

## **MEETING OF THE TRUST BOARD IN PUBLIC** **WEDNESDAY 1 APRIL 2020**

A meeting of the Trust Board will take place at 9.30am on Wednesday 1 April 2020.

### **Due to the Covid 19 pandemic and associated government guidance:**

- members of public will not be admitted to the meeting but Board papers will be posted on the Trust's website and audio access to the meeting will be arranged, if possible;
- the meeting will not be preceded by the usual clinical and departmental visits;
- the meeting Agenda will be restricted to essential business only.

### **AGENDA**

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1	Apologies, Declarations of Interest and Chairman's Introduction	Chair	Information	
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3	Matters arising and update on actions	Chair	Discussion	10
4	Chief Executive's Report	CEO	Discussion	Verbal
5	Covid 19 Pandemic Response Update	CEO & Execs	Discussion	Verbal
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	(a) Integrated Performance Report Summary Overview			
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8	Feedback from Council of Governors	Chair	Information	Verbal
9	Any other business	Chair	Discussion	

### **Date and Time of next Board meeting in public**

The next Board meeting in public will be at 9.30am on Wednesday 3 June 2020 – details to be confirmed in light of prevailing Covid19 position and guidance

## **MINUTES OF TRUST BOARD MEETING IN PUBLIC**

**HELD ON 5 FEBRUARY 2020**

<b>Present:</b>	Mr D White	- Chairman
	Mr C Cobb	- Chief Operating Officer
	Professor E Denton	- Medical Director
	Ms S Dinneen	- Non-Executive Director
	Professor N Fontaine	- Chief Nurse
	Mr J Foster	- Non-Executive Director
	Mrs J Hannam	- Non-Executive Director
	Mr J Hennessey	- Chief Finance Officer
	Mr S Higginson	- Chief Executive
	Mr T How	- Non-Executive Director
	Mr P Jones	- Chief People Officer
	Professor D Richardson	- Non-Executive Director
<b>In attendance:</b>	Ms F Devine	- Director of Communications
	Mr J P Garside	- Board Secretary
	Mr S Hackwell	- Director of Strategy
	Mr A Lundrigan	- Chief Information Officer
	Ms V Rant	- Assistant to Board Secretary
	Members of the public and press	

### 20/001 **APOLOGIES, DECLARATIONS OF INTEREST AND CHAIRMAN'S INTRODUCTION**

Apologies were received from Dr Chrispin and Dr O'Sullivan.

No conflicts of Interest were declared in relation to matters for consideration by the Board.

Mr White welcomed Ms Dinneen and Mrs Hannam to their first meeting of the Board.

### 20/002 **PATIENT/FAMILY REFLECTIONS**

Ms Fiona Springall (Children and Young People's Learning Disability Specialist Nurse) and Ms Melanie Bruce (Norfolk Community Health & Care Trust Clinical Psychologist) attended the Board meeting to discuss the experience of Jack, an 11 year old patient with autism and learning disabilities.

Jack was required to attend the hospital for a non-urgent blood test. Jack's needs were very specific and a person centred approach was crucial to help him through the process. A series of desensitisation visits were undertaken to build Jack's confidence and to familiarise him with visiting the hospital, photos were provided of the environment on his iPad and a story board was developed to illustrate steps on the way.

Mr Hackwell asked the team if there were any improvements that could be made in strengthening our partnership working. Ms Springall indicated that the number of referrals has increased but there are disconnected electronic systems across organisations.

Mr White thanked the team for attending and emphasised the need to continue working with our external partners to improve working relations and communication between organisations.

20/003 **REFLECTIONS ON VISITS**

Mr White indicated that the Board visits were working well and are an important part of assurance triangulation for the Board. The visits also provide the Board with an opportunity to speak and listen to staff and patients across the organisation.

(a) Brundall Ward

Professor Richardson and Professor Denton visited Brundall Ward which specialises in the care of elderly orthopaedic patients and treatment of fractured neck of femur. A review of the pathway of care of these patients is underway to ensure that these patients are looked after on Brundall Ward or through an outreach service.

Staff indicated that the activity and pressure on the ward has been increasingly challenging for some time but there was a positive atmosphere. The flow of patients out of the ward can be less than optimal at times which does increase the pressure on the team.

(b) Easton/EAUS

Mr Foster, Mr Hennessey and Professor Fontaine visited Easton Ward (EAUS - Emergency Assessment Unit - Surgical).

The Ward sees around 60 to 85 patients on a daily basis. Some patients are seen and discharged on the same day and some are seen as inpatients. Flow through the unit is sometimes restricted which can impact on the flow of patients out of the Emergency Department. The team indicated that the flow of patients could be improved if they could integrate with the Same Day Admissions Unit.

The ward appeared to be operating well and the atmosphere was calm and controlled. The ward was fully staffed and performance in appraisals/mandatory training is good.

(c) NNUH Pathology

Mr How, Mr Higginson and Mr Hackwell visited the NNUH Pathology Laboratory. The team are working to install new equipment as part of a managed service. This will enhance specialist testing capability. The laboratory is challenged in being able to recruit biochemists and immunologists.

There is a need to review financial aspects of the Eastern Pathology Alliance agreement to ensure that the level of risk and reward is appropriate for the service being provided.

(d) Delivery Suite

Ms Dinneen, Mr Cobb and Mr Garside visited the Delivery Suite. The team were proud of the changes and improvements that they have made, notably a new bereavement suite facility and also revised triage and assessment facilities.

There were some IT issues identified, which should be reasonably easy to resolve. Ms Dinneen reflected that the theatres on the unit appeared to be under-utilised and asked if this capacity could be used by other specialties. Professor Fontaine explained that theatre capacity on the Delivery Suite is reserved for elective caesarean sections and a theatre has to remain on stand-by for emergency activity.

(e) Older People's Emergency Department

Mrs Hannam and Mr Jones attended OPED. The ward appeared clean and calm and liaison with the ambulance service and for discharge of patients is working well. There are challenges arising from the use of bays and waiting rooms being used for patients overnight.

The team indicated that space on the ward is at a premium and the layout could be reconfigured in order to assist flow. There is a desire to operate the department 7 days per week when there is sufficient consultant cover. Some patients at end of life are being transferred from care homes without advanced care plans. This is something that needs to be improved through action in the community. Mr Higginson recognised that there are patients that are coming to hospital at the end of their life that could be looked after in a more suitable environment in the community. Professor Fontaine reported that a course has been developed to assist people to have conversations with patients about their preferred plan of care at the end of their life. The course will be going live in March and will be available to care homes and GPs.

(f) Dermatology Outpatients

Mr White and Mr Lundrigan visited the Dermatology Outpatient department. The environment was clean and quiet. The team were working strongly together and were regularly sharing learning in order to improve their services. Some issues of concern were indicated relating to demand and capacity. The unit is currently fragmented with the service being provided in four location and consolidation of the service would assist improvements to be made.

The demand for dermatology services has grown and there is a need to work with external healthcare partners to look at alternative solutions. One of the Dermatologists is working with a GP practice to review processes for referral to the department and there will clearly be opportunities for transforming outpatient and follow-up services.

20/004 **MINUTES OF PREVIOUS MEETING HELD ON 29 NOVEMBER 2019**

The minutes of the meeting held on 29 November 2019 were agreed as a true record and signed by the Chairman.

20/005 **MATTERS ARISING AND UPDATE ON ACTIONS**

The Board reviewed the Action Points arising from its meeting held on 29 November 2019 as follows:

19/063(f) (Nov '19) Carried forward. Analysis of ED attendances - Mr White asked if it was possible for more in-depth analysis to be provided on patients attending the ED in order to determine if alternative pathways can be put in place to ease pressures. Mr Higginson indicated that it should be possible to provide a breakdown of adult, paediatric patients and the age range of patients attending the ED.

**Action: Mr Cobb/Mr Lundrigan**

19/063(f) (Nov '19) Carried forward. Theatre utilisation Mr How highlighted that data on Theatre Utilisation was not being included in the IPR and it was confirmed that this would be reintroduced to future reports.

**Action: Mr Lundrigan**

19/063(f) (Nov '19) A review of Theatre utilisation is on the agenda for the next Finance, Investments and Performance Committee on 26 February 2020. Action closed.

20/006 **CHIEF EXECUTIVE REPORT**

The Board received a report from Mr Higginson in relation to recent activity in the Trust since the last Board meeting and not covered elsewhere in the papers.



Mr Higginson expressed his gratitude to all our staff for the continued work to deliver services to patients during this challenging period.

A number of initiatives have been taken to aid Emergency Department (ED) performance and additional capacity has been created on Gissing Ward to facilitate patient flow. Performance against the ED target in January was 76% being a 7% improvement on December performance (69%).

87% of our frontline staff have been vaccinated for flu and we have the highest vaccination rate in the East of England.

The CQC has provided its initial feedback following the service inspection in December and Well-led Review in January. Staff were reported to have been enthusiastic, open and welcoming. The Well-led review found the Trust Board to be cohesive and found members to be speaking with one voice about the challenges faced by the Trust. It is anticipated that the final inspection report will be completed in March 2020.

Our forecast financial outturn for 2019/20 has been agreed with the regional team at £16m worse than Plan. The position has been driven by high numbers of non-elective patients which has in turn displaced our elective activity. Additional escalation beds have also been opened during the winter period and this has increased staffing costs.

An analysis of the Staff Survey results is underway. There is an indication that there is an improvement compared to the previous year. The national results are expected to be published in February.

Professor Fontaine reported that preparation work has been carried out in relation to Coronavirus, to ensure the Emergency Planning Tripartite pathways are in line with Public Health England (PHE) guidance. Patients returning from affected areas are being directed to self-isolate and to call the NHS 111 helpline if they are experiencing symptoms of a cough, fever or shortness of breath. Professor Denton confirmed that there have been no confirmed cases of the virus in Norfolk to date.

## 20/007 **REPORTS FOR INFORMATION AND ASSURANCE**

### (a) Integrated Performance Report Overview

The Board received and discussed the Integrated Performance Report (IPR) from the Executive Directors.

### (b) Quality and Safety Committee (28.01.20)

Mrs Hannam informed the Board that Committee members had visited Buxton Ward and Gissing Ward on 28 January 2020 as the clinical visit part of its meeting. The Committee was assured that people are being appropriately treated in the escalation pathway on Gissing Ward. Mrs Hannam expressed surprise that the hospital has only one paediatric ward. The team on Buxton were impressive but are challenged by the complicated mix of patients on the ward.

Mr Higginson highlighted that the Estates Strategy includes options to increase capacity for our paediatric patients and also parents' accommodation. The Committee received an update from Mr Cobb concerning the use of escalation areas and plans for opening the new ward block.

Mrs Hannam reported that Committee members had been assured by the work to improve processes for reporting and learning from incidents. The Committee heard that patients are being increasingly involved in order to improve the quality of our services.

The Committee reviewed the draft Research Strategy and recommends it for approval.

(c) IPR – Quality, Safety and Patient Experience

Professor Denton reported that the HSMR is lower than the expected rate, at 86.9. The SHMI has increased to 111 and a cohort review of 50 patient records is underway to determine why the gap is widening between the HSMR and SHMI. The review is being undertaken in collaboration with our commissioners and community care colleagues to look at cases across all organisations.

Professor Fontaine reported that we continue to perform well against infection, prevention and control metrics. The number of reported incidents is high but most are reported as causing no or low harm to patients. The number of pressure ulcers per 1,000 bed days is low at 0.8 but the number of patients admitted from eh community with pressure ulcers continues to be an issue.

The number of falls per 1,000 bed days is 0.1. Although the number is lower than the national average we will be implementing a quality improvement programme to look at reducing the number further.

We continue to score well in the Friends and Family Test at 94% for December 2019. The themes of concerns raised through our Patient Advice and Liaison Service are around appointments and cancellations of outpatient appointments. The number of compliments submitted is increasing and we have introduced 'compliment of the week' to promote demonstrations of good working practice across the organisation.

Non-Executives noted that the maternity data is no longer included in the IPR and requested for this to be reintroduced. **Action: Professor Fontaine**

Ms Dinneen noted that mortality data was for August 2019 and asked about the time lag in reporting of mortality rates. Professor Denton explained that there is always a time-lag in this national data being published as it goes through a process of collation and analysis. We review the data that is submitted in order to identify outlying areas, so that any issues can be addressed while we wait for the national data to be published.

Professor Fontaine reported that the number of whistle blowing concerns raised with the regulators has fallen. The Serious Incident Group meetings provide staff with an opportunity to discuss fears or concerns openly and we have received positive feedback about this process. The staff survey also indicates an improvement in staff feeling that they can raise concerns.

Professor Denton indicated that it has been reassuring to find that the number of staff raising concerns, or suggesting changes or sharing learning has increased. We welcome feedback from our staff and issues/concerns raised by staff are taken seriously. An e-learning training module has been introduced to help staff to understand the Duty of Candour process and we are closely monitoring key performance indicators.

Mr White reflected on the improvements that have been made to Duty of Candour processes and to change cultures around staff raising concerns. Given adverse publicity from elsewhere, Mr White asked for specific reassurance that we do not take staff finger prints as part of our investigation processes and Mr Higginson confirmed that this is so; we encourage staff to raise concerns and protect the wellbeing of staff who do so.

(d) Finance, Investments and Performance Committee (20.01.20 & 29.01.20)

Mr How informed the Board that there has been a £16.2m deterioration in the financial position. The planned deficit was £20.7m but due to the loss of central funding, the Trust is projecting a revised deficit of £57.8m.

As we move into 2020/21, it is likely that financial support will be needed as the gap between current income assumptions and estimated cost pressures is significant.

The capital plan for 2020/21 is still in its early stages of development but aims to balance affordability with meeting our essential service developments and needs.

(e) IPR – Finance, Performance and Productivity

Mr Cobb reported that December had been challenging for Emergency Department (ED) performance with attendances averaging at 390 patients per day. GP streaming has helped to ease pressure in the ED and it is hoped that as this process embeds it will become a routine part of our ED service.

Bed occupancy remains high and we are frequently running at a 95% occupancy level and have more patients than we have capacity. We have managed to generate additional inpatient beds and performance was improved following the reconfiguration of beds.

Mr Cobb reported that the current footprint of our ED is not able to accommodate the growth in the number of attendances and the layout is also sub-optimal. Mr Higginson informed the Board that in light of continued growth in attendances, plans are being developed for redesign and redevelopment of the ED and this plan has the support of local MPs. Mr Hackwell informed the Board that a team is being established to develop the Business Case for expansion/reconfiguration of the ED. We are hoping to develop a Strategic Outline Business Case within the next few months.

Mr Cobb reported that the number of cancelled operations has been high due to high levels of bed demand for non-elective patients. It is going to be challenging to achieve the requirement to have no patients waiting longer than 52 weeks on the RTT pathway by the end of March 2020.

(f) People and Culture Committee (29.01.20)

Professor Richardson informed the Board that the CQC inspectors had been interested to learn about the work of the People and Culture Committee. There is positive indication that improvements are happening and this is evidenced in the improved staff survey results. Work continues to identify areas to target for improvement actions. There is more work to be undertaken to address diversity and BAME representation at all levels within the organisation.

Professor Richardson informed the Board that whilst there were four NEDs in attendance at the meeting it had not been well attended by executive or divisional representatives. Discussion at the meeting had been useful but increased attendance by the Executives and divisional representatives will be essential if the Committee is to realise its full potential. The Board needs to monitor this.

Mr White asked about progress for organisational development and leadership programmes. Mr Jones explained that a training needs analysis is underway to engage with staff at all levels to understand requirements.

The Workforce and Education Strategy needs reviewing and this will be considered by the Committee prior to review by the Board.

(g) IPR - Workforce

Mr Jones reported that there has been positive improvement in a number of key areas of focus including line management and diversity. This suggests that we are moving in the right direction but there is further improvement that can be made.

Mr Jones reported that there has been a 7% growth in staff which has increased our workforce costs. Work is ongoing to address premium pay costs. Registered nurse vacancies have decreased to 11%.

Mandatory training compliance has improved but there is still further work to be undertaken to reach the 90% target. Women & Children, Clinical Support Services and Corporate Services have achieved 90% compliance and an improvement plan is in place for the remaining divisions.

Appraisal compliance has improved compared to 2018 but there is further work in order to achieve the 90% target. Work has been underway to improve effectiveness of appraisals and a deep dive exercise is underway to look at the barriers to improvement.

(h) Updated draft Terms of Reference

The Board **approved** the updated Terms of Reference for its People and Culture Committee.

20/008 **DRAFT RESEARCH STRATEGY (BAF 3.3)**

The Board received a report from Professor Denton concerning the 2020-2025 Research Strategy. This is a significant step towards achieving our Strategic Goal 3 and enhancing the Trust's position as a research organisation. The Strategy has been reviewed by the Quality & Safety Committee and is recommended for approval.

Non-Executives enquired about the criteria for selecting areas of research and the level of investment that is required for research studies. Professor Denton explained that there are a number of considerations that influence the choice of areas of research including financial viability, specialty interests, availability of funding/research grants and population needs. Research is funded through NIHR grants, commercial funding and charitable funding.

Professor Denton explained that there is robust evidence of better outcomes and quality of care in research active organisations. It is hoped to 'pump prime' targeted areas and charitable funding has been awarded to support research related to frailty and the older population.

Professor Denton explained that there will be an annual plan for delivery of objectives but there is more work needed to define the timelines and metrics to measure progress. This will be overseen by the Quality and Safety Committee.

The Board **approved** the Research Strategy for 2020-2025.

20/009 **QUESTIONS FROM MEMBERS OF THE PUBLIC**

Questions were raised with regard to communication concerning the arrangements for patients with coronavirus. Public Health (England) have requested that any public announcements should be channelled through them, to ensure consistency and clarity of messaging.

20/010 **ANY OTHER BUSINESS**

There was no other business.

20/011 **DATE AND TIME OF NEXT MEETING**

The next meeting of the Trust Board in public will be held on Wednesday 1 April 2020  
– with details to be confirmed depending on the coronavirus situation and guidance.

Signed by the Chairman: ..... Date: .....

**Decisions taken:**

	<b>Decision</b>
20/007	The Board <b>approved</b> the updated Terms of Reference for its People and Culture Committee.
20/008	The Board <b>approved</b> the Research Strategy for 2020-2025.

