendas such as adult safeguarding and infection prevention and control.

Professor Mandy Ashton, Non-Executive Director (Retired July 2019)

Mandy has worked in healthcare for more than 30 years in roles including nursing and policy making in both community and hospital settings. In 2008 she became a professor in clinical leadership with De Montfort University in Leicester. She was awarded an OBE for services to nursing and healthcare.

Siobhan McClelland, Non-Executive Director (20 May 2019 – 22 November 2019)

Siobhan has worked in the health and care field for more than 30 years and is experienced in using research and evidence to turn policy into practice in the planning, commissioning and delivery of health, social care and wellbeing services. Siobhan originally trained as a general manager in the NHS before moving into higher education researching and teaching health policy, management and economics.

The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust Board Executive Directors

Caroline Shaw CBE, Chief Executive

Caroline joined us as Interim Chief Executive at the start of 2019 and was appointed permanently in September 2019 after making a considerable positive impact. She started her NHS career as a nurse before moving into midwifery and then leadership roles at trusts around the country, including Leicester, Nottingham and Manchester. She became a commander of the Order of the British Empire (CBE) in 2013 for services to the NHS.

Laura Skaife-Knight, Deputy Chief Executive

Laura joined the Queen Elizabeth Hospital in October 2019 following 12 years at Nottingham University Hospitals NHS Trust, where she was Director of Communications and External Relations. She has almost 20 years' experience working at large acute teaching hospitals; including Leicester and Derby. Her portfolio at QEH includes: Strategy, Digital/ICT, external stakeholder relations, Sustainability and Transformation Partnership, communications and engagement, staff and public engagement, culture, membership, governors, volunteers and fundraising, as well as deputising for the Chief Executive.

Dr Frankie Swords, Medical Director

Frankie completed her medical training in Oxford and then London and had been a consultant physician, specialising in endocrinology, for more than 10 years. She held various leadership positions at the Norfolk and Norwich University Hospital, before joining QEH as Medical Director in September 2019.

Libby McManus, Chief Nurse

Libby joined the QEH as Chief nurse in July 2019 from Royal Free London NHS Foundation trust where she had been Chief Transformation Officer, leading change at scale across a growing group of hospitals. Her portfolio at QEH includes ensuring that the patient experience is at the heart of everything we do and the professional leadership of nurses, midwives and AHPs.

Denise Smith, Chief Operating Officer

Denise joined us in April 2019 from Sherwood Forest Hospitals NHS Foundation Trust (SFH), where she had been Deputy Chief Operating Officer since 2017. She became our substantive Chief Operating Officer in March 2020. Her portfolio includes the operational service delivery of the Clinical Divisions, to achieve the annual operational plan and constitutional standards, and Estates and Facilities Services.

Chris Benham, Finance Director

Chris joined the team in January 2020 from University Hospitals of Leicester NHS Trust, where he was the Director of Operational Finance for four years having spent the previous three years working as the Deputy Director of Finance at Calderdale and Huddersfield NHS Foundation Trust. He began his NHS career as the Assistant Director of Finance at Shrewsbury and Telford Hospitals NHS Trust in April 2009.

Advisors to the Board (non-voting)

Carmel O'Brien, Director of Patient Safety (From November 2020)

Cath Castleton, Director of Human Resources (From January 2020)

Carly West-Burnham, Director of Strategy (From January 2020)

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 2019/20 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 2019/20 is shown in the following table:

Better payment practice code	Number	£'000
Non NHS		
Total bills paid in the year	50,820	77,900
Total bills paid within target	3,925	6,566
Percentage of bills paid within target	7.7%	8.4%
NHS		
Total bills paid in the year	1,456	15,720
Total bills paid within target	79	5,857
Percentage of bills paid within target	5.5%	37.3%
Total		
Total bills paid in the year	52,276	93,620
Total bills paid within target	4,004	12,423
Percentage of bills paid within target	7.7%	13.5%

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
- Promote an open and fair culture

The 2019 CQC inspection found the Trust to be 'inadequate' in the 'Well-Led' domain and the organisation remains in Quality Special Measures. To address this, developing our leadership team and management formed one of the eight Strategic Priorities for our Integrated Quality Improvement Plan, under the executive lead of our Chief Executive Officer.

During 2019/20, we secured a fully substantive Executive and Non-Executive team with the Governor's Council appointing three new Non-Executive Directors. The Chairman has taken the Non-Executive Director contingent of the Board to the maximum allowed by the constitution, with high-calibre appointments with senior level experience.

We have received 'Well-Led' support from NHS England and NHS Improvement (NHSE/I) and established a new Board Development Programme to support assimilation of new Board Directors into a cohesive, high-performing unitary board.

The Board Programme has been structured into three areas of development, Board-craft, Board responsibilities and high performing unitary boards – all areas identified by the CQC and the 2018 Board Review.

We have adopted strategies to address and respond to this feedback, including bespoke leadership development programmes for the Divisional Leadership Teams and wider Trust leaders. As part of our longer-term quality improvement work, we identified how important it is to create a culture of quality improvement that involves and engages staff to drive and sustain improvements. The Trust has adopted QSIR (Quality, Service and Improvement Redesign) as its improvement methodology and trained a cohort of staff to take forward improvement projects in their areas.

Income statement

QEH has met the requirement of Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) that the Trust's income from the provision of goods and services for the purposes of the health service in England must be greater than its income from the provision of goods and services for any other purposes. Other income which the Trust has received has had no impact on its provision of goods and services for the purposes of the health service in England.

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' 2019/20 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 2019/20.

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 Chief Executive (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 (Executive Director appointments) have made no changes to the remuneration of Executive Directors in post in 2019/20.

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

Wednesday 24 June 2020

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 2019/20 for Executive Directors or other very senior managers.

No Executive Directors of the Trust earned more than £150,000, in a substantive appointment in 2019/20. However, the Chief Executive is seconded from another Trust and did earn more than £150,000. All Executive Director salaries are within the benchmarked range for foundation trusts of the size of the QEH.

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

- 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 taxpayer 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 nonexecutive director expenses for 2019/20 were £7,113. Aggregate governor expenses were £7,511.

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 2019/20.

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 2020 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, King's Lynn, NHS Foundation Trust in the financial year 2019/20 was £245,000 - £250,000 (2018/19 - £180,000-£190,000); this was 10.14 (2018/19 – 7.76) times the median remuneration of the workforce, which was 24,157. In 2019/20, 7 members of the workforce received remuneration in excess of the highest paid director. Remuneration ranged from £7,413 to £302,326

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		
	2019/20	2018/19
	£	£
Midpoint of banded remuneration of highest paid* director - full year effect	247,500	187,500
Median total remuneration	24,157	24,214
Ratio	10.14	7.76

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

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

The highest paid director of the Trust in 2019/20 and 2018/19 was the Chief Executive.

Foundation Trust Directors' Remuneration Report		1st April 2019 to 31st March 2020						1st April 2018 to 31st March 2019					
Salaries and allowances		(a) Salary	(b) Expense payments (taxable)	(c) Performance pay and bonuses	(d) Long-term performance pay and bonuses	(e) All pension-related benefits	(f) TOTAL (a to e)	(a) Salary	(b) Expense payments (taxable)	(c) Performance pay and bonuses	(d) Long-term performance pay and bonuses	(e) All pension-related benefits	(f) TOTAL (a to e)
		Bands of £5,000	To nearest £100	Bands of £5,000	Bands of £5,000	Bands of £2,500	Bands of £5,000	Bands of £5,000	To nearest £100	Bands of £5,000	Bands of £5,000	Bands of £2,500	Bands of £5,000
Edward Libbey (to 22/10/18)	Chairman							25-30	1200	-	-	-	30-35
Prof Steve Barnett	Chairman	50-55	1,600	-	-	-	55-60	20-25	-	-	-	-	20-25
Ian Pinches (to 30-Sep-18)	Non-executive							5-10	-	-	-	-	5-10
David Thomason (to 31-Mar-19)	Non-executive		-	-	-	-		10-15	-	-	-	-	10-15
Ian Harvey	Non-executive		-	-	-	-		10-15	-	-	-	-	10-15
Mandy Ashton (to 31-Jul-19)	Non-executive	0-5	300	-	-	-	0-5	10-15	120	-	-	-	10-15
Dr Siobhan McClelland (from 20-May-19 to 22-Nov-19)	Non-executive	5-10	200				5-10						
Alan Brown	Non-executive	10-15	300	-	-	-	10-15	10-15	100	-	-	-	10-15
David Dickinson	Non-executive	10-15	-	-	-	-	10-15	5-10	-	-	-	-	5-10
Simon Roberts (from 20-May-19)	Non-executive	5-10	500				10-15						
Dr Ian Mack (from 1-Apr-19)	Non-executive	10-15					10-15						
Graham Ward (from 26-Aug-19)	Non-executive	5-10	200				5-10						
Jackie Schneider (from 14-Oct-19)	Non-executive	0-5	-				5-10						
Caroline Shaw	Chief Executive	245-250		-	-	-	245-250	50-55	-	-	-	-	50-55
Laura Skaife-Knight (from 21-Oct-19)	Deputy Chief Executive	55-60	-				55-60						
Jon Green	Chief Executive			-	-	-		155-160	-	-	-	65-67.5	155-160
Frankie Swords (from 1-Jan-20)	Medical Director	40-45	-				40-45						
Nick Lyons (to 31-Aug-19)	Medical Director	65-70	-	-	-	-	65-70	155-160	-	-	-	-	155-160
Libby McManus (from 15-Jul-19)	Chief Nurse	55-60	100				60-65						
Emma Hardwick (to 25-May-19)	Director of Nursing	65-70	200	-	-	-	65-70	115-120	-	-	-	5-7.5	120-125
Chris Benham (from 2-Jan-20)	Finance Director	25-30					25-30						
Liz Sanford (from 28-Aug-19 to 1-Jan-20)	Director of Finance	0-5					0-5						
Roy Jackson (to 23-Aug-19)	Director of Resources	60-65	200	-	-	-	60-65	135-140	-	-	-	0	134-140
Denise Smith (from 29-Apr-19)	Chief Operating Officer	30-35					30-35						
Jon Wade (to 24-Apr-19)	Chief Operating Officer	5-10	500	-	-	-	55-60	120-125	6,700	-	-	92.5-95	215-220
Clara Moore (to 28-Aug-18)	Chief Operating Officer							50-55	2,700	-	-	25-27.5	75-80

Notes

The taxable expenses relate to business mileage sums paid in excess of HMRC rates – tax is payable on the excess so only the excess value paid to the Director is disclosed

Seconded staff are disclosed at the full cost to the Trust and not what the individual has been paid as a salary. The cost to the Trust includes employer on-costs such as pension and national insurance contributions paid by the employer to the relevant authority.

Liz Sanford - the disclosure relates to the uplift in salary for acting-up as Finance Director. Her substantive salary has been absorbed by her substantive employer

Prior year only

Left in year

Secondment

Foundation Trust Directors Remuneration Report		Pension Benefits 1st April 2019 to 31st March 2020							
Pension Benefits		(a) Real increase in pension at pension age	(b) Real increase in pension lump sum at pension age	(c) Total accrued pension at pension age as at 31 March 2020	(d) Lump sum at pension age related to accrued pension at 31 March 2020	(e) Cash equivalent transfer value at 1 April 2019	(f) Real increase in Cash Equivalent Transfer Value	(g) Cash Equivalent Transfer Value at 31 March 2020	(h) Employer's contribution to stakeholder pension
		Bands of £2,500	Bands of £2,500	Bands of £5,000	Bands of £5,000	£000	£000	£000	£000
Libby McManus	Chief Nurse (from 15-Jul-19)	0-2.5	2.5-5	55-60	170-175	1,141	45	1,231	-
Emma Hardwick	Director of Nursing (to 28-May-19)	-	-	35-40	115-120	838	4	887	-
Chris Benham	Director of Finance (from 2-Jan-20)	-	n/a	20-25	n/a	239	9	280	-
Roy Jackson	Director of Resources (to 28-Aug-19)	-	-	60-65	180-185	1,465	(14)	1,465	-
Jon Wade	Chief Operating Officer (to 29-Apr-19)	-	-	25-30	50-55	325	1	346	-
Laura Skaife-Knight	Deputy Chief Executive (from 21-Oct-19)	0-2.5	0-2.5	20-25	40-45	255		312	-
Frankie Swords	Medical Director (from 1-Jan-20)	0-2.5	0-2.5	45-50	100-105	693	26	23	-

Patient safety

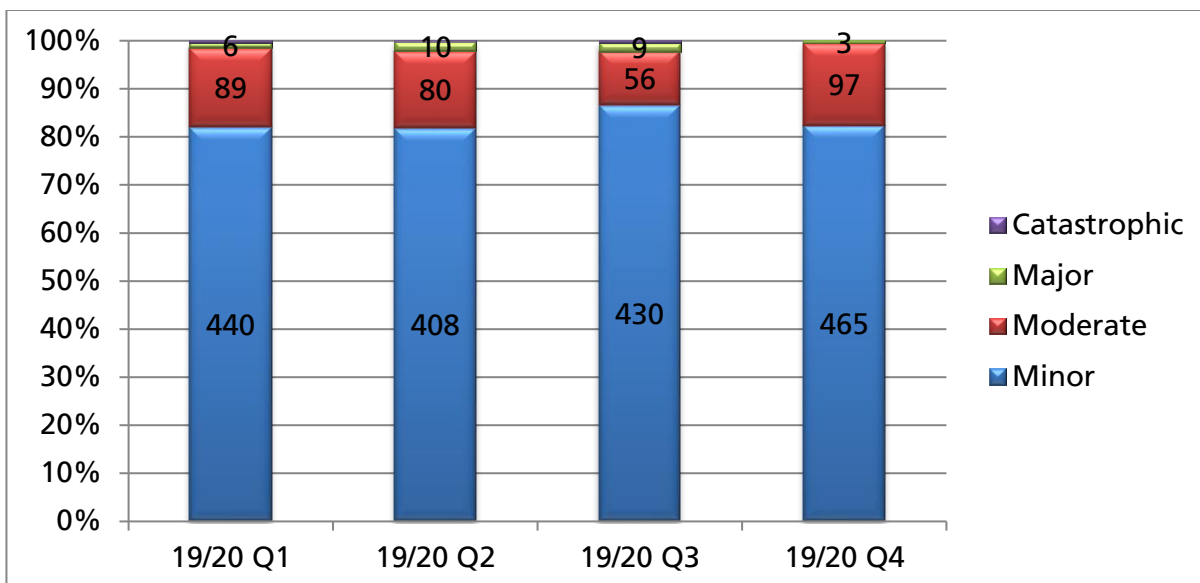
Incident reporting and Never Events

We have seen a reduction in the reporting of patient safety incidents during 2019/20. The total patient safety incident reporting rates for 2019/20, excluding pressure ulcers reported on admission, was 7,007. This is a 9.1% drop in reporting from the previous year. Safety incidents resulting in severe harm or death have reduced in the year by 9.3% to 29 incidents.

Total Reported Incidents

	Total Reported Patient Safety Incidents Excluding Pressure Ulcers on Admission	Safety incidents that resulted in severe harm or death
2019/20	7007	29
2018/19	7710	32
2017/18	6474	29

Patient Safety Incident Reporting Harm Outcome



While the level of harm would appear to have reduced slightly, we cannot identify the reasons for the reduction in incidents overall, however, it has been agreed that ensuring an increase in incident reporting is a quality priority for 2020/21.

The way we manage incidents, the reporting, investigation and identification of actions was reviewed in 2019/20 with a number of programmes identified, which will be taken through into 2020/21. Key areas of focus have been:

- Improving the quality of serious incident investigations by the completion of Root Cause Analysis and Human Factors training of more than 80 staff

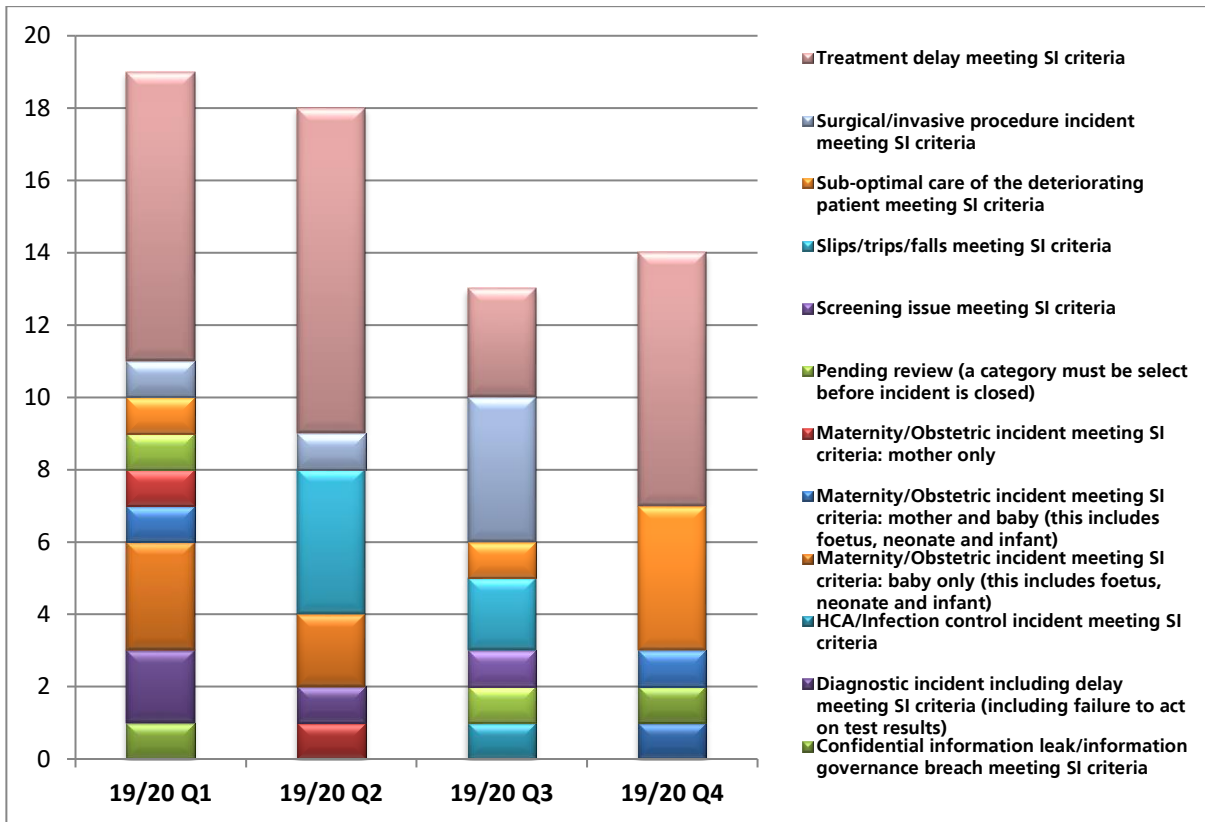
- Implementing an Executive led bi-weekly moderate/Serious Incident (SI) panel
- Executive sign-off process for all Serious Incidents
- Review of the processes and timeliness to ensure compliance with Duty of Candour
- Improving the capability of Datix, the incident reporting system to support Divisional ownership of monitoring all incidents
- Clearing a backlog of historic SI investigations
- Improving the quality of investigations, in quarter 4 of 2019/20 our commissioners have been able to close 100% of SIs submitted for review with no requests for improvements
- Developing accurate reporting systems for monitoring of moderate incidents to enable a more timely approach to investigations
- Production of quarterly themed patient safety reports
- Production of Patient Safety Alerts and bulletins to share learning Trust-wide

SIs reported in financial year

Total number of SIs by Division 2019/20

	Clinical Support Services	Medicine	Surgery	Women & Children	Non-Clinical	Total
19/20 Q1	1	10	2	5	1	19
19/20 Q2	1	13	3	3	0	20
19/20 Q3	1	5	5	2	0	13
19/20 Q4	0	12	1	1	0	14
Total	3	40	11	11	1	66

Categories of serious Incidents declared during 2019/20

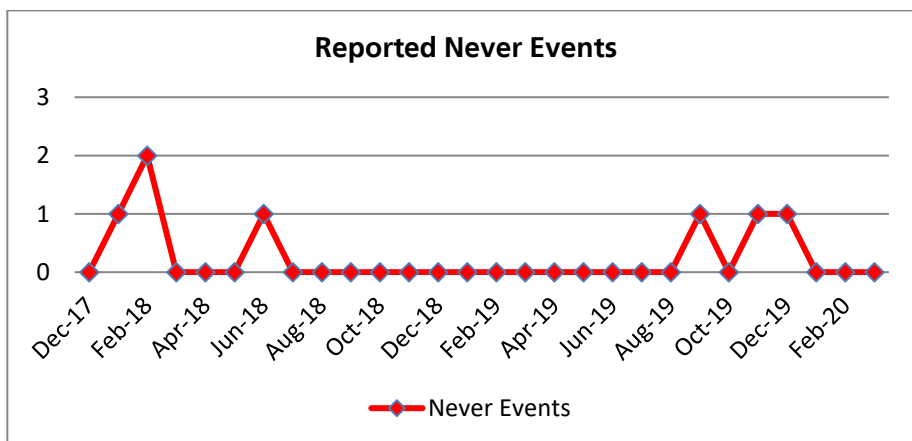


Never Events

We declared three Never Events during 2019/20 in the categories of:

- IVT injection into the incorrect eye
- Wrong side peripheral nerve block performed on a patient prior to foot surgery
- Incorrect size implant used during an operation performed for a Right Total Hip Replacement

Never Events reported since December 2017



During 2019/20 we developed processes for identification of themes of learning from incidents. Key areas of focus are:

- Sticking to policies, protocols and operating procedures.
- Poor documentation, either poor or absent recording of care planning in the notes or completion of risk assessments eg: falls risk assessment
- Unsafe manoeuvres used to restrain the patients
- Individual clinical knowledge gaps to interpret findings
- Human factor errors

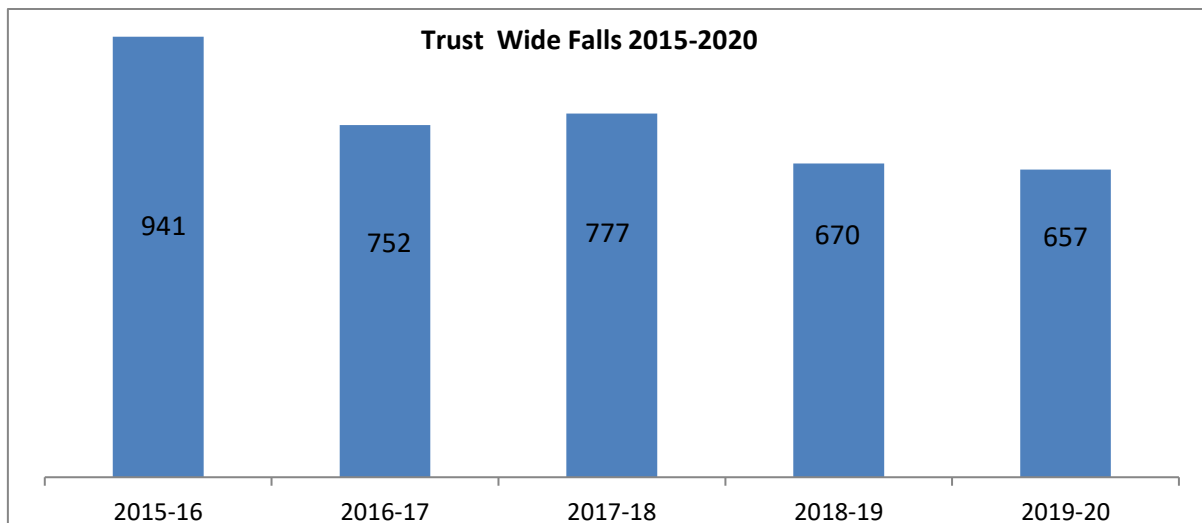
The CQC highlighted in their findings that we are not learning from patient safety incidents. We are ensuring systems and processes are put in place within the organisation to learn from errors. This work is developing and will be a focus for us throughout 2020/21.