**Action Points Arising:**

	<b>Action</b>
19/063(f) (Nov '19) Analysis of ED attendances	Mr White asked if it was possible for more in-depth analysis to be provided on patients attending the ED in order to determine if alternative pathways can be put in place to ease pressures. Mr Higginson indicated that it should be possible to provide a breakdown of adult, paediatric patients and the age range of patients attending the ED. <b>Action: Mr Cobb/Mr Lundrigan</b>
19/063(f) (Nov '19) Theatre utilisation data in IPR	Theatre utilisation Mr How highlighted that data on Theatre Utilisation was not being included in the IPR and it was confirmed that this would be reintroduced to future reports. <b>Action: Mr Lundrigan</b>
20/007 (Feb '20) Maternity data in IPR	Non-Executives noted that the maternity data is no longer included in the IPR and requested for this to be reintroduced. <b>Action: Professor Fontaine</b>

## Action Points Arising from Trust Board meeting (public) – 5 February 2020

Item	Action	Update – March 2020
20/005 (Nov '19) Analysis of ED attendance	Mr White asked if it was possible for more in-depth analysis to be provided on patients attending the ED in order to determine if alternative pathways can be put in place to ease pressures. Mr Cobb confirmed that reporting is available which would provide a breakdown and confirmed that this could be included in future IPRs. Mr Higginson indicated that it should be possible to provide a breakdown of adult, paediatric patients and the age range of patients attending the ED. <b>Action: Mr Cobb/Mr Lundrigan</b>	Demographic data showing patients coming to ED – <b>attached</b> . Action closed.
20/005 (Nov '19) Theatre Utilisation data in IPR	Theatre utilisation Mr How highlighted that data on Theatre Utilisation was not being included in the IPR and it was confirmed that this would be reintroduced to future reports. <b>Action: Mr Lundrigan</b>	Theatre utilisation slide reintroduced to IPR. IPR reporting to Board to be reviewed as part of 20/21 Board development programme. Theatre Utilisation metrics to be reviewed by FI&P Committee – scheduled for June 2020. Action closed.
20/007 (Feb '20) Maternity data in IPR	Non-Executives noted that the maternity data is no longer included in the IPR and requested for this to be reintroduced.	Maternity dashboards included in IPR. Action closed.

JPG 27 March '20

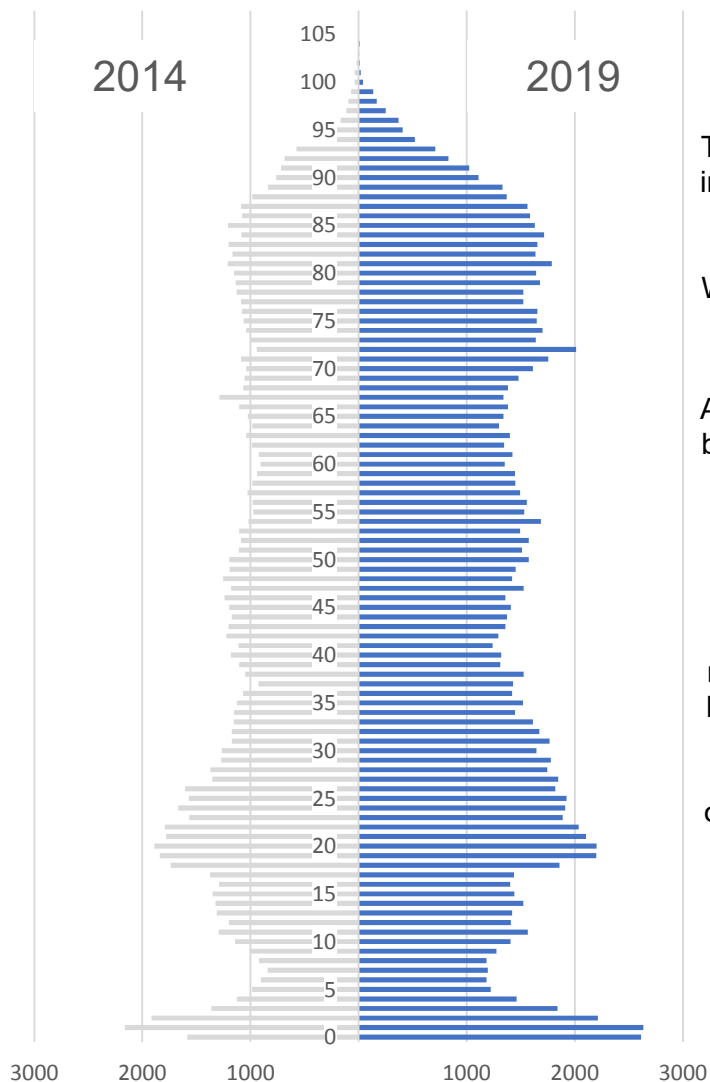


## Our Vision

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

## Age Profiles of Patients attending A&E & MIU

### Over Time

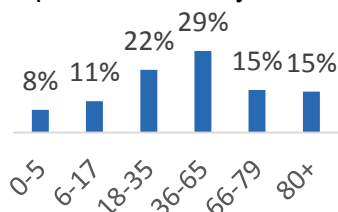


Whilst overall volumes of A&E activity have increased, age distribution has not changed significantly in the last 5 years.

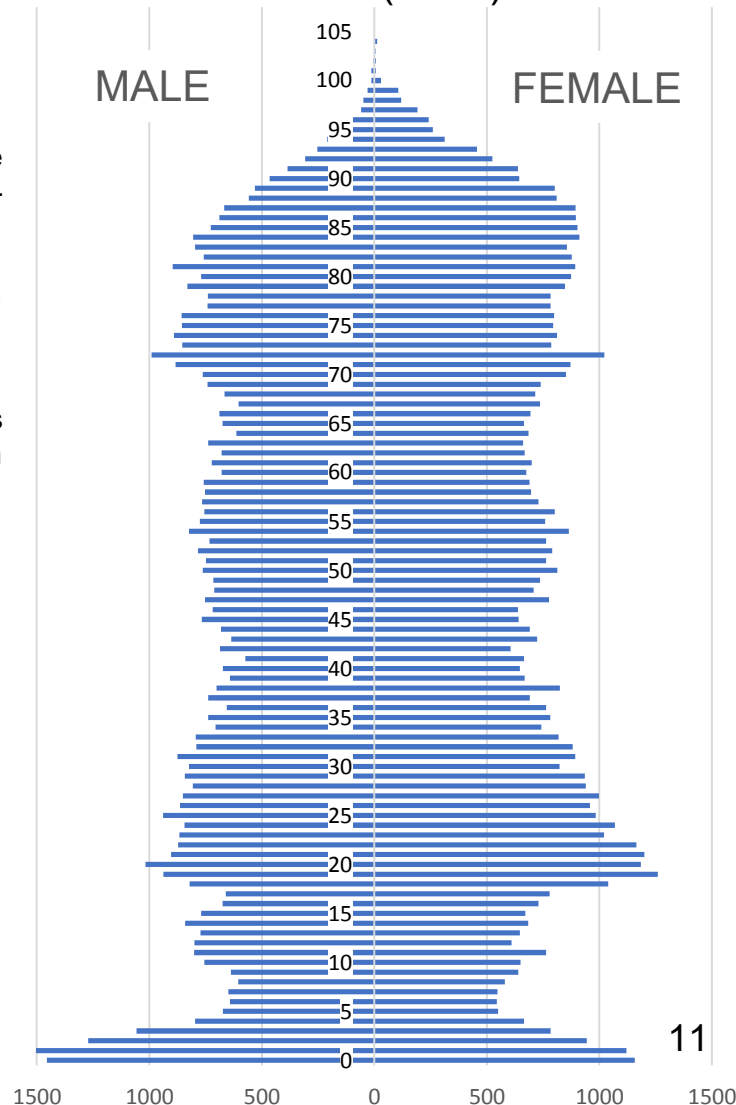
The exception is a noticeable increase in the number of 70-75 year olds attending A&E (see left). The post-World War 2 baby boom generation turned 70 in 2016 and their high survival rate is evident.

Across gender, A&E usage is broadly consistent apart from some asymmetry in the 0-5, 19-25 and 85+ age groups.

What is clear from both charts is that there are age groups which attend A&E more frequently than others. In order to better understand these groups, we have chosen six age-bands in order to provide comparative profiles for analysis:



### Gender (2019)





## Our Vision

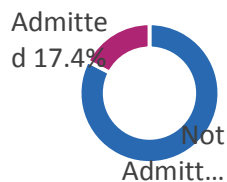
To provide every patient  
with the care we want  
for those we love the most

# Norfolk and Norwich University Hospitals



NHS Foundation Trust

## 0-5



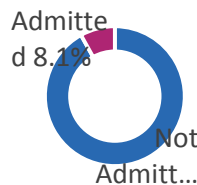
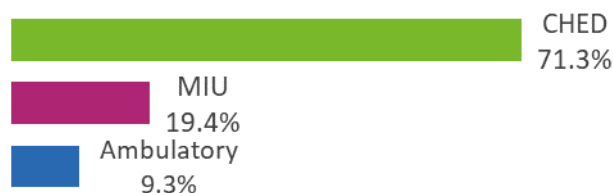
### Top Five Presenting Complaints (% of Total)

- 1) Fever (12.4%)
- 2) Head injury (11.9%)
- 3) Short of breath (7.7%)
- 4) Injury of shoulder / arm / elbow / wrist / hand (7.2%)
- 5) Difficulty breathing (6.2%)

### Summary

Fever or respiratory issues prevalent.  
More likely to be admitted than 6-17 year olds.  
Use of specialist service (CHED).  
Highest proportion streamed to Resus (1.7%)

## 6-17



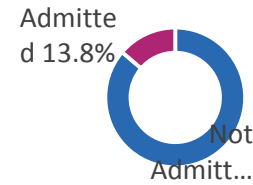
### Top Five Presenting Complaints (% of Total)

- 1) Injury of shoulder / arm / elbow / wrist / hand (25.0%)
- 2) Injury of hip / leg / knee / ankle / foot (16.3%)
- 3) Head injury (6.0%)
- 4) Abdominal pain (5.1%)
- 5) Pain in hip / leg / knee / ankle / foot (4.9%)

### Summary

Injuries extremely common (nearly one in two).  
High use of specialist service (CHED) and local service (MIU – one in five).  
Rarely admitted (less than 1 in ten).

## 18-35



### Top Five Presenting Complaints (% of Total)

- 1) Abdominal pain (10.0%)
- 2) Injury of shoulder / arm / elbow / wrist / hand (8.6%)
- 3) Injury of hip / leg / knee / ankle / foot (8.3%)
- 4) Chest pain (5.9%)
- 5) Not Recorded (5.5%)

### Summary

Rarely admitted. More likely to be ambulatory than acute.  
No specialised service. Non-specific symptoms and injuries prevalent.





## Our Vision

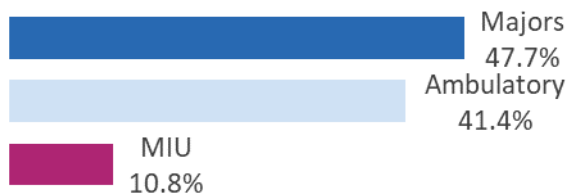
To provide every patient  
with the care we want  
for those we love the most

# Norfolk and Norwich University Hospitals



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## 36-65



Admitted 20.8%



Not Admitted

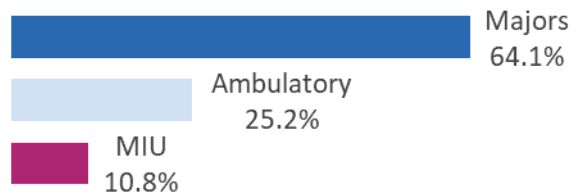
### Top Five Presenting Complaints (% of Total)

- 1) Chest pain (10.1%)
- 2) Injury of shoulder / arm / elbow / wrist / hand (8.2%)
- 3) Injury of hip / leg / knee / ankle / foot (7.9%)
- 4) Abdominal pain (7.7%)
- 5) Pain in hip / leg / knee / ankle / foot (5.9%)

### Summary

One in five admitted.  
Almost as likely to be ambulatory as acute.  
No specialised service. Non-specific  
symptoms and injuries prevalent.

## 66-79



Admitted 39.7%



Not Admitted

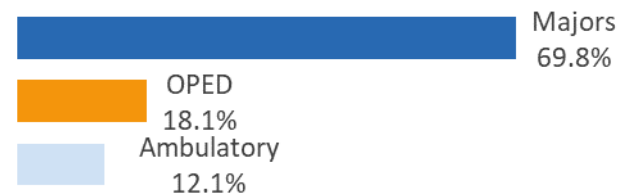
### Top Five Presenting Complaints (% of Total)

- 1) Chest pain (9.7%)
- 2) Short of breath (8.1%)
- 3) Injury of shoulder / arm / elbow / wrist / hand (6.6%)
- 4) Abdominal pain (6.4%)
- 5) Injury of hip / leg / knee / ankle / foot (5.8%)

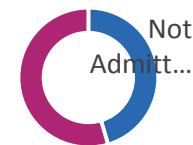
### Summary

Often admitted (two in five). High acuity with  
only one in four ambulatory.  
No specialist service. Non-specific symptoms  
and injuries prevalent.

## 80+



Admitted 54.5%



Not Admitted

### Top Five Presenting Complaints (% of Total)

- 1) Short of breath (9.5%)
- 2) Falls / unsteady on feet (8.7%)
- 3) Chest pain (7.6%)
- 4) Not Recorded (6.0%)
- 5) Injury of hip / leg / knee / ankle / foot (5.7%)

### Summary

Often admitted (one in two) with high acuity.  
Use of specialist service (OPED).  
Frailty and respiratory conditions prevalent.



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

Norfolk and Norwich University Hospitals



NHS Foundation Trust

# Integrated Performance Report

March 2020 (February 2020 data)



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

# Norfolk and Norwich University Hospitals



NHS Foundation Trust

INTEGRATED  
PERFORMANCE  
REPORT

## KPI Summary



### Summary Table

Domain	Metric Name	Detail Page	Responsible Role	National Standard	Latest Internal Target	Monthly			Q1	Quarterly			Year YTD
						Dec	Jan	Feb		Q2	Q3	Q4	
Finance	Outpatient Activity vs Plan	<a href="#">🔗</a>	DOD	0	0	-5,485	-1,165	-2,897	-93	-8,297	-10,979	-4,062	-23,430
	Non Elective Activity vs Plan	<a href="#">🔗</a>	DOD	0	0	-401	-503	-677	-553	-356	-533	-1,180	-2,622
	Day Case Activity vs Plan	<a href="#">🔗</a>	DOD	0	0	94	95	193	918	402	126	288	1,734
	Elective Inpatient Activity vs Plan	<a href="#">🔗</a>	DOD	0	0	-298	-352	-201	-552	-881	-797	-553	-2,783
	ED Activity vs Plan	<a href="#">🔗</a>	DOD	0	0	-249	-599	-277	945	1,724	-58	-876	1,736
Performance	4Hr Standard	<a href="#">🔗</a>	DOD	95%	92.0%	69.6%	76.6%	77.0%	78.4%	78.2%	71.6%	76.8%	76.2%
	Ambulance >60	<a href="#">🔗</a>	DOD	0	4	643	384	256	216	365	1,804	640	3,025
	Cancer 2 Week Wait	<a href="#">🔗</a>	DOD	93%	93.0%	83.0%	70.7%	76.6%	89.4%	73.1%	79.4%	73.6%	79.2%
	Cancer 31day First	<a href="#">🔗</a>	DOD	96%	96.0%	96.4%	94.5%	95.9%	97.1%	97.4%	96.5%	95.1%	96.7%
	Cancer 62day GP Referral	<a href="#">🔗</a>	DOD	85%	84.9%	68.4%	63.9%	65.7%	76.0%	69.5%	67.3%	64.8%	69.8%
	RTT Performance Incomplete	<a href="#">🔗</a>	DOD	92%	83.5%	78.0%	77.0%	76.6%	83.3%	81.9%	79.0%	76.8%	80.5%
	RTT Waiting List Incomplete	<a href="#">🔗</a>	DOD		40,930	46,991	50,179	50,603	43,629	45,614	46,991	50,603	50,603
	DM01 Diagnostics	<a href="#">🔗</a>	DOD	99%	99.0%	98.3%	98.2%	99.3%	97.5%	97.8%	97.8%	98.8%	97.9%
	Theatre Utilisation - Main	<a href="#">🔗</a>	DOD	85%	85.0%	76.9%	78.3%	79.7%	84.3%	81.9%	78.7%	79.0%	81.2%
	Theatre Utilisation - DPU	<a href="#">🔗</a>	DOD	80%	80.0%	68.6%	71.5%	66.5%	72.7%	71.3%	69.5%	68.9%	70.8%
	SSNAP Score	<a href="#">🔗</a>	DOD	80	80.0	68.0	72.0	78.0	76.0	72.0	68.0	78.0	78.0
	Serious Incidents	<a href="#">🔗</a>	DND/HOM			11	20	38	54	59	56	58	227
Quality	Friends & Family Test (Likely & E. Likely to recommend)	<a href="#">🔗</a>	DND/HOM	95%	95.0%	94.4%	94.8%	95.4%	95.6%	95.0%	94.5%	95.0%	95.1%
	HSMR (data 3 months in arrears)	<a href="#">🔗</a>	DND/HOM		100.00	85.57	84.63	86.12	88.51	86.32	85.57	86.12	86.12
	HOHA C. difficile Cases	<a href="#">🔗</a>	DND/HOM	0	0	1	2	0	4	1	3	2	10
	MRSA cases (Hospital Acquired)	<a href="#">🔗</a>	DND/HOM	0	0	0	0	0	0	0	0	0	0
	Patients Boarding	<a href="#">🔗</a>	DND/HOM	20	29.6	63.8	74.2	79.8	51.8	53.2	64.5	76.9	60.2
	Number of Complaints	<a href="#">🔗</a>	DND/HOM			86	103	126	275	274	338	229	1,116
	Mandatory Training Compliance	<a href="#">🔗</a>	COD	90%	90.0%	89.7%	89.3%	89.8%	89.3%	89.5%	89.7%	89.8%	89.8%
Workforce	Non Medical Appraisals	<a href="#">🔗</a>	COD	85%	85.0%	81.6%	79.6%	81.0%	79.7%	78.7%	81.6%	81.0%	81.0%
	Sickness Absence Rates (Annualised, 1month in arrears)	<a href="#">🔗</a>	COD	3.90%	3.9%	4.4%	4.4%		4.2%	4.2%	4.4%	4.4%	4.4%

## REPORT TO THE TRUST BOARD

<b>Date</b>	<b>1 April 2020</b>
<b>Title</b>	<b>Chair's key Issues from Quality and Safety Committee Meeting on 24.03.20</b>
<b>Lead</b>	<b>Dr Geraldine O'Sullivan – Non-Executive Director (Committee Chair)</b>
<b>Purpose</b>	<b>For Information and assurance</b>

### 1 Background/Context

The Quality and Safety Committee met on 18 February and 24 March 2020. Papers for the meeting were circulated to Board members for information in the usual way. The meeting was quorate and was held by tele/videoconference. Erica Betts and John Rees (Public Governors) attended as observers.