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

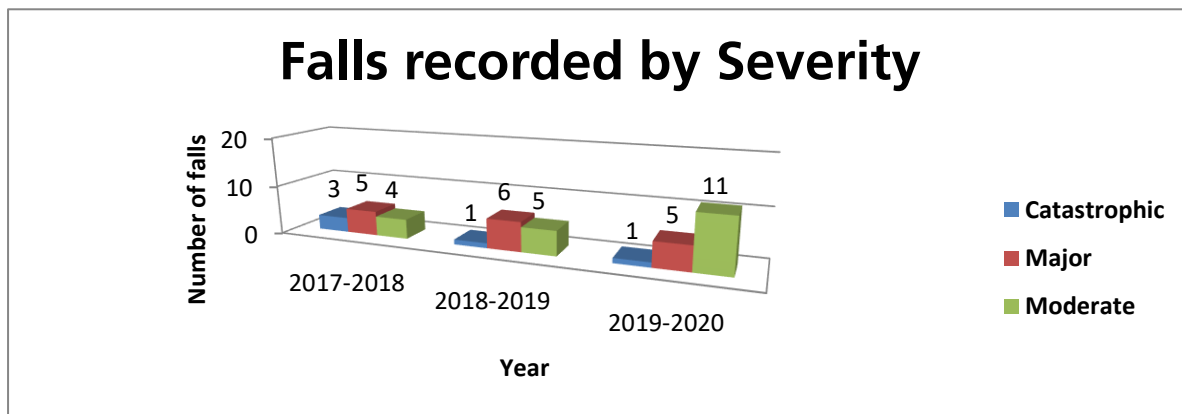
Over the past 12 months, we have continued to monitor performance against an agreed benchmark set in 2015, committing us to fewer than five falls per 1,000 beds days for all our adult inpatients.

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

Over the past 12 months we have consistently seen a reducing trajectory of adult inpatient falls resulting in the lowest falls rate in a 12-month period for five years. We also continue to robustly review and investigate falls that result in harm, benchmarking ourselves against similar organisations.



However, the Trust saw a slight increase in falls that resulted in major harm, a significant increase in those with moderate harm, but saw a continued reduction in catastrophic harm when comparing data from the past three years.



Our aim for this year was to reduce adult inpatient falls with harm by 20% which we have not achieved, but the Trust did not exceed the national falls benchmark rate per 1,000 bed days of 6.63 or the national benchmark for falls with harm which is 0.19 per 1,000 bed days.

Improving End of Life care

We are improving End of Life care for our patients and their families. Further changes we have made to strengthen bereavement support for families during the COVID-19 pandemic will become the way we do things moving forward.

Key elements include:

- Creating 40 ward-based end-of-life champions and six medical champions.
- Launching and starting to embed a new End of Life Care Strategy (2020-2025) across the organisation
- Confirming the appointment of a new Palliative Care Locum Consultant
- Registering for the third round of the National Audit of the Care at End of Life (NACEL) - audit period: 1 April- 31 May 2020
- Adopting the ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) process – a personalised process to create and record a plan containing care preference and appropriate clinical recommendations for a person’s clinical care in the event of a future emergency.

Patient and carer experience

During 2019/20 we actively engaged with patients, their carers and members of the public so they could contribute to improving the quality of services that we provide.

We identified three key strategies that would enable us to improve patient experience based on what patients and the public told us. These included:

- Improving the patient experience as measured by the Friends and Family Test
- Using learning from compliments, complaints, national surveys and feedback to enhance the quality of the services we offer our patients
- Ensuring the environment is appropriate for clinical care and a positive patient experience

Measuring and reporting patient experience

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

- Promoting the Friends and Family Test
- Hosting events for patients and the public
- Seeking invitations to attend meetings and events run by organisations in the community to listen to their members' views
- Listening to patient stories at Board meetings
- Participating in national patient surveys
- Patient and public representation at key committees
- Proactively responding to patients' and carers' feedback posted on the NHS website and Care Opinion websites, Facebook and Twitter

The value of some of these activities is described below:

Friends and Family Test (FFT)

We have 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.

Hosting events

The Governors' Council and the patient experience team hosted events in conjunction with local statutory, community and voluntary sector partners. This year two were held covering Prostate Cancer and Inflammatory Bowel Disease. We also held a week of activities in May 2019 to support Dementia Awareness.

Governors also attended meetings organised by other statutory bodies to understand how changes in the NHS are likely to affect our patients, raise concerns and learn more about the processes. These meetings included Norfolk and Waveney Sustainability and Transformation Partnership (STP) meetings, West Norfolk Clinical Commissioning Group meetings, Healthwatch Norfolk STP Meeting and forums arranged by Healthwatch Cambridgeshire/Peterborough.

Establishing patient groups

We have also established a visually impaired group that meets alternate months – both face-to-face and via teleconference. The group includes patient representatives and support charities, During the past 12 months our Chief Executive, Caroline Shaw, has toured the hospital with visual impairment glasses and equipment and changes have been made to signs and the estate across the hospital to support the visually impaired.

Compliments, Complaints, Concerns and Comments

Our Patient Advice and Liaison Service (PALS) is a confidential point of contact for patients or relatives who may have concerns about their current or previous treatment. The team 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.

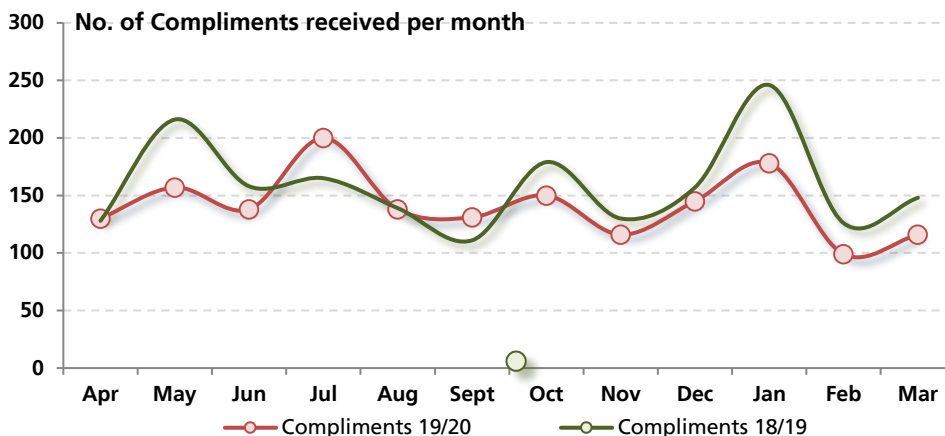
The PALS Department continues to promote its service by featuring on the front page of the Trust's website, regularly visiting the wards, occupying an accessible location in the main entrance and having a prominent position on one of the Trust's newer initiatives, bedside placemats. The placemats are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

This year, we have improved the way we categorise information to reduce the use of "general information". During 2019/20 3,541 PALS contacts were logged (excluding compliments). The top themes are identified in the table below:

PALS by Sub-subject (primary)	Numbers
General Information	718
Access to Health Records	214
Travel Expenses	205
Enquiry	143
Poor Communication	135
Clinical Care	91
Complaints Procedure	87
Discharge Arrangements	87
Concern	82
Lack of Information	78
Staff Attitude	77

Compliments

Along with feedback and concerns which are shared with the department, the PALS team also logs any compliments which are shared with them, either when 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 2019/20 we recorded 1,702 compliments, down from 1,906 in 2018/19.



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

Formal Complaints

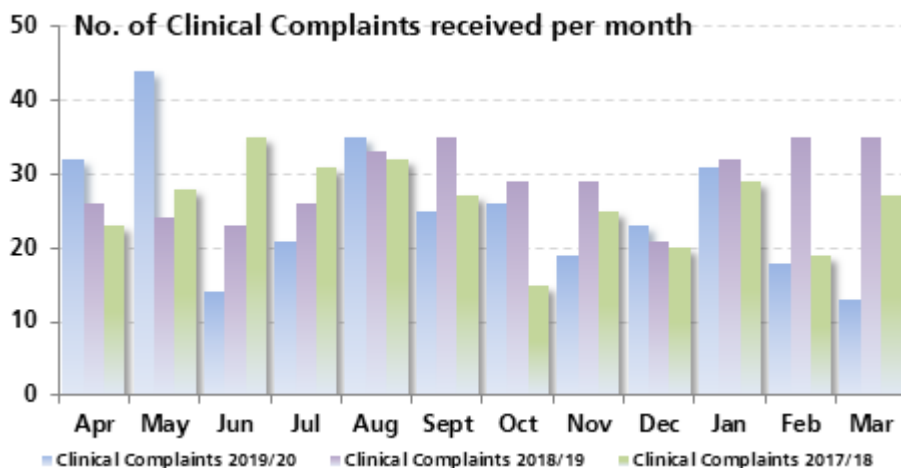
During the year, we received 388 formal complaints, down 9% on the previous year (422).

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

Complaints by method	Numbers
Email	202
Letter	119
Via Pals	27
Complaint form	23
Telephone	10
Window enquiry	5
Letter from MP	1
Ward visit	1

Main themes from the complaints we receive from patients and their families

Complaints by sub subject (Top 10)	
Communication with patient	54
Delay or failure in treatment or procedure	24
Delay or failure to diagnose	17
Communication with relatives/carers	16
Appointment delay (including length of wait)	16
Attitude of Medical Staff	14
Delay or failure to undertake scan/x-ray etc	11
Inappropriate treatment	11
Discharge Arrangements (including lack of or poor planning)	10
Failure to provide adequate care (including overall level of care provided)	9



We use DatixWEB to provide a learning tool for all areas. Our average response rate to complaints has decreased this financial year, achieving a rate of 37% of complaints responded to within the set timeframe. The low compliance rate was significantly contributed to by our divisions not adhering to agreed timeframes to provide responses and staffing challenges within the Complaints Department.

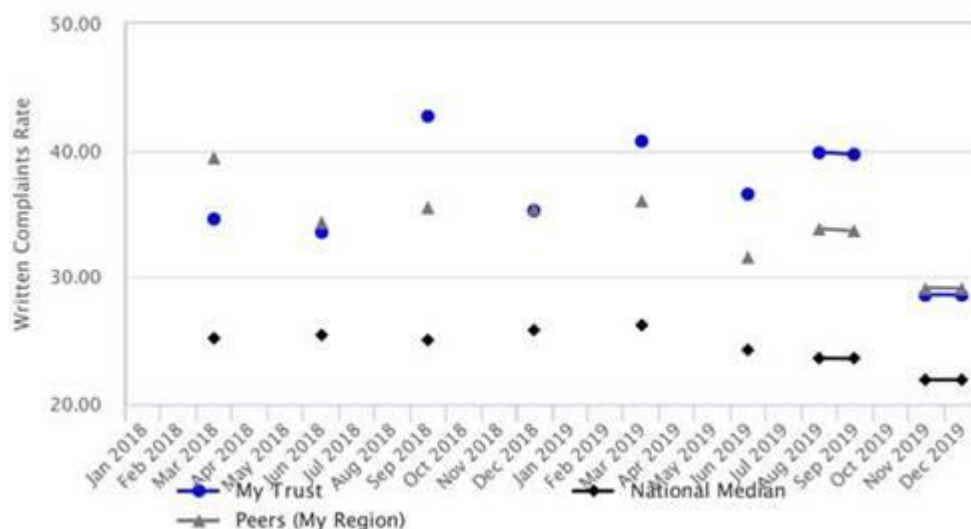
Thanks to an ambitious recovery plan the backlog has now been cleared with extra staff in place to support the team. The trajectory has been achieved and response rates have continued to improve.

Formal Complaint Response rates

Trust	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Clinical Complaints 2019/20	32	44	14	21	35	25	26	19	23	31	18	13
Response Rates (%) 2019/20	7%	21%	10%	26%	17%	33%	43%	29%	50%	57%	72%	75%
Non-Clinical Complaints 2019/20	2	3	10	17	10	7	13	5	2	3	5	10

The complaints process was revised in March 2020 to improve timescales at each stage of the process and additional support is being provided to the Divisional Teams from the Complaints Team to ensure more timely replies to patients and their families when concerns are raised.

Written complaints rate



The latest data on Model Hospital (December 2019) show that our complaint rate is 28.64 which is in Quartile 3. The complaint rate is the count of written complaints made by or on behalf of patients about an organisation per 1,000 staff (whole time equivalents) .

The peer median score for this month is 29.15 and the national median score is 21.95. Before December 2019, our rate had been above the peer and median scores since September 2018.

Further improvements for 2020/21 include:

- A new Head of Patient Experience has been recruited to lead on the development of key priorities linked to the Corporate Strategy to enable improvements to the care we deliver to patient and their families
Campaign to ensure Trust-wide understanding and awareness of the changes within the Complaints Policy
- Aiming to respond to 90% of complaints within 30-working days
- Standardising internal training for staff on all aspects of the complaint process and improving staff guides on how to investigate and respond to complaints
- We will focus on Learning Experience and Action Plan (LEAP). Initiatives are in place to ensure all LEAPs are completed on Datix and learning from complaints is shared effectively. Patient stories and quarterly newsletters will be shared as part of the launch of our new process.

Parliamentary and Health Service Ombudsman (PSHO)

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 happens 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, eight complaints were referred to the PSHO.

- Two are currently under PSHO investigation and awaiting an outcome.
- Five are at preliminary referral stage and we are awaiting a decision on whether the PSHO will proceed to investigation stage.
- One complaint was not upheld by the PSHO.

CASE STUDY

Getting it Right Programme (for our patients and each other)

This programme was designed to improve patient experience following a theme of complaints relating to reported behaviour of some staff towards each other and to patients and visitors.

It focuses on compassion and caring from staff, positively affecting both experience and safety and reducing the frequency of complaints of poor staff attitude.

It is designed for multi-disciplinary attendance and provides a chance to discuss why we come to work and to reconnect with both the Trust's values and behaviours and personal drivers. Within the session the patient voice is shared with the use of complaints and patient experience data and staff are encouraged to explore what they perceive to be barriers to providing compassionate care.

The presentation is designed to promote both reflection and discussion and staff are encouraged to share their own stories. Areas that are covered include, privacy and dignity, compassion, "what good looks like," empathy and civility within teams.

It was launched in March 2020 and over 4 sessions 36 staff attended from several clinical areas. Each session lasts approximately 2 hours and staff are asked to sign and take away a pledge as they leave, stating how they plan to make a difference. It has been well evaluated but is very much an iterative process using feedback to inform content/delivery going forward.

Listening to patients

Patient and public involvement is integral to how hospitals plan and improve their services so listening to patients, their carers and the public and acting on what they tell us is vital. We have identified three key strategies to improve patient experience and introduce service improvements based on what patients and the public tell us.

These include:

- Improving the patient experience as measured by the Friends and Family Test
- Using learning from compliments, complaints, national surveys and feedback to enhance the quality of the services we offer our patients
- Ensure the environment is appropriate for clinical care and a positive patient experience.

Measuring and reporting patient experience

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

- Promoting the Friends and Family Test to receive anonymous but timely feedback
- Hosting events for patients and the public
- Seeking invitations to attend meetings and events of organisations in the community
- Listening to patients' stories at board meetings

- Participating in National Patient Surveys
- Patient and public representation at key committees
- Undertaking mock Care Quality Commission visits which include interviews with patients and carers (if they are present during the visit). The reports from these visits and any resulting action plans are considered by the Governors' Patient Experience Committee, the Trust Patient and Carer Experience Steering Group and by the Service Line Quality and Business Boards covering the wards or departments visited
- Annual PLACE (Patient Led Assessments of the Care Environment) inspections
- Reading and responding to patients' and carers' feedback posted on the NHS Website and Care Opinion websites, Facebook and Twitter.

Friends and Family Test (FFT)

We found the free-text comments submitted with the FFT responses gave a valuable insight into issues and concerns that are important to patients. The FFT allows us to make changes based on patient feedback far more quickly than when awaiting results from other types of feedback. It 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 further.

As a snapshot guide, our inpatients FFT score at the end of February 2020 was 94%, compared with a national average of 96%. For accident and emergency patients it was 93%, compared with the national average of 85%.

We are taking the following actions to improve these scores 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, information screens and additionally to staff through regular internal communications
- Reviewing negative feedback, sharing with colleagues and providing an action plan to resolve issues highlighted by patients
- Monitoring feedback following changes to ensure positive impact
- Sharing actions between areas.

Patient stories at Board

To ensure that the patient's voice is heard at board level, patients and their carers have attended board meetings to tell their stories, giving senior management the chance to hear about our care at first-hand and to learn what patients value most. It also provides an opportunity for patients and carers to describe experiences where care could have been improved and in so doing, enables the organisation to act on this feedback.

National Patient Surveys

There were five surveys published between April 2019 and March 2020 relating to the experience of patients – National Cancer Survey (2018), National Maternity Survey (2019),

National Inpatient Survey (2018), National Emergency Survey (2018) and National Children and Young Persons Survey (2018).

Survey	Month sampled	Month Published	Response Rate
National Cancer Survey 2018	April – June 2018	September 2019	69% (average national response 64%)
National Children and Young Person’s Survey 2018	November – December 2018	November 2019	25.71% (average national response rate 25%)
National Emergency Survey 2018	September 2018	October 2019	37.06% (average national response 30%)
National Inpatient Survey 2019	July 2018	June 2019	45% (average national response rate 45%)
National Maternity Survey 2019	January – February 2019	January 2020	37.97% (average national response rate 36.5%)

National Cancer Survey

There were a number of positive improvements reported in the National Cancer Survey. These included four areas in which we were significantly better than other Trusts.

- Patient found it easy to contact their Clinical Nurse Specialist
- Staff explained how operation had gone in understandable way
- All staff asked patient what name they preferred to be called by
- Practice staff definitely did everything they could to support the patient

There were two areas in which the Trust was significantly poorer than other Trusts.

- Always or nearly always enough nurses on duty
- As far as you know, was your GP given enough information about your condition and the treatment you had at the hospital.

National Emergency Survey

The Biennial National Urgent and Emergency Care Survey (results published October 2019) took place during September 2018 with a response rate of 39% (3.6% higher than the previous survey and 9% above the national average). The Divisional Leadership teams received the report and integrated the improvement work required into the Section 31 CQC condition notice and IQIP. During 2019/20 the main ED reception area was reconfigured to improve patient and staff experience; we created a new ambulance handover area to help reduce

handover times and ambulance crews can now present patients directly to our new Same Day Emergency Care unit.

National Maternity Survey

Women were asked a range of questions about the care they received before, during and after birth. QEH has improved in three key areas, many relating to the divisional focus on specific actions, including:

- Patients were given enough information about their own physical recovery – the Trust was significantly better than other Trusts
- Midwives gave the help needed at home, postnatally
- Parents received support and advice about feeding their baby during evenings, nights and weekends

We were also significantly better than other Trusts in relation to mothers being given a choice about where to have postnatal care.

The areas for improvement include:

- Treating mothers with respect and dignity during labour and birth
- Confidence and trust in the staff caring for you during labour and birth

National Children and Young Person's Survey

Parents gave staff at QEH full marks when it came to the care of their children in the national survey, results of which were published at the end of 2019.

The latest NHS Children and Young Person's Survey results showed that respondents were 100% satisfied with the care in four areas:

- Children having enough privacy when receiving treatment
- Staff speaking to children in a way they could understand
- Staff answering children's questions
- Staff being friendly

The Trust improved in three areas compared to the 2016 survey:

- The type of ward children stay on
- Advice given about caring for children at home
- Staff doing everything they can to help with pain

Ninety-six percent of parents felt their child was well looked after by staff and 97% had confidence and trust in staff looking after their child and felt that they were listened to.

The survey also showed that staff are looking after the whole family with 94% of respondents saying they were well looked after by staff.

The survey identified there is more work to do when it comes to children and families being informed what happens next with their care and parents receiving written information about the child's treatment.

National Inpatient Survey

Results of the National Inpatient Survey (2018), which were published in June 2019, highlighted areas where we need to focus improvements. Noise at night continues to be a problem for many patients, at times there are not enough nurses were on duty and there

were too many delays in responding to call bells. Members of teams did not work well together at times and patients were not satisfied with the way we handled getting them home (discharge).

An action plan is addressing each of these areas with many actions already complete. For example:

- Our successful recruitment campaign has brought the Trust's nurse vacancy rate down to 5% - one of the lowest in the country.
- Multi-disciplinary board rounds and cross division meetings, alongside divisional newsletters and a closed social media page have improved communications and team working
- We have extended the opening hours for the Discharge Lounge and plan to expand its footprint; we have clarified the escalation process to support discharge delays and are taking part in system-wide initiatives to improve patient experience

How we have used feedback to improve the experience of our patients and their carers

- Red Bag project to improve communication between hospital and care homes to streamline paperwork
- Carers' Cards rolled out across the Trust to support unpaid carers who provide emotional and personal support to patients, especially those with dementia, delirium and learning disabilities
- Streamlining the zebra crossing points, improving visibility and addressing issues raised by the hospital's visually impaired group
- Improving the experience of mums during birth, midwives are providing more regular conversations about 'how things are going'
- Professional Midwifery Advocates introduced to provide support, ensuring all risks are discussed and decisions can be supported throughout the pregnancy pathway
- Local children helped us to improve the experience of adolescents on the children's ward
- Meeting area signs were introduced to help patients waiting for collection either by taxi or relatives to identify the most appropriate area to wait
- Our Maternity discharge booklet was enhanced to include more information to support infant feeding and physical recovery. Maternity support workers were trained to help with feeding

Communicating learning locally within wards and departments

- 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
- Improvements are discussed at sessions for clinical staff in mandatory training and through development courses
- Actions taken in response to patient feedback are shared with areas experiencing similar problems

Working with Healthwatch Norfolk

Relationships with Healthwatch Norfolk have been strengthened over the past year.

Healthwatch Norfolk hosts the Norfolk and Waveney-wide Patient Experience Leads meetings

on a bi-monthly basis at their headquarters in Wymondham. The local Community Engagement Officer visited the hospital on a monthly basis sitting in a selection of outpatient areas across the Trust focussing on areas where we felt we needed support and also areas that were key to projects being managed by Healthwatch. All areas have welcomed Healthwatch's engagement with patients and staff. The areas visited were: Physiotherapy, Pain Clinic, Diabetes (including antenatal diabetes), Ophthalmology, Dermatology, Discharge Lounge, Audiology, Breast Care Unit (both screening and symptomatic clinics), Ambulatory Emergency Care, Neurophysiology and Cardio-Respiratory. Feedback is provided on the day to the nurse in charge and compiled into a monthly report sent to the Trust and then distributed out to the teams to share.

Staff Report

Our staff

As a Trust, we aim to create a culture where staff feel comfortable speaking up knowing they will be listened to, where staff feel valued and supported to deliver their true potential and where staff enjoy coming to work and are proud to be part of Team QEH.

The Trust's People Strategy will be designed around six priority areas outlined below to form the basis of the People Plan.

- Attraction, recruitment and retention; workforce planning
- Leadership and development
- HR systems
- HR processes
- Consequences of actions
- HR metrics

We 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 and staff outcomes, people productivity and financial sustainability. We will continue to report, investigate and act on incidents and use patient, carer and staff feedback.

Staff numbers (whole time equivalents) are detailed below (externally audited)

	31 March 20			31 March 2019		
	Permanent	Other (Agency & Bank)	Total	Permanent	Other (Agency & Bank)	Total
	WTE (whole time equivalents)					
Medical and dental	361	37	399	339	45	384
Ambulance staff	7	0	7	6	0	6
Administration and estates	590	19	608	573	19	591
Healthcare assistants and other support staff	794	117	911	714	125	839
Nursing, midwifery and	845	125	970	805	133	938

health visiting staff						
Nursing, midwifery and health visiting learners	1	0	1	2	0	2
Scientific, therapeutic and technical staff	318	8	326	325	12	337
Healthcare science staff	56	4	60	54	3	58
Social care staff	0	0	0	0	0	0
Total average numbers	2972	310	3282	2818	339	3156

Gender

Breakdown of staff by gender (31 March 2020)

Category	Female	Male	Total
Executive Directors	5	1	6
Non-Executive Directors	1	6	7
Senior Managers	24	19	43
Other	2748	781	3529
Grand Total	2778	807	3585

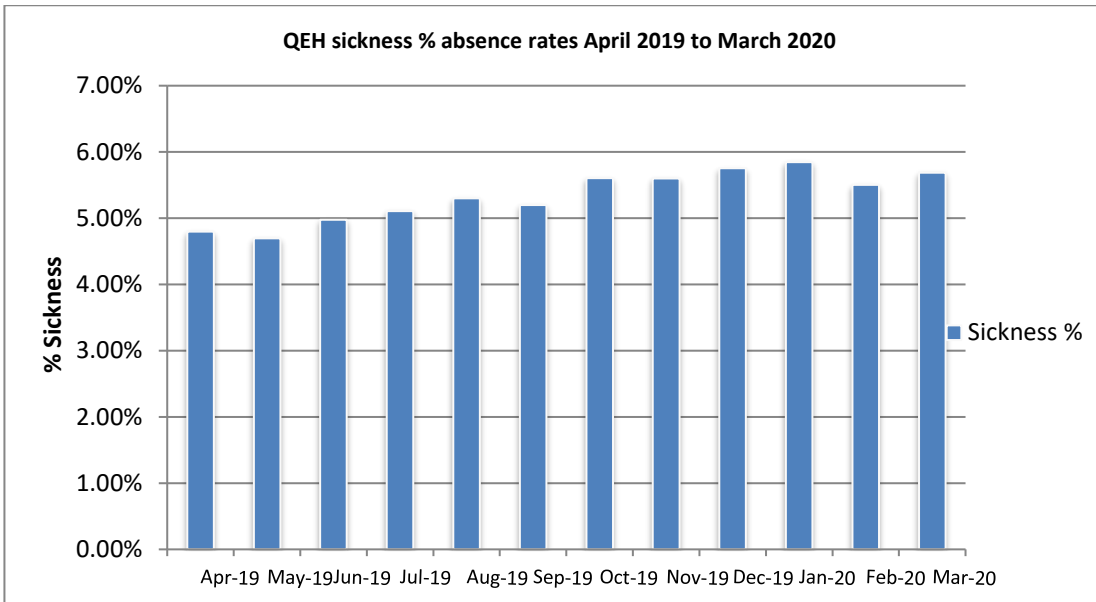
For information on gender and pay at QEH visit the [government's gender pay gap service website \(https://gender-pay-gap.service.gov.uk/Employer/LjqQsney\)](https://gender-pay-gap.service.gov.uk/Employer/LjqQsney)

Staff sickness

Our sickness rate was 5.68% at the end of March 2020, against a target of 4% (from a starting position of 5.3% at the end of 2018/19). We have focused on:

- Review of long-term sickness cases
- Strengthened support and training for managers
- December 2019: absence correlation review
- New health and wellbeing programme
- Sickness reduction targets for all Divisions/Corporate Services

Reducing sickness absence to 4% and seeing a 50% reduction in staff sickness related to stress, anxiety and depression remains a priority going into 2020/21, building on the work we have already started. This includes the implementation of a Trust-wide health and wellbeing programme, further training to support managers, auditing current processes and data and undertaking a further review of our Absence Policy.



We continue to enhance the offer we make to our workforce and make a positive impact on individuals' lives and for the organisation. Our Occupational Health service continues to deliver programmes to promote the health and wellbeing of our staff. Over the past year, the team has supported our work towards NHS England's National CQUIN (Commissioning for Quality and Innovation) target relating to Improving Staff Health and Wellbeing. The key elements of this strategy are developing a preventative programme in addition to the reactive support available to staff.

This programme consists of four objectives:

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

See page 74 for further information about our staff health and wellbeing programme for 2010/21.

Recruitment case study

Bringing our nursing vacancies down to a record low

The Best of Work, Best of Life; promoting QEH as a place with a deep sense of community, where staff have high regard for each other, a fierce pride in their hospital and a love of the area in which they live.

Our innovative campaign knitted all these aspects together to:

- Reduce its vacancy rate
- Support recruitment into traditionally hard to recruit into positions
- Explore alternative recruitment methods for areas with high turnover rates
- Support our objective to recruit 140 international nurses by February 2020
- Promote our sense of community, and the area as a great place to live, grow and develop

Supported by our Charitable Fund, the first phase (September) featured staff in and out of work, developed into:

- Paid for advertising: digital marketing across online partner sites
- Billboards at motorway service stations on the A1 to the Midlands
- Billboards on train platforms on the cross-country line to Manchester
- Billboards at East Midlands Airport

We also created a dedicated website: www.teamqeh.com and targeted social media, particularly Twitter, tagging organisations aligned with our campaign, such as LoveWestNorfolk and VisitNorfolk.

We created a Job of the Week platform on the TeamQEH.Com/recruitment website, which is promoted through social media channels.

During October and November 2019, page views on TeamQEH.com topped 4,300 for each month and the number of click-throughs and quality of candidates for many vacancies allowed us to close applications early and move on to interview and appointment stages earlier.

The campaign material was also used during our successful recruitment campaign to the Philippines, which resulted in 140 new recruits. As the number of staff from overseas is increasing we are developing a growing network of support including:

- Intensive programme in preparation for the Objective Structured Clinical Examination
- A preceptorship programme
- Individual support from the Practice Development team
- Informal clinical supervision
- Attendance at the People Committee to share their experiences
- Welcome celebration hosted by the Filipino Association of West Norfolk (for Filipino nurses)
- During 2020/21 we will develop a network group for our BAME staff (from black, Asian and minority ethnic backgrounds).

Vacancy rates

In June 2019, the overall Trust vacancy rate was 14.77%. As a result of all Trust recruitment campaigns and initiatives this reduced to 10.69% by January 2020. Staff turnover has reduced to 11.79% and ward-based nursing vacancy rates have fallen to 5%, the lowest level ever for QEH and one of the lowest rates in the country.

Staff communications and engagement

Strengthening staff engagement

There was clear evidence from our 2019 CQC results, staff surveys and listening events that staff felt disengaged, did not feel listened to and morale was low. Our staff survey results in 2018 were among the worst in the country.

Further improving staff engagement has been a significant focus and one of our strategic priorities for 2019/20. We are making good progress, as evidenced by our 2019 staff survey results (see below), which demonstrated improvements in every area. We were the only Trust in the region to achieve this. However, there remains much to do if we are to create the right culture at the Trust; one where staff feel valued, supported, listened to and able to develop their true potential.

Staff engagement during COVID-19

During the COVID-19 outbreak, which began in March 2020, a 12-week plan was initiated to help meet the ever-changing needs of staff. This included clinical psychology support, a dedicated staff support booklet and a proactive focus on 'Speak Up' and listening to and responding to staff feedback during this incredibly challenging and pressured times.

Staff support helplines were set up, and we created a "wobble room" on each ward area and in our Sacred Space where staff could go when the stresses of battling coronavirus and often being separated from their families overwhelmed them. We recognised the need for staff to have somewhere they could go to look after their mental health and gain support while on duty. Each room housed a "Wobble Box" containing items to help staff refocus their mind and thoughts.

Clinical Psychology implemented an outreach service for staff undertaking daily ward sessions with staff to help maintain emotional wellbeing.

Food boxes were delivered daily to our COVID-19 wards so staff that were unable to leave their areas had food and drink provided to help them through their shift. Self-care packages containing toiletries and sanitary items were given to staff who were staying away from home in order to continue being able to attend work.

A hardship fund was created to support staff suffering financially during this time and we secured deals with local companies to support staff with discounts and priority shopping at discounted rates.

Looking to 2020/21

The Trust has appointed a new Head of Staff Engagement and has a Staff Engagement programme for 2020/21 which has been agreed by the People Committee. Progress is monitored at this Committee monthly.

We have developed a new Staff Engagement Programme for 2020/21 (below), which the People Committee has approved. It aims to deliver, by 2021, a further step change in staff engagement and how people feel about working at QEH.

STAFF ENGAGEMENT at QEH



#TeamQEH
#BetterTogether

There will be 3 main areas of focus in 2020/21 – in response to the staff feedback, notably: (1) culture and learning, (2) reward and recognition and (3) health and wellbeing (spanning physical, mental and financial health).

The Trust's Deputy CEO (as Executive Lead for this strategic objective) has recently convened a Staff Engagement action group, utilising existing resource (comprising clinical and non-clinical colleagues) to support delivery of this priority work.

We have developed a new Corporate Strategy, which has staff engagement at its very heart. The Key Performance Indicators we have set ourselves for year one of our new strategy, which relate to our People, and have been approved by our People Committee, are:

- Further improving overall staff engagement scores, and to be in the top third in the country for these scores in the 2020 staff survey results
- Improving scores for staff feeling valued at work from 38% to 45%
- Improving staff recommending us as a place to work from 51% to 60%
- Reducing our vacancy rate to below 10% for all staff groups
- Reducing turnover to 10% and vacancy rate to 12% for AHP's and Nursing and Midwifery staff
- Achieving an 85% compliance rate for mandatory training
- Achieving a 90% compliance rate for appraisals (with an increase in the number of staff who say they have a good quality appraisal)
- Improving QEH's reputation as a place to work by improving our recruitment processes to reduce the number of vacancies
- Increasing the response rate to the national staff survey to >50%

- We will have improved development, learning and training opportunities for all members of Team QEH and staff will feel part of a strong team working across QEH and our health and social care systems

Developing an engaged, enabled and empowered workforce, which is well-led and supported, ensures they are getting the best possible experience, and would recommend the Trust as a place to work and receive care.

We are committed to constantly improving our culture and increase staff engagement, which is supported by a comprehensive internal communications and engagement programme designed to support key messages and promote visibility of senior leaders across the Trust.

This includes:

- In the Know, the new-look weekly round-up of key messages, information and updates from across the Trust
- Fortnightly briefings from the Chief Executive – open to all staff and information slides are shared with all staff (digitally) immediately after the event. The briefing includes updates on our key operational and financial performance
- The fortnightly #BetterTogether blog from the Chief Executive
- Medical Director's briefings each month for consultants and other senior medical staff and a monthly blog
- Monthly meetings with Junior Doctors
- Chief Operating Officer's briefings – two each month, one for corporate and support teams and one for estates and facilities (suspended during COVID-19)
- Chief Nurse briefings (monthly) for nurses, midwives, healthcare assistants and Allied Health Professionals
- Regular listening events for staff; led by the Chief Executive and Executive Team
- Regular meetings with staff-side representatives
- A closed Facebook group created in May 2019 to share staff updates and promote interaction and discussion between staff – with a growing membership of more than 1,600
- Sharing messages through social media, reaching a growing network of staff using the platforms as a communication and engagement tool
- Team of the Week to celebrate our staff.

During 2019/20 we introduced a new staff ideas scheme (and an idea of the month) so that we empower staff to implement their own ideas, launched a new Quality Improvement staff newsletter to share good practice and a new patient safety newsletter so that sharing learning from incidents and complaints becomes the norm at QEH.

Through our response to COVID-19, we have taken the opportunity to further strengthen our communications and engagement with staff and partners and our local community. In the initial phase of the pandemic we held daily staff briefings with Q&A sessions and issued updates after each of the three daily incident team meetings. Later this evolved into a single, more comprehensive daily update and briefing sessions from the Incident Command Team leadership (Chief Operating Officer, Medical Director and Chief Nurse). We have maintained our commitment to open and transparent communications and have consistently listened to feedback from staff and acted on this quickly.

Trust Values

We have set out clearly how we will continue to transform care with our Integrated Quality Improvement Programme (IQIP).

This reflects our values:

We listen: We deliver forward thinking quality services through listening to, learning from, and empowering those we work with.

We act: We take personal responsibility and respect the dignity and individuality of each person in our care, and the professionalism and skills of our team members, ensuring we make the most effective and efficient use of the resources available to us.

We Care: We provide safe, compassionate and attentive services for patients and a positive working environment for our colleagues.

We believe that delivering long-lasting improvements will only be delivered if staff are allowed to take ownership of service improvements.

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 demonstrate 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 our good standing and reputation.

Recognition awards

Recognising the importance of valuing and rewarding our staff – and the impact this has on overall morale and staff experience – we have invested significantly in this agenda over the past year. This includes:

- Monthly Living our Values Awards
- Idea of the month awards
- Team QEH Annual Staff Awards – with more than 400 nominations received in 2019
- Recognising retirements and long-serving staff
- Thank you cards for our staff – to be used by line managers
- Celebrating achievements through our Chief Executive's blogs, staff briefings and Board reports
- National awards and honours for our staff and volunteers
- Team of the Week

Looking to 2020/21, rewarding, recognising and valuing our staff is central to our new Staff Engagement Programme, and will see:

- The introduction of Long Service Awards for staff marking 20, 25, 30, 35 and 40 years of service in year

- QEH Hero award – linking to our 40th anniversary celebrations
- Staff idea of the month winner
- Visual displays of all award winners across our hospital
- Celebrating International Day of the Midwife, International Nurses’ Day and Year of the Nurse and Midwife
- Recognising the contribution of wider staff groups, including World Administration Day, Healthcare Science Week etc.
- Celebrating our diversity and international staff through themed food months
- Introduction of more social events for Team QEH (For example, quiz nights and a staff party to mark 40th anniversary of QEH)

National Staff Survey 2019

The Trust achieved a response rate of 42% in the 2019 staff survey, below last year’s rate (44%), and below the national Acute Trust average of 47%.

The Trust improved in every area – but improved most in these domains	
“I will probably look for a job at a new organisation in the next 12 months”	From 25% down to 19.3% - benchmarking group’s average of 19.9%
“My organisation acts on concerns raised by patients / service users”	57.6% to 66.9% - Moved from being 1% above the worst, to closer to the national average
“Communication between senior management and staff is effective”	21.2% to 29.7% - Moved from being nationally one of the worst in this area.

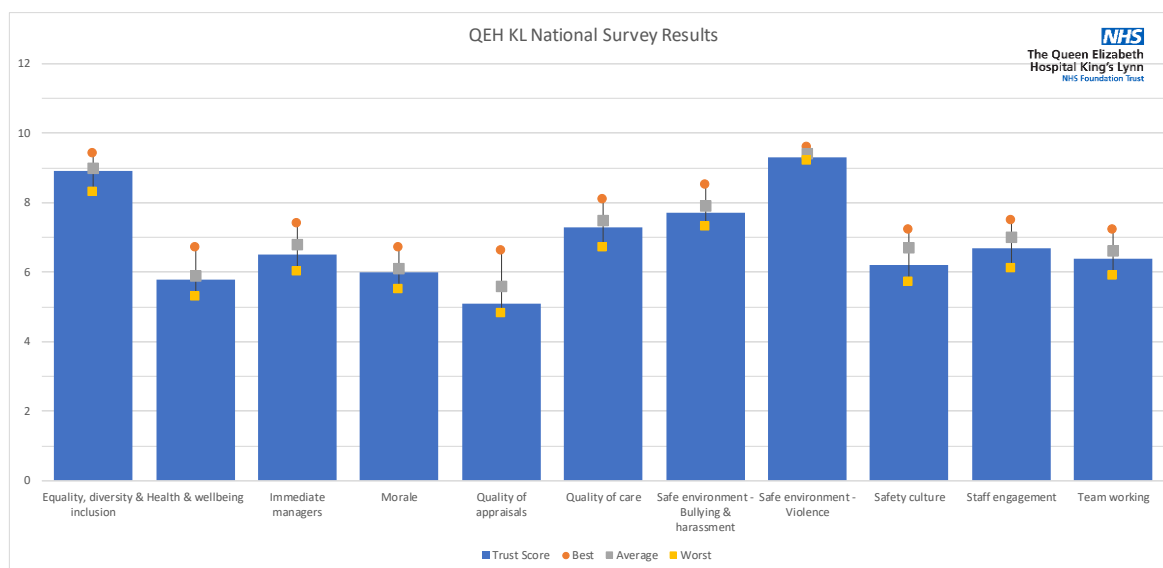
Statistically significant improvements were noted for: Morale (5.7 to 6.0); Safety culture (6.0-6.2); Quality of Care (7.1 to 7.3) and overall, staff engagement for the Trust improved to 6.7/10 from 6.5/10 in 2018 (the average for the benchmarking group in 2019 is 7.0/10 and worst in the benchmarking group is 6.1/10).

Themes	2018		2019		Significant Change
	Score	Response	Score	Response	
Equality, diversity & inclusion	8.7	1,359	8.9	1,346	▲
Health & wellbeing	5.7	1,364	5.8	1,352	▬
Immediate managers	6.4	1,358	6.5	1,345	▬
Morale	5.7	1,338	6.0	1,317	▲
Quality of appraisals	4.8	1,164	5.1	1,139	▲
Quality of care	7.1	1,161	7.3	1,158	▲
Safe environment - Bullying & harassment	7.6	1,349	7.7	1,340	▬
Safe environment - Violence	9.2	1,352	9.3	1,341	▬
Safety culture	6.0	1,354	6.2	1,344	▲
Staff engagement	6.5	1,360	6.7	1,352	▲
Team working	6.2	1,349	6.4	1,345	▲

The overall results for QEH showed a shift from being among the worst in the NHS for staff survey results to closer to the national average. This demonstrates that the priorities focussed on in 2019 have yielded some success, with improvements seen across the board, albeit modest positive movement. This includes improvements when it comes to:

- Effective communication
- Staff feeling comfortable speaking up and seeing positive change when people do so

- Staff feeling involved in decision-making



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.4	6.7	7.4	6.7	6.6	8.1	8.5	9.6	7.2	7.5	7.2
Trust Score	8.9	5.8	6.5	6	5.1	7.3	7.7	9.3	6.2	6.7	6.4
Average	9	5.9	6.8	6.1	5.6	7.5	7.9	9.4	6.7	7	6.6
Worst	8.3	5.3	6	5.5	4.8	6.7	7.3	9.2	5.7	6.1	5.9
<i>Responses</i>	1,346	1,352	1,345	1,317	1,139	1,158	1,340	1,341	1,344	1,352	1,345

Looking to 2020/21, will aim to build on these results, with a greater focus on:

- Encouraging people to share feedback and speak up (so that this becomes the cultural norm)
- Improving staff health and wellbeing
- Continuing the good work we are doing to reward, value and recognise staff, including introducing long service awards, 'one-off gestures' and doing more to celebrate our successes and focus on the many positives
- Focus on ensuring there is clarity on staff roles and responsibilities and 'who's who' in the organisation (including who our senior management team are)
- A focus on line managers and how their role and behaviour impacts on what staff feel about working at QEH
- More training, development and career opportunities for staff across QEH with greater visibility of opportunities
- Quality of appraisals

Trust-level and Divisional-level action plans are in place to support improvements, which have been informed by the quarterly pulse surveys we complete, the national staff survey results, listening events and feedback we receive from staff throughout the year.

Staff development – investing in Team QEH

We plan to develop new roles and individually tailored career pathways through greater engagement with schools, colleges and our community to offer pre-employment and volunteering opportunities to attract a more diverse workforce from our local community. These new roles will seek to ensure the Trust can attract individuals to hard-to-recruit posts and contribute to the planned reduction in agency spend, as will our focused recruitment plans.

The Trust offers a substantial 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. We are developing staff through supported learning and professional development opportunities.

Flexible routes are also being developed for other professions such as Nursing, Occupational Therapy and Physiotherapy.

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 our corporate strategy and ensure safe levels of staff. These include Physician Associates, Nurse Specialist, Assistant Practitioner and Nurse Associate roles. Our aim is to not only cover hard-to-fill vacancies but also to be prepared for any future shortages through introducing new ways of working and implementation of new posts.

Our Education and Practice Development Team works closely across all disciplines, to increase inter-professional learning and development opportunities.

We will work with partners to secure the benefits from national and regional systems and continue to develop electronic systems to support more streamlined working, aiming to reduce paper processes. We are developing a culture to transform our services and meet the wider health and social care agenda in the STP 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 wellbeing activities, such as pilates, yoga, dancing and sewing, as well as continuing support for dementia awareness, mindfulness and mental health first aid.

Leadership Development Programmes

We have leadership programmes ranging from band 2 staff to Board level to support and develop our staff, including:

- STP System Leadership Programme – this programme for director/associate director level leaders across Norfolk and Waveney allows them to consider their role in strategic system change and to work through system issues
- Board development and Divisional Leadership Team development
- Clinical Director development programme – set up by our Medical Director
- Middle Managers Leadership – focusing on self-awareness and leading yourself and others, quality improvement and leading change and applying learning to practice
- Band 5 and Band 6 Leadership Development Programme – we have been chosen as the regional hub for the Institute of Healthcare Management, enabling us to expand leadership development opportunities at Team QEH to band 5s and band 6s across the Trust and maximising opportunities for our staff to achieve their true potential and helping us to deliver outstanding care

Bands 2 and bands 3 - A Health Education East-funded programme for 200 band 2 and band 3 clinical facing healthcare assistants to undertake a preparation for study programme.

Health Education East Healthcare Academy

The Trust is working with HEE as a pilot site for the Healthcare Academy programme. The academy allows young people to gain an increased awareness of roles in the NHS – in particular nursing and midwifery, with the aim of providing a pipeline for people to join healthcare and enhancing partnerships with higher education. The approach is being used to strengthen our ‘grow your own’ initiatives and career development pathways.

Our ambition to introduce a School of Nursing in West Norfolk

We are working with the College of West Anglia to establish a School of Nursing to provide accredited training for registered and unregistered nurses. The College of West Anglia is currently identifying and confirming the requirements to become an accredited provider in partnership with the University of East Anglia.

The intention is for all participants to complete placements at the QEH where we will support them through their courses and encourage them to remain working with us after graduation.

Equality and Diversity

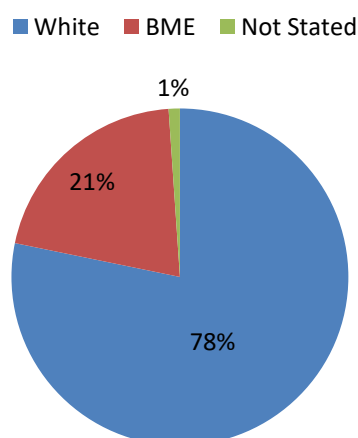
We continue to have a strong commitment to Equality and Diversity, aligning our values to positively influence our culture. We continue to promote Diversity and Equality of opportunity in all forms and we are working to deliver a safe and accessible service for our patients. To achieve this, we work to develop conditions for staff to be themselves. We will unlock potential to create possibilities, a work environment in which all employees feel valued because of the differences they bring to the Trust. Staff deserve an environment in which they feel respected, valued and empowered.