### 2 Key Issues/Risks/Actions

Due to the Covid 19 pandemic, the meeting was not preceded by clinical/departmental visits.

#### Items received for information and assurance:

1	Covid response:	19	<p>The primary focus of the meeting was on the Trust's response to the Covid19 pandemic. The Committee was updated with respect to:</p> <ul style="list-style-type: none"> <li>- daily rhythm of management and troubleshooting;</li> <li>- infection control and 'zoning' within the hospital;</li> <li>- bed capacity, clinical equipment, viral testing, personal protective equipment,</li> <li>- outpatient transformation and remote working for staff;</li> <li>- partnership working, especially with UEA and other NRP partners;</li> <li>- staff training and support for staff.</li> </ul> <p>The Committee was assured by the extent and detail of preparation underway in the Trust to address the forthcoming challenges.</p> <p>Arrangements have been made for scheduled weekly updates to Committee members – striking the balance between providing adequate NED oversight and support without becoming operational or burdensome.</p>
2	Maternity:		<p>The Committee received a report from Ms Emma Hardwick (Head of Midwifery) with regard to the ongoing work to safeguard and improve maternity services. This supplemented the clinical visit and review undertaken by the Committee in February.</p>

	i) NHSR Maternity Incentive Scheme ii) Update on Saving Babies Lives (national safety initiative)	The Committee was assured by the significant work that has been undertaken and agreed to receive quarterly update reports hereafter.
3	Management of non- Covid patients	As part of follow-up from review of serious incidents, the Committee briefly discussed arrangements for continuation of some urgent cancer work, some urgent surgery and some eye surgery, using facilities off the NNUH site. This is part of a structure aimed at monitoring and avoiding harm to patients on waiting lists, especially whilst normal elective work is interrupted.

### 3 Conclusions/Outcome/Next steps

The next Committee meeting is scheduled for 21 April 2020.

#### Recommendation:

The Board is recommended to **note** the work of its Quality & Safety Committee.



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# Integrated Performance Report (Quality, Safety and Patient Experience Section)

March 2020 (February 2020 data)



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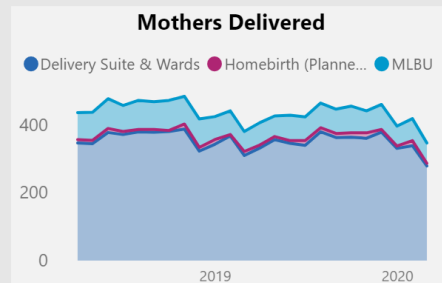
## Maternity: Deliveries

Chief Nurse  
Nancy Fontaine



### Month Selector

Most Recent ▼



Mothers Delivered			Midwife Led			1:1 Care		
Month	2019	2020	M	2019	2020	M	2019	2020
February	382	348	Feb	19.1%	24.1%	Feb	98.7%	100.0

### Data Observations

348 mothers were delivered in February, a decrease from February last year (348) and from last month's daily average, dropping to an average of 12 per day from 13.5 per day in January.

60 deliveries (of the 348) were in MLBU, 8 were Homebirths and 280 were delivery suites and wards

The proportion of midwife led deliveries remained stable at 24.1%.

The proportion of Elective Caesarian's was at its highest since April 2019 (16.4%) but only slightly higher than at the same time last year (15.2%).

1:1 Care in Labour continued its increase from 96.7% in September 2019 and is 100% in February

### Management Comments and Actions

1:1 care was 100% this month.

348 women delivered this month. The emergency LSCS rate this month is 17.8% down from last month's 23.1% and in line with the year average of 17.7%.

There were 3 homebirths in the month with 5 BBA's including one woman who delivered on route, one who laboured to fast to attend the hospital.

The service will continue to work with users to review information provided to support their decision making for birth preparation.

### Babies Delivered

● Current Year ● Last Year ● Preceding Year

### Elective Caesarean Deliveries

18%

### 1:1 Care in Labour

100%

### Midwife Led

40%

95%



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Month Selector

Most Recent ▼

These metrics focus on babies' health, monitoring number of unplanned NICU admissions, cumulative early neonatal deaths (within 7 days of birth) and stillbirths.

Unplanned NICU Admissions (37+ wks)

● Current Year ● Last Year



Unplanned NICU Adm.

Month	2019	2020
February	13	9

FYTD Neonatal Death

M	2019	2020
Feb	7	4

Annualised Still Births

M	2019	2020
Feb	4.0	2.7

### Data Observations

There were 9 unplanned NICU admission in February, continuing the trend of fewer unplanned admissions compared with the same month last year for the last 11 months.

Cumulative early neonatal deaths have remained static at 4 since November 2019, compared with 7 for the same time last year.

Annualised stillbirths have maintained a reduction from 2018/19 levels (a range from 4.2 to 5.3) consistently reporting between 2.3 and 2.7 from June 2019 onwards.

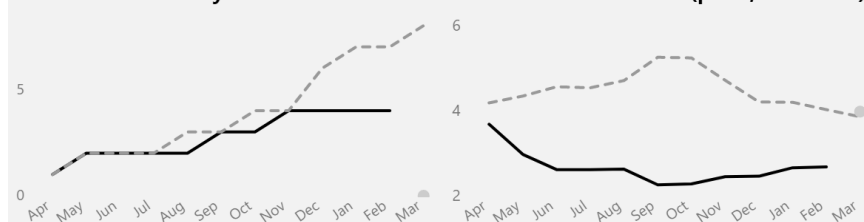
### Management Comments and Actions

There were 9 unplanned admissions to the NNUH NICU for babies >37 weeks gestations, the reason included RDS, sepsis and hypoxia.

Proactive work continues between maternity services and the neonatal team following the national ATTAIN programme and we discuss all low appgars and cord gases at a MDT meeting weekly and lessons learnt is shared with the teams.

Cumulative Early Neonatal Deaths

Annualised Still Births (per 1,000 births)







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## Mortality Rate

Medical Director  
**Erika Denton**

**NNUH Digital Health**  
business intelligence

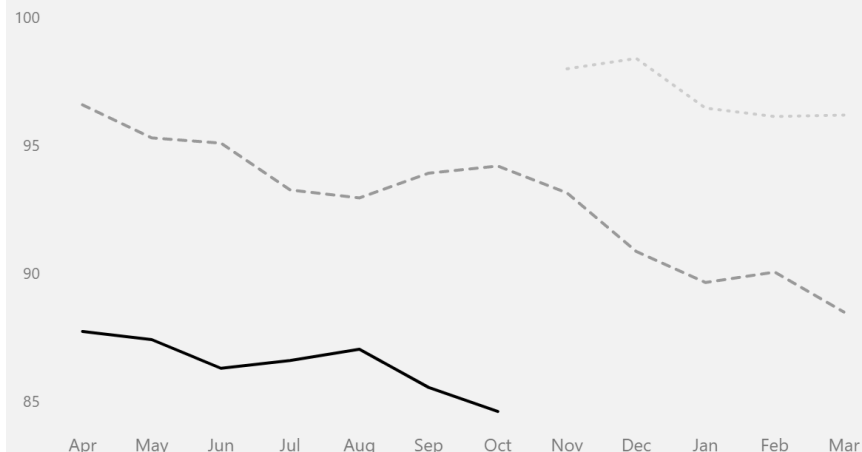
Month Selector

Most Recent ▼

The Trust's key mortality standard, Hospital Standardised Mortality Ratio (HSMR) is the ratio of the observed number of in-hospital deaths to the number of expected in-hospital deaths multiplied by 100. HSMR expected deaths are calculated from logistical regression models with a specified case-mix. All information is shown up until the same point in time, in order to show like for like.

**HSMR (rolling 12 month)**

● Current Year ● Last Year ● Preceding Year



**HSMR**

Month	2018	2019
October	94.2	84.6

**SHMI**

M	2018	2019
Oct	106.1	110.5

**Crude Mortality**

M	2018	2019
Oct	3.6%	3.7%

### Data Observations

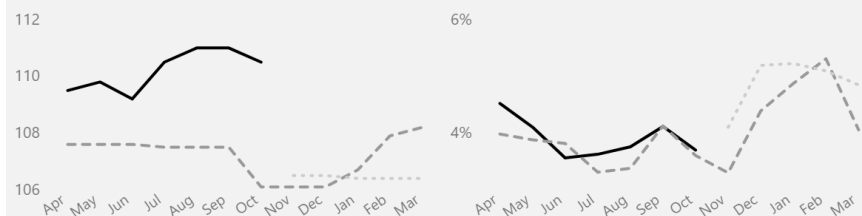
HSMR remains lower than expected with a downward rolling 12 month trend. SHMI remains as expected with an upward rolling 12 month trend. The gap between HSMR and SHMI thus continues to widen. Further analysis suggests that this is being driven by a higher than average palliative care case load and out of hospital deaths. Please note that the IPR HSMR breakdown data is presented at whole specialty level reflecting all in-patient deaths for that specialty (versus diagnosis groups falling within the HSMR basket relating to the specialty).

### Management Comments and Actions

The Trust remains 1 of 3 Trusts (within the East of England peer group of 16) with an HSMR within the 'lower than expected' range. There are no HSMR outlying diagnosis groups and no new CUSUM alerts this month. There are a number of SHMI outlying diagnosis groups. To investigate the SHMI, an SJR cohort review of 50 out of hospital deaths sampled from each of the outlying SHMI diagnosis groups is being arranged.

**SHMI (rolling 12 month)**

**Crude Mortality Rate**





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## Infection Prevention & Control (1)

Chief Nurse  
Nancy Fontaine

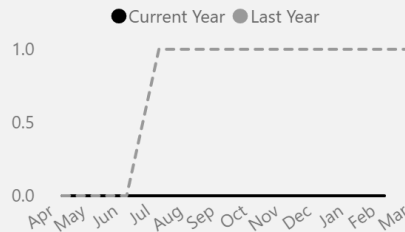


Month Selector

Most Recent ▼

**Infection Prevention & Control: Alert Organisms reported to PHE** These metrics are submitted to Public Health England as part of their ongoing national surveillance into Health Care Associated Infections, the results of which are made public. Please note - new methodology for reporting C. difficile began in April 2019. **Please note all information presented here is showing cumulative Financial Year to Date.**

### Hospital Acq. MRSA



### MRSA FYTD

Feb 2018	Feb 2019
1	0

### HOHA C.diff FYTD

Feb 2018	Feb 2019
10	10

### Total C.diff FYTD

Feb 2018	Feb 2019
63	63

### MSSA FYTD

Feb 2018	Feb 2019
10	20

### CPE FYTD

Feb 2018	Feb 2019
4	4

### Data Observations

There were no cases of MRSA bacteraemia or trajectory C. difficile in February 2020. HAI C. difficile increased by 6 cases to a cumulative total of 63 cases to date. Mattishall and Mulbarton remain on Supportive measures.

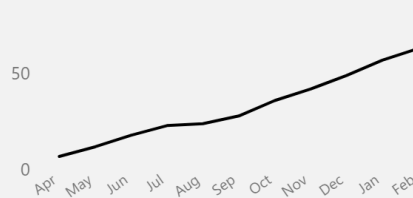
### Management Comments and Actions

All wards in the L and M block have had their ventilation ductwork cleaned. The World Health Organisation (WHO) declared the n-CoV (WN-CoV) outbreak a Public Health Emergency of International Concern (PHEIC) 30/01/20. On 11/02/20 WHO named the disease caused by this novel coronavirus as Covid-19. The virus is referred to as SARS-CoV2. For IP&C guidance, please see the Covid-19 banner on the NNUH intranet. Our approach will be guided by PHE guidelines.

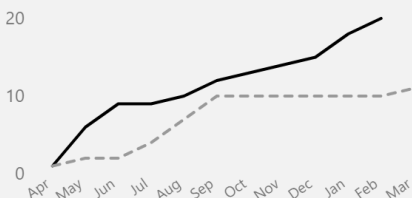
### Trajectory C. difficile



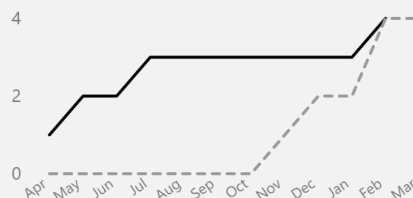
### Total HAI C. difficile



### MSSA HAI



### CPE Positive Screens





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## Infection Prevention & Control (2)

Chief Nurse  
Nancy Fontaine



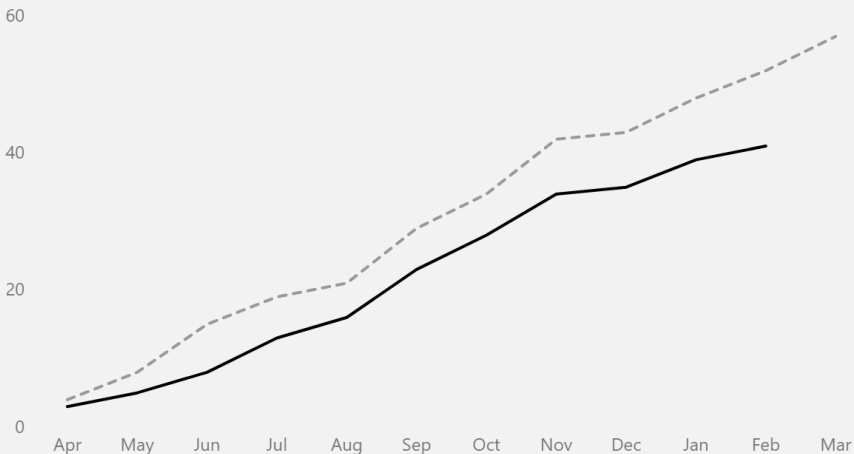
Month Selector

Most Recent



### E. Coli (Trust Apportioned)

● Current Year ● Last Year



### E. Coli FYTD

Feb	
2018	2019
52	41

### Klebsiella FYTD

Feb	
2018	2019
13	12

### Pseudomonas FYTD

Feb	
2018	2019
15	13

### Data Observations

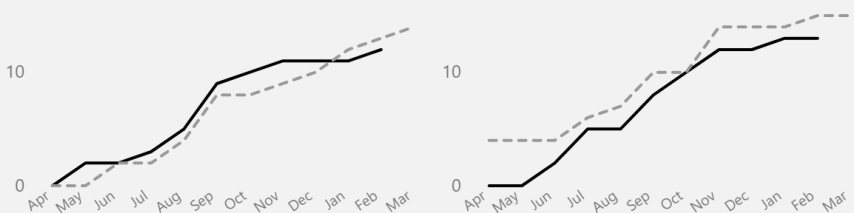
E.coli, klebsiella and pseudomonas remain lower than the year to date period last year.

### Management Comments and Actions

In 2016 the Department of Health and Social Care set an ambition to halve the number of Gram Negative Blood Stream Infections by March 2021. Recognising this as a complex challenge with more than 50% of infections occurring in people outside hospital settings, in July NHSI revised the data for achievement of this goal to March 2024 with a 25% reduction.

### Klebsiella (Trust Apportioned)

### Pseudomonas (Trust Apportioned)





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## Patient Safety

Chief Nurse  
Nancy Fontaine

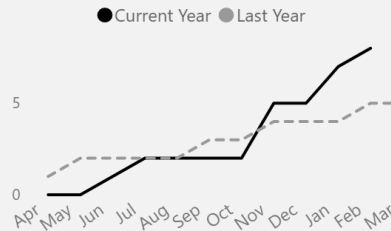


### Month Selector

Most Recent ▼

Monitoring elements which contribute to patient safety. Never Events are shown as cumulative financial year to date. Pressure Ulcers and Patient Falls are measured per 1,000 patient bed days.

### Never Events (Cumulative)



### Never Events FYTD

Feb 2018	2019
5	8

### Recorded Incidents (DATIX)

Feb 2019	2020
1,840	1,941

### Serious Incidents

Feb 2019	2020
15	38

### Pressure Ulcers /1000 bed days

Feb 2019	2020
0.7	1.0

### Patient Falls /1000 bed days

Feb 2019	2020
0.3	0.2

### Data Observations

There were 40 SI's reported. 17 of these were commissioning SI's around breach of 12hr DTA. A new process has been agreed to manage the reporting of these for the future. Of the remaining SI's there were as follows: 1 x Never Event (retention of guidewire), 1 x Adverse Media, 1 x Blood Product, 6 IP&C, 2 Maternity, 4 Patient Falls, 3 Sub Optimal care, 2 Surgical Procedure, 3 Treatment Delay. 3 SI's for Feb have been voided. Duty of Candour compliance was (19/23) 83%.

#### Medication Incidents

There were 103 incidents reviewed by the Medicines Management Committee with 94 No Harm and 9 low hard incidents.

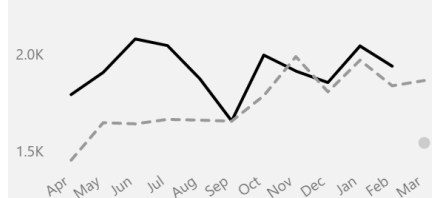
Duty of Candour has a compliance rate of 83% for this month.

### Management Comments and Actions

3 Voided SI's were x2 duplicate entry onto StEIS for 12hr DTA Breaches and x1 Treatment delay incident which following further investigation did not identify any significant care delivery problems which would have impacted the outcome for the patient. CEO assurance panel held on 10th March to review a number of Ophthalmology SI's reported over the last few months. Key risks and learning identified. A number of changes to admin processes have been introduced to manage the waiting list more effectively.

We are continuing to check data quality within Datix to ensure that the IPR is reporting accurate position. For example, this month we are reporting 40 SIs in our SI log and IPR is reporting 38. Duty of Candour figures will be reported directly from Datix as of this month's figures.

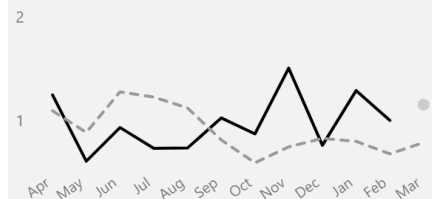
### Incidents



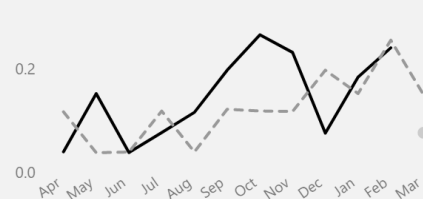
### Serious Incidents



### Hosp. Acq. Pressure Ulcers/1000bed days



### Patient Falls per 1000 bed days





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## Patient Experience

Chief Nurse  
Nancy Fontaine



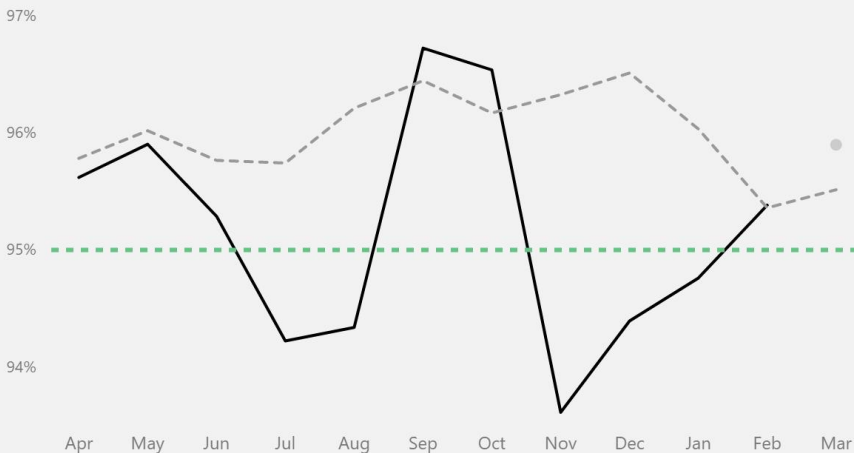
### Month Selector

Most Recent ▼

The Friends and Family Test is a national survey which provides people who have had contact with NHS services with the opportunity to provide feedback on their experiences. The Friends and Family score below is the percentage of people who responded as likely or extremely likely to recommend our service to others. The process of recording compliments was changed in Dec 2018, compliments provided to staff are now recorded on Meridian.

### Friends & Family Score

● Current Year ● Last Year ● Preceding Year



### Friends & Family

Month	2019	2020
February	95.4%	95.4%

### Compliments

M	2019	2020
Feb	215	73

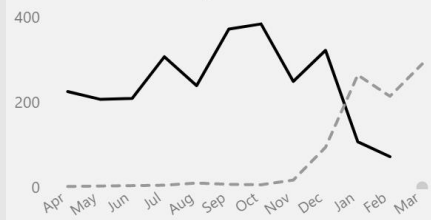
### Data Observations

The FFT score has increased slightly from last month 95.4% (94.8%) recommenders, still below target overall. Last February the recommender score was the same figure. A&E is at 95.61% which is another improvement. The FFT questions are supplemented for inpatients and these consistently show high levels of satisfaction with eg; staff introducing themselves, privacy and dignity and kindness and compassion. Compliments – the actual number of compliments recorded on Meridian is 167 (a decrease from last month – 172), rather than the number of 73 pulled through to the IPR. The disparity is similar to last month and being looked into.

### Management Comments and Actions

Business owner comments – Each department and division reviews their own scores and comments and takes action accordingly; reporting to PEEG via the divisional deep dive process. We are looking at how to increase the take up of the FFT via SMS texting and other opportunities. From April the process for collecting FFT is changing and we will not be restricted by specific timings. This should help with numbers.

### Compliments





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## Patient Concerns

**Chief Nurse**  
**Nancy Fontaine**

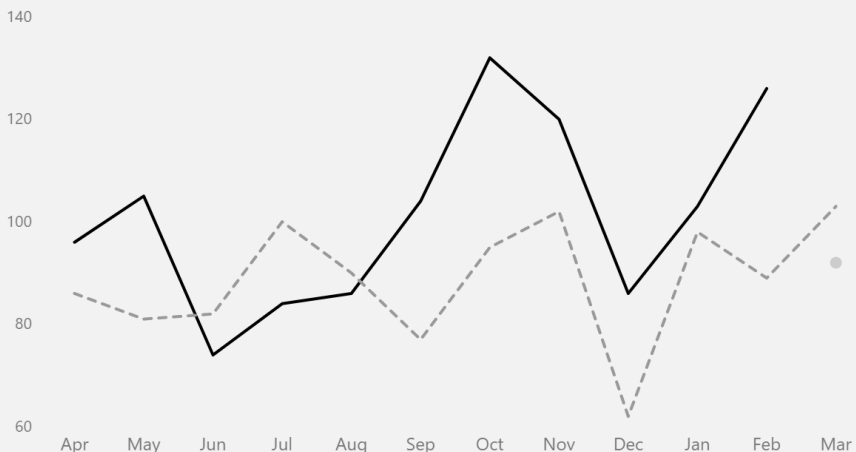
Month Selector

Most Recent ▼

PALS include enquiries relating to messages of best wishes and thanks, as well as complaints, concerns, suggestions, signposting and general enquiries.

**Complaints**

● Current Year ● Last Year ● Preceding Year



**Complaints**

Month	2019	2020
February	89	126

**PALS Enquiries**

M	2019	2020
Feb	211	243

**PALS Closed <48hrs**

M	2019	2020
Feb	80.1%	83.5%

### Data Observations

PALS: The number of PALS enquiries was 243, a decrease from last month (255). 'Enquiries' tend to be confirmation of information around appointments whereas 'concerns' are those that require intervention and resolution. Themes – continue to be around appointments/cancellations of outpatient appointments as well as more complex issues with patients currently on wards or who need additional support to make a formal complaint. The PALS and Complaints teams work closely to ensure smooth and easy access to raising concerns. Complaints: there was an increase in the number of formal complaints in February, 126 (compared to 103 last month).

### Management Comments and Actions

Each department and division is responsible for reviewing PALS/Complaints feedback and making improvements where necessary. This is reported through to PEEG through the divisional deep dive process.

**PALS Enquiries**

**PALS Closed within 48hrs**





## REPORT TO THE TRUST BOARD

<b>Date</b>	<b>1 April 2020</b>
<b>Title</b>	<b>Chair's Key Issues from Audit Committee Meeting on 25.03.20</b>
<b>Lead</b>	<b>Julian Foster – Non-Executive Director (Committee Chair)</b>
<b>Purpose</b>	<b>For Information and assurance</b>

### 1 Background/Context

The Audit Committee met on 25 March 2020. Papers for the meeting were circulated to Board members for information in the usual way. The meeting was quorate and was held by tele/video conference. Jackie Hammond (Public Governor) attended as observer.

### 2 Key Issues/Risks/Actions

Items of note considered at the meeting included:

Items received for information and assurance:		
1	Emergency Preparedness, Resilience and Response & Business Continuity	The Committee received an update on the Trust's EPRR&BC response to Covid 19. It was noted that the Quality & Safety Committee will lead on providing Board assurance with respect to our Covid response.
2	Risk Management update	The Committee reviewed the CRR, its ongoing development and improving formatting. Further comment was given and the CRR will be updated with Covid19-related risks prior to review by the Board at its May meeting.  Concern was expressed that there are still separate risk registers held which are not incorporated within the CRR. An action was made for these risk registers to be incorporated within the CRR as a matter of priority.
3	Board Assurance Framework – Quarterly Review	CQC comments from the latest inspection were noted: <i>"We reviewed the BAF [and] found all the threats to strategic objectives RAG rated with mitigating actions. There were clear review processes and dates documented for each at relevant review committees and management board. The BAF was discussed at trust board. Minutes showed appropriate assurance was received regarding control and mitigations."</i>

		Due to the extreme operational position it has not yet been possible for the executive to derive Key Deliverables for 2020/21. These will need to reflect the changed context and it is intended to return to this as the situation allows.
4	Appointment of Internal Auditors for 2020/21	The contract for RSM to provide Internal Audit services was extended for a further year, in anticipation that this should be reviewed with the new CFO during 2020/21.
5	LCFS Progress Report 2019/20 & Plan for 2020/21	The update from the Counter Fraud Service shows an improving risk position for the Trust. It is recognised that sadly there will be increased opportunities for fraud arising from the exceptional pandemic circumstances. The LCFS Plan was agreed and a briefing document on Covid-related fraud risks has been uploaded onto the Diligent Resource Centre
6	Committee self-assessment & Work Programme for 2020/21	The Committee reviewed its performance over the last year and agreed its reporting schedule and Work Programme for 2020/21 to include: i) annual review of Organisational Governance Framework and annual reports from the other board assurance committees; ii) quarterly review of the corporate risk register iii) increased on staff reporting through the Conflicts of Interest system iv) follow-up on the NHSI/CQC Use of Resources Assessment

#### Issues to highlight and escalate:

7	Private meeting with auditors	The Committee held its scheduled meeting in private with the internal and external auditors in order to gain assurance as to whether there were any issues of transparency or similar concerns with respect to the conduct of the audit exercises.  The Committee was assured that there are no concerns, other than the issue of responding to some internal audit reports in a timely manner, but the internal auditors complemented the high degree of commitment to developing the new IA plan.
8	Internal Audit programme 19/20 & implementation of recommendations	The Committee monitors progress in implementing recommendations arising from internal audit and there is ongoing concern about the time taken to respond to internal audit reports. This has improved over the year but will require further attention once the current exceptional position has improved. This year we have received a number of partial-assurance reports and some prioritised actions need to be finalised if we are to avoid a negative Head of Internal Audit opinion in the 2020 financial statements.
9	Internal Audit programme 20/21	The Committee agreed to defer finalisation of the programme and to postpone its commencement until after the next Audit Committee meeting in May. This will avoid distraction from the pandemic response and also allow for review of some of the intended audits by the new CFO to ensure best 'fit' with the changed circumstances.



10	Timetable for External Audit, Final Accounts & Annual Report	<p>Due to the Covid19 pandemic, NHSE/I will be issuing amended guidance to the year-end timetable. Trusts have been briefed to expect that:</p> <ul style="list-style-type: none"> <li>• there will no longer be a requirement to include a quality report in the annual report;</li> <li>• Auditor assurance work on quality accounts and quality reports should cease for 2019/20;</li> <li>• there are potential revisions to thresholds for agreement of balances;</li> <li>• annual report requirements may be 'streamlined', subject to HM Treasury agreement;</li> <li>• draft accounts are due on 27 April and audited accounts on 25 June.</li> </ul> <p>As matters stand, pending further guidance and progress with the year end, it is intended to continue with our internal timetable with the aim of producing the audited Annual Report and Accounts for approval by the Board at its meeting scheduled for this purpose on 27 May.</p>
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### 3 Conclusions/Outcome/Next steps

The next Committee meeting is scheduled for 27 May 2020, to focus on approval of the Annual report and Accounts.

#### Recommendation:

The Board is recommended to **note** the work of its Audit Committee.

## REPORT TO THE TRUST BOARD

<b>Date</b>	<b>1 April 2020</b>
<b>Title</b>	<b>Chair's Key Actions from Finance, Investments and Performance Committee meetings on 26.02.20 and 25.03.20</b>
<b>Lead</b>	<b>Tim How – Non-Executive Director (Committee Chair)</b>
<b>Purpose</b>	<b>For Information and assurance</b>

### 1 Background/Context

The Finance, Investments and Performance Committee met on 26 February and 25 March 2020. Papers for the meeting were circulated to Board members for information in the usual way. Both meetings were quorate. Due to the Covid 19 pandemic, the meetings were not preceded by clinical/departmental visits.

### 2 Key Issues/Risks/Actions

Items of note considered at the meetings included:

#### Items received for information and assurance:

1	Theatre Productivity (26.2.20)	The Committee received a report from Dr Leary (Chief of Division – Surgery) concerning surgical activity. This is a key component to establishing the Trust's operational and financial plans. The Committee was informed that our theatres routinely operate longer than any other hospital in the region. Utilisation rates are complicated by case mix (e.g. multiple 'changeovers' v long cases), cleaning times etc. As the Theatre complex forms a key part of our pandemic escalation plan, further consideration is suspended. In due course, a 3-5 year surgery strategy & theatre productivity plan will form a key part of the MTFS and has been added to the Committee future Work Programme.
2	Estates Strategy and Capital Plan (26.2.20)	The draft Estates Strategy and draft Capital Programme were reviewed. The Committee requested: i) Estates strategy – review linkage to other strategies, MTFS & finance/productivity ii) Capital programme – categorise by area of intended benefit: compliance, quality or efficiency/productivity
3	Annual Business planning (2020/21) in light of Covid 19 (25.3.20)	The national timetable had anticipated that by this stage Trust's would have concluded contract negotiations with commissioners and would be finalising activity and financial plans for 2020/21. The NHS Operational Planning timetable has however now been suspended in light of the Coronavirus pandemic.  In accordance with NHSE/I guidance: a) non-urgent elective operations are to be postponed – to free-up resources and staff to manage the emergency situation;

		<p>b) a revised financial model (block payments) will apply until 1 August 2020;</p> <p>c) additional costs that Trust's incur relating to the coronavirus emergency will be refunded (subject to scrutiny);</p> <p>d) there is an expectation that strong financial governance remains in place in Trusts.</p>
4	Covid 19 expenditure (25.3.20)	<p>The Committee was updated with regard to exceptional expenditure associated with the Trust's response to the pandemic. Expenditure is being authorised in accordance with the Scheme of Delegation but it is obviously outside of 2019/20 Budget. The Committee was assured that:</p> <ul style="list-style-type: none"> <li>- we have arrangements in place for executive-level approval of expenditure;</li> <li>- these arrangements balance oversight with the need for the most rapid response commensurate with the emergency situation.</li> </ul> <p>In accordance with national guidance, evidence is being collated to document the costs incurred in responding to the pandemic so that these may be reclaimed from central funds.</p>
5	IPR metrics (25.3.20)	The IPR metrics will need some revision to be most relevant to our changed circumstances. This may include information concerning the numbers of outpatient consultations undertaken remotely; the revised bed base; and waiting times for non-Covid patients.
6	Relevant extract from Board Assurance Framework (25.3.20)	The Committee reviewed those elements of the Board Assurance Framework that are relevant to its remit. It is relevant to note that actions and decisions taken during the present pandemic crisis remain consistent with the Trust's Strategic Objectives – for example the investment to enhance digital capability (BAF 3.1), work to progress outpatient transformation (BAF 4.3) and actions to enhance specialist capacity and capability (BAF 1.3 & 2.3).
7	Draft Committee Work Programme 2020/21 (26.2.20)	<p>The Committee agreed its reporting schedule &amp; Work Programme for the year ahead (subject to the prevailing operational position). The lessons and impact of the pandemic will be significant and far-reaching but, as matters stand, topics for future consideration include:</p> <ul style="list-style-type: none"> <li>- review of MTFS;</li> <li>- financial benchmarking;</li> <li>- staff establishment review;</li> <li>- 3-5yr surgery strategy;</li> <li>- consolidating lessons learned – remote working, outpatient transformation etc</li> </ul>

#### Issues to escalate and/or for action:

8	Covid 19 - Urgent investment in HDU & isolation beds	<p><b>Strategic Threat 1.3</b>    <b>High level and unpredictability of emergency demand creates circumstances that threaten quality of service</b></p> <p><b>Strategic Threat 2.3</b>    <b>Limited capacity of specialist physical infrastructure (e.g. Critical Care capacity)</b></p>
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	<p><b>(BAF 1.3 &amp; 2.3)</b></p> <p>(25.3.20)</p>	<p>The Committee received an outline case for expanding the Trust's bed capacity in the areas of HDU/Critical Care and source isolation. This is consistent with the Trust's Strategic Objective to provide specialist care, and is required urgently to enhance the Trust's ability to care for the unprecedented number of patients requiring such intensive support.</p> <p>All the modelling for the pandemic clearly points to a significant increase in demand for HDU/Critical Care beds and the executive has been exploring how we might rapidly increase capacity in this area. As well as our escalation plans to utilise additional areas within the hospital, two additional schemes have been developed:</p> <ul style="list-style-type: none"> <li>i) completion and fit out of the 3<sup>rd</sup> floor of the new ward block, to accommodate 25 HDU level beds</li> <li>ii) purchase of a new 10 bedded modular isolation ward.</li> </ul> <p>We have been successful in securing capital support from NHSE/I, in the sum of £8.9M, to implement these schemes and have been requested to implement them without delay. Given the urgency of the situation, the offer of capital has been accepted and the schemes initiated, in accordance with CEO &amp; Chair Emergency Powers under Standing Orders.</p> <p>The Committee considered the outline schemes:</p> <ul style="list-style-type: none"> <li>- the costs associated with their development are being documented to be reclaimed as part of our Covid-related expenditure;</li> <li>- it will be necessary to assess the revenue implications for purposes of future planning;</li> <li>- procurement will be through a Procurement Framework;</li> <li>- work is underway to assess the best location for the Isolation Unit (subject to planning), not least to ensure appropriate clinical adjacencies and flexibility in future use;</li> <li>- workforce solutions for both these schemes are being explored but both have strong clinical and divisional support.</li> </ul> <p>These developments will enhance the Trust's facilities to provide specialist care for patients. The Committee will monitor implementation of the schemes and recommends that the Board:</p> <ul style="list-style-type: none"> <li>i) <b>ratifies</b> the decision to proceed with procuring: <ul style="list-style-type: none"> <li>• completion and fit out of the 3<sup>rd</sup> floor of the new ward block, to accommodate 25 HDU level beds</li> <li>• purchase of a new 10 bedded modular isolation ward;</li> </ul> </li> <li>ii) <b>approves</b> capital borrowing of £8.9M to fund these schemes on Terms and Conditions, and with delegated authorities, as previously agreed;</li> <li>iii) <b>delegates</b> responsibility to the Committee to provide Board oversight and assurance on implementation of the schemes, so that they can be implemented and available for patient care as swiftly as possible.</li> </ul>
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9	<p>Equipment replacement approval:</p> <p>i) Nuclear Medicine</p> <p>ii) Bedframes</p> <p><b>(BAF 2.3)</b></p> <p>(26.2.20)</p>	<p><b>Strategic Threat 2.3 – Deliverable:</b>  <b><i>“There are clear plans in place to deliver the additional specialist capacity required to meet projected patient needs and demand over the next 10 years”</i></b></p> <p>The Committee received and reviewed two business cases. Both projects have been through a full business case development process; (Strategic Outline Case (SOC), Outline Business Case (OBC) and Full Business Case (FBC)). They have been taken to the Business Case Review Panel, approved by the Hospital Management Board at Full Business Case stage and the costs were included in the draft budget and financial planning assumptions for 2020/21.</p> <p>Both projects involve long-term managed service contracts and risk transfer to a third party. As such the whole life value of each contracts exceeds £2m and requires Board approval. <b>The Full Business cases (as considered by the Committee) have been uploaded to the Diligent Resource Centre for access by Board members as required.</b></p> <p><u><i>i. Nuclear Medicine equipment replacement programme</i></u></p> <p>Equipment obsolescence and repeated failure of equipment in nuclear medicine has been well recognised and repeatedly discussed by the Board and its committees. It has been one of the highest clinical risks facing the Trust – for which this project is primary mitigation. It includes replacing the gamma cameras which were 18 years old and have been decommissioned as clinically unsafe.</p> <p>The proposed solution is for a mixed arrangement of capital and managed service. It has been procured through the NHS Shared Business Services Procurement Framework, for a 7 year contract totalling £3.94M. Relevant capital funds were requested and received, as part of the Trust’s 2019/20 capital plan and these have been employed in commencing building work to enable installation of the new equipment without delay.</p> <p><u><i>ii. Essential Patient Equipment (EPE): Tranche 1 – bed frame replacement, maintenance and management</i></u></p> <p>A review of EPE (beds, trolleys, mattresses and associated equipment) identified a number of areas of need, with replacement of the bed frame stock being prioritised for Tranche 1.</p> <p>The proposed solution is for a managed service including bed frame replacement and maintenance – including an offsite storage &amp; maintenance facility, provision of 1055 new bed frames to replace existing outdated bed-stock, including 200 beds with the capacity to operate as an ultra-low bed for patients who are vulnerable to falls, ‘buffer’ stock to be employed at times of escalation. The contract cost is £4.87M over 10 years, with an additional two two-year extension options, and has been taken into account in the 20/21 financial assumptions.</p> <p>Following review, the Committee <b>agreed</b> to recommend to the Board that it approves the FBC for:</p>
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- |  |  |  |
|--|--|--|
|  |  | a) replacement and maintenance of the Nuclear Medicine equipment and associated costs;<br>b) replacement and maintenance of the Trust's bed stock. |
|--|--|--|

### 3 Conclusions/Outcome/Next steps

The next Committee meeting is scheduled for 22 April 2020, to focus on supporting the Trust's pandemic response.