We recognise that some groups in society continue to experience discrimination and for that reason we work towards being a progressive Trust, reflecting the growing diversity of the local community and the needs of our workforce. We understand that some groups may not be protected by law. We are therefore 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 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 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.

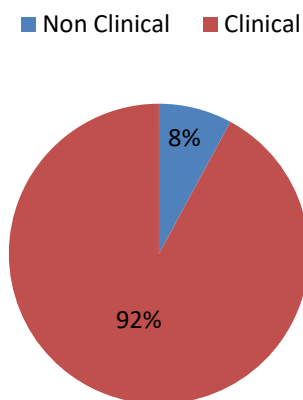
The Trust seeks to ensure that we deliver on the requirements outlined by the Equality Act 2010, which are to have due regard to the need to:

Total Staff By Ethnicity March 2020



- 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

Breakdown of Staff with BME Background



In March 2019, the Trust completed the NHS Employers’ Diversity and Inclusion Partners programme. This has supported the Trust in establishing a platform to share and discuss issues with employees and union representatives. The Inclusion Partners programme gives us updates on legislation at a national level. This engages the Trust with other local and national NHS organisations and has developed Equality Diversity partnership working on possible future Equality Diversity projects. This programme supports Trusts to progress and develop their equality performance over a 12-month period 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. 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 speak up, whether it is general feedback or highlighting safety concerns. We want them to be confident that their concerns will be addressed in a constructive and timely way.

We support 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 Trust is committed to developing the right culture, and one where staff feel empowered to speak up with safety concerns and have confidence that concerns will be listened to, investigated and acted on.

In 2019/20, 25 staff raised concerns with our Freedom to Speak Up Guardian; this compares to 15 the previous year. In addition, 23 staff spoke up in support of a colleague who had already spoken up in 2018/19 and three did the same in 2019/20.

Much work has taken place in 2019/20, including:

- Regular communications to staff signposting to the ways in which you can raise concerns (see below) – ‘Who can I tell?’
- We have recruited 14 new Freedom to Speak Up Champions from across the Trust to support this work
- One of the areas of focus in our new Staff Engagement programme will be culture and learning, and this includes further strengthening our Speak Up work
- Developing a single Speaking Up Policy, merging the Speaking Up and Whistleblowing Policies
- A new quarterly meeting with the Freedom to Speak Up Guardian, CEO, Deputy CEO, Non-Executive Director lead for Speak Up and other Executive Directors to review cases and themes
- Input from the national Freedom to Speak Up Team, which has offered constructive criticism to our plans
- Learning from good practice across the NHS, including reports from the National Guardian’s Office
- Contributing to a national pulse survey from the National Guardian’s Office during COVID-19 to share QEH views on the impact of the pandemic on Speaking Up; there was an increase in Speaking Up cases at QEH, largely staff sharing helpful suggestions for improvement during this challenging period.

**Speaking up
Who can I tell?**

Who to escalate to

- Your Line Manager
- Your Divisional Leadership Team
- The Executive Team
- Your Union rep

Freedom to Speak Up Guardian

David Trevanion
Call: 07966881840
Email: David.Trevanion@nhs.net

QEH Whistleblowing helpline

Call: 01553 613949

Where you can escalate concerns or share feedback

- 1-2-1s with your Line Manager
- Team meetings
- Huddles
- CEO/COO/Chief Nurse/MD briefings
- Listening events
- Handovers

WE LISTEN WE ACT WE CARE

Whistleblowing

Members of staff and their colleagues can contact the QEH whistleblowing line if they wish to raise concerns. The line is managed by our Deputy CEO.

Local Counter Fraud Service (LCFS)

The Trust works closely with our designated local counter fraud specialist as part of the national scheme led by NHS Counter Fraud Authority. This involves proactive and reactive work to ensure that precious NHS resources are not lost to fraud. It gives a clear route for concerns in relation to fraud to be reported and investigated, and development of an anti-fraud culture. We take all necessary steps to counter fraud and bribery in accordance with

guidance or advice issued by NHS Protect. This process is detailed in the organisation's Anti-Fraud and Bribery Policy.

Staff health and wellbeing

Improving the health and wellbeing of our staff is one of the three main priorities in our staff engagement programme for 2020/21. It is divided into the following three main areas of focus:

- Physical health
- Mental health
- Financial health

1. Physical Health

We are working with internal and external agencies to improve the knowledge and services available to staff to look after their physical health. Staff Health MOT's will be conducted as part of a 12-month calendar of events. We encourage our staff to look after their physical health, because introducing a healthier lifestyle not only brings physical benefits but can also make a difference to a person's mental wellbeing.

In 2019/20 the trust employed a staff physiotherapist and continued to use the fast track referral process for staff. The Trust continued to put into place a number of adjustments for colleagues to support their attendance at work.

A number of support groups were also in place, including smoking cessation, weight management and a staff gym.

2. Mental Health

Our improvement plan recognises the essential role mental health has in achieving health for all staff. We introduced monthly Schwartz Rounds, an evidenced-based programme to support the emotional demands on healthcare workers, enabling staff to reflect on aspects of our work and re-charge their emotional batteries. This is important if we are to continue providing great care.

A number of actions were taken in 2019/20, including a roll out of mental health awareness training for all staff and, working in partnership with Unison, additional training was provided on resilience training. Further work is being done across the STP to work collaboratively to address stress and anxiety and musculoskeletal absences, concentrating on preventative health and well-being measures.

We have plans to introduce Mental Health First aiders across the Trust as well as conducting regular "temperature check" surveys to give quick, anonymous feedback on how well staff feel they are being managed, engaged and supported. Looking ahead to 2020/21 we are due

to sign The Time to Change Employer Pledge. This is a commitment to changing the way we think and act about mental health at every level of the organisation.

3. Financial health

Integral to our well-being programme is an understanding of the importance of how financial concerns can affect our employees' mental and physical health, as well as recognising that as income providers we play a vital role in our workforce's financial lives. Over the next year we will provide access at work to free financial advice and support as well as improving what information is available to staff.

The Insight wellbeing service remains available to access free for all staff 24/7. This includes counselling and support in areas including relationship problems, financial concerns and legal issues.

Our Be Well intranet page will be further developed to signpost to information about our wider health and wellbeing package. A calendar of monthly campaigns and wellbeing days, which include training on managing stress, building resilience, time management, improving sleep and developing nutrition will be included.

Our volunteers

The number of volunteers who carry out vital roles across our sites continues to grow. We currently have 352 volunteers providing valued and vital support to 56 of our departments. In March 2020, to ensure the safety of our volunteers, we suspended volunteering activities on site when lockdown was introduced in response to the COVID-19 pandemic. The decision was taken to protect our volunteers, many of who were elderly and therefore considered vulnerable. This news was well received by our volunteers and many are keen to restart volunteering when safe to do so.

During 2019/20, our volunteers gave more than 38,000 hours of their time, equating to £279,140 of work given freely (based on min wage for 2019 for adults excluding National Insurance contributions)

2019/20 volunteer developments

We have introduced a number of new roles; including an expanded volunteer driver scheme to reduce the amount the Trust spends on taxis and to reduce patient waiting times.

Our volunteers are working closely with partners across Norfolk and Waveney to signpost volunteer opportunities to other third sector groups who are finding recruitment particularly difficult. We are developing a "passport" for volunteers to be trained to the same level and be able to move across sectors/Trusts without the need for re-training.

Recognising the important role nutrition plays in recovery from illness and operations, plans are in place to introduce MealMates to support patients and staff on our wards later in 2020.

Our 'Pharmacy Runners' project has been hugely successful, reducing patient waiting times for discharge and helping the Trust with patient flow and admissions.

Looking ahead

We have successfully applied for NHS Improvement/England funding to appoint a short-term co-ordinator to target resources where they are most needed during times of greatest pressure during the winter.

We will be setting up a “settle in service” to help patients on the first day of discharge. This work, proven to reduce re-admissions within 72 hours, will dovetail with the Red Cross Home Help service. Volunteers will assess the environment is safe as well as, potentially, obtain essential groceries.

We have submitted a business case for a dedicated Butterfly co-ordinator to help support end of life patients. We will be working closely with the Ann Robson Trust, which is already working with other hospitals.

Health and safety

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

The main projects for the year 2019/20 were:

- On-going monitoring of health and safety folders in all departments via scheduled Health and Safety audits. This gives 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 our web-based system for the safe management of Control of Substances Hazardous to Health (COSHH). Our database of assessments continues to develop and expand
- Supporting and developing a Trust-wide network of staff at all levels, from senior managers to local risk champions, confident and competent about health and safety
- Continuing to contribute to groups such as the falls steering group, and close working with patient safety, patient experience, Infection Prevention and Control (IPAC) and Risk Management teams
- Managing and updating the combined Estates and Facilities risk register with regular monthly updates to the Risk Committee.
- Populating the Premises Assurance Model (PAM) with 2017-19 data, and production of a summary report, in preparation for PAM becoming a mandatory return from April 2020.

Training

The Health and Safety team develops and delivers training packages and ensures 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, injury caused by physical or mental strain, accident caused by some other means and exposure to hazardous substance/electricity/infection etc.

There were 375 staff safety incidents reported during 2019/20, and there were 402 reported during 2018/19. This represents a reduction of 27 incidents between the two years.

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

During 2019/20, the Health and Safety Department reported 12 staff injuries to the Health and Safety Executive.

These were due to employees sustaining injuries during work related activities or being absent for or requiring a change of duties for more than seven days. This is a small reduction in reportable incidents from 2018-19, when there were 15 RIDDOR reports made. 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 Forum in July 2020.

Looking ahead to 2020/21:

- Completion of the Premises Assurance Model 2020
- Developing in-house health, safety and risk management training
- Monthly reviews of the risk register to continue
- Involvement with improvement projects across the Trust

Fire Safety

The (Regulatory Reform) Fire Safety Order 2005 requires that we effectively plan, organise, control, monitor and review preventive and protective measures that have been identified as the general fire precautions you need to take to comply with the Fire Safety Order.

The main projects for the year 2019/20 were:

L1 fire alarm upgrade (An L1 system provides the highest standard for protection with detectors in all rooms and high-risk areas, including roof spaces and voids. Some low-risk areas, such as stairways, lobbies and small cupboards do not need detectors). This is a legal requirement to ensure we are fully compliant across our main site and has been on-going since late 2017 with the wards requiring to be introduced to the project

- Compartmentation upgrades
- Upgrades to areas including SDEC (Same Day Emergency Care, AEC, Churchill ward, Discharge Lounge, changes to mains power installations, compartmentation and Damper works.
- North Cambs Hospital Endoscopy upgrades
- Removal of Asbestos in the internal stairs
- Evacuation aids implementation
- Live joint fire exercise with Norfolk Fire and Rescue
- Familiarisation with local fire crews
- Whole-site risk assessment

- Departmental risk assessments
- Mobile suppression units
- Day to day issue management

Fire safety training

Fire training is reviewed and updated on a regular basis to keep up to date with national incidents and incidents within the Hospital itself, and annual training needs analysis is completed to ensure appropriate training is delivered, this training also instructs upon the legal requirements for staff and managers to ensure there is oversight control of fire risks at the local level.

- Mandatory and ward-based training sessions delivered = 120 sessions
- Fire warden training = 19 sessions
- Evacuation and ski pad training = 14 sessions

Incidents

All fire incidents are recorded on to Datix for investigation and management; there were two notable incidents in 2019/20, one was a car fire in the car park which the fire service dealt with, the second was a near miss with a microwave being inappropriately used.

Looking ahead to 2020/2021: Fire safety is always of paramount importance. The L1 project and the compartmentation is the first call upon the capital programme for 2020/2021. This scheme which will place QEH with other fully fire compliant hospitals is planned to include all areas of the Trust, including the wards. The L1 system and the compartmentation limitations are legal requirements that the Trust must comply with.

Estates

Our hospital is now 40 years old and in need of modernisation via national capital investment. The site has seen limited redevelopment and investment since construction, even though the demographic that the Trust serves has significantly changed and aged, and demand on our services is increasing considerably year-on-year. The site's clinical capacity requirements now go well beyond the intent of its original design and departments are not co-located in a way that is consistent with modern care pathways.

We have developed a £250m case to modernise the site, including our estate and digital infrastructure. Significant long-term capital investment would enable a mix of new, refurbished and redeveloped accommodation, making it fit for the future for patients and the communities we serve and which will enable QEH to fulfil its role alongside system partners in delivering the future strategy for the Norfolk and Waveney health and care system.

Investment would support the development of some key priority areas, which we would aim to complete in phases, including: a new emergency floor, including frailty unit, upgraded inpatient wards, new theatres, a single outpatient department and expanded endoscopy facility and a new facility for women and children's services.

This would mean our patients receive excellent care in state-of-the-art facilities, and QEH would become a place where people want to come to work and are proud to work, with improved recruitment and retention.

Investments in our estate during 2019/20, working to improve patient experience, included:

- Modifications to the heating mains pipework to significantly reduce heating costs and energy consumption
- Upgrades of lighting to highly efficient LED lighting
- Refurbishing hospital wards to support 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
- Starting a five-year rolling programme to replace and upgrade the roof and upgrade 10 wards
- Upgrades to footpaths

Looking ahead our Estates Strategy includes:

- Completion of improvements to the Emergency Department and main entrance
- Upgrading operating theatre ventilation systems
- Replacing autoclaves in the Sterile Services Department
- Upgrading the electrical infrastructure to the main kitchen
- Investing in our communities with the appointment of apprentices to the trades' staff teams
- Further developing our sustainability agenda through investment in carbon management and staff development
- Continuing to refurbish the hospital roof
- Refurbishing hospital corridors and toilet facilities.

In light of COVID-19 and the fact we will likely be treating some COVID-19 patients for some time yet, we are developing plans to create a COVID (yellow) part of our hospital and non-COVID (green) part of our hospital – so that we have physically separated areas. COVID will significantly impact on the work we prioritise on our estate on the year to come.

Expenditure on Consultancy

The Trust has spent £787K on consultancy in 2019/20; the level of expenditure on consultants has increased from £766K in 2018/19. This minor increase reflected the greater level of support required by the Trust to identify areas of medium and long-term financial improvement during 2019/20. The expenditure on consultants was split between PricewaterhouseCoopers, MNO Consultancy Limited, QA Governance Services and L&S Hardy Consulting.

Off-payroll engagements

We can confirm that all existing off-payroll engagements outlined below have 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.

All off-payroll engagements as of 31 March 2020, for more than £245 per day	Number of engagements
Number of existing engagements as of 31 March 2020	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	-
Number that have existed for between two and three years at the time of reporting	-
Number that have existed for between three and four years at the time of reporting	-
Number that have existed for four years or more at the time of reporting	-
All new off-payroll engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020, for more than £245 per day and last longer than six months	
Of which:	
Number assessed as within scope of IRS35	-
Number assessed as not within scope of IRS35	1
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	-
Number of engagements reassessed for consistency/assurance purposes during the year	-
Number of engagements that saw a change to UR35 status following the consistency review	-
For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020	
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" during the financial year. This figure must include both off-payroll and on-payroll engagements.	-

Exit packages: Other (non-compulsory) departure payment						
	Expected sign	Number of payments agreed 2019/20	Total value of agreements in 2019/20	Number of payments agreed 2018/19	Total value of agreements in 2018/19	Sub code
Voluntary redundancies including early retirement contractual costs	+					STA0720
Mutually agreed resignation (MARS) contractual costs	+					STA0730
Early retirement in the efficiency of the service contractual costs	+					STA0740
Contractual payments in lieu of notice	+	19	10	2	13	STA0750
Exit payments following employment tribunals or court orders	+					STA0760
Non-contractual payments requiring HMT approval (special severance payments) *	+					STA0770
Total	+	19	10	2	13	
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 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 2018 to 31 March 2019. The total percentage of the total pay bill spent on facility time was 0.01%. 15 employees (13.84 WTE) were relevant union

officials, two of which spent 0% of their working hours on facility time; 12 relevant union officials spent between 1% and 50% of their working hours on facility time. 68.97% of facility time was spent on paid trade union activities as a percentage of total paid facility time.

Relevant Union Officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
15	13.84 wte

Percentage of time spent on facility time

Percentage of time	Number of Employees
0%	2 staff
1-50%	12 staff
51-99%	zero staff
100%	1 staff

68.97% of facility time was spent on paid trade union activities as a percentage of total paid facility time

Percentage of total pay bill spent on facility time

	Percentage
Percentage of total pay bill spent on facility time	0.01%

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 2020, 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.	<p>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.</p> <p>The Trust also has in place a 'Dispute Resolution Procedure', to deal with disputes relating to the Trust's constitution.</p> <p>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.</p>
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 2019/20'.
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 2019/20'.
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.	<p>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.</p> <p>No relationships or circumstances have been identified that are likely to affect, or could appear to affect, directors' judgement.</p>
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.	<p>See Board of Directors' Biographies. The Board is substantively appointed as at 31 March 2020.</p> <p>The skills and experience reflected in the Board membership, mean that the Board is balanced and appropriate to the requirements of the Trust.</p>

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) and the 'Board of Directors' – the 'Nomination and Remuneration Committee (Executive 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.	<p>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.</p> <p>The Trust's appointed Governors represent the views of a range of local strategic partners.</p>
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.	<p>Board and Director performance evaluation methodologies employed include:</p> <ul style="list-style-type: none"> • Self-assessment (after each Board meeting) • ED appraisal • NED appraisal (involving the Governors) <p>In 2019/20, the Board completed the self-certification requirements in relation to 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'.</p> <p>In 2019, the Trust commissioned a review of its Corporate Governance methodologies and structure, undertaken by a senior NHSE/I colleague.</p> <p>The Trust intends to commission an independent review, to revisit the findings and recommendations of the PwC-led review of November 2018, as reported to the Board in public in January 2019.</p>

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.	<p>Governance-related reviews were undertaken by Grant Thornton as part of the Trust's Internal Audit programme during 2019/20.</p> <p>In 2019, the Trust commissioned a review of its Corporate Governance methodologies and structure, undertaken by a senior NHSE/I colleague. The reviewer had no other connection to the Trust.</p> <p>The Trust intends to commission an independent review, to revisit the findings and recommendations of the PwC-led review of November 2018, as reported to the Board in public in January 2019. The intended reviewer has no other current connection with the Trust.</p>
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).	<p>See sections on:</p> <ul style="list-style-type: none"> • 'The Directors' Report' • 'The Audit Committee and 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	<p>A trust should disclose in the annual report:</p> <ol style="list-style-type: none"> 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 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 2019/20

C. 3. 9	<p>A separate section of the annual report should describe the work of the committee in discharging its responsibilities. The report should include:</p> <ul style="list-style-type: none"> • 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 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 in 2019/20.
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 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'. Harvey Nash have, during the period, been used to support recruitment and provide benchmarking information, taking into account NHS guidance, in relation to salaries for newly appointed executive directors. There is no other connection with the Trust.
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 2020.

The Board of Directors

The Board of Directors has, during 2019/20, met in public on eight occasions. The Board has also met in private on 11 occasions 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 2020, the Board of Directors was made up of the Chairman, six non-executive directors and six voting executive directors. The six voting executive board positions at 31 March were: The Chief Executive; the Deputy Chief Executive, the Director of Finance; the Medical Director, the Chief Nurse and the Chief Operating Officer. As at 31 March 2020, 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.

The Trust is in a challenged position currently and in Special Measures. During 2019/20, the Trust Chairman led the Governors' Council in undertaking non-executive director recruitment and selection, to increase the non-executive complement on the Board in line with the Trust's constitutional provisions. This has improved 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 meetings and working groups
- Lead Governor meetings with the Chairman
- Outcomes from Governor questionnaire to improve working practices with the Board

The Chair, the Vice Chair and the Senior Independent Officer

In a Foundation Trust, the Trust Chair chairs both the Board of Directors and the Governors' Council. The Queen Elizabeth Hospital's constitution makes provision for the Board's appointment of a Senior Independent Director, who has particular duties regarding working with the Governors' Council and the Board of Directors to address any issues where it is inappropriate for the Chair to do so. The Trust's current Senior Independent Director was appointed by the Board in June 2019. The appointment was supported by the Governors' Council. The roles of Vice Chair (appointed by the Governors' Council in January 2019) and Senior Independent Director are currently held by the same Non-Executive Director.

In 2019/20, the Trust Chair has had no other significant commitments that have had an adverse impact on his role as Chair of the Foundation Trust.

Register of Directors' Interests

All directors are required to complete and keep up to date their declarations of interest, which are recorded in the Register of Directors' Interests. A copy of the register (Board

member extract) is presented regularly 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 2020:

- The Senior Leadership Team (SLT) – 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 Committee
- The Finance and Activity Committee
- The People Committee
- The Nomination and Remuneration Committee (Executive Director Appointments)
- The Education, Research and Innovation Committee
- The Audit Committee.

The Audit Committee and audit

The Audit Committee met five times during 2019/20. 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 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. Grant Thornton provided the Trust's Internal Audit function in 2019/20. 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 2019/20.

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

Nomination and Remuneration Committee (Executive Appointments)

The committee reviews and makes recommendations to the Board on the composition, balance, skill mix and succession planning of the Board. It oversees recruitment and appointment of the Chief Executive Officer (for the approval of the Governors' Council), recruitment and appointment of other Executive Directors and approves the remuneration of the Chief Executive Officer, Executive Directors and other Directors reporting to the Chief Executive. During the year the committee approved appointments for the position of Chief

Executive, Deputy Chief Executive, Chief Nurse, Chief Operating Officer, Medical Director, Director of HR and Director of Patient Safety.

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 2019/20, performance evaluation methodologies employed include:

- Board Self-assessment (after each Board meeting throughout 2019)
- Executive Director appraisal
- Non-Executive Director appraisal
- Externally facilitated Board Development Programme, including a significant element of self-assessment against ‘High Performing Board’ best practice and the CQC’s Well-Led Key Line of Enquiry
- Performance evaluation of the Audit Committee – using the model criteria of the NHS Audit Committee Handbook
- The Board completed a comprehensive governance review and rolled out a revised governance structure

In 2019/20, the Board completed the self-certification requirements in relation to General Condition 6 of the NHS Provider Licence. In 2019/20 the Board also made its Corporate Governance Statement and declarations concerning AHSCs and the training of governors.

The Trust intends to commission an independent review, to revisit the findings and recommendations of the PwC-led review of November 2018, as reported to the Board in public in January 2019.

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. The Trust’s Constitution was reviewed in 2019/20 and changes relating to terms of office for Governors were approved at the Trust’s Annual Members’ Meeting in 2019.