#### Recommendation:

The Board is recommended to:

- i) **ratify** the decision to proceed with procuring:
    - completion and fit out of the 3<sup>rd</sup> floor of the new ward block, to accommodate 25 HDU level beds
    - purchase of a new 10 bedded modular isolation ward;
  - ii) **approve** capital borrowing of £8.9M from DH to fund these schemes on Terms and Conditions and with delegated authority as previously agreed;
  - iii) **delegate** responsibility to the FI&P Committee to provide Board oversight and assurance on implementation of the schemes, so that they can be implemented and available for patient care as swiftly as possible.
- and
- iv) **approve the FBC for**
    - replacement and maintenance of the Nuclear Medicine equipment and associated costs; and
    - replacement and maintenance of the Trust's bed stock.



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# Integrated Performance Report (Finance, Performance and Productivity Section)

March 2020 (February 2020 data)



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INTEGRATED  
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## ED Performance

Chief Operating Officer  
Chris Cobb

**NNUH Digital Health**  
business intelligence

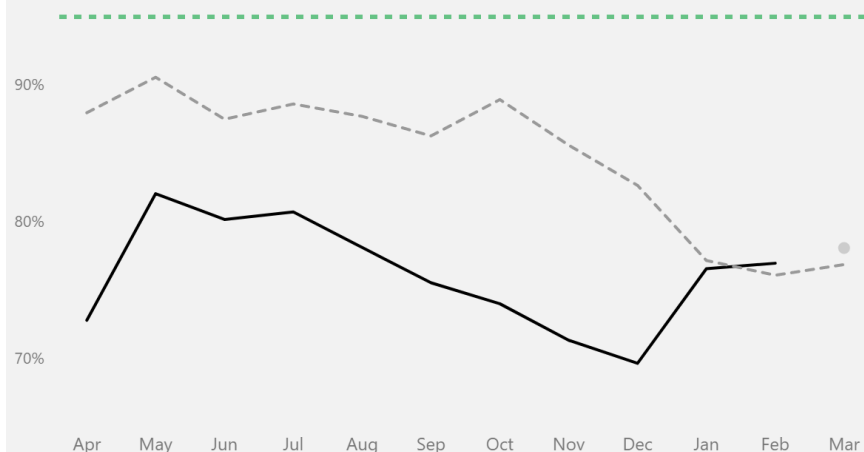
Month Selector

Most Recent ▼

The four hour access standard refers to the pledge set out in the NHS Mandate that at least 95 per cent of patients attending A&E should be admitted to hospital, transferred to another provider or discharged within four hours. Nationally information is reviewed by combining performance for both the NNUH and the walk-in centre. Key factors which can affect performance include the number of attendances, their mode of arrival and their acuity as well as patient flow throughout the hospital.

ED 4Hr Access Target - Combined

● Current Year ● Last Year ● Preceding Year



ED Combined Performance

Month	2019	2020
February	76.1%	77.0%

12 Hour Breaches

M	2019	2020
Feb	0	28

Ambulance Handovers

M	2019	2020
Feb	538	256

### Data Observations

4h performance was at 65.9% (77.0% combined), an improvement from 65.1% (76.6% combined) in January.

Paediatric 4h performance was 91.5% maintaining the improvement in January to 91.7%, after the 12-month low of 73.2% in December.

Minors' 4h performance was 86.3% continuing improvement from 84.9%, in January after the 12-month low of 71.3% in December.

There were 28 12-hour breaches in February, the highest number on record. Of these, 16 patients were waiting for an NNUH bed, 12 were waiting for an external mental health bed.

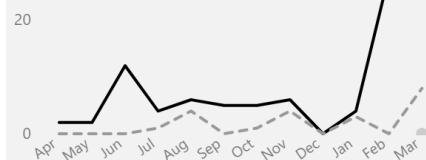
The daily average of Ambulance conveyances has reduced in February to 123 having been relatively static for the past 12 months at around 132 conveyances per day.

Conversion rate was 26.1% in February, a reduction from 27.9% in January against an increasing trend from July 2019's 23.8% onwards.

55.8% of ED attenders had an initial assessment within 15 min, a 12-month high and an improvement from 49.5% in January

### Management Comments and Actions

12 Hour Breaches



Ambulance Handovers (60+ mins)







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## Patient Flow

Chief Operating Officer  
Chris Cobb



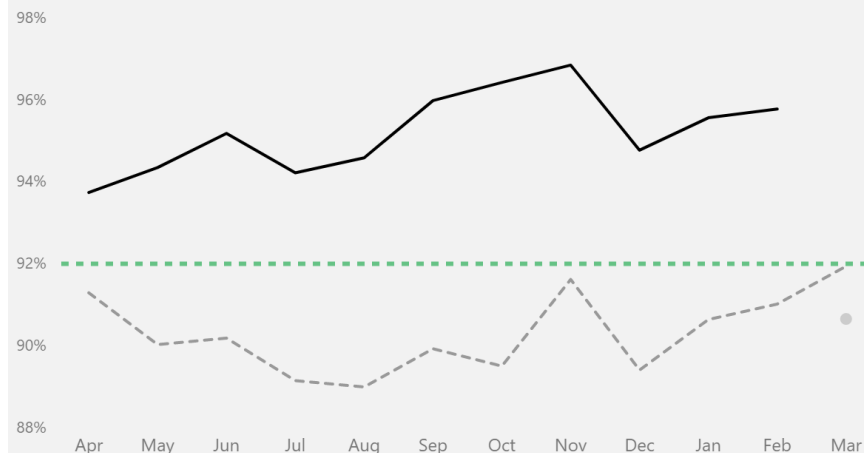
### Month Selector

Most Recent ▼

Bed occupancy gives an indication of the pressures faced by the hospital and its capacity to accommodate variations in demand and ensure that patients can flow through the system. The target is to keep occupancy below 92%. Please note that bed occupancy reporting was changed from 01/04/2019, to capture patients on beds who were not assigned to a bed appropriately on the PAS system. This change brings our 19/20 bed occupancy rate up by approximately 3%. The figures are hence not completely comparable to 18/19 figures.

### Bed Occupancy Rate (GAB & ESC)

● Current Year ● Last Year ● Preceding Year



### Bed Occupancy Rate

Month	2019	2020
February	91.0%	95.8%

### Avg. LoS (Inc. 0)

M	2019	2020
Feb	3.8	4.2

### Avg. Patients Boarding

M	2019	2020
Feb	56.2	79.8

### Data Observations

Bed occupancy rate in February was 95.8%, with little change from January's 95.6%.

The average length of stay (including 0 LoS) remained at 4.2 days in February, following the 12 month high of 4.3 in December. Prior to this, LoS had been relatively static since December 2018 (approx. 3.9 days). The length of stay excluding 0 Los remained stable also at 5.8.

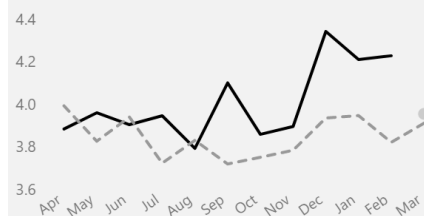
On average, there were 147 patients with a length of stay of greater than 21 days on each day in February, the highest number of 'super stranded patients' on record from April 2017 onwards. This time last year the average was 106.

The average number of boarders per day in February was 80, an increase from 74 in January, the highest number of boarders on record from April 2017 onwards. This time last year the average was 56.

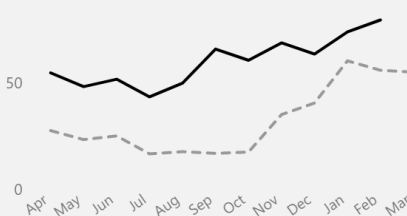
The daily average number of delayed transfers of care patients in February was 31, a decrease from 36 in January. This is the lowest recorded number of DTOCs for 10 months (April 2019).

### Management Comments and Actions

### Avg. Length of Stay (Inc. 0 LoS)



### Avg. Patients Boarding





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## Theatre Utilisation

Chief Operating Officer  
Chris Cobb



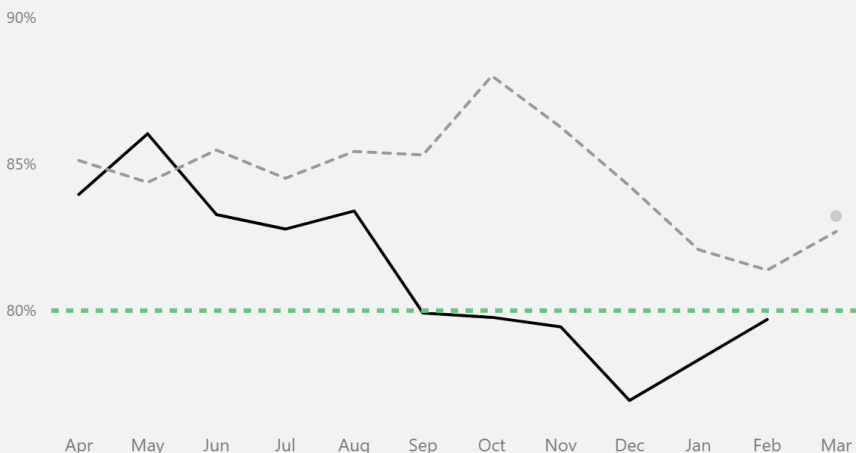
### Month Selector

Most Recent ▼

Utilisation is a measure of how efficiently the trust is using its Theatres, looking at operative minutes as a percentage of total planned operation time. Increased use of the planned operation times leads to better use of staff resource, improved patient experience and improved management of elective lists. The cancellations metric monitors operations cancelled for clinical or non-clinical reasons within 3 days of the scheduled date.

### Main Theatre Utilisation

● Current Year ● Last Year ● Preceding Year



### Main Theatre Utilisation

Month	2019	2020
February	81.4%	79.7%

### DPU Theatre Utilisation

M	2019	2020
Feb	71.6%	66.5%

### Cancellations

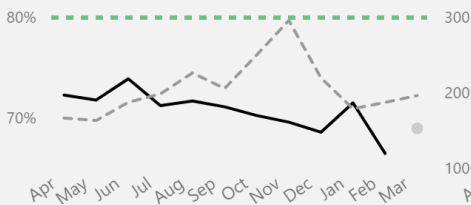
M	2019	2020
Feb	197	221

### Data Observations

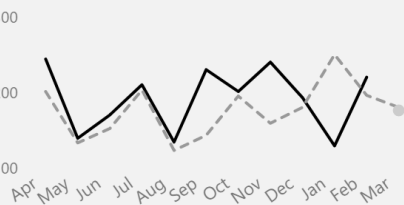
Main's theatre utilization in Feb 2020 was at 79.7%, a continued slight improvement from December's 12-month low of 76.9%.  
DPU's utilization fell to 66.5% in Feb 2020, which is the lowest utilisation in the last 24 months.  
There were 221 short notice (cancelled within 3 days of the scheduled date) cancellations in Feb 2020. 63% of cases were cancelled due non-clinical reasons, 33% due to clinical reasons (4% not specified).

### Management Comments and Actions

### DPU Theatre Utilisation



### Cancellations





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## RTT Performance

Chief Operating Officer  
Chris Cobb



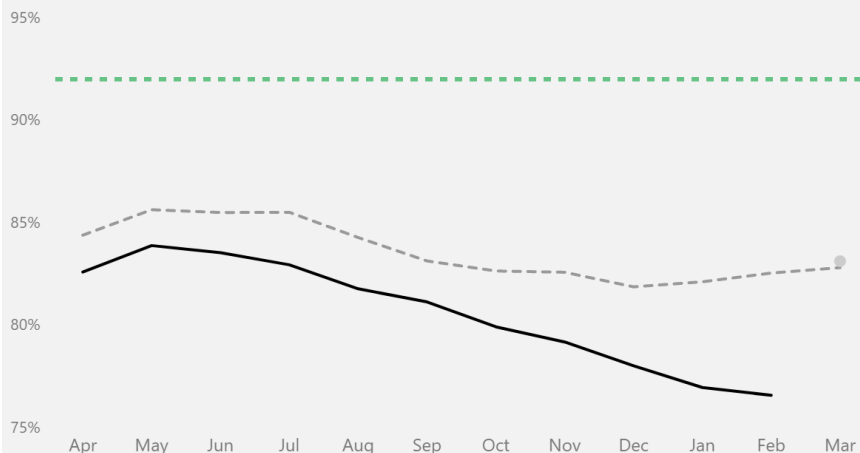
### Month Selector

Most Recent ▼

The RTT key performance indicator measures how trusts are delivering on a patient's right to receive treatment within 18 weeks of being referred to a consultant-led service. The standard is that at least 92% of patients should be treated within this timeframe. This standard has not been met since October 2014 and is a problem for acute NHS trusts across the country.

### RTT Performance

● Current Year ● Last Year ● Preceding Year



### RTT Performance

Month	2019	2020
February	82.5%	76.6%

### Waiting List

M	2019	2020
Feb	41,123	50,603

### Backlog

M	2019	2020
Feb	7,178	11,852

### Data Observations

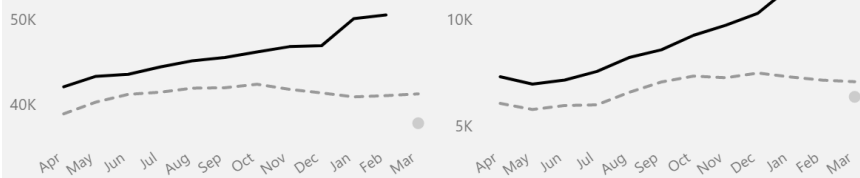
- RTT performance has decreased for the 10th consecutive month.
- The overall waiting list size has increased for 13th consecutive month.
- The overall Backlog has increased in size for the 9th consecutive month.
- This month saw a decrease in 52 week waits and a plateau in 40 week waits.
- In Feb 20 there were 39 patients waiting more than 52 weeks; 13 in Orthopaedics, 12 in Ophthalmology, 9 in General Surgery and 2 in Gynaecology, There is also 1 patient in plastic surgery, 1 in Urology and 1 in Vascular Surgery.
- ENT shows continued signs of improvement with an overall decrease in waiting list size over the year.

### Management Comments and Actions

- High levels of demand, cancellations and an increase in Cancer/Urgent case mix is pushing routine waits further out. A reduction in the number of PA's and WLI due to the pension tax, and cancellations are driving this increase.
- Increasing levels of 40+ weeks waits, with ongoing robust daily management to reduce the risk of 52 week breaches; however, there has been a significant increase within Gen Surg, Ophthal, Gynae and T&O. Clinical Harm management processes are in place.
- NNUH element of 20/21 RTT RAP is complete and the central Norfolk system demand management schemes from commissioners are to be included once received before the RAP can be finalised.
- The impact of COVID 19 has meant that patients are cancelling long waiting appointments and HBS/Insourcing has been affected due to lack of staffing. The 52 week zero position for March is impacted with likely higher numbers than were forecast as a result of this.

### Waitlist Size

### Backlog





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## DM01 Diagnostics

Chief Operating Officer  
Chris Cobb



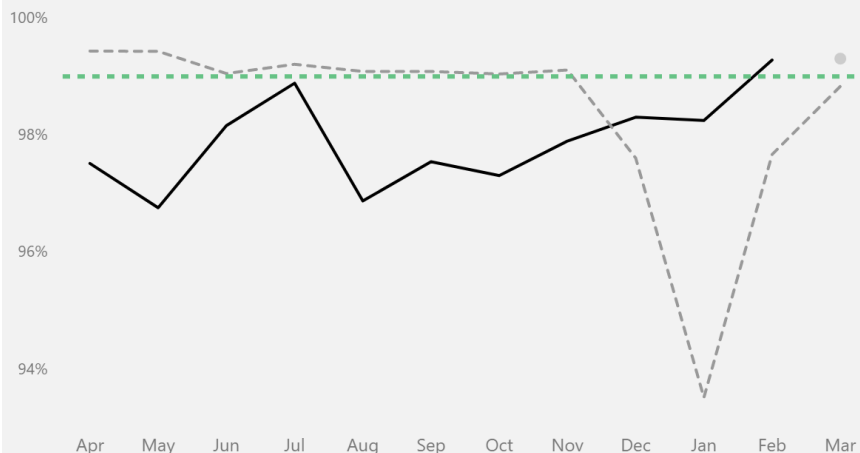
### Month Selector

Most Recent ▼

The DM01 key performance indicator measures how trusts are delivering on a patient's right to receive certain diagnostic tests within 6 weeks of the clinical decision that the test was required. The standard is that at least 99% of patients should be treated within this timeframe. We typically meet this standard however equipment failures within Radiology and winter pressures result in considerable strain on our ability to deliver this.

### Diagnostic Performance

● Current Year ● Last Year ● Preceding Year



### Diagnostic Performance

Month	2019	2020
February	97.7%	99.3%

### Waiting List

M	2019	2020
Feb	12,297	10,271

### Breaches

M	2019	2020
Feb	287	74

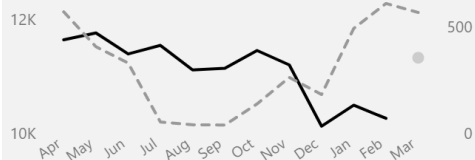
### Data Observations

- DM01 Performance has met the 99% target for the first time in 12 months.
- Breaches are the 74 which is the lowest point in over 12 months.
- The overall waiting list size is stable at 10,271 and is moving in a downward trend.
- Cystoscopies are the most challenged exam type at 81.95% and 37 breaches.
- MRI has recovered from last months dip.

### Management Comments and Actions

- All radiological modalities have recovered the standard and are working to achieve in March 20; however, the impact of COVID 19 remains to be seen as patients will likely cancel appointments to self-isolate.
- Issues remain within Urology and Paediatric Surgery for delivery of Cystoscopy standard. This remains as a result of high levels of escalation into DPU impacting on the number of daycase lists available for this diagnostic procedure, this impacted on the forecast DM01 recovery in Jan 20 and will likely continue to impact until extra theatre capacity is on line in April 20. The impact of COVID 19 remains to be seen.
- The Trust recovered the DM01 standard in Feb 20 as forecast; however as patients self-isolate and reduced numbers of diagnostic procedures take place, performance may be impacted from March 20 onwards.

### Waiting List



### Breaches





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## Cancer Performance: 2ww

Chief Operating Officer  
Chris Cobb



### Month Selector

Most Recent ▼

The 2WW Standards monitor the trust against the delivery of a first assessment within 14 days of the receipt of a 2WW referral. 93% of both the GP 2WW and Breast Symptomatic 2WW patients should be seen within this time frame.

### 2 Week Wait Performance

● Current Year ● Last Year ● Preceding Year



### 2ww Performance

Month	2019	2020
February	88.1%	76.6%

### Waiting List

M	2019	2020
Feb	855	1,150

### Backlog

M	2019	2020
Feb	105	213

### Data Observations

Please note we are currently in the process of combining the NNUH data with the Acute Service Integration sites. Weekly snapshots of the ASI position (currently 13/03/2020) are available within the detailed cancer pages of this report, and this page will be updated to show combined data in due course.

Provisional February data shows an increase in performance for NNUH to 76.6%, and for all sites combined to 79.6%. The waiting list has increased from 1052 (Jan 20) to 1150 (Feb 20) at NNUH, which is 35% than Feb 19 (855). With the addition of ENT and Urology at JPUH, the combined waiting list size was 1095 in Jan 20 and 1199 in Feb 20.

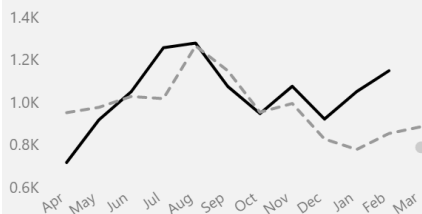
Dermatology performance has remained steady at 21.2% (Feb 20) compared to 18.5% (Jan 20). The waiting list has also remained steady at 303 (Feb 20) compared to 310 (Jan 20), whilst the backlog has increased from 86 (Jan 20) to 110 (Feb 20).

There were 494 breaches in Feb 20, of which 447 were due to inadequate capacity.

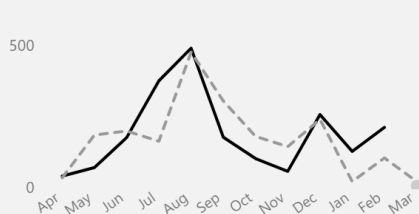
### Management Comments and Actions

Performance increase to 76.6% (79.6% including ASI) from January's low performance. Main breaching bodysites were Lower GI and Skin. Teams are looking at providing additional two week wait capacity in the coming weeks to reduce the current backlog.

### Waiting List



### Backlog





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# Norfolk and Norwich University Hospitals



NHS Foundation Trust

INTEGRATED  
PERFORMANCE  
REPORT

## Cancer Performance: 31 Day

Chief Operating Officer  
Chris Cobb



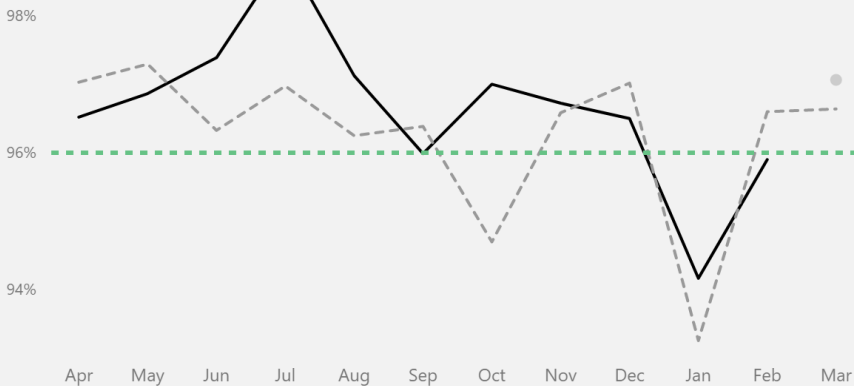
### Month Selector

Most Recent ▼

The 31 Day Treatment Standards monitor the trust against the delivery of definitive cancer treatments within 31 days of a decision to treat. For a First Definitive Treatment, 96% of patients should receive their treatment within this timeframe. Subsequent treatments are also monitored, with targets for chemotherapy (98%), radiotherapy (94%) and surgery (94%).

### 31 Day First Performance

● Current Year ● Last Year ● Preceding Year



### 31 Day Performance

Month	2019	2020
February	96.6%	95.9%

### Waiting List

M	2019	2020
Feb	56	88

### Backlog

M	2019	2020
Feb	7	27

### Data Observations

Please note we are currently in the process of combining the NNUH data with the Acute Service Integration sites. Weekly snapshots of the ASI position (currently 13/03/2020) are available within the detailed cancer pages of this report, and this page will be updated to show combined data in due course.

Provisional February data shows an increase in performance for NNUH to 95.8% and JPUH has reported performance of 100% for ENT and Urology. The waiting list has been fluctuating over the last several months, but overall has shown an increase from 59 (Jun 19) to 88 (Feb 20). There are no additions to the waiting list from JPUH.

Dermatology performance has continued decline to 82.6% (Feb 20) from a peak of 100% (Jul 19). There has also been a continued decline in Gynaecology performance to 40.0% (Feb 20) from 100% (Dec 19). Previously, between Mar 19 and Dec 19, performance consistently fluctuated between 85% and 100%.

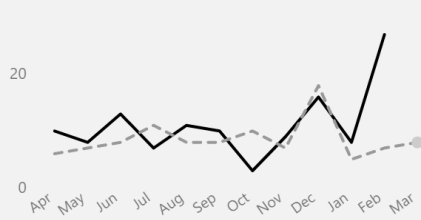
### Management Comments and Actions

Standard will be achieved in month after final validation and recording of treatments.

### Waiting List



### Backlog







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## Cancer Performance: 62 Day

Chief Operating Officer  
Chris Cobb



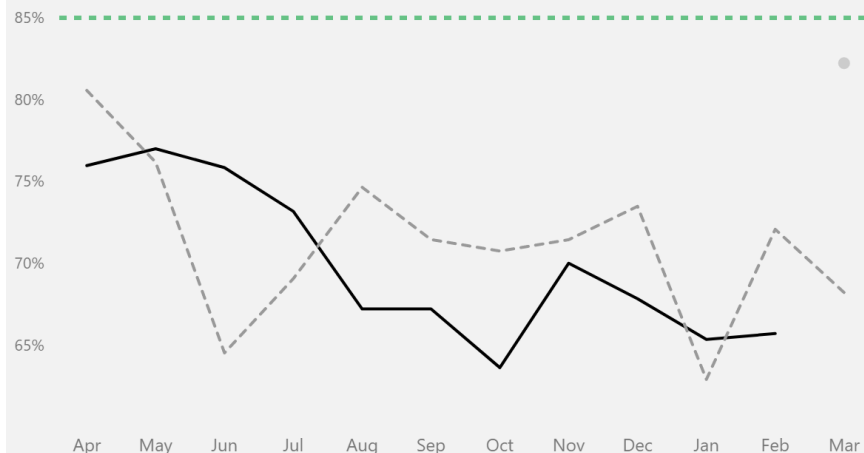
The 62 Day GP standard monitors the trust's delivery of a first definitive treatment within 62 days of receiving a 2WW referral. The target is to treat 85% of patients within this timeframe.

### Month Selector

Most Recent ▼

### 62 Day GP Performance

● Current Year ● Last Year ● Preceding Year



### 62 Day Performance

Month	2019	2020
February	72.1%	65.7%

### Waiting List

M	2019	2020
Feb	1,926	2,450

### 104+ Day Waiters

M	2019	2020
Feb	6	19

### Data Observations

Please note we are currently in the process of combining the NNUH data with the Acute Service Integration sites. Weekly snapshots of the ASI position (currently 13/03/2020) are available within the detailed cancer pages of this report, and this page will be updated to show combined data in due course.

Provisional February data shows a slight increase in performance for NNUH to 65.5%, and for all sites combined to 66.2%. The waiting list has increased from 2326 (Jan 20) to 2450 (Feb 20), which is 27% higher than in Feb 19 (1926). With the addition of ENT and Urology at JPUH, the combined waiting list size was 2532 in Jan 20 and 2684 in Feb 20. There were 58 breaches in Feb 20, of which 28.5 were due to inadequate capacity and 14.5 due to diagnostic delay.

### Management Comments and Actions

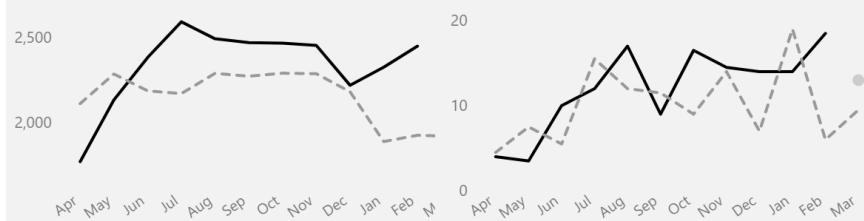
Currently provisional performance at 65.5%, once final validation is completed we expect performance to be approx 67%

Main body sites with 62 day breaches are Urology (diagnostic delays) Lower GI (delays to first appointment/Endoscopy) and Gynaecology (delays to theatre)

Over 104 day patients has risen with the majority of patients within Urology

### Waiting List

### 104+ Day Waiters





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## Stroke

Chief Operating Officer  
Chris Cobb



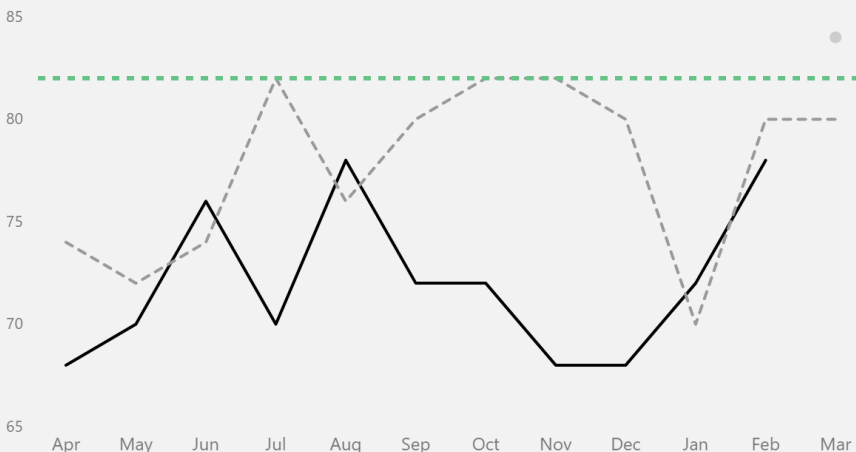
### Month Selector

Most Recent ▼

Stroke's key standard, Sentinel Stroke National Audit Programme (SSNAP), measures the quality and organisation of stroke care within the Trust. SSNAP considers 10 distinct domains. Domain 2 shown below focuses on the Stroke Unit, including admission within 4hrs. Domain 3 is based on Thrombolysis, including the 1hr clock start target. Each domain is graded according to their score.

### SSNAP

● Current Year ● Last Year ● Preceding Year



Month	MetricName	2019	2020
February	SSNAP - Score	80	78
	Domain 2 - Score	73	71
	Domain 3 - Score	71	68

Month	MetricName	2019	2020
February	SSNAP - Grade	B	B
	Domain 2 - Grade	C	C
	Domain 3 - Grade	B	C

### Data Observations

The SSNAP score has increased by 6%, achieving an overall high B rating; in context with the highest number of diagnosed strokes since July 2019

### Management Comments and Actions

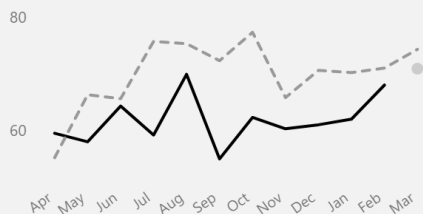
Scanning has improved by 10% due to new Hyper Acute/TIA Lead improving processes, however, challenges continue in the Stroke Unit domain due to the lack of hospital alerts and Stroke unit capacity

There is engagement with EEASt through the Stroke Network to improve alerting the Stroke Alert Nurses

### Domain 2: Stroke Unit (inc. 4hr)



### Domain 3: Thrombolysis (inc. 1hr)







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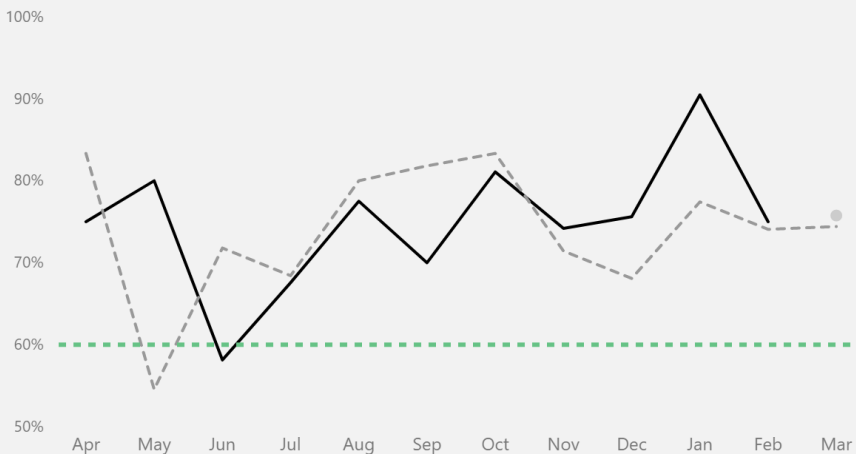
Month Selector

Most Recent ▼

Cardiology in the Trust is considered in three distinct areas: number of eligible Non-ST-Elevation Myocardial Infarction (NSTEMI) who were treated in 72 hours, number of eligible patients receiving a Primary Percutaneous Coronary Intervention (PPCI) within 150 minutes of first calling for medical attention (Call to Balloon), and the number of eligible patients receiving a PPCI within 60 minutes of arriving at the hospital (Door to Balloon).

**NSTEMI**

● Current Year ● Last Year ● Preceding Year



**NSTEMI**

Month	2019	2020
February	74.1%	75.0%

**Call to Balloon**

M	2019	2020
Feb	65.5%	69.4%

**Door to Balloon**

M	2019	2020
Feb	77.4%	91.4%

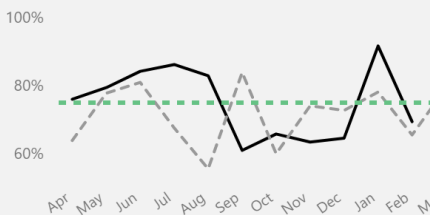
### Data Observations

NSTEMI <72 hrs: Standard achieved. For 10 out of 40 PT's 3 had comorbidities. 7 required other investigations.  
Call to balloon >150mins: Jan data revalidated and achieved 91%. In February the standard was not achieved. This relates to 11 out of 36 PT's. For 3 PT's this was due to ambulance delays, 4 PT's were transferred in from another hospital, 1 PT was already an inpatient at NNUH, 1 PT needed other emergency treatment pre PCI and for 2 PT's other investigations were required first.  
Door to balloon >60 minutes: Standard achieved. Fully met for 32 out of 35 PT's. The 3 not achieved required other investigations first.

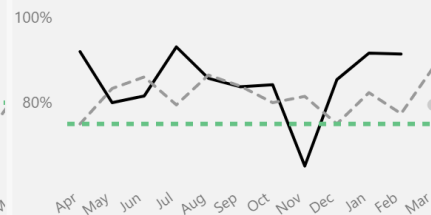
### Management Comments and Actions

NSTEMI <72 hrs: No changes to current plans.  
Call to balloon >150mins: Meeting with East will not continue but they will be send ambulance log numbers to facilitate their learning.  
Door to balloon >60 minutes: No changes to current plans.

**Call to Balloon**



**Door to Balloon**





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## Plan vs Activity: Admitted

Chief Operating Officer  
Chris Cobb

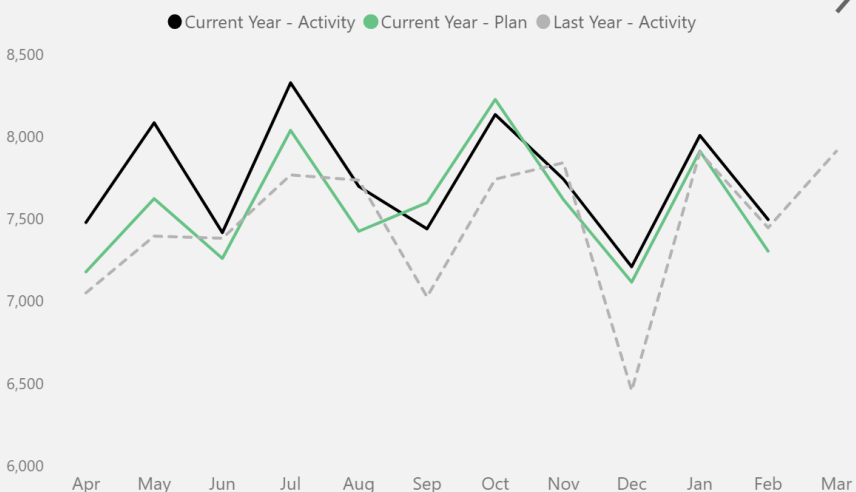
NNUH Digital Health  
business intelligence

Month Selector

Most Recent

Activity for the current year seen in context of last years activity and the current year's plan. Admitted activity: Daycase Elective, Inpatient Elective and Non-Elective Discharges.

### Daycase Elective



### Daycase Elective

Measure	Feb
Current Year - Activity	7,499
Current Year - Plan	7,306
Last Year - Activity	7,449

### Inpatient Elective

Measure	Feb
Current Year - Activity	926
Current Year - Plan	1,127
Last Year - Activity	907

### Non-Elective Discharges

Measure	Feb
Current Year - Activity	4,810
Current Year - Plan	5,487
Last Year - Activity	4,958

### Data Observations

Daycase/RDA: February performance was 3% (193 cases) over plan and 50 cases more than prior year. Surgery underperformed by 296 cases compared to plan, driven by Ophthalmology (-111) and Urology (-91). W&C were slightly up on plan, due to over performance in paediatrics. Medicine over performed in month by 475 cases, mainly in Gastro and Haematology.