Directors (voting board members) 1 st April 2019 - 31 st March 2020	Date of end of current NED terms of office	Audit Committee 5 meetings		Nomination and Remuneration Committee (ED Appointments) 4 meetings		Meetings attended out of 11 Board of Director (Ordinary) Meetings
Prof. Stephen Barnett – NED Trust Chairman From 05 November 2018	Nov 2021			✓	4/4	11/11
Alan Brown – NED, Vice Chair and SID	May			✓	3/4	11/11

Chair of Charitable Funds Committee From 01 May 2018	2021					
David Dickinson – NED Chair of Audit Committee From 02 July 2018	July 2021	Chair	5/5	✓	3/4	10/11
Dr Ian Mack – NED Chair of the Quality Committee. Chair of the Finance and Activity Committee (April 2019 to December 2019 From 01 April 2019	April 2022	✓	4/4	✓	3/4	11/11
Graham Ward – NED Chair of the Finance and Activity Committee (January 2020 onwards) From 26 August 2019	August 2022	✓	1/1	✓	1/2	7/7
Simon Roberts – NED Chair of the People Committee From 20 May 2019	May 2022			✓	4/4	9/10
Jackie Schneider – NED From 14 October 2019	October 2022			✓	2/2	4/4
Caroline Shaw Chief Executive Officer From 14 January 2019				✓	2/2	10/11
Laura Skaife-Knight Deputy CEO From 21 October 2019						5/5
Chis Benham Director of Finance From 1 January 2020			1/1			2/2
Dr Frankie Swords Medical Director From 3 June 2019						9/9
Libby McManus Chief Nurse From 15 July 2019						8/8
Denise Smith Chief Operating Officer From 29 April 2019						11/11
Liz Sanford Acting Director of Finance from August 2019 – December 2019			1/1			5/5
Prof. Amanda Ashton – NED From January 2019 – July 2019		✓	1/1	✓	2/2	4/4
Dr Siobhan McClelland From 20 May 2019 to 22 November 2019				✓	1/2	3/4
Jon Wade Chief Operating Officer From 21 November 2016 to 29 April 2019						1/2
Emma Hardwick Chief Nurse From 16 January 2017 to 28 May 2019						0/2 (2 sub)
Dr Nicholas Lyons Medical Director From 01 April 2017 to 31 August 2019						1/1
Roy Jackson Director of Finance & Resources			2/2			4/4

From 01 February 2018 (Substantive) to 23 August 2019						
Karen Charman Director of HR & OD From 03 July 2017 – to 05 July 2019						0/3 (3 sub)
Patrick Johnson Chief Transformation Officer (Fixed term, 12 months) From 29 October 2018 – to 28 June 2019						2/3
KEY:	✓ = Committee member	No longer serving on the Board of Directors				

The Role of the Governors' Council

The Governors' Council:

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

Statutory duties for governors:

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

Governors:

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

Advice and training for Governors:

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

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

The composition of the Governors' Council

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.

2019/20 Election report

In January 2020, the Trust held elections in all areas in both public and staff constituencies.

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 Civica Election Services (CES), formerly Electoral Reform Services.

The Cambridgeshire, Staff Clinical and Staff Non-Clinical constituencies were uncontested and candidates from these areas automatically became members from 1 February 2020 as follows:

Constituency/ Area	Governors to Elect	Contested?	Name	Term
Public & Staff Constituencies				
Cambridgeshire	2	No	Malcolm Bruce Betty Lewis	3 years 3 years
Staff Clinical	2	No	Gavin Walker (1 vacancy remains)	3 years
Staff Non-Clinical	1	No	David Close	3 years

West Norfolk, South East Lincolnshire and Breckland, North Norfolk and the Rest of England constituencies were contested as detailed:

Constituency/ Area	Governors to Elect	Contested - Yes nominations	Turnout %	Name	Term
Public Constituency					
West Norfolk	5	6	12.7	Tracy Corbett Esme Corner Jonathan Dossetor Penny Hipkin Mike Press	3 years
South East Lincolnshire	2	3	10.2	Martyn West Colin Dobbins	3 years 2 years
Breckland, North Norfolk & The Rest of England	1	2	9.5	Alan Clarke	3 years

Meetings of the Governors' Council

The Governors' Council has met formally in public, seven times during 2019/20 (including the Annual Members' Meeting) and has also met at three private extraordinary meetings.

The dates and venues for the Governors' Council meetings in 2020 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 FTMembership@qehkl.nhs.uk for details.

Following successful re-election, Esme Corner, was re-appointed as Lead Governor at the February 2020 Governors' Council meeting. A new role of Deputy Lead Governor was approved in February 2020, with Malcolm Bruce subsequently elected to the position. The Lead/Deputy Lead Governor has direct contact with NHS England/NHS Improvement on behalf of the Governors' Council, should this prove necessary and in line with policy. The Lead/Deputy Lead Governor also works with the Trust 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 challenging work programmes:

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

Membership recruitment - In 2019/20, the Committee continued to work to maintain the public membership and to address some areas of underrepresentation 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. Membership recruitment took place at venues held within the Trust, including the Governors' Healthcare Events. The membership total reduced slightly during 2019/20, mainly due to the

new General Data Protection Regulation (May 2018) which has enabled easier automatic membership removal via an 'unsubscribe' link on all emails.

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 and has developed an engagement strategy, which includes a programme of healthcare events for members. In 2019, two Healthcare events were held at the Trust; a Prostate Cancer Event in May and an Inflammatory Bowel Disease Event in November.

The Nomination and Remuneration Committee – (Non-Executive Director appointments) – to make recommendations to the Governors' Council regarding the appointment and remuneration of Non-Executive Directors. The Terms of Reference for this committee have been drawn up in alignment with the Code of Governance and Monitor's 'Your Statutory Duties – A Reference Guide for NHS FT Governors'. The committee making recommendations to the Governors' Council in respect of Non-Executive Director appointments is comprised of governors and the Trust Chair. The Governors' Nomination and Remuneration Committee recruited three new Non-Executive Directors which culminated in appointments commencing in May, August and October 2019.

The Patient Experience Committee – Undertakes work and make 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 2019/20:

- 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 the patient and the public in a variety of areas of the Trust's work, including:

- Relationships and formal liaison with West Norfolk Patient Partnership and affiliated GP Patient Participation Groups
- 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
- Sustainability and Transformation Partnership and Consultation Meeting(s)
- West Norfolk Association Meetings
- Governors' Council Meetings
- Healthcare Events
- 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.

Constitution Working Group – This Committee undertakes 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 2019/20

Constituency	Name	Current Term / Period remaining Years	Governors' Council Meetings attendance	Nomination and Remuneration	Membership & Communications	Patient Experience Committee Member	Business Committee Member
West Norfolk (9)	Steve Clark (re-elected Feb 2017) 2 nd term	3/0	4/6	<input type="checkbox"/>		<input type="checkbox"/>	Chair
	Simon Clarke (elected Feb 2019) 2 nd term	3/2	7/7				<input type="checkbox"/>
	Tracy Corbett (elected Feb 2020) 1 st term	3/3	1/1				
	Esmé Corner OBE (re-elected Feb 2020) (Lead Governor) 4 th term	3/3	7/7	<input type="checkbox"/>	<input type="checkbox"/>	Chair	<input type="checkbox"/>
	Jonathan Dossetor (re-elected Feb 2020) 4 th term	3/3	5/7	<input type="checkbox"/>	Chair	<input type="checkbox"/>	
	Ann Easton (elected Feb 2019) 1 st term	3/2	6/7			<input type="checkbox"/>	
	Penny Hipkin (re-elected Feb 2017) 4 th term	3/3	7/7	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	Patrick Kavanagh (elected Feb 2017) 1 st term	3/2	4/7		<input type="checkbox"/>	<input type="checkbox"/>	
	Mike Press (elected Feb 2020) 1 st term	3/3	1/1				
	Barrie Taylor (re-elected Feb 2017) 3 rd term	3/0	4/6			<input type="checkbox"/>	
	Kenneth Wicks (elected Feb 2019) 1 st term	3/2	5/7		<input type="checkbox"/>		<input type="checkbox"/>
Cambridgeshire (3)	Jenny Brodie (Feb 2019) 3 rd term	3/2	7/7			<input type="checkbox"/>	<input type="checkbox"/>
	Malcolm Bruce (Feb 2020) 2 nd term (Deputy Lead Governor)	3/3	6/7		<input type="checkbox"/>	<input type="checkbox"/>	
	Betty Lewis (Feb 2020) 4 th term	3/3	7/7		<input type="checkbox"/>	<input type="checkbox"/>	
Breckland, North Norfolk & Rest of England (2)	Clive Monk (re-elected Feb 2017) 2 nd term	3/0	7/7			<input type="checkbox"/>	<input type="checkbox"/>
	Alan Clarke (elected Feb 2020) 1 st term	3/3	1/1				
	Dale Welch (elected Feb 2019) 1 st term	3/2	7/7			<input type="checkbox"/>	
South East Lincolnshire (2)	Colin Dobbins (elected Feb 2020) 1 st term	2/2	1/1				
	Alan Maltby (elected Feb 2019) 1 st term	3/0	7/7		<input type="checkbox"/>	<input type="checkbox"/>	
	Martyn West (elected Feb 2020) 1 st term	3/3	1/1				
	Sue Robinson (elected Feb 2019) 1 st term	3/2	2/6			<input type="checkbox"/>	
Staff Clinical (3)	Vacancy						
	Julie Calton (re-elected Feb 2017) 2 nd term	3/0	5/7	<input type="checkbox"/>		<input type="checkbox"/>	
	Gavin Walker (Feb 2020) 1 st term	3/3	0/1				
	Anthony Wilson (Feb 2019) 1 st term	3/2	3/5			<input type="checkbox"/>	
Staff Non-Clinical (3)	David Close (Feb 2020) 1 st term	3/3	1/1				
	Dave Coe (re-elected Feb 2017) 3 rd term	3/0	4/6	<input type="checkbox"/>			<input type="checkbox"/>
	Chaz Scholefield (elected Feb 2019) 1 st term	3/2	4/7	<input type="checkbox"/>	<input type="checkbox"/>		
	Dan Todd (elected Feb 2019) 1 st term	3/2	2/7			<input type="checkbox"/>	
Appointed Governors (7)							
BC King's Lynn & W Norfolk*	Paul Kunes – from June 2015		4/7	<input type="checkbox"/>			<input type="checkbox"/>
Breckland Council	Peter Wilkinson – from June 2019		3/5				
	Ian Sherwood – until May 2019		0/2				
College of West Anglia	Ann Compton – from Feb 2017		3/7			<input type="checkbox"/>	

Freebridge Cmty Housing**	Andy Walder – from March 2017		6/7	<input type="checkbox"/>			<input type="checkbox"/>
Norfolk County Council	Thomas Smith – from June 2019		4/5				
	Sandra Squire – until May 2019		0/2				
West Norfolk Carers	Jane Evans – from Feb 2017		4/7		<input type="checkbox"/>	<input type="checkbox"/>	
UEA	Sue Madden – from Nov 2019		2/2				
	Paul Dansie – until Oct 2019		0/4				
Key:	Governors no longer serving on the Governors' Council as at 31-3-2020						
Key: *Borough Council of King's Lynn & West Norfolk **Freebridge Community Housing							

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 open to patients, the public and NHS staff. Becoming a member shows that you are interested in the hospital and its future.

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

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

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

Members of Staff

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

How do I apply to become a member?

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

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

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

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

The Membership Strategy

The public membership total was 7,406 at the end of March 2020.

Current Foundation Trust Public Membership

The QEH Public Constituency	Members	Members
	31/03/2019	31/03/2020
Gender		
Male	2930	2804
Female	4732	4602
Constituency		
Breckland, North Norfolk & Rest of England	1332	1283
Cambridgeshire	698	701
SE Lincs	576	552
West Norfolk	5056	4870
Age		
16-21	841	721
22-29	870	961
30-39	559	527
40-49	630	588
50-59	767	754
60-74	1811	1697
75+	1607	1607
Not stated	577	551
Ethnicity		
White	7223	6981
Mixed	36	34
Asian or Asian British	77	71
Black or Black British	37	37
Other	20	19
Not stated	269	264
Total	7662	7406

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 19 May 2020. 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 the Annual Governance Statement.

Finance and use of resources

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

Area	Metric	2019/20				2018/19			
		Quarterly Scores				Score			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial Sustainability	Capital Service capacity	4	4	4	2	4	4	4	4
	Liquidity	3	3	4	4	4	4	4	4
Financial Efficiency	I&E Margin	4	4	4	2	4	4	4	4
Financial Controls	Distance from Financial Plan	1	1	1	1	4	4	4	4
	Agency Spend	4	4	4	3	4	4	4	4
Overall Score		3	3	3	3	4	4	4	4

Overall, we scored a 3 for finance and use of resources which shows performance requires improvement; this is an improvement on the previous year and is driven by us delivering our financial plan for the year. However, the overall rating continues to reflect that we are not consistently making best use of our resources to provide high quality, efficient and sustainable care for patients and we will continue work to improve this rating.

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

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

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

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

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

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.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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

A handwritten signature in black ink, appearing to read 'C Shaw'.

Caroline Shaw

Chief Executive

Wednesday 24 June 2020

Annual Governance Statement

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust for the year ended 31 March 2020 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

Risk Management

For the first half of the year the Medical Director had executive responsibility for the Trust's Risk Management function. However, from November 2019 an Executive level Director of Patient Safety was appointed in order to increase executive level support for the risk management and patient safety function.

The Director of Patient Safety has line management responsibility for the 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 management training at appropriate levels throughout the Trust. The Director of Patient Safety is supported at a senior level by the Associate Director of Quality Improvement. Along with Executive level responsibility for risk management the Director of Patient Safety is also responsible for the Trust's Clinical Audit function, the Trust's compliance with the Duty of Candour, and the management, reporting and learning from Serious Incidents and Never Events.

An executive level Risk Committee, initially chaired by the Chief Nurse or Medical Director, has been meeting monthly throughout the year. From December 2019 the Risk Committee has been chaired by the Director of Patient Safety and, as part of the Trust's governance review, has been re-named the Assurance & Risk

Executive Group (A®) which convened in January 2020. The A® meets monthly and reports to the Senior Leadership Team, which reports to the Trust Board. The A® receives a Significant risk report at every monthly meeting, which includes all risks graded at 15 or above. The A® also scrutinises Divisional and departmental risks by means of risk reports. The A® provides assurance to the Board, via the Senior Leadership Team, regarding the management of risk in accordance with Trust policy and escalates concerns by means of a Chair's Assurance report.

The Trust's Risk Management Strategy 2019-2022 was approved in June 2019 and the Strategy was refreshed during March 2020 in line with the development of the Trust's new five-year Corporate Strategy, the Board Assurance Framework and associated governance arrangements. The A® have lead responsibility for the implementation of the Trust's Risk Management Strategy under the leadership of the Director of Patient Safety.

The Trust's Risk Management Policy and Procedure have also been reviewed and refreshed at the end of the year to ensure alignment with the Risk Management Strategy, the Board Assurance Framework and associated governance arrangements.

The Trust's risk management process is to score or 'grade' risks in accordance with Trust policy, requiring the application of a National Patient Safety Agency 5x5 matrix system, which takes account of the likelihood and impact of the risk, if it were to be realised.

Each Division and department articulates its risks on the Datix Risk Register. Low risks (those graded below 6) are managed at department or local level and presented to Divisional Leadership Teams on an annual basis. Moderate risks (those graded between 8-12) are managed at Divisional level and are reviewed at the A® at least every 3 months. Significant risks (those graded at 15 or above) are managed at Divisional level, with a nominated Executive Lead and are included in Significant risk reports to the A® on a monthly basis. The Significant risk report is also received by the Trust Board and the relevant Board Committee (in accordance with the alignment of a responsible Committee for each significant risk).

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

The Board Assurance Framework and Board oversight of significant risks

The Board of Directors agrees and monitors the Board Assurance Framework and all significant risks (those graded at 15 or above) included on the Trust's Risk Register. The Board Assurance Framework sets out the principal risk to the delivery of each of the Trust's strategic objectives and also aligns all significant risks to the most appropriate strategic objective and principal risk. Each significant risk has a lead Executive Director and a responsible board level committee assigned to it.

Monthly significant risk reports to the Trust Board and the responsible Board level committee detail controls in place to mitigate against significant risks. Any gaps in controls are highlighted through this process, allowing appropriate management action to be agreed and taken. The Board agrees target risk ratings for principal risks which could affect the achievement of the Trust's strategic objectives and also for significant risks aligned to each objective. The Board assesses residual risk and examines its risk profile by means of alignment of significant risks to the most relevant strategic objective. The Board seeks assurance that effective internal controls and mitigations are in place through reports to the responsible Board level committee.

The Board has articulated its risk appetite associated with each of its strategic objectives and principal risks and this is included in the Board Assurance Framework (BAF).

During the year the Board has received training on risk management, the Board Assurance Framework and the development of risk appetite with external facilitation and support provided by NHS England and Improvement.

The Internal Audit review of the Board Assurance Framework, undertaken in 2018/19, and reported in April 2019, 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. Two low priority actions were recommended during the Internal Audit review:

- The development of a Risk Management Strategy which recorded the agreed process for escalation and reporting of risks to the BAF - the Trust approved its Risk Management Strategy in June 2019. The Strategy was refreshed in March 2020 in line with the development of the Trust's five-year Corporate strategy and also to further strengthen and reflect the escalation process to the BAF.
- Review of the Trust's Risk Management Policy and Procedure to ensure appropriate review and circulation - this action was achieved during 2019/20 with a further review undertaken during March 2020 in line with the revised Corporate strategy and governance arrangements at the Trust.

The risk and control framework

The Board completed its Corporate Governance Statement in accordance with Licence Condition 4 in 2019 and confirmed statements in relation to:

- Those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS
- Having regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time

The Board were unable to confirm statements in relation to:

- The effectiveness of governance structures
- The responsibilities of Directors and subcommittees
- Reporting lines and accountabilities between the Board, its sub committees and the Executive Team

- The submission of timely and accurate information to assess risks to compliance with the Trust's licence
- The degree and rigour of oversight the Board has over the Trust's performance.

During the year, the Board commissioned reviews of the Trust's corporate and clinical governance structures and sources of the Board's assurance.

The formal governance review of Board committee structures was completed in October 2019. This has resulted in strengthening the Trust's governance and reporting structure - streamlining the number of committees and clarifying reporting lines and accountabilities between the Board, its committees and the Executive Team.

New and revised Non-Executive Director-led Board committees have been operational since January 2020, all reporting directly to the Trust Board:

- Quality Committee (formerly the Quality and Performance Committee)
- Finance and Activity Committee
- People Committee (formerly the Workforce Committee)
- Education, Research and Innovation Committee

alongside continuation of the:

- Audit Committee
- Nomination and Remuneration Committee (Executive Director Appointments)

A number of Executive-led groups are in the process of being convened which report into the Senior Leadership Team, notably:

- Assurance and Risk Executive Group (commenced January 2020)
- Clinical Governance Executive Group
- People Executive Group
- Operational Service Delivery Executive Group
- Investment and Innovation Executive Group

The Trust's Executive Team, Board and key Non-Executive Director led Board level Committees meet on a regular, programmed basis to scrutinise and oversee the Trust's operations, with additional oversight arrangements commissioned where required.

During the year the Trust has put in place a range of systems to provide assurance to the Board in respect of the Trust's compliance with a range of healthcare standards. This includes systems to support the Board's assurance and decision-making with comprehensive information. The Integrated Performance Report is a key report which has been reviewed and streamlined for 2019/20 and will continue to be further developed and strengthened, in line with best practice, in 2020/21.

The Trust has an Integrated Quality Improvement Plan (IQIP) in place, covering strategic priorities, Licence Conditions reporting and Care Quality Commission

(CQC) Must / Should actions – reporting internally to the Senior Leadership Team (Quality), the Trust Board and externally to the Oversight and Assurance Group and the CQC.

Corporate Objectives and Principal Risks

Following the articulation of Corporate Objectives during the previous year, the Board reviewed and re-articulated its principal risks to the delivery of its strategic objectives through the Board Assurance Framework as follows:

1. 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 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 the Trust becomes unsustainable clinically and/or financially, due to failure to:

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

During the year the Board Assurance Framework has been received by the Board on a quarterly basis. This has ensured that the Board has monitored its position and mitigations in respect of these three principal risks throughout 2019/20. In addition, the Board and its reporting committees consider all significant risks and their associated mitigations on a monthly basis as described in the sections above.

During 2019/20, a comprehensive programme of staff, patient and stakeholder engagement has been undertaken and this has resulted in the development of a new five-year Corporate Strategy and supporting strategies, including the Risk Management Strategy as described above.

As part of the development of the Trust's new Corporate Strategy and governance review, the Trust's strategic objectives have been reviewed and revised. The new strategic objectives for 2020/21 were approved by the Trust Board during March 2020 and are as set out below:

- SO1 - Quality 1: To consistently provide safe and compassionate care for our **patients** and their families
- SO2 - Quality 2: To modernise our **hospital** (estate, digital infrastructure and medical equipment) to support the delivery of optimal care
- SO3 - Engagement 1: To Strengthen **staff** engagement to create an open culture with trust at its centre
- SO4 - Engagement 2: To work with **patients** and **system partners** to improve patient pathways and ensure clinical and financial sustainability
- SO5 – Healthy Lives 1: To support our **patients** to improve health and clinical outcomes
- SO6 – Healthy Lives 2: To maximise opportunities for our **staff** to achieve their true potential so that we deliver outstanding care

In line with revised governance structures and Corporate Strategy a new Board Assurance Framework has been developed for 2020/21. New principal risks will be agreed for each of the new Strategic Objectives and all significant risks will be aligned to the most appropriate Strategic Objectives. Lead Executive Directors and responsible Committees will also be identified. This work has been undertaken in-conjunction with NHSI and has included review of best practice against the Board Assurance Framework process. The Board Assurance Framework review commenced during Quarter Four of 2019/20 and will be approved by the Board during Quarter One of 2020/21.

Risk reporting through the committee structure

The Board has in 2019/20 been alerted to risks identified at the committees, via Chair's Assurance reports. There are plans to further review and refine this methodology for effectiveness during the coming year as part of the ongoing implementation of the Trust's new governance structure and Board Assurance Framework.

Committees reporting to the Board are required to review their Terms of Reference on an annual basis and also 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 seek assurance regarding the effectiveness of its committees.

The Significant risk report received by the A® is also received by the Trust Board on a monthly basis. Significant risk reports are received by the relevant Board Committee in accordance with the alignment of a responsible Committee for each significant risk. For example, the Quality Committee is responsible for all significant risks aligned to the Trust's strategic objective relating to quality.

Committees reporting to the Board

The Senior Leadership Team (SLT) is chaired by the CEO and the membership in 2019/20 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 SLT 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 SLT 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 Policy was introduced in 2018/19 which provides a framework for the monitoring and management of the Trust's performance and risk.

The Quality 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 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 People Committee oversees and monitors the Trust's workforce issues and risks including those relating to organisational development, recruitment, retention, sickness absence management, and staff satisfaction, experience and engagement. The People Committee also oversees the delivery of the Trust's People 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 and appointment of the Chief Executive Officer and recruitment and approval of other Executive Director appointments.

The Audit Committee

The Audit Committee is responsible for overseeing the effectiveness of the Trust's internal 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.

An Anti-Fraud and Bribery policy is in place at the Trust. In addition, the Trust has a nominated Counter Fraud Champion whose key roles and duties include:

- Promote awareness of fraud, bribery and corruption within the Trust
- Understand the threat posed by fraud, bribery and corruption
- Understand best practice on counter fraud

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 at the Trust. The LCFS has also ensured that a programme of fraud awareness materials has been published for staff via the Trust's intranet site.

Throughout the last financial 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 2019/20 to be submitted by 30 April 2020. The outcomes from the assessment are being considered with an action plan to be agreed with management to address areas for improvement.

Nine LCFS referrals were investigated during the year and these included cases of working whilst sick, falsification of timesheets, conflicts of interest and misuse of Trust equipment amongst other alleged offences.

In 2019/20 disciplinary action is underway where recommended by LCFS with no cases resulting in criminal conviction.

The Care Quality Commission (CQC) and Quality Risk

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' following its latest inspection in April 2019 which reported in July 2019. The Trust remains in Quality Special Measures following its CQC inspection of 2018.

In July 2019 the Trust was formally rated as follows:

Overall Rating for the Trust	Inadequate
Are Services at this Trust safe?	Inadequate
Are Services at this Trust effective?	Inadequate
Are Services at this Trust caring?	Requires Improvement
Are Services at this Trust responsive?	Requires Improvement
Are Services at this Trust well-led?	Inadequate

The latest inspection report details 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. The Foundation 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, is subject to the following Notices and Conditions;

- Section 29A Maternity (May 17, 2018)
- Section 31 Maternity and Midwifery Services (July 19, 2018)
- Section 31 Urgent and Emergency / Gynaecology (March 18, 2019)
- Section 29A Medicine (March 19, 2019)
- Section 31 Diagnostic and Screening Procedures (May 21, 2019)
- Section 29A Diagnostic and Screening Procedures (May 23, 2019)
- General Medical Council (April 29, 2019)

The Trust engages openly and transparently with the CQC and concerns or queries are responded to promptly. Productive and routine 'CQC and Provider Relationship meetings' are held, where quality improvement updates are discussed and progress against the Integrated Quality Improvement Plan shared.

The Trust has in place a high-level Integrated Quality Improvement Plan (IQIP), which is managed through key work-streams covering eight strategic priorities and include the findings and recommendations within both the 2018 and 2019 CQC reports. This high-level plan is supported by 'Plans on a Page' which have been developed with the staff involved and detail the actions required to deliver the required improvements, with key milestones and outcome measures.

The Trust has established a robust governance structure which supports the delivery and monitoring of the IQIP and includes a monthly Oversight and Assurance Group comprising key external stakeholders and regulatory bodies, including NHS England and Improvement, Healthwatch and the CQC. In addition to this, the Trust routinely reports its compliance and progress against its Section 31 Notices to the CQC on a monthly basis.

To provide assurance of progress and evidence that improvements have been effectively completed and are embedded and sustained, the Trust established an IQIP Evidence Assurance Group which is Chaired by the Chief Nurse. The members of this group, which includes a patient representative, undertakes a review of action evidence and where there is sufficient evidence and assurance of improvement the action is closed and moved to 'Business as Usual'.

To support the delivery of the IQIP, additional resource was secured in the form of three Quality Improvement Managers (QIM), each aligned to specific work-streams. The QIMs supported the Divisions and their teams in the delivery of improvement actions through quality improvement projects.

As part of the Trust's work to develop and sustain a culture of continual quality improvement to ensure it consistently delivers safe, high quality care for our patients, it has adopted Quality Service Improvement and Redesign (QSIR) as its preferred Quality Improvement methodology. It is acknowledged that improving and well performing Trusts have introduced a level of improvement capability into their organisations, helping generate a culture of quality improvement.

QSIR is the only nationally accredited QI methodology training programme and is all about service improvement. The first cohort of 35 staff completed this training in September 2019 and a further 30 staff commenced cohort two in March 2020. Four staff have commenced the QSIR Facilitator Training Programme with the QSIR College, with the aim of delivering QEHI in-house QSIR staff training thereafter. In 2019/20 we launched a new monthly Quality Improvement newsletter to share staff-led improvements across the organisation.

Since the launch of the IQIP in June 2019, the Trust has provided evidence and assurance of sustained progress. The IQIP comprises of 206 improvement actions, of which 106 had been completed (as assessed internally) in line with the agreed timeframes by March 2020. External assurance of improvement has in turn been formally recognised by NHS England/Improvement in relation to Maternity Services with the Trust being removed from the NHS England/Improvement Maternity Intensive Support Programme in September 2019, with a further external review of evidence relating to conditions within the Section 31 Notice supporting an application to apply to the CQC to lift these conditions.

The Trust is expecting to be re-inspected by the CQC during the second half of 2020, with preparations well underway.

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 2019 CQC inspection found the Trust to be 'Inadequate' in the 'Well-Led' domain.

The Trust has received Well-Led support from NHS Improvement and an independent Board Review was jointly commissioned by the Trust and NHS Improvement in November 2018. In 2019/20, all key findings and recommendations of the Independent Review have been addressed. The Trust has during 2019/20 made high calibre appointments to its substantive Board and has increased the Non-Executive Director contingent from five to seven (in line with constitutional provisions), to improve oversight. The Board has a comprehensive, externally facilitated Board development plan in place, supported by NHS England/Improvement.

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), ward visits and Patient-led Assessments of the Care Environment (PLACE) inspections. Service users are also involved through a number of active service user groups and via their responses to patient satisfaction surveys.

The public is represented by elected Governors' participation in projects and on key groups, such as the 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 views of Governors and public members have been taken into account and have informed the development of the Trust's new Corporate Strategy which will be launched in June 2020.

The Patient Experience Committee, Business Committee and Membership and Communications Committees of the Governors' Council review detailed quality, performance and financial risk respectively, and devise the annual plan for the year in relation to communications and engagement with members and Governors. These Committees report back to the Governors' Council at every meeting. Further work will be undertaken in 2020/21 to align the workplans of the Governors Committees to the new Corporate Strategy and to further strengthen relationships with Governors. This will involve a review of the Terms of Reference, membership of Committees and new workplans for the year. A Board development session which will be attended by the Chairman, CEO, Executive Team, Non-Executive Directors and Governors will take place in 2020 to support this work and build relationships further.

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. Learning from incidents and complaints are regularly shared across the organisation via a patient safety newsletter and other bulletins, such as the Medical Directors' bulletin.

Following extensive engagement with patients, staff, Governors, members, volunteers and external stakeholders, the Trust has developed a new five-year Corporate Strategy, with new strategic objectives. This will be formally approved in June 2020. The strategy has three clear areas of focus: Quality, Engagement and Healthy Lives and annual milestones against which we will track progress quarterly, and report to the Senior Leadership and Trust Board. One of the key underpinning strategies is the People Strategy, which will be presented to the June 2020 People Committee for sign-off, and to ensure alignment with the Corporate Strategy. Progress against the People Key Performance Indicators in the Corporate Strategy and People Strategy, will be monitored through the People Committee. In addition, skill-mix papers and recommendations are regularly presented to the Trust Board.

The Trust has in place an independent Freedom to Speak Up Guardian and has recently recruited 13 new Freedom to Speak Up Champions from across the organisation. This important post is supported by a Non-Executive Director. The Freedom to Speak Up Guardian has reported to the People Committee and the Board in 2019/20, and reports quarterly to the National Guardian's Office.

The Trust has in 2019/20 amalgamated its Whistleblowing and Freedom to Speak Up Policies, to clarify for staff, the range of opportunities to raise any concerns. All Whistleblowing and Freedom to Speak Up cases are reported to the Board. We regularly communicate across the organisation about the importance of Speaking Up and creating a culture where staff feel comfortable raising concerns and confident that they will be listened to when they do so. This work remains a key focus going into 2020/21, including 'culture and learning' being a central part of the Trust's new Staff Engagement Programme. In 2020 we will commence new quarterly meetings with the Trust's Freedom to Speak Up Guardian, Non-Executive Director Lead, CEO, Deputy CEO, and key Executive Team colleagues to discuss Speak Up matters.

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 and Disability Equality Standard Action Plans and delivery is being monitored by the People Committee.

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.

The Foundation Trust has published on its website an up to date register of interests for Board members which has been received at regular intervals throughout the year at public Board meetings.

The Trust's Management of Conflicts of Interest (including Gifts, Hospitality and Sponsorship) Policy sets out the staff required to declare their interests annually and periodically, if their interest changes. LCFS are currently undertaking a review of the Trust's declared interests to check compliance and adherence to the Trust's

Policy. If any issues are identified as a result of this, the Policy will be updated accordingly and the Managing Conflicts of Interests Policy will be relaunched to fulfil the following responsibility: The Foundation Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance. The review will include compliance with the Trust's policy regarding declaration of gifts and hospitality.

Developing Workforce Safeguards

Our aim is to deliver high quality patient care, which is supported by a workforce who are engaged, highly skilled and competent. The quality of experiences and outcomes of people who use our services are a direct result of interactions with staff. We want to be an employer of choice, attracting and retaining quality staff whilst supporting them with continued development, identifying talent to succession plan for the future, whilst creating a flexible workforce that can adapt to the ever-changing environment whilst maintaining financial stability. "Growing our own" workforce strategies will form an important part of our sustainable future workforce.

The Trust has articulated its aim and vision for the current and future workforce in its new Corporate Strategy and People Strategy. As a Trust we want to create a culture at QEH where staff feel comfortable speaking up knowing they will be listened to, where staff feel valued and supported to deliver their true potential and where staff enjoy coming to work and are proud being part of Team QEH.

The Trust's People plan will be designed around six priority areas outlined below which will form the basis of the People Plan for the Trust:

- Attraction, Recruitment and Retention
- Leadership and Development Plan
- HR Systems
- HR Processes
- Consequences of Actions
- HR Metrics

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 staff and 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.

It is really important that we listen to and respond to feedback from patients and staff and learn when we get things wrong. We will be further improving staff and external stakeholder communications and engagement in 2020/21 and using feedback from compliments, complaints, surveys, incidents and 'listening' as well as national Constitutional Standards and Regulatory actions to inform our Corporate Strategy and our annual milestones, and key underpinning strategies;

including our People Strategy, Estates Strategy, Clinical Services Strategy and Digital Strategy.

Sustainable Development

The Foundation Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. The sustainable development management plan will progress for ratification through the relevant governance committees in early 2020.

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.

In a normal year, the Board agrees budgets and annual plan targets that incorporate significant efficiency improvement requirements. All efficiency, cost improvement and transformation plans are quality impact-assessed by the Medical Director and Chief Nurse, and the delivery of those improvements is monitored at divisional level. Regular meetings take place with Executive Directors and Divisional Leadership Teams to review performance in delivering plans.

For 2020/21, the Trust is following the national guidance for financial planning and contracting issued as a result of COVID-19. Whilst this guidance covers up until the 31 October the Directors of the Licensee consider that the Trust will have adequate resources made available to it to deliver commissioner requested services during 2020/21.

The Trust remains in breach of its Provider Licence. The Trust is working to address the issues relating to the undertakings agreed with NHSI accordingly, including quality and operational improvements and improved financial performance. The Trust is expecting the opinion of the external auditor to reflect concerns of the Trust's financial sustainability in respect of the Trust's economic, efficient and effective use of resources.

The Board has considered its Going Concern position at its meeting on 27 May 2020 as part of the 2019/20 annual report approval process. After consideration of risks and uncertainties the Board agreed that the use of the 'going concern' basis is appropriate. There are no material uncertainties related to events or conditions that may cast significant doubt about the ability of the Trust to continue as a going concern.

The Trust reports on the delivery of its financial plans at regular meetings with the Regulator, NHS England/Improvement.

The Trust has delivered its financial plans and Costs Improvement Plan for 2019/20. It is clear however, that the financial challenge for 2020/21 and beyond will be significant for the Trust and the region. Agreement and delivery of the Trust's plans, including the Financial Improvement Trajectory will require considerable levels of Cost Improvement Programme (CIP) delivery, robust controls and transformational ways of working.

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 (compliance to be reviewed in 2020)
- Executive management of Trust finance and activity plans
- Regulatory reviews of Reference Costs
- Lord Carter review – 'Model Hospital' toolkit
- Cost Improvement Programme (Quality Impact Assessed)
- Service Line Reporting
- Procurement Strategy
- 'Getting it Right First Time' (GIRFT) reviews

Assurance on financial controls is provided by Internal and External Audit and by independent and peer reviews.

Through the Internal Audit programme for 2019/20 the Trust has commissioned a range of audits to provide assurance that resources are used economically, efficiently and effectively:

- Delivering sustainable CIPs
- Core Financial Systems
- Medical Job Planning
- Procurement
- Business Planning

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

Information Governance

Information risk is managed through the Information Governance and Compliance Forum which reports to the Assurance and Risk Executive Group. 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 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 will comply with the requirements to submit its Data Security and Protection Toolkit for 2019/20 in September 2020, in line with national requirements.

The key data security risk to the Trust continues to be Cyber Security. There are very clear plans in place to mitigate the risks, as presented to the Board in December 2019. A Board development session on Cyber Security is planned for 2020.

During the year, there has been one serious incident that required disclosure in relation to personal data. Following an internal investigation and the mitigating measures already 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 trust-wide communications, incident reports and data security audits in all departments and wards to identify and mitigate areas of risk.

Data Quality and Governance

The Trust has robust processes in place to ensure the accuracy of all performance data with clear validation processes to support the quality and accuracy for key performance indicators including elective waiting time data. A Standard Operating Procedure is in place to provide clarity around the process of data capture/validation and sign off. This is reviewed on an annual basis.

To facilitate this, the Trust has data quality guidance and support which is available to all employees which is in line with good practice and comparable NHS Trusts. Data quality training is embedded in the Trust's induction process. Monthly data quality reports identifying data quality issues are consistently reported to the Trust's Information Governance Committee for action and resolution.

Internal Audit has undertaken a Data Quality review of externally submitted data in March 2020. The audit reviewed five externally reported results/indicators. The review outcome articulated partial assurance with improvement required, with three clear recommendations for action which will be taken forward during 2020/21.

Our response to COVID-19

The Trust developed robust plans to deal with the impact of Coronavirus (COVID-19), including planning for our bed (capacity), people and equipment requirements. We worked closely with local system and national partner agencies (including Public Health England and NHS England/Improvement) to ensure our patients, public and staff remained safe.

We set up an Incident Control Team, led by our Chief Operating Officer, and supported by our Medical Director, Chief Nurse and Divisional Directors, so that there is a single forum for strategic decision-making. This supported by our Incident Control Room (tactical command), which was led by the Trust's Head of Patient Flow. The Trust's Non-Executive Lead for Emergency Prevention, Preparedness and Response, with the whole Trust Board briefed and involved in our response.

We revised the Trust's Governance arrangements in light of COVID to put measures in place that would maintain effective corporate governance while adhering to national guidance about social distancing and recognising the operational pressures being experienced by the Trust's executive, clinical and operational teams. This included public Board of Directors Meetings, and Governors' Council meetings not being held in public, consistent with arrangements in place across the wider NHS, with shortened virtual meetings taking place instead, including for Board Committees. For the public Board of Directors' meeting, papers were published in advanced as normal and due to the exceptional circumstances a paper was published on our website and shared via social media after the meeting summarising the key discussion points and decisions from the meeting, in the spirit of openness and transparency.

The Trust's risk register was updated to reflect COVID-related risks and daily updates of COVID-related incident reporting occurred.

Extensive internal and external communications were shared to keep staff, Governors, patients, partners and external stakeholders well-informed.

The Trust developed a bespoke staff engagement programme to maximise our support for staff, which included listening to staff, encouraging staff to speak up with feedback and concerns and supporting staff health and wellbeing, drawing on best practice from across the NHS.

Many positive changes which were implemented at an accelerated pace during COVID – including the digitisation of our hospital, with more than 80% of outpatient appointments transferring to phone and video consultations. This will continue beyond COVID. The learning from COVID will help to strengthen our plans, including business continuity plan and pandemic plan, moving forward.

We are in the process of developing a detailed recovery plan to transition the Trust back to business as usual as COVID passes. This plan has four key components: notably people, clinical pathways and theatres, site reconfiguration and contracts and regulatory – each with Executive Leads.

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 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, committees reporting to Board, my Executive Directors and Senior Leadership Team, and 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.

During the year, internal audits were commissioned in the following areas:

- Radiology - partial assurance
- Core Financial Systems - significant assurance
- Cost Improvement Programmes - significant assurance
- Cyber Security - partial assurance
- Emergency Department - partial assurance
- Infection Prevention and Control - partial assurance
- Clinical Audit - partial assurance
- Security Service Review - advisory
- Procurement (draft) – partial assurance
- Data Quality (draft) – partial assurance
- Emergency Preparedness, Disaster Recovery and Business Continuity (draft) – partial assurance)
- Risk Management – audit in progress
- Medical Job Planning – audit in progress
- Data Security Protection Toolkit – audit in progress
- Business planning – audit in progress

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 Head of Internal Audit opinion for 2019/20 is as follows:

'Our overall opinion for the period 1 April 2019 to 31 March 2020 is that based on the scope of reviews undertaken and the sample tests completed during the period, that Partial assurance can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and control. The level of non-compliance in certain areas puts some system objectives at risk. The weaknesses identified which put system objectives at risk have resulted in high rated recommendations identified within the following partial assurance rated audit reports for Radiology, Clinical Audit, Emergency Department, Data Quality, Cyber Security and Emergency Preparedness Resilience and Response audits.'

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 directors 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 2019/20 independent reviews have included:

Infection Prevention and Control

UNICEF – 'Baby Friendly' review

HEE – Quality Interventions Review (Obstetrics & Gynaecology and medicine learner and educator review)

External Review of Education and Learning carried out in association of Health Education England (HEE)

'Getting it Right First Time' (GIRFT) reviews

Peer review of the Diabetic Foot Service

The Trust has responded to concerns raised as a result of these reviews and progress to deliver resulting action plans is monitored by the appropriate committees.

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.

Conclusion

My AGS review and my broader observations lead me to conclude that while progress has been made in some areas in 2019/20, there remain significant internal control issues for the Trust to address in 2020/21, within the areas of quality, as reflected in the findings of the 2018 and 2019 CQC inspections, workforce, clinical and longer-term financial sustainability as described above.

The Trust's Internal Auditor has identified eight 'partial assurance' areas with a number of high rated recommendations, and no 'Red' / 'no assurance' findings. In respect of those areas where controls need to be strengthened, we have improved our processes for reviewing and following up outstanding internal audit recommendations. Moving into 2020/21 I am satisfied this focus on implementation of recommendations will be maintained to ensure adequate assurance that weaknesses are being addressed in a timely manner.

Whilst the Trust is impacted by the COVID-19 pandemic at the start of this new financial year, I will continue to work with my team in 2020/21 to strengthen the Trust's internal controls and sources of assurance for the Board, in order to ensure that the Trust can deliver its strategic objectives.

A handwritten signature in black ink that reads "Cshaw". The letters are cursive and connected.

Caroline Shaw
Chief Executive

Wednesday 24 June 2020

Financial Report 2019/20

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The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust

Annual Accounts

For the year ended 31 March 2020

THE QUEEN ELIZABETH HOSPITAL KING'S LYNN NHS FOUNDATION TRUST

These accounts for the year ended 31 March 2020, 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*.

A handwritten signature in black ink, appearing to read 'cshaw', is positioned in the center of the page.

Caroline Shaw - Chief Executive

Wednesday 24 June 2020

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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 2020 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 2020 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 2020 and the Department of Health and Social Care Group Accounting Manual 2020.

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: £4.0m (2018/19: £3.4m)
 financial statements as a whole 2% (2018/19: 2%) of total revenues

Risks of material misstatement vs 2018/19

Recurring risks		
Fraudulent expenditure recognition	◀▶	
Valuation of land and buildings	◀▶	
Recognition of NHS and non-NHS income	◀▶	

2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. 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 Council as a body may better understand the process by which we arrived at our audit opinion. These matters were addressed, and our results 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.

We continued to perform procedures over going concern. However, due to changes in the NHS cash regime we no longer consider there to be material uncertainty related to going concern and this not separately identified as a key audit matter in our report this year.

	The risk	Our response
<p>Fraudulent expenditure recognition</p> <p>Accruals: £8.9m (2018-19: £11.9m)</p> <p>Refer to page 141 (accounting policy) and page 135 (financial disclosures)</p>	<p>Effect of irregularities</p> <ul style="list-style-type: none"> - There is a risk that the Trust may seek to improve its financial position by the manipulation of expenditure recognition (for example by deferring expenditure to a later period through the understatement of liabilities at year end). - We consider the risk to specifically relate to accruals, as they represent the key mechanism for management to manipulate year-end outturn. 	<p>Our procedures included:</p> <ul style="list-style-type: none"> — Segregation of duties: We 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 performed a year-on-year review of accruals, and sought explanation for significant movements; — Test of detail: We tested payments made and invoices received in April 2020 to identify whether the expenditure in the year was materially complete. We performed a sample test of accruals to supporting evidence to ensure these were accurate and measured appropriately. <p>Our results</p> <p>We found expenditure recognition to be acceptable.</p>

	The risk	Our response
<p>Valuation of Land and Buildings</p> <p>(£64.3 million; 2018/19: £64.0 million)</p> <p><i>Refer to page 143 (accounting policy) and page 136 (financial disclosures)</i></p>	<p>Subjective valuation</p> <ul style="list-style-type: none"> Land and buildings are required to be held at current value in existing use. 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 a modern equivalent asset. The appropriate valuation of land and buildings relies on the expertise of the external valuer and the accuracy of the records provided to the valuer to prepare the valuation. The Trust had a full valuation at 1 April 2019. The trust considered any potential impacts on the valuation, and concluded that this reflects an appropriate valuation at 31 March 2020. 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. <p>Disclosure Quality</p> <ul style="list-style-type: none"> There is a risk that uncertainties expressed by the Trust's valuer relating to the impact of the Covid-19 pandemic on market-based valuations of land and buildings will be inappropriately disclosed. 	<p>Our procedures included:</p> <ul style="list-style-type: none"> Specialist involvement: We engaged valuation specialists for the review of the full valuation performed by Management's expert. Benchmarking assumptions: We compared the valuer's assumptions to externally derived data in relation to the indices used and the market conditions cited. Assessing valuer's credentials: We critically assessed the scope, qualifications, experience and independence of the Trust's external valuer; Test of detail: We considered the movement in indices between the valuation date of 1 April 2019 and the year end date of 31 March 2020 in order to assess if there was a material movement; Test of detail: We critically assessed the useful economic lives applied to ensure consistent with the valuation basis; and Test of detail: We used a valuation specialist to challenge the assumptions used in completing the valuation of land and building values. Assessing transparency: We considered the adequacy of the disclosures relating to the key judgements and the degree of estimation involved in concluding whether there has been any material movement in the value of land and buildings since the date of the full valuation (1 April 2019). Specifically we considered the adequacy of disclosures of the uncertainty caused by the Covid-19 pandemic on market data used to underpin the valuer's assumptions relating to assets valued at current value, and management's consideration of these factors when arriving at the year-end valuation figures. <p>Our results</p> <ul style="list-style-type: none"> We found the valuation of land and buildings to be acceptable. We found the disclosures in relation to the uncertainties caused by the impact of the Covid-19 pandemic on the Trust's market-based valuations to be acceptable.

2. Key audit matters: our assessment of risks of material misstatement (continued)

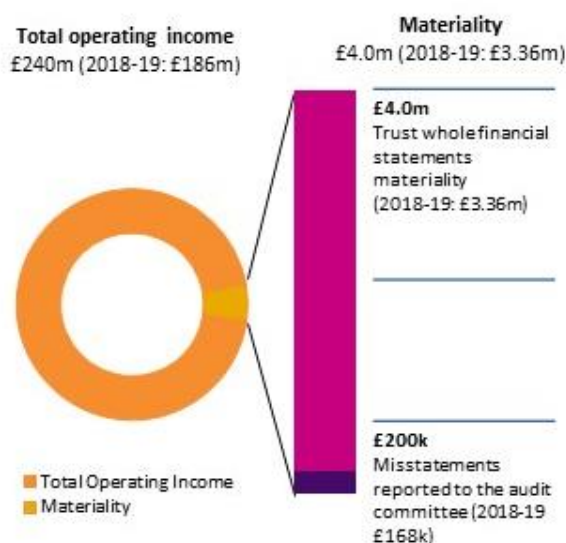
	The risk	Our response
<p>Recognition and estimation of NHS and non-NHS income</p> <p>(Income: £239.4 million; 2018/19: £189.0 million)</p> <p><i>Refer to page 141 (accounting policy) and page 135 (financial disclosures).</i></p>	<p>Subjective estimate:</p> <p>The Trust earned £239.4 million of operating income in 2019/20, of which £194.6 million was patient income from NHS bodies. The two largest sources are NHS England (£23.0 million) and Clinical Commissioning Groups (£170.6 million).</p> <p>There is a risk that the Trust recognises income to which it is 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.</p> <p>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.</p> <p>Operating income also includes £44.8 million earned from activities other than delivering patient care. The largest item for the Trust is sustainability funding (£25.5 million).</p> <p>There is a risk that the Trust recognises income to which it is not entitled.</p>	<p>Our procedures included:</p> <ul style="list-style-type: none"> — Control operation: we inspected documentation for a sample of commissioners to confirm that contracts had been agreed for the delivery of services; — Test of detail: we obtained 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 accounting treatment. — Test of detail: we reviewed invoices and credit notes raised around the year end date to ensure the income had been recognised in the correct accounting period. <p>Our results</p> <p>We found the recognition and estimation of NHS and non-NHS income to be acceptable.</p>

3. Our application of materiality

Materiality for the Trust financial statements as a whole was set at £4.0 million (2018-19: £3.36 million), determined with reference to a benchmark of total operating income (of which it represents approximately 2%). 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 £0.2 million (2018-19: £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.