Elective: February activity was well down against plan (by 18%) but slightly up on prior year. In Medicine this is due to cardiology switching to daycase. Surgery were 124 down against plan driven predominantly by Urology (-56) and ENT (-29). Gynae were over plan, though.

Non Elective: Activity was below plan (by 677 cases) and also down on prior year (by 148 cases). Paediatrics were on plan and activity levels were similar to Feb 19. General Surgery, Urology, Plastics, T&O/Spinal and General Medicine were all down against plan, but OPM/Stroke were over.

### Management Comments and Actions

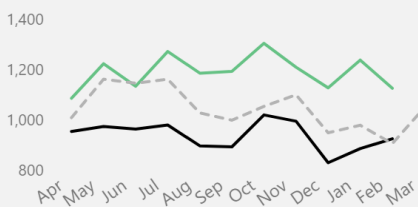
Daycase/RDA: Cardiology in particular has seen a switch of activity from elective to daycase due to recording changes which were not anticipated in the plan. There is no monetary impact. This will be monitored going forward.

Closely monitoring impact of Aylsham suite on daycase performance skewing trends.

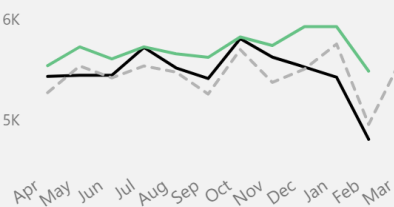
Elective: Work is being done within the Performance Meetings as part of business planning for 2020/21 to understand areas of underperformance better and work up appropriate speciality action plans, particularly in Surgery.

Non Elective: Reduction in EAUS spells due to moving to block contract, skewing figures against plan for surgical specialties. This will be addressed through business planning for 2020/21.

### Inpatient Elective



### Non-Elective Discharge





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## Plan vs Activity: Non-Admitted

Chief Operating Officer  
Chris Cobb



Month Selector

Most Recent

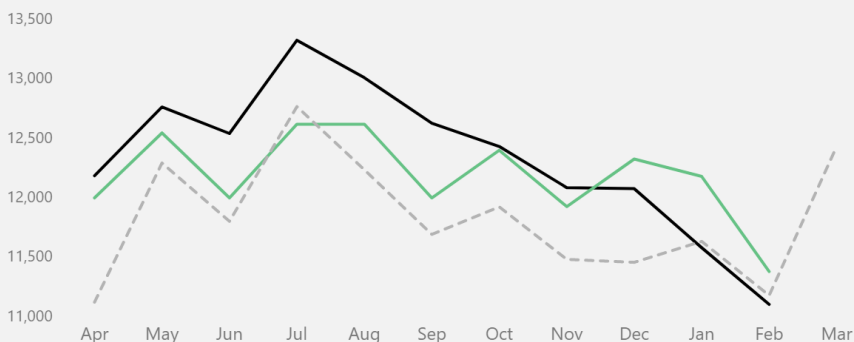


Activity for the current year seen in context of last years activity and the current year's plan. Non-Admitted activity: Outpatient and Emergency Department Attendances.

### Outpatient



### Emergency Department Attendances



### Outpatient

Measure	Feb
Current Year - Activity	61,443
Current Year - Plan	64,340
Last Year - Activity	62,301

### Emergency Department

Measure	Feb
Current Year - Activity	11,099
Current Year - Plan	11,376
Last Year - Activity	11,175

#### Data Observations

**Outpatient**  
Consultant Led News were 8% down on plan and 7% down on prior year, driven by Ophthalmology, General Surgery and Gastro.  
Consultant Led Follow Ups were under plan by 3% and 1.2% down on prior year. Underperformance in medicine was the biggest driver, particularly clinical oncology (-289) and Gastro (-169).  
W&C were under plan, due to combined underperformance of 304 in paediatrics specialties.  
Non Consultant outpatients were down against plan across the board, but particularly in Palliative medicine (-590) and therapies (-328)

**A&E**  
Performance was 2.4% under plan (-277 attendances) and on a par with Feb 19 activity.

#### Management Comments and Actions

**Outpatient**  
EAUS activity now recorded as outpatient but not counted in activity figures due to block funding arrangement, skewing figures. This will be addressed through business planning for 2020/21.

February 2020

## Core Slide 38

### Finance - Lead Director John Hennessey

#### Executive Summary

- **The reported deficit** for the year to date at month 11 is £52.9m which is **£31.4m** adverse to budget. In month there was a deficit of £8.0m which was £5.0m adverse to budget. Adverse performance against the Control Total excluding the £2.8m variance due to the reversal of PSF/FRF funding was £2.2m. Compared to the forecast produced at month 9 an improvement of £160k was reported.
- **Income** Excluding adjustments for the NHSE Specialised block (£2.8m), N&WCCG block (£3.0m), the income based on actual activity to date is £2.9m adverse to budget. Of which key variances inclusive of CIP targets are: Electives under performance £7.0m, Non electives under performance £4.1m, Outpatients under performance £2.7m, Day-cases under performance £0.3m, A&E over performance £0.4m. YTD CIP plan is £7.9m.
- **Other Income:** YTD £22.1m Adverse of which £18m relates to PSF/FRF. In month £4.8m adverse mainly due to £2.8m PSF/FRF, reversal of TPW private patient income £1.2m and £0.7m clinical income CIP not achieved
- **Pay** is overspent year to date by £10.5m (3.0%). Key areas of overspend are Medicine £3.7m, Urgent & Emergency Care £2.2m, Surgery £1.6m, CSS £0.7m. In all areas the overspend is being driven by temporary staffing costs i.e. locums, bank, agency, overtime. In month pay was overspent by £1.7m mainly due to £0.3m CIP unidentified, £0.6m CIP categorisation change and £0.8m temporary staffing.
- **Non Pay** is overspent by £4.1m year to date. In month favourable to plan by £0.5m mainly due to: Spire outsourcing £0.4m, delayed opening of New Ward Block and Outsourced Renal Dialysis £0.4m, offset by HPV Mobilisation costs (£0.1m) and Unidentified CIP £0.1m
- **The CIP Target is £26.6m.** The budget for M10 year to date is £23.6m. Year to date £21.8m was achieved representing an underperformance of £1.8m .
- **Forecast:** The forecast remains in line with the projection at month 9, £16.2m adverse to plan.

SUMMARY INCOME AND EXPENDITURE ACCOUNT	In Month			Year to Date			Full Year Forecast		
	Actual £m	Budget £m	Variance (adv)/fav £m	Actual £m	Budget £m	Variance (adv)/fav £m	Forecast £m	Budget £m	Variance (adv)/fav £m
Clinical Income excluding NT Drugs	38.3	37.8	0.5	440.4	437.5	2.9	482.9	478.6	4.3
NT Drugs	5.3	5.9	(0.6)	60.6	64.8	(4.2)	65.6	70.7	(5.1)
Other Income	6.1	10.9	(4.8)	85.6	107.7	(22.1)	96.6	118.5	(21.9)
<b>TOTAL OPERATING INCOME</b>	<b>49.7</b>	<b>54.6</b>	<b>(4.9)</b>	<b>586.6</b>	<b>610.0</b>	<b>(23.4)</b>	<b>645.1</b>	<b>667.8</b>	<b>(22.7)</b>
Pay Costs	(33.0)	(31.3)	(1.7)	(354.2)	(343.7)	(10.5)	(388.7)	(375.2)	(13.5)
Drugs	(6.4)	(7.0)	0.6	(71.8)	(76.8)	5.0	(77.7)	(83.8)	6.1
Other Non Pay Costs	(14.7)	(15.2)	0.5	(173.1)	(169.0)	(4.1)	(193.1)	(184.2)	(8.9)
<b>TOTAL OPERATING EXPENSES</b>	<b>(54.1)</b>	<b>(53.5)</b>	<b>(0.6)</b>	<b>(599.1)</b>	<b>(589.5)</b>	<b>(9.6)</b>	<b>(659.5)</b>	<b>(643.2)</b>	<b>(16.3)</b>
<b>EBITDA</b>	<b>(4.4)</b>	<b>1.1</b>	<b>(5.5)</b>	<b>(12.5)</b>	<b>20.5</b>	<b>(33.0)</b>	<b>(14.4)</b>	<b>24.6</b>	<b>(39.0)</b>
Depreciation	(0.8)	(1.0)	0.2	(9.0)	(9.6)	0.6	(9.8)	(10.6)	0.8
Finance Costs	(2.8)	(3.1)	0.3	(31.6)	(32.5)	0.9	(34.5)	(35.6)	1.1
Other - PDC, Disposals & Interest Income	0.0	0.0	0.0	0.2	0.1	0.1	0.2	0.1	0.1
<b>(Deficit)/surplus after tax excluding Donated Additions</b>	<b>(8.0)</b>	<b>(3.0)</b>	<b>(5.0)</b>	<b>(52.9)</b>	<b>(21.5)</b>	<b>(31.4)</b>	<b>(58.5)</b>	<b>(21.5)</b>	<b>(37.0)</b>
Adjustment for donated depreciation	0.1	0.1	0.0	0.8	0.7	0.1	0.8	0.8	0.0
<b>(Deficit)/surplus on a Control Total basis</b>	<b>(7.9)</b>	<b>(2.9)</b>	<b>(5.0)</b>	<b>(52.1)</b>	<b>(20.8)</b>	<b>(31.3)</b>	<b>(57.7)</b>	<b>(20.7)</b>	<b>(37.0)</b>
Adjustment for PSF/FRF/MRET	(0.8)	(3.6)	2.8	(12.0)	(30.0)	18.0	(12.8)	(33.6)	20.8
<b>(Deficit)/surplus Excl. PSF/FRF/MRET</b>	<b>(8.7)</b>	<b>(6.5)</b>	<b>(2.2)</b>	<b>(64.1)</b>	<b>(50.8)</b>	<b>(13.3)</b>	<b>(70.5)</b>	<b>(54.3)</b>	<b>(16.2)</b>



## Core Slide 39

## Finance - Lead Director John Hennessey

### Income and Expenditure Summary as at M11 – Feb 2020

The reported I&E position for M11 is a deficit of £8.0m, against budget of £3.0m. This is a 5.0m adverse variance in month (adverse variance of £31.4m year to date).

The key in month variances are PSF Funding £2.8m adverse, Private Patient income £1.2m, Clinical income CIP £0.7m, Pay £1.7m adverse, Non Clinical Supplies £0.6m favourable, Depreciation and Interest favourable £0.5m

### Summary of I&E Indicators

Income and Expenditure	Actual / Forecast £'000	Budget / Target £'000	Variance to Budget (adv) / fav £'000	Direction of travel (variance)	RAG
In month (deficit) / surplus	(8,046)	(2,991)	(5,055)	↓	Red
YTD (deficit) / surplus	(52,934)	(21,538)	(31,396)	↓	Red
Forecast (deficit) / surplus	(57,757)	(20,691)	(37,066)	↓	Red

NHS Clinical Income (exc Drugs) YTD	440,362	437,465	2,897	↑	Green
Other Income YTD	85,439	107,760	(22,321)	↓	Red
Pay YTD	(354,164)	(343,748)	(10,416)	↓	Red
Non Pay (exc Drugs) YTD	(173,064)	(168,970)	(4,094)	↓	Red
Net Drugs YTD	(11,229)	(11,998)	769	↑	Green
Non Opex YTD	(40,278)	(42,047)	1,769	↑	Green
CIP Target YTD	21,778	23,636	(1,858)	↓	Red

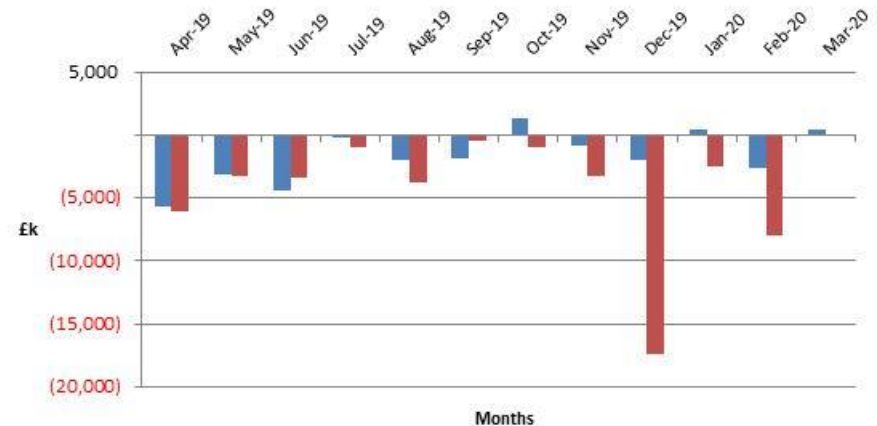
### Other Indicators

Cash at Bank	8,806	1,155	7,651	↑	Green
Borrowings	(160,897)	(136,963)	(23,934)	↓	Red

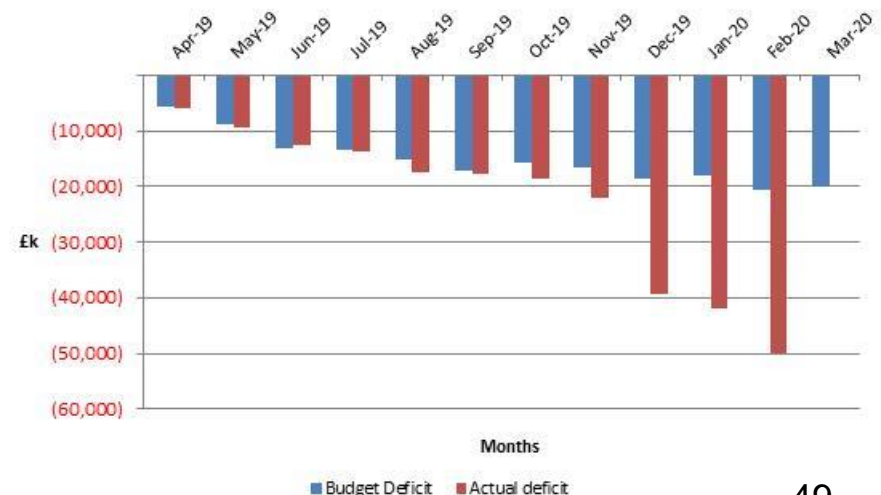
Green	Favourable or nil variance
Amber	Adverse Variance less than £200k
Red	Adverse Variance more than £201k

↑	In month improvement and YTD favourable
↑↓	In month improvement and YTD adverse
↔	No change
↓↑	In month deterioration and YTD favourable
↓	In month deterioration and YTD adverse

Monthly I&E deficit against budget for 2019/20



Cumulative I&E deficit against budget for 2019/20





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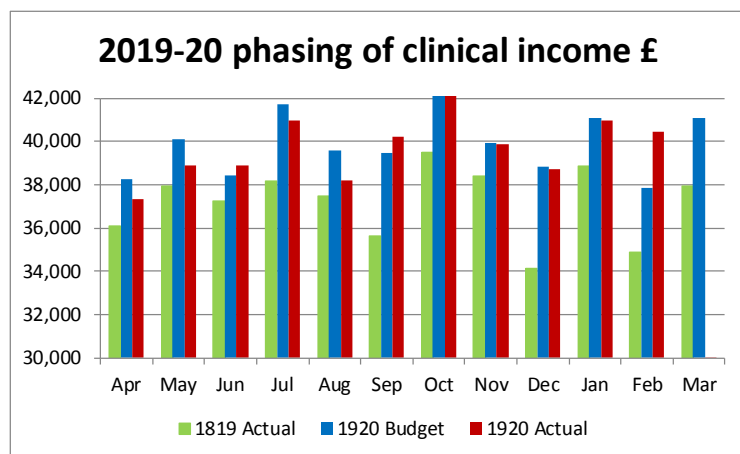
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February 2020

## Core Slide 40 Finance - Lead Director John Hennessey

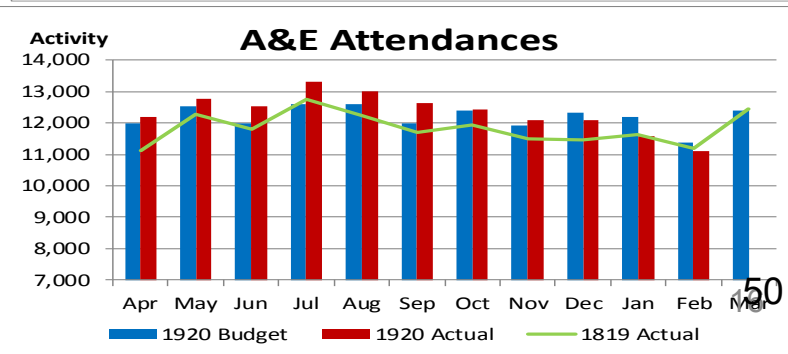
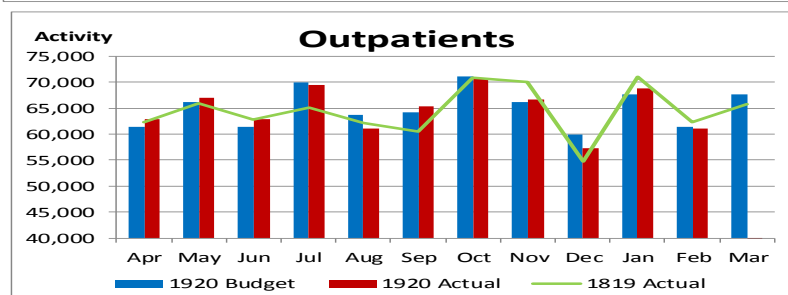
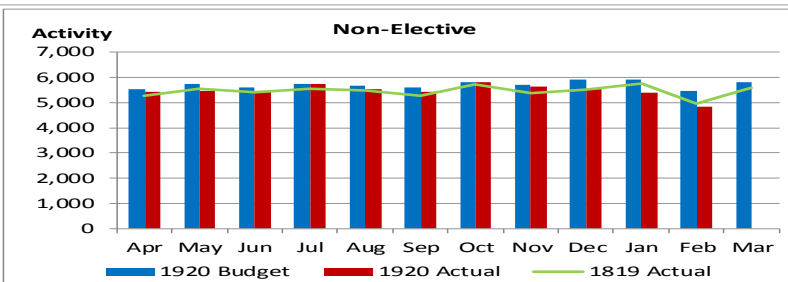
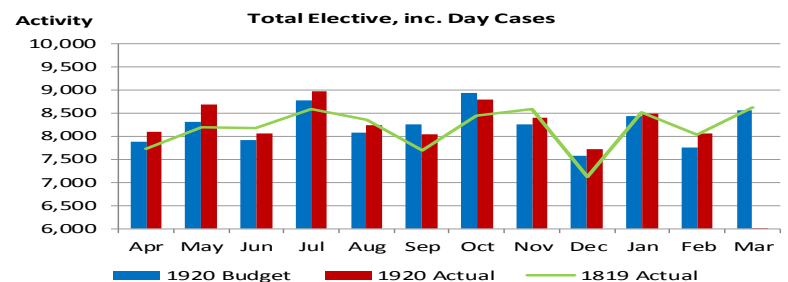
### Income Analysis

The chart below sets out the monthly phasing of the clinical income budget for 2019/20. This phasing is in line with activity phasing which is how the income is recognised. The phasing is responsive to actual days and working days, hence the monthly variation.