4. We have nothing to report on going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not 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. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

Our responsibility is to conclude on the appropriateness of the Accounting Officer's conclusions and, had there been a material uncertainty related to going concern, to make reference to that in this audit report. However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks to the Trust's business model, and analysed how those risks might affect the Trust's financial resources or ability to continue operations over the going concern period. We evaluated those risks and concluded that they were not significant enough to require us to perform additional audit procedures.

Based on this work, we are required to report to you if we have anything material to add or draw attention to in relation to the Accounting Officer's statement in Note 1.2 to the financial statements on the use of the going concern basis of accounting with no material uncertainties that may cast significant doubt over the Trust's use of that basis for a period of at least twelve months from the date of approval of the financial statements.

We have nothing to report in these respects, and we did not identify going concern as a key audit matter.

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 2019-20.

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 2019-20 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 102 the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.
- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

Our conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources is adverse.

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

Adverse Conclusion

As a result of the matters outlined in the basis for adverse conclusion paragraph below, we are unable to satisfy ourselves that, in all significant respects 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 2020.

Basis for adverse conclusion

Following an inspection by the Care Quality Commission (CQC) in September 2018, the Trust was rated as "Inadequate" and was placed back into special measures as a result. A follow up CQC report in July 2019 did not show sufficient progress against this rating and the Trust was therefore in special measures for the whole of 2019/20.

The ongoing breach of license conditions and inadequate CQC rating 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 April 2020, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

The significant risks identified during our risk assessment are set out overleaf together with the findings from the work we carried out on each area.

Significant Risk	Description	Work carried out and judgements
Financial sustainability:	<p>The NAO Code of Audit Practice requires us to consider 'sustainable resource deployment'.</p> <p>The ongoing financial position and the Trust's reliance on support from the NHSi exposes the Trust to operational and financial challenges in terms of financial sustainability.</p>	<p>Our work included:</p> <ul style="list-style-type: none"> • Reviewing the Trust's performance against its agreed target year-end outturn and CIP target at year-end; • Reviewing the correspondence with NHS Improvement where they confirmed support through providing further funding. <p>Our findings on this risk area:</p> <ul style="list-style-type: none"> - The Trust has prepared a financial strategy setting out its plans and initiatives to improve its financial position. - The conversion of loans to Public Dividend Capital and the new funding regime give greater certainty that cash will be available to the Trust. - Additionally the Trust achieved a breakeven position in the year. - We are satisfied that the Trust had adequate arrangements for planning its finances and sustainable resource deployment.
Informed decision making:	<ul style="list-style-type: none"> - In September 2018, the Trust was placed back into special measures after being rated inadequate by the CQC, and remains in special measures as at issue of this report. - In forming our value for money opinion in 2019/20 we have considered progress against the results of the regulator's findings and the Foundation Trust's action plan. 	<p>Our work included:</p> <ul style="list-style-type: none"> • 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 April 2018 in relation to the Trust. <p>Our findings on this risk area:</p> <p>The latest CQC inspection (July 2019) rated the Trust as inadequate. Ongoing monitoring has been in place as the Trust addresses the issues raised but no further inspection has been formally carried out. The Trust has remained in special measures throughout the year. This is evidence of weaknesses in the Trust's arrangements for informed decision making.</p>

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 for the year ended 31 March 2020 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

Chartered Accountants
Botanic House
100, Hills Road
Cambridge
CB2 1AR

Wednesday 24 June 2020

Statement of Comprehensive Income and Expenditure

	2019/20	2018/19
Note	£000	£000
Operating income from patient care activities	3 194,616	170,396
Other operating income	3 44,759	18,214
Operating expenses	4, 7 (237,142)	(222,666)
Operating surplus/(deficit) from continuing operations	<u>2,233</u>	<u>(34,056)</u>
Finance income	8 70	45
Finance expenses	8 (2,316)	(1,812)
Net finance costs	<u>(2,246)</u>	<u>(1,767)</u>
Other gains / (losses)	9 (12)	(5)
Surplus / (deficit) for the year from continuing operations	<u>(25)</u>	<u>(35,828)</u>
Surplus / (deficit) for the year	<u><u>(25)</u></u>	<u><u>(35,828)</u></u>
Other comprehensive income		
Will not be reclassified to income and expenditure:		
Revaluations	11 850	-
Total comprehensive income / (expense) for the period	<u><u>825</u></u>	<u><u>(35,828)</u></u>
Adjusted financial performance (control total basis):		
Surplus / (deficit) for the period	(25)	(35,828)
Remove net impairments not scoring to the Departmental expenditure limit	-	-
Remove I&E impact of capital grants and donations	197	132
Remove 2018/19 post audit PSF reallocation (2019/20 only)	(122)	-
Adjusted financial performance surplus / (deficit)	<u>50</u>	<u>(35,696)</u>

We delivered a deficit of £25k including provider sustainability funding, financial recovery funding and MRET of £25,578k.

All income and expenditure are derived from continuing operations.

The notes on pages 136 to 170 form part of these accounts.

Statement of Financial Position

	Note	31 March 2020 £000	31 March 2019 £000
Non-current assets			
Intangible assets	10	425	503
Property, plant and equipment	11	95,232	83,325
Receivables	13	487	1,044
Total non-current assets		96,144	84,872
Current assets			
Inventories	12	2,156	2,102
Receivables	13	22,023	13,935
Cash and cash equivalents	14	14,216	4,402
Total current assets		38,395	20,439
Current liabilities			
Trade and other payables	15	(32,248)	(24,608)
Borrowings	17	(134,969)	(42,169)
Provisions	18	(262)	(134)
Other liabilities	16	(1,516)	(604)
Total current liabilities		(168,995)	(67,515)
Total assets less current liabilities		(34,456)	37,796
Non-current liabilities			
Borrowings	17	(213)	(78,067)
Provisions	18	(231)	(228)
Other liabilities	16	(523)	(533)
Total non-current liabilities		(967)	(78,828)
Total assets employed		(35,423)	(41,032)
Financed by			
Public dividend capital		57,474	52,690
Revaluation reserve	22	12,464	11,614
Income and expenditure reserve		(105,361)	(105,336)
Total taxpayers' equity		(35,423)	(41,032)

The financial statements on pages 135 to 170 were approved by the Board on 27 May 2020 and signed on its behalf by:



Caroline Shaw, Chief Executive
Wednesday 24 June 2020

Statement of Changes in Taxpayers Equity

Statement of Changes in Equity for the year ended 31 March 2020

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2019 - brought forward	52,690	11,614	(105,336)	(41,032)
Surplus/(deficit) for the year	-	-	(25)	(25)
Revaluations	-	850	-	850
Public dividend capital received	4,784	-	-	4,784
Taxpayers' and others' equity at 31 March 2020	57,474	12,464	(105,361)	(35,423)

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' and others' equity at 1 April 2018	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' and others' equity at 31 March 2019	52,690	11,614	(105,336)	(41,032)

The accompanying notes form part of these financial statements

Information on reserves

Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based upon the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Addition PDC may also be issued to trusts by the Department of Health and Social Care (DHSC). A charge, reflecting the cost of capital utilised by the Trust, is payable to DHSC as the public dividend capital dividend.

Revaluation Reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in assets valuations are charged to the revaluation reserve to the extent of the 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	2019/20 £000	2018/19 £000
Cash flows from operating activities			
Operating surplus / (deficit)		2,233	(34,056)
Non-cash income and expense:			
Depreciation and amortisation	4.1	6,443	6,809
Income recognised in respect of capital donations	3.4	(142)	(155)
(Increase) / decrease in receivables and other assets		(7,531)	(4,721)
(Increase) / decrease in inventories		(54)	89
Increase / (decrease) in payables and other liabilities		1,093	271
Increase / (decrease) in provisions		132	(154)
		<u>2,174</u>	<u>(31,917)</u>
Net cash flows from / (used in) operating activities			
Cash flows from investing activities			
Interest received	8	70	45
Purchase of intangible assets	10	(28)	(21)
Purchase of PPE and investment property	11	(9,817)	(4,197)
Sales of PPE and investment property		2	6
		<u>(9,773)</u>	<u>(4,167)</u>
Net cash flows from / (used in) investing activities			
Cash flows from financing activities			
Public dividend capital received		4,784	371
Movement on loans from DHSC		14,901	36,296
Capital element of finance lease rental payments		-	(90)
Interest on loans		(2,271)	(1,704)
Other interest		(1)	(11)
Interest paid on finance lease liabilities		-	(9)
		<u>17,413</u>	<u>34,853</u>
Net cash flows from / (used in) financing activities			
Increase / (decrease) in cash and cash equivalents			
Cash and cash equivalents at 1 April - brought forward			
		<u>4,402</u>	<u>5,633</u>
Cash and cash equivalents at 31 March			
	14	<u>14,216</u>	<u>4,402</u>

The accompanying notes on pages 139 to 170 form part of these financial statements

NOTES TO THE ACCOUNTS

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the DHSC Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2019/20 issued by the DHSC. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

The Board is required under IAS 1 Presentation of Financial Statements 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 dissolution without transfer of its services to another entity.

These accounts have been prepared on a going concern basis and the factors taken into consideration in making this assessment are set out below.

The Trust reported a surplus of £0.05m in the year with a deficit of £35.7m in the previous year.

The Trust draft annual plan for 2020/21 was not agreed, as nationally the annual planning process has been paused as a result of the required focus and response to the COVID-19 virus pandemic for an initial four-month period until 31 July 2020.

In that regard, funding for the ten-month period until 31 October 2020 has been confirmed. All NHS providers will receive a guaranteed minimum level of funding that should provide funds sufficient to deliver a break-even position through the period. It will be through a 'block' arrangement with our commissioners along with a top up sufficient to enable costs including special COVID 19 costs to be fully met.

In addition, it has been announced that the NHS Cash and Capital Regimes for 2020/21 have been reformed. The reforms include the conversion of historic NHS debt into PDC and a move away from interest bearing loans for future interim revenue support which instead will be provided as PDC. This means that our NHS debt of £134.161m will be converted to PDC during 2020/21. The reforms also confirm that future revenue support will be available for exceptional short-term cash flow requirements and longer-term revenue support for providers in financial distress. As with any entity placing reliance on other group entities 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.

Against that backdrop, the Board of Directors has carefully considered the principle of going concern. After making enquiries and considering the impact of the NHS cash reforms, in particular the assurance over funding for the period to 31 October 2020, the conversion of historic NHS debt to PDC and the assurance over revenue support for providers in financial distress, the Directors have a reasonable expectation that the Trust will have access to adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts for the going concern assessment period.

Note 1.3 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 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 valuation for 2019/20 was performed by professional Chartered Surveyors Boshier and Company on the basis of market value as at 1 April 2019. 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 13.

Untaken annual leave

Under Trust policy with respect to annual leave, staff (with the exclusion of doctors) 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 2020 in respect of those staff who are doctors, on maternity leave, long-term sickness leave or suspended. The estimated costs of untaken annual leave as at 31 March 2020 was £322,770, (31st March 2019 £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 1.4% of the Trust net assets. Charitable fund income is about 1.0% of Trust income. The Directors therefore consider that the non-consolidation of the accounts of the Charitable Fund with those of the Trust is 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 on-going basis. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods. The estimates and judgements that have had a significant effect on the amounts recognised in the financial statements are outlined below.

The following are assumptions about the future and other major sources of estimation uncertainty that have a risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

An asset valuations exercise was carried out in November 2019 with a valuation date of 1 April 2019. In applying the Royal Institute of Chartered Surveyors (RICS) Red Book Global Valuation Global Standards 2020, the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19. The valuer's report clarifies that "the inclusion of the 'material valuation uncertainty' declaration does not mean that the valuation cannot be relied upon. It is used in order to be clear and transparent with all parties, in a profession manner that – in the current extraordinary circumstances – less certainty can be attached to the valuation than would otherwise be the case". The value in the report has been used to inform the measurement of property assets at valuation in these financial statements. With the value having declared this material uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust.

As the valuation was at 1 April 2019, the value of the assets disclosed in the accounts, represents the value at 1 April 2019 rolled forward for any additions, disposals, depreciation and amortisation.

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. For 2019/20 there has been no movement on the partial spells estimate.

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 1.4.5 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15.

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Note 1.4.6 Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

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 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.

or

- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control;
- or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

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 a valuation of land and buildings as at 1 April 2019. The valuation was performed by Boshier and Company Chartered Surveyors.

The valuation of the owner-occupied property was on the following basis of value and assumptions: the assets which are held for their service potential and are in use are valued at their current value in existing use.

The Valuer's opinion of market value was primarily derived using the depreciated replacement cost method of valuation as the specialised nature of the asset means that there is no market transactions of this type of asset except as part of the enterprise in occupation and is subject to the prospect and viability of the continued occupation and use.

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 DHSC 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 i.e.:
 - management are committed to a plan to sell the asset
 - an active programme has begun to find a buyer and complete the sale
 - the asset is being actively marketed at a reasonable price
 - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
 - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

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 1.8.10 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	15	80
Plant & machinery	5	15
Transport equipment	7	7
Information technology	7	7
Furniture & fittings	5	15

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 1.9.5 Useful lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Software licences	7	7

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 Cash and Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.13 Financial instruments and financial liabilities

Note 1.13.1 Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), or that are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described above/below.

Note 1.13.2 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 1.13.3 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 1.13.4 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 1.13.5 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 1.13.6 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 1.13.7 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 1.13.8 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 1.14 Leases

The Trust as Lessee

Note 1.14.1 Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for 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 1.14.2 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 1.14.3 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 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective for 31 March 2020:

		Nominal rate
Short-term	Up to 5 years	0.51%
Medium-term	After 5 years up to 10 years	0.55%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2020:

	Inflation rate
Year 1	1.90%
Year 2	2.00%
Into perpetuity	2.00%

Note 1.15.1 Clinical negligence costs

The NHS Resolution (NHSR), formerly NHS Litigation Authority, operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSR, which, in return, settles all clinical negligence claims. Although the NHSR is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSR on behalf of the Trust is disclosed in note 19.1 but it is not recognised in the Trust's accounts.

Note 1.15.2 Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHSR 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 1.16 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 Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in

GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the DHSC (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 1.17 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.18 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 1.19 Foreign Exchange

The actual, functional and presentational currencies of the Trust are sterling.

Note 1.20 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.21 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 1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20

Note 1.23 Accounting standards that have been issued but have not yet been adopted

IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2020. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the re-measurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

Due to the Covid-19 pandemic the DHSC has postponed the implementation of IFRS 16 until 1 April 2021

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 £193.6m (2018/19 £169.6m), 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 1.5

Note 3.1 Income from patient care activities (by nature)	2019/20	2018/19
	£000	£000
Acute services		
Elective income	30,432	29,513
Non elective income	67,592	67,322
First outpatient income	12,920	12,744
Follow up outpatient income	16,051	14,960
A & E income	10,624	8,995
High cost drugs income from commissioners (excluding pass-through costs)	14,189	11,795
Other NHS clinical income	35,180	22,133
All services		
Private patient income	125	64
Agenda for Change pay award central funding*	-	2,223
Additional pension contribution central funding**	5,772	-
Other clinical income	1,731	647
Total income from activities	194,616	170,396

*Additional costs of the Agenda for Change pay reform in 2018/19 received central funding. From 2019/20 this funding is incorporated into tariff for individual services.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

	2019/20	2018/19
	£000	£000
Income from patient care activities received from:		
NHS England	22,993	13,938
Clinical commissioning groups	170,592	153,463
Department of Health and Social Care	9	2,223
Other NHS providers	122	10
NHS other	31	-
Non-NHS: private patients	125	64
Non-NHS: overseas patients (chargeable to patient)	53	24
Injury cost recovery scheme	424	647
Non NHS: other	267	27
Total income from activities	194,616	170,396
Of which:		
Related to continuing operations	194,616	170,396

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2019/20	2018/19
	£000	£000
Income recognised this year	53	24
Cash payments received in-year	127	24
Amounts written off in-year	89	6

Note 3.4 Other operating income	2019/20			2018/19		
	Contract	Non-	Total	Contract	Non-	Total
	income	contract		income	contract	
	£000	£000	£000	£000	£000	£000
Research and development	544	-	544	635	-	635
Education and training	6,622	468	7,090	6,288	-	6,288
Non-patient care services to other bodies	4,937	-	4,937	4,154	-	4,154
Provider sustainability fund (PSF)	5,084	-	5,084	1,221	155	1,221
Financial recovery fund (FRF)	17,083	-	17,083	-	-	-
Marginal rate emergency tariff funding (MRET)	3,533	-	3,533	-	-	-
Receipt of capital grants and donations	-	142	142	-	155	155
Other income	6,333	13	6,346	5,761	-	5,761
Total other operating income	44,136	623	44,759	18,059	310	18,214
Of which:						
Related to continuing operations			44,759			18,214

****Analysis of other operating income: Other**

	2019/20	2018/19
	£000	£000
Car Parking income	1,753	1,658
Catering	653	664
Pharmacy sales	71	49
Property rental (not lease income)	505	394
Staff accommodation rental	12	12
Estates recharges (external)	289	363
IT recharges (external)	2	46
Staff contribution to employee benefit schemes	17	20
Clinical tests	2,586	2,361
Clinical excellence awards	215	194
Other income generation schemes	235	-
Other income not already covered	(5)	-
	6,333	5,761

Note 3.5 Additional information on contract revenue (IFRS 15) recognised in the period

	2019/20	2018/19
	£000	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	-	5

Note 3.6 Transaction price allocated to remaining performance obligations

	31 March 2020	31 March 2019
	£000	£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

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 4 Operating Expenses

Note 4.1 Operating expenses

	2019/20	2018/19
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	6,028	5,663
Purchase of healthcare from non-NHS and non-DHSC bodies	2,501	3,199
Staff and executive directors' costs	164,861	152,582
Remuneration of non-executive directors	135	122
Supplies and services - clinical (excluding drugs costs)	15,071	14,861
Supplies and services - general	2,996	3,138
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	18,873	16,739
Inventories written down	-	91
Consultancy costs	678	766
Establishment	2,617	2,115
Premises	6,138	6,272
Transport (including patient travel)	932	1,047
Depreciation on property, plant and equipment	6,321	6,686
Amortisation on intangible assets	122	123
Movement in credit loss allowance: contract receivables / contract assets	(404)	287
Increase/(decrease) in other provisions	160	-
Change in provisions discount rate(s)	12	10
Audit fees payable to the external auditor		
audit services- statutory audit	61	55
other auditor remuneration (external auditor only)	8	9
Internal audit costs	127	110
Clinical negligence	5,212	5,759
Legal fees	109	-
Insurance	94	111
Education and training	1,268	464
Rentals under operating leases	496	548
Car parking & security	37	49
Hospitality	22	44
Losses, ex gratia & special payments	289	6
Other services, e.g. external payroll	-	84
Other	2,378	1,726
Total	237,142	222,666
Of which:		
Related to continuing operations	237,142	222,666

In addition, the external auditor audits the Queen Elizabeth Hospital Charitable Fund and the fee is £5,820 (2018/19 £5,820), the charity is responsible for the payment of this fee.

Note 4.2 Other auditor remuneration

	2019/20	2018/19
	£000	£000
Other auditor remuneration paid to the external auditor:		
Audit-related assurance services	8	9
Total	8	9

Note 4.3 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1m (2018/19: £1m).

Note 5 Employee benefits

	2019/20	2018/19
	Total	Total
	£000	£000
Salaries and wages	118,535	112,634
Social security costs	11,441	11,192
Apprenticeship levy	592	539
Employer's contributions to NHS pensions	18,993	12,437
Temporary staff (including agency)	15,690	16,037
Total staff costs	165,251	152,839
Of which		
Costs capitalised as part of assets	390	251

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:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2020 is based on valuation data as 31 March 2018, updated to 31 March 2020 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The employer contribution rate for 2019/20 is 20.6%. (2018/19: 14.38%)

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 7 Operating Leases

This note discloses costs and commitments incurred in operating lease arrangements where the Trust is the lessee, on leases classified as other.

	2019/20 £000	2018/19 £000
Operating lease expense		
Minimum lease payments	496	548
Contingent rents	-	-
Total	496	548
	31 March 2020 £000	31 March 2019 £000
Future minimum lease payments due:		
- not later than one year;	357	138
- later than one year and not later than five years;	571	502
- later than five years.	-	125
Total	928	765
Future minimum sublease payments to be received	-	-

Note 8 Finance

Note 8.1 Finance income

Finance income represents interest received on assets and investments in the period.

	2019/20	2018/19
	£000	£000
Interest on bank accounts	70	45
Total finance income	70	45

Note 8.2 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2019/20	2018/19
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	2,316	1,798
Finance leases	-	2
Total interest expense	2,316	1,800
Unwinding of discount on provisions	(1)	1
Other finance costs	1	11
Total finance costs	2,316	1,812

Note 8.3 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

No interest was incurred in either 2019/20 or 2018/19 in respect of late payment of commercial debts

Note 9 Other Gains/(losses)

	2019/20	2018/19
	£000	£000
Gains on disposal of assets	-	5
Losses on disposal of assets	(12)	(10)
Total losses on disposal of assets	(12)	(5)

Note 10 Intangible Assets

Note 10.1 Intangible assets - 2019/20

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2019 - brought forward	951	951
Additions - purchased / internally generated	28	28
Additions - donations of physical assets (non-cash)	16	16
Valuation / gross cost at 31 March 2020	995	995
Amortisation at 1 April 2019 - brought forward	448	448
Provided during the year	122	122
Amortisation at 31 March 2020	570	570
Net book value at 31 March 2020	425	425
Net book value at 1 April 2019	503	503

Note 10.2 Intangible assets - 2018/19

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2018	930	930
Additions	21	21
Valuation / gross cost at 31 March 2019	951	951
Amortisation at 1 April 2018	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 11 Property, plant and equipment

Note 11.1 Property, plant and equipment - 2019/20

	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2019 - brought forward	4,610	74,631	-	2,897	31,022	177	18,590	679	132,606
Additions	-	2,286	-	12,307	1,225	-	1,574	-	17,392
Impairments	-	-	-	-	-	-	-	-	-
Revaluations	-	850	-	-	-	-	-	-	850
Reclassifications	-	79	-	(108)	-	-	29	-	-
Disposals / de-recognition	-	-	-	-	(184)	(19)	-	-	(203)
Valuation/gross cost at 31 March 2020	4,610	77,846	-	15,096	32,063	158	20,193	679	150,645
Accumulated depreciation at 1 April 2019 - brought forward	-	15,230	-	-	19,640	168	13,700	543	49,281
Provided during the year	-	2,865	-	-	1,989	4	1,449	14	6,321
Disposals / de-recognition	-	-	-	-	(170)	(19)	-	-	(189)
Accumulated depreciation at 31 March 2020	-	18,095	-	-	21,459	153	15,149	557	55,413
Net book value at 31 March 2020	4,610	59,751	-	15,096	10,604	5	5,044	122	95,232
Net book value at 1 April 2019	4,610	59,401	-	2,897	11,382	9	4,890	136	83,325

Note 11.2 Property, plant and equipment - 2018/19

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2018 - as previously stated	4,610	73,099	2,461	29,062	177	18,001	679	128,089
Valuation / gross cost at 1 April 2018 - restated	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
Accumulated depreciation at 1 April 2018	-	12,009	-	18,006	163	12,207	524	42,909
Provided during the year	-	3,221	-	1,948	5	1,493	19	6,686
Disposals / de-recognition	-	-	-	(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 11.3 Property, plant and equipment financing - 2019/20

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2020								
Owned - purchased	4,610	55,768	15,096	10,104	5	5,009	109	90,701
Owned - donated	-	3,983	-	500	-	35	13	4,531
NBV total at 31 March 2020	4,610	59,751	15,096	10,604	5	5,044	122	95,232

Note 11.4 Property, plant and equipment financing - 2018/19

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £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 11.5 Donations of property, plant and equipment

	2019/20 £000
Medical equipment	126
Software	16
	<u>142</u>

Note 12 Inventories

	31 March 2020 £000	31 March 2019 £000
Drugs	870	741
Consumables	1,273	1,340
Energy	13	21
Total inventories	<u><u>2,156</u></u>	<u><u>2,102</u></u>
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £32,295k (2018/19: £30,070k). Write-down of inventories recognised as expenses for the year were £75k (2018/19: £91k).

Note 13 Trade Receivables

Note 13.1 Receivables

	31 March 2020 £000	31 March 2019 £000
Current		
Contract receivables	19,402	13,049
Allowance for impaired contract receivables / assets	(653)	(1,298)
Prepayments (non-PFI)	2,110	1,363
VAT receivable	613	170
Other receivables	551	651
Total current receivables	<u><u>22,023</u></u>	<u><u>13,935</u></u>
Non-current		
Contract receivables	487	658
Other receivables	-	386
Total non-current receivables	<u><u>487</u></u>	<u><u>1,044</u></u>
Of which receivable from NHS and DHSC group bodies:		
Current	17,983	12,488

The increase in contract receivables is due to the increase in Profitability Sustainability Funding and Financial Recovery Funding from £1.2m in 2018/19 to £8.2m in 2019/20. Prepayments have increased due to the employment of 157 overseas nurses with consequent prepaid three-year visas.

Note 13.2 Allowances for credit losses

	2019/20	2018/19
	Contract receivables and contract assets £000	Contract receivables and contract assets £000
Allowances as at 1 April - brought forward	1,298	-
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018		1,011
New allowances arising	109	287
Reversals of allowances	(513)	-
Utilisation of allowances (write offs)	(241)	-
Allowances as at 31 Mar 2020	653	1,298

Note 14 Cash and cash equivalents

Note 14.1 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.

	2019/20	2018/19
	£000	£000
At 1 April	4,402	5,633
Transfers by absorption	-	-
Net change in year	9,814	(1,231)
At 31 March	14,216	4,402
Broken down into:		
Cash at commercial banks and in hand	23	29
Cash with the Government Banking Service	14,193	4,373
Total cash and cash equivalents as in SoFP & SoCF	14,216	4,402

Note 14.2 Third party assets held by the Trust

The Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the Trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March	31 March
	2020	2019
	£000	£000
Bank balances	1	-
Total third-party assets	1	-

Note 15 Trade and other payables

	31 March 2020 £000	31 March 2019 £000
Current		
Trade payables	9,868	6,843
Capital payables	8,556	1,107
Accruals	8,664	11,923
Social security costs	1,733	1,599
Other taxes payable	1,524	1,421
Other payables	1,903	1,715
Total current trade and other payables	32,248	24,608

Note 16 Other liabilities

	31 March 2020 £000	31 March 2019 £000
Current		
Deferred income: contract liabilities	1,516	604
Total other current liabilities	1,516	604
Non-current		
Deferred income: contract liabilities	523	533
Total other non-current liabilities	523	533

Note 17 Borrowings

Note 17.1 Borrowings

	31 March 2020 £000	31 March 2019 £000
Current		
Loans from DHSC	134,969	42,169
Total current borrowings	134,969	42,169
Non-current		
Loans from DHSC	213	78,067
Total non-current borrowings	213	78,067

Note 17.2 Reconciliation of liabilities arising from financing activities - 2019/20

	Loans from DHSC	Finance leases	Total
	£000	£000	£000
Carrying value at 1 April 2019	120,236	-	120,236
Cash movements:			
Financing cash flows - payments and receipts of principal	14,901	-	14,901
Financing cash flows - payments of interest	(2,271)	-	(2,271)
Non-cash movements:			
Application of effective interest rate	2,316	-	2,316
Carrying value at 31 March 2020	135,182	-	135,182

Note 17.3 Reconciliation of liabilities arising from financing activities - 2018/19

	Loans from DHSC	Finance leases	Total
	£000	£000	£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 17.4 Analysis of Loans with Department of Health and Social Care

The Trust has 30 loans outstanding with the DHSC, the details of which are contained in the table below

	Loan Value £000	Expiring
Normal Capital Investment Loan	150	2020/21
Normal Capital Investment Loan	634	2021/22
Interim Capital Loan x 3	14,118	**
Interim Revenue Loan x 24	102,413	**
Revolving working capital facilities x 1	17,630	**
	<u>134,945</u>	

**On 2 April 2020, the DHSC, NHS England and NHS Improvement announced reforms to the NHS cash regime for the 2020/21 financial year. During 2020/21 existing DHSC interim revenue and capital loans as at 31 March 2020 will be extinguished and replaced with the issue of PDC to allow the repayment. The affected loans totalling £134,161k loan principal is classified as current liabilities within these financial statements. As the repayment of these loans will be funded through the issue of PDC, this does not present a going concern risk for the Trust.

Note 18 Provisions for liabilities and charges

Note 18.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs £000	Pensions: injury benefits £000	Other £000	Total £000
At 1 April 2019	91	168	103	362
Change in the discount rate	3	9	-	12
Arising during the year	2	20	138	160
Utilised during the year	(15)	(16)	(9)	(40)
Unwinding of discount	-	(1)	-	(1)
At 31 March 2020	<u>81</u>	<u>180</u>	<u>232</u>	<u>493</u>
Expected timing of cash flows:				
- not later than one year;	15	15	232	262
- later than one year and not later than five years;	46	63	-	109
- later than five years.	20	102	-	122

Total	81	180	232	493
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Note 18.2 Clinical negligence liabilities

At 31 March 2020, £119.6m was included in provisions of NHS Resolution in respect of clinical negligence liabilities of the Trust (31 March 2019: £94.7m).

Note 19 Contractual capital commitments

	31 March 2020 £000	31 March 2019 £000
Property, plant and equipment	1,068	817
Intangible assets	-	-
Total	1,068	817

Note 20 Financial instruments

Note 20.1 Carrying values of financial assets

	Held at amortised cost £000	Total book value £000
Carrying values of financial assets as at 31 March 2020		
Trade and other receivables excluding non-financial assets	19,581	19,581
Cash and cash equivalents	14,216	14,216
Total at 31 March 2020	33,797	33,797

	Held at amortised cost £000	Total book value £000
Carrying values of financial assets as at 31 March 2019		
Trade and other receivables excluding non-financial assets	12,159	12,159
Cash and cash equivalents	4,402	4,402
Total at 31 March 2019	16,561	16,561

Note 20.2 Carrying values of financial liabilities

	Held at amortised cost £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2020		
Loans from the Department of Health and Social Care	135,182	135,182
Trade and other payables excluding non-financial liabilities	27,649	27,649
Total at 31 March 2020	162,831	162,831

Carrying values of financial liabilities as at 31 March 2019	Held at amortised cost £000	Total book value £000
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

Note 20.3 Maturity of financial liabilities

	31 March 2020 £000	31 March 2019 £000
In one year or less	162,618	61,210
In more than one year but not more than two years	213	35,533
In more than two years but not more than five years	-	39,560
In more than five years	-	2,974
Total	162,831	139,277

The maturity profile has changed due to the DHSC reforms with respect to interim revenue and capital loans detailed in note 19.4 above.

Note 21 Losses and special payments

	2019/20		2018/19	
	Total number of cases Number	Total Value of cases £'0000	Total number of cases Number	Total Value of cases £'0000
Losses				
Cash Losses	1	0	3	0
Fruitless Payments	18	75	12	115
Bad debts and claims abandoned	24	96	122	15
TOTAL LOSSES	43	171	137	130
Special Payments				
Compensation under court order or legally binding arbitration award	0	0	0	0
Ex-gratia Payments	19	105	24	54
TOTAL SPECIAL PAYMENTS	19	105	24	54
GRAND TOTAL	62	276	GRAND TOTAL	161
Compensation payments received		57		

Note 22 Revaluation Reserve

		31-Mar-20		31-Mar-19	
	Land	Buildings	Total		
	£000	£000	£000	£000	£000
Revaluation Reserve at April 1	2,330	9,283	11,614	11,614	
Transfer	(1,414)	1,414	-		
Impairments	-		-	-	
Revaluation Gains	-	850	850	-	
	916	11,547	12,464	11,614	

Note 23 Contingent Liabilities

The trust has a contingent liability in relation to the Flowers versus East of England Ambulance case, in relation to costs of overtime being taken into account in the calculation of the holiday pay. This has not been provided for on the basis that the case is being appealed.

Note 24 Related Parties

	Receivables		Payables	
	31-Mar-20	31-Mar-19	31-Mar-20	31-Mar-19
	£000	£000	£000	£000
Other NHS Bodies	15,707	12,488	4,757	4,440
Other Government Bodies including Local Authorities	667	231	5,107	3,086
Department of Health and Social Care	-	-	-	-
Charitable Funds	16	15	-	-
	16,390	12,734	9,864	7,526
	Income		Expenditure	
	2019-20	2018-19	2019-20	2018-19
	£000	£000	£000	£000
Other NHS Bodies	224,574	181,010	13,610	14,049
Other Government Bodies including Local Authorities	117	43	32,015	25,051
Department of Health and Social Care	46	2,243	-	-
Charitable Funds	159	303	-	-
	224,896	183,599	45,625	39,100

List of Related Parties:

Department of Health and Social Care
HM Revenue & Customs
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 Resolution
Health Education England
Cambridgeshire University Hospitals NHS Foundation Trust
Cambridgeshire Community Services NHS Trust
Cambridge & Peterborough NHS Foundation Trust
Norfolk and Norwich University Hospital NHS Foundation Trust
North West Anglia 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 £159,314 (£303,213 2018/19), as disclosed above, from The Queen Elizabeth Hospital King's Lynn 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 25 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 Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the Trust is not exposed to the degree of financial risk faced by business entities. Also, financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the Trusts internal Auditor's.

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 2020 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 Clinical Commissioning Groups, 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 risk.

Note 26 Events after balance sheet date

There have been no material post balance sheet events. The impacts of COVID-19 are discussed in the annual report (Page 18) and also in the basis of preparation in Note 1.2

Glossary of clinical and NHS terminology

A

Accountability – the requirement for organisations to report and explain their performance.

Acute – describes a disease of rapid onset, severe symptoms and brief duration. The majority of hospital services provided by QEH are for acute illnesses.

Admission – the point at which a person enters hospital as a patient.

Agency staff – staff working at QEH but employed by a private recruitment agency.

B

Bank staff – staff who are available for short-term or flexible work to help manage vacancies more effectively.

Best practice – a way of working that is officially accepted as being the best to use.

C

Caldicott Guardian – a senior person responsible for protecting the confidentiality of patient and service-user information and enabling appropriate information-sharing. Each NHS organisation is required to have a Caldicott Guardian.

Capital expenditure – the money allocated for buildings, equipment or land, also known as fixed assets.

Care Quality Commission (CQC) – the independent regulator of health and social care in England. The CQC regulates care provided by the NHS, local authorities, private companies and voluntary organisations.

Clinical Commissioning Groups (CCGs) – the NHS organisations responsible for planning and funding the majority of healthcare.

Clinical outcomes – the end result of a medical intervention, such as survival or improved health.

Clostridium difficile (C. diff) – a healthcare-associated intestinal infection that mostly affects elderly patients with other underlying diseases.

Commissioning – the process of identifying the needs of local people and funding services to meet those needs; commissioning is done at a number of different levels in the NHS, but the majority of services patients receive are commissioned by the Clinical Commissioning Group for their local area.

Community care – long-term care for people who are mentally ill, elderly, or disabled which is provided in the patient's own home, in a residential or care home rather than in hospitals.

Commissioning for Quality and Innovation (CQUIN) – a system of reward payments made by commissioners to hospitals to encourage better experience, involvement and outcomes for patients.

D

Dementia – describes a set of symptoms that may include memory loss and difficulties with thinking, problem-solving or language. Dementia is caused when the brain is damaged by diseases, such as Alzheimer’s Disease or a series of strokes.

Discharge to assess – enabling patients to be assessed for their longer-term health and social care needs at home or in the community, rather than waiting for this to happen in hospital.

E

Early Warning Score (EWS) – a categorisation that uses data taken from routine patient observation to calculate a score indicating potential severity of illness and to act as a prompt to nursing staff to request a medical review at specific trigger points. (PEWS is a specific type of early warning score designed to assess children.)

Elective care – care that is planned. This is usually where the patient is referred by their GP or other healthcare professional. Appointments, treatments and admissions to hospital will be confirmed in advance.

Elective surgery – an operation that is planned ahead and for which the patient will be given a date to be admitted to hospital.

Emergency Department (ED) (also known as Accident and Emergency) – the department specialising in the care of patients with life-threatening or life-changing needs, which require immediate, specialist care.

Equality and diversity – equality is about creating a fairer society where everyone can fully take part. It means giving people an equal opportunity to have their individual needs considered and met, in recognition that society comprises different people with different needs at different times. Diversity is the positive recognition of difference.

End of life care – ensuring that the care people receive at the end of life is compassionate, appropriate, and gives people choices regarding where they die and how they are cared for. Care is co-ordinated across health and social care services.

E-observations – a digital system for recording vital signs of a patient (such as blood pressure, temperature and heart rate). Often using a mobile device to collect and store patient observations, creating a set of information that can assist in making clinical judgments. This can help indicate signs of deterioration, for example sepsis and acute kidney injury.

F

Financial control total – the maximum amount of deficit or surplus that an NHS organisation is required to achieve. This amount is set by NHS Improvement and agreed with each organisation, or as part of the wider health and care community.

First attendance – the first or only time a patient attends hospital after being referred by their GP or health professional.

Follow-up attendances – the second and subsequent times patients attend hospital for assessment, diagnosis or treatment as an outpatient.

Foundation Trust – see ‘NHS Foundation Trust’.

Friends and Family Test (FFT) – the national patient satisfaction programme which gives every patient the opportunity to feedback on the quality of their care.

Full-time equivalent (FTE) – the measurement and calculation of total staff numbers, using a standard working day. Also known as whole time equivalent (WTE).

G

Getting It Right First Time (GIRFT) – the Getting It Right First Time (GIRFT) programme aims to bring about higher-quality care in hospitals, at lower cost, by reducing unwanted variations in services and practices

H

Health Scrutiny Committee/Overview and Scrutiny Committee – a function of local councils in England. The committee has the responsibility to review policies, decisions and services in their own council and in other organisations, including the NHS, which may impact on local residents.

Healthcare Assistant (HCA) – staff who work under the guidance of a qualified healthcare professional, usually a nurse. Sometimes staff working in HCA roles are known as nursing assistants, nursing auxiliaries or auxiliary nurses.

Healthwatch Norfolk/Peterborough – the local service affiliated to Healthwatch England, the national consumer champion in health and care. They have statutory powers to ensure the voice of the consumer is strengthened and heard by those who commission, deliver and regulate health and care services.

Hospital Standardised Mortality Rates (HSMR) – an indicator of healthcare quality that measures if the death rate at a hospital is higher or lower than you would expect. The HSMR compares the expected rate of death in a hospital with the actual rate of death. Factors such as age and severity of illness are taken into account.

I

Information Governance – the set of multi-disciplinary structures, policies, procedures, processes and controls implemented to manage information to ensure an organisation's regulatory, legal, risk, environmental and operational requirements.

Inpatient – a patient who is admitted to hospital for a period of treatment or to undergo an operation. Inpatients are those that stay in hospital for 24 hours or more.

Integrated Care System (ICS) – new developments in NHS care which bring together commissioners and healthcare providers to plan and deliver care without organisational and financial boundaries.

Integrated discharge – planning and managing a patient's discharge from hospital across all services and all part of the hospital.

Intervention – any measure to improve health or alter the course of disease.

L

Locum staff – nurses and doctors employed by the NHS on a temporary, fixed-term basis.

M

Methicillin Resistant Staphylococcus Aureus (MRSA) – is a type of bacteria that is resistant to a number of commonly used antibiotics. It lives on the skin and is mostly harmless unless it gets deeper into the body, for example, if it gets into a wound or where the skin is broken.

Model Hospital – a digital information service designed to help NHS providers improve their productivity and efficiency by comparing and benchmarking performance against peers/ other centres.

N

National emergency access standard – a national standard for all Emergency Departments/Accident and Emergency Departments. The standard measures the number of patients seen, admitted or discharged within four hours; hospitals are expected to achieve 95%. It is often known as the ‘four hour’ standard.

National Patient Survey – ensures patients and the public have a real say in how NHS services are planned and developed. Getting feedback from patients and listening to their views and priorities is vital for improving services. All NHS trusts in England are legally required to carry out local surveys asking patients their views on their recent health care experiences. There are inpatient, maternity and outpatient surveys.

Never events – serious, but largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

NHS Improvement – is responsible for overseeing NHS trusts, as well as independent providers that provide NHS-funded care. It has recently merged with NHS England and is often referred to as NHSE/I.

NHS Trust – a statutory, self-governing NHS organisation providing healthcare services. NHS trusts – and NHS Foundation trusts - provide the majority of hospital, mental health and ambulance services. Their income is derived from service agreements and contracts with clinical commissioning groups or, for some highly specialist services, NHS England. They have freedom to decide staff numbers and rates of pay and some powers to invest and borrow money.

Non-elective care – is provided when the patient is assessed as needing treatment or hospital admission urgently or in an emergency.

Non-Executive Director – a member of the Trust’s Board of Directors who is not part of the Executive Team. A Non-Executive Director typically does not engage in the day-to-day management but is involved in policy making and planning exercises. In the NHS Non-Executive Director appointments are managed by NHS Improvement. Non-Executive Directors have voting rights on the Board.

O

On-the-day cancellation – refers to a planned operation that is cancelled on the day the patient was due to arrive (at hospital), after the patient has arrived in hospital or on the day of the operation if the patient is already in hospital.

Overview and Scrutiny Committee – see Health Scrutiny Committee.

P

Palliative care – services for people living with a terminal illness where a cure is no longer possible. Palliative care aims to treat or manage pain and other physical symptoms. It will also help with any psychological, social or spiritual needs.

Parliamentary Health Service Ombudsman (PHSO) – the Ombudsman makes final decisions on complaints that have not been resolved by the NHS in England and UK government departments and other public organisations.

Pathway of care – the planned and most efficient way to provide care from referral to diagnosis, treatment and follow-up care. Pathways are in place for most common diseases and conditions, using evidence-based practice to determine the best way for patients to be seen and treated.

Patient Administration System (PAS) – computerised system to record non-medical patient details such as name and address as well as appointments/visits to the hospital.

Patient Advice and Liaison Service (PALS) – provides information, advice and support to help patients, families and their carers. **Patient experience** – the experience a patient has in our hospitals, whether as an inpatient or an outpatient. This includes not only the care received

Patient experience – how it feels to be an inpatient or an outpatient. This includes not only the care received, but also aspects such as the hospital facilities and the patient's comfort throughout their visit.

Patient flow – the different elements that make up a patient's progress through the hospital system from referral through to diagnosis, treatment and discharge. This includes all of the staff, departments and organisations who are involved in providing the end-to-end care.

Provider Sustainability Fund (PSF) – national bonus monies allocated to Trusts by quarter based on performance versus plan, including financial plan and emergency access performance. Previously called Sustainability and Transformation Fund.

Public Sector Equality Duty – the public sector's legal duty to eliminate discrimination, advance equal opportunities, and foster good relations, and publish data on progress.

Q

Quality Account – every NHS Trust is required to publish a Quality Account, setting out how we continue to improve the quality of services we provide covering three key areas: patient safety, clinical effectiveness and patient experience.

Quality assurance – the maintenance of a desired level of quality in a service or product, especially by means of attention to every stage of the process of delivery or production.

Quality Innovation, Productivity and Prevention (QIPP) – a large-scale programme to drive forward quality improvements in NHS care, at the same time as making healthcare more efficient.

Quality governance framework – a set of standards for trusts to continuously monitor themselves against.

R

Radiology – is the science that uses images to diagnose and, in some cases, treat diseases. It is a general term which covers X-ray, CT and MRI scans.

Re-admissions – the number of patients re-admitted as an emergency within either 7 or 28 days of being discharged following previous treatment.

Resilience – the ability of an organisation to adapt and respond to disruptions, whether internal or external, to deliver organisationally agreed critical activities.

Respiratory – the specialty which deals with illnesses and conditions affecting breathing.

Referral to Treatment (RTT) – national maximum waiting times set out in the NHS Constitution from the point a patient is referred to hospital by their GP.

S

Safety culture – the attitude, beliefs, perceptions and values that employees share in relation to safety in the workplace. Safety culture is part of organisational culture; a positive safety culture is a key part of improving the quality of care.

Staff engagement – encouraging 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.

Single Oversight Framework (SOF) – sets out how our regulator NHS Improvement oversee NHS Trusts and NHS foundation trusts, helping to determine the level of support they need based on a range of performance measures.

Sustainability and Transformation Partnership (STPs) – joint health and social care partnerships for improving the health of local people through joined-up working and the development of new models for providing services. There are 44 partnerships across England including the one for Norfolk and Waveney, which includes QEH.

Sustainability and Transformation Fund (STF) – a national budget to support the development of NHS services, set up in 2015. It is allocated to hospitals based on their achievement of a number of specific targets. Now called Provider and Sustainability fund. See Provider Sustainability Fund.

T

Tertiary care – there are three levels of healthcare in the NHS: primary care (the first point of contact for patients including GPs, dentists, pharmacists and opticians); secondary care (specialist services, often provided by a hospital, that patients are referred to from primary care); and tertiary care which is further specialised treatment and care provided by professionals with specific expertise in a given field, for example neurosurgery, cardiac surgery and cancer management.

Tertiary referrals – referrals for specialist care from consultant to consultant. These can be within the same hospital/service or between different hospitals and services.

V

VTE - Venous thromboembolism is a condition in which a blood clot forms, most often in the deep veins of the leg, groin or arm (known as deep vein thrombosis, DVT) and travels in the circulation, lodging in the lungs (known as pulmonary embolism).

W

Waiting times – the period that a patient may wait before being seen at a routine appointment or for admission to hospital. The standards and maximum waiting periods are set nationally under the NHS Constitution.