The income position in February is an over performance of £0.35m. This is made up of under delivery in Electives (£0.4m), Non Electives (£1.2m) offset by Norfolk and Waveney Block adjustment of £0.9m (£3.0m YTD) and Specialised Block adjustment of £0.4m (£2.8m YTD)

Income (£'000s)	Current month			Year to date		
	Budget	Actual	Variance	Budget	Actual	Variance
Daycase (inc. Reg Day Attd)	4,054	4,379	326	47,044	48,526	1,482
Elective	3,707	3,316	-391	43,509	37,021	-6,488
Non Elective	13,038	11,857	-1,181	149,668	145,726	-3,942
Marginal Rate Reduction	-758	-758	0	-8,342	-8,342	0
Accident & Emergency	1,619	1,595	-24	19,064	19,493	429
Outpatients	6,773	6,796	23	78,566	78,229	-336
CQUIN	408	387	-20	4,715	4,646	-69
C&V	5,649	5,508	-141	65,234	65,979	746
Other	3,445	5,201	1,757	38,008	49,083	11,075
<b>Total</b>	<b>37,934</b>	<b>38,282</b>	<b>348</b>	<b>437,465</b>	<b>440,362</b>	<b>2,897</b>





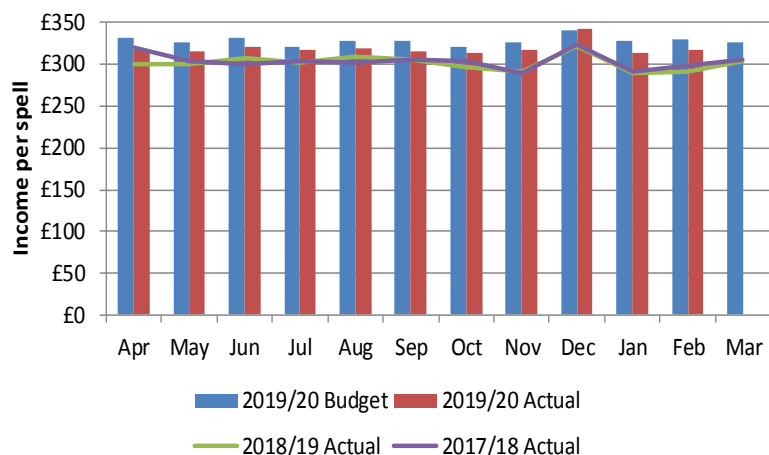


February 2020

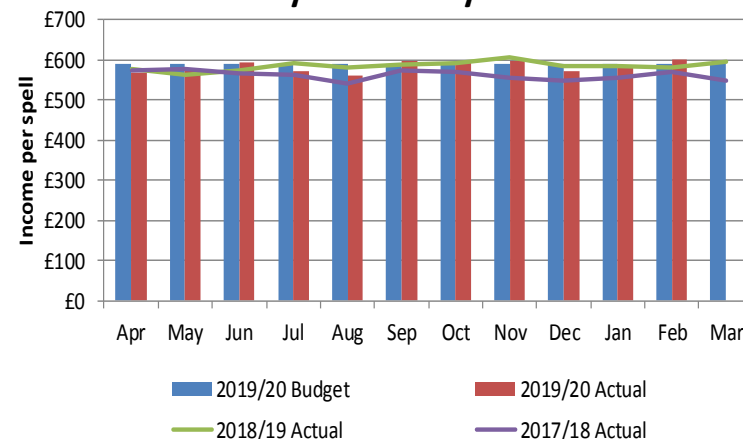
## Core Slide 41

**Finance** - Lead Director John Hennessey

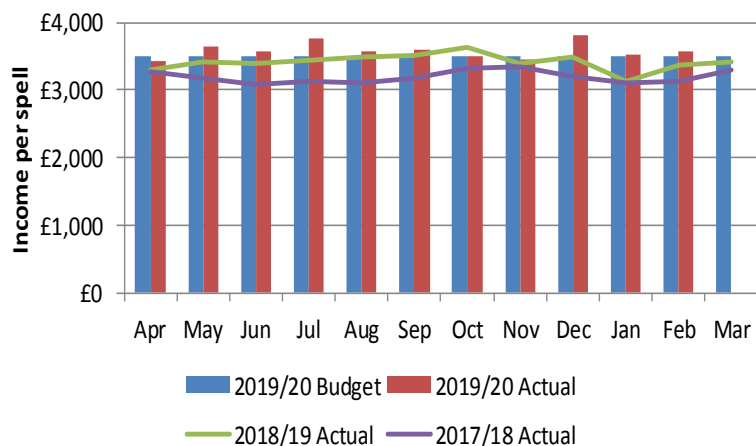
**Total Income Analysis (exc. Other)**



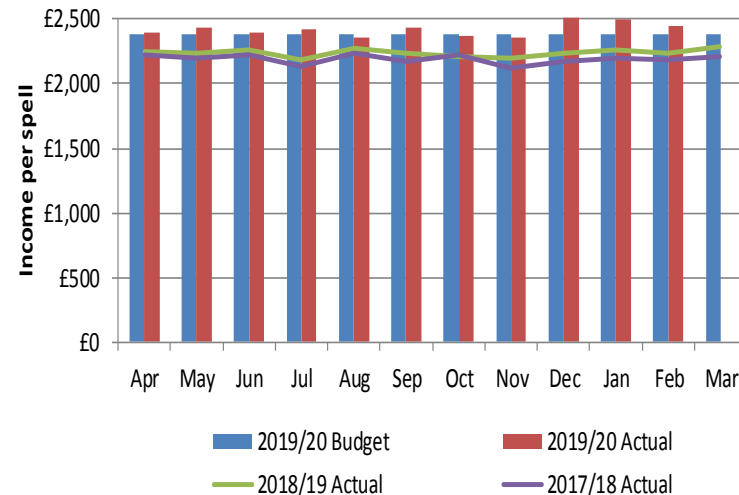
**Day Case Analysis**



**Elective Analysis**



**Non Elective Analysis (exc. Marginal Rate)**





February 2020

## Core Slide 42

## Finance - Lead Director John Hennessey

### Pay Analysis

Monthly Expenditure (£)						
As at February 2020	Feb-20	Jan-20	Dec-19	Nov-19	Oct-19	Sep-19
	£'000	£'000	£'000	£'000	£'000	£'000
<b>Budgeted costs in month</b>	<b>31,330</b>	<b>31,430</b>	<b>30,957</b>	<b>30,833</b>	<b>31,387</b>	<b>31,372</b>
<b>Actuals:</b>						
<b>Substantive staff</b>	<b>29,141</b>	<b>28,839</b>	<b>28,862</b>	<b>28,382</b>	<b>28,644</b>	<b>28,380</b>
Medical External Locum Staff*	268	235	149	252	201	221
Medical Internal Locum Staff	624	704	555	585	607	585
Additional Medical Sessions	376	323	351	338	366	337
Nursing Agency Staff*	609	502	541	517	529	486
Nursing Bank Staff	1,206	1,177	1,210	1,163	1,123	1,110
Other Agency (AHPs/A&C)*	218	307	362	258	247	249
Other Bank (AHPs/A&C)	194	196	156	184	183	174
Overtime	346	244	368	401	366	377
On Call	8	216	213	208	214	223
<b>Total temporary expenditure</b>	<b>3,848</b>	<b>3,905</b>	<b>3,906</b>	<b>3,906</b>	<b>3,835</b>	<b>3,761</b>
<b>Total Pay costs</b>	<b>32,989</b>	<b>32,744</b>	<b>32,768</b>	<b>32,288</b>	<b>32,478</b>	<b>32,141</b>
Variance Fav / (Adv)	(1,659)	(1,314)	(1,811)	(1,455)	(1,091)	(769)
Monthly Movement Increase/(Decrease)	221	456	290	(190)	337	585
<b>Temp Staff costs % of Total Pay</b>	<b>12%</b>	<b>12%</b>	<b>12%</b>	<b>12%</b>	<b>12%</b>	<b>12%</b>
<b>Memo: Total agency spend in month*</b>	<b>1,095</b>	<b>1,044</b>	<b>1,052</b>	<b>1,027</b>	<b>976</b>	<b>956</b>

Data taken from the workforce return as agreed with deputy workforce director each month.

Actuals taken from NHSI return which is generated from the ledger.

Employed substantive provided by payroll. This is converted into WTE that are populated in the ledger, and reported to NHSI, via the workforce return. sourced from payroll.

The table below represent s the substantive WTE movement in the last 12 month's.

Jul-19 Includes £267k of 18/19 accrual releases, split as follows:

- Agency £181k
- Internal Locums £44k
- External Locums £42k

Sep-19 includes £0.6m pay award for Consultants and Oct-19 includes £0.5m pay award for junior doctors.

Substantive Staff Growth over 12 month period	Feb-19	Feb-20	12 month Substantive Increase	12 month Substantive Increase %
Staff Group	WTE	WTE	WTE	%
A&C	1,442	1,567	125	8.7%
AHP	587	606	19	3.3%
Apprentices	68	66	(2)	(2.9%)
Medical	1,059	1,128	69	6.5%
Midwives	211	206	(5)	(2.3%)
Nursing	2,943	3,195	252	8.6%
Other	228	253	24	10.7%
Science, Professional Technical	685	703	18	2.6%
<b>Grand Total</b>	<b>7,223</b>	<b>7,724</b>	<b>501</b>	<b>6.9%</b>

Premium Pay by Division (Excl. On Call)	Feb-20	Jan-20	Dec-19	Nov-19	Oct-19	Aug-19	Jul-19
Division	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Medicine	1,343	1,202	1,286	1,235	1,133	1,153	1,136
Emergency & Urgent Care	591	610	563	611	576	544	606
Surgery	1,067	967	1,075	1,123	1,102	1,025	1,136
Women & Childrens	284	300	243	236	267	269	278
Clinical Support	449	363	342	412	369	363	488
Services	92	240	172	74	169	181	158
R&D Projects	14	7	11	7	4	3	6
<b>Total</b>	<b>3,841</b>	<b>3,689</b>	<b>3,693</b>	<b>3,698</b>	<b>3,620</b>	<b>3,538</b>	<b>3,807</b>

18/19 Balance Sheet accrual releases of £267k excluded from Divisional Breakdown





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

# Norfolk and Norwich University Hospitals



NHS Foundation Trust

February 2020

## Core Slide 43

## Finance - Lead Director John Hennessey

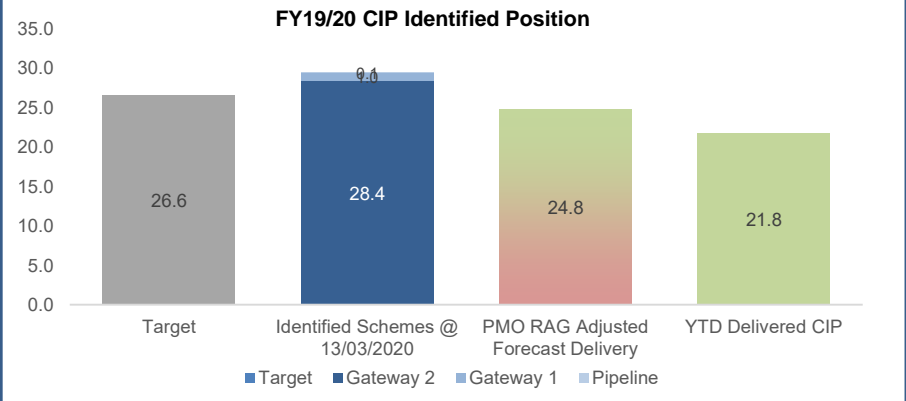
### CIP Analysis

#### FY19/20 YTD CIP Performance

- The Trust has delivered £21.8m of CIPs against a FIP Board approved plan of £24.5m, an under-performance of £2.7m arising through adverse performance in:
  - Clinical income initiatives, particularly within surgical specialties and theatre productivity schemes;
  - Pay initiatives, including temporary spend and planned vacancies; and
  - Under-recovery of private patient income against plan, including the reduction of £0.9m of accrued receipts which have not yet been received by the Trust.
- The £21.8m of YTD delivery represents an underperformance of £1.8m against the annual plan of £23.6m.

#### FY19/20 CIP Plan Development

- To date £29.5m of opportunity has been identified to be developed through the Trust's governance gateway process, of which £28.4m has been approved through Gateway 2.
- The risk adjusted forecast delivery for FY19/20 is currently calculated as £24.8m based on the latest forecast financial performance of in delivery schemes, progress against milestone delivery and performance against quality and performance indicators.



Category	FIP Approved Plan YTD £'000	Actual YTD £'000	Variance £'000
Clinical Income	8,626.7	6,977.9	(1,648.8)
Pay*	3,935.3	4,748.0	812.7
Non-pay*	8,388.9	9,158.4	769.5
Other Income*	2,921.3	307.6	(2,613.8)
Non-Opex	627.8	585.9	(41.9)
	<b>24,500.0</b>	<b>21,777.7</b>	<b>(2,722.2)</b>

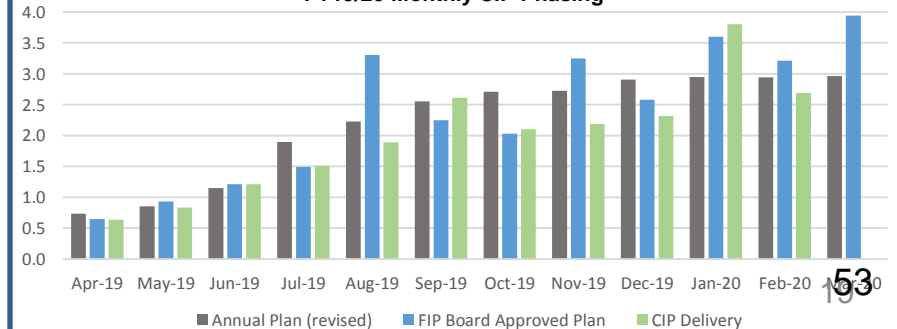
\*Information is shown as the savings identified net of any costs associated with the delivery of clinical income initiatives.

#### FY19/20 Performance by Division

Division	Number of schemes 'In Delivery'	CIP Delivery		
		YTD FIP Board Approved Plan £'000	YTD Actual £'000	YTD Variance £'000
Medicine	22	6,359.9	6,498.6	138.8
Surgery	26	7,322.0	5,753.5	(1,568.5)
Women & Children's	26	2,231.1	2,350.8	119.7
Clinical Support Services	32	4,008.9	2,502.6	(1,506.3)
Emergency & Urgent Care	7	453.5	522.5	69.0
Corporate	13	4,124.6	4,149.7	25.1
Cross-Divisional*	7	-	-	-
	<b>133</b>	<b>24,500.0</b>	<b>21,777.7</b>	<b>(2,722.2)</b>
YTD per Annual Plan		23,635.3	23,635.3	
Variance to Annual Plan		<b>864.7</b>	<b>(1,857.6)</b>	

\*Cross-divisional plan and actuals have been allocated to the relevant divisions

#### FY19/20 Monthly CIP Phasing





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February 2020

## Core Slide 44

## Finance - Lead Director John Hennessey

### Summary by Division

#### Medicine

**Clinical Income** - M11 overachieved by £358k - £51k prior mth catch-up, £307k overachievement in month, mainly due to an increase in non-elective income in OPM and Neurosciences (Stroke), along with an increase in day case income mainly driven by Cardiology, Gastroenterology and Haematology. This is partly mitigated by a reduction in elective income, mainly in Cardiology and outpatient income. Year to date overachieved by £2,294k mainly due to an overachievement in day case activity. In month £285k ahead of forecast.

**Other Income** - M11 drugs income underachieved by (£413k), offset by an underspend on drugs. YTD drugs income underachievement (£3,280k). In month drugs income in-line with forecast. Other income £21k in month, £299k YTD. In month income slightly behind forecast.

**Pay** - M11 overspend of (£659k). (£167k) Oncology - (£96k) Oncology Nursing & (£54k) Radiotherapy. (£122k) Neurosciences - (£58k) Stroke Medical including External Locum Consultant & Junior Doctors and (£58k) nursing. (£119k) Respiratory - (£63k) Medical Staff & (£56k) Hethel Ward. (£70k) OPM - (£74k) nursing. (£69k) Gastro - (£44k) nursing and (£26k) Medical Staff. (£42k) Renal - (£26k) nursing & (£17k) Medical. (£40k) Cardiology - (£36k) Nursing & (£4k) Medical Staff. (£32k) Renal - (£13k) Medical Staff & (£18k) Langley Ward and JPU. In month expenditure, (£118k) higher than forecast mainly due to AMU increase in agency expenditure.

**Non-Pay** - M11 drugs cost underspent by £376k, offset by an underachievement on drugs income, YTD drugs underspent £3,386k. M11 clinical supplies (£98k). (£80k) Cardiology - overspend on med & surg and stents in PCI and Pacing - partly offset by an increase in activity. (£25k) Respiratory - Respiroincs (Sleep Apnoea) - pass-through to CCGs. YTD (£1,871k). In month expenditure £235k lower than forecast. M11 Non-Clinical Supplies (£66k). (£24k) Gastroenterology - capacity support costs and (£19k) Oncology and (£14k) Neurosciences - Stroke pass-through payment. YTD (£587k). In month expenditure £77k lower than forecast.

#### Emergency and Urgent care

**Income** - Clinical Income £335k ahead of plan, due to increased activity in A&E. £236k Increased Income to increase CHS (Offset in Non-pay), £59k Over achievement in EAAA Recharges, offset by (£120k) of Unachieved CIP. (£391k) behind forecast due to reduced Clinical income (due to GP streaming) and accrual adjustment on CHS Income.

**Pay** - External locum overspend £666k, internal locum overspend £941k split between UCC & A&E Medical. Bank overspend £634k agency overspend £778k partially offset by overachieve of vacancy factor against pay costs (£894k). Slightly ahead of Forecast.

**Non-Pay** - (£403k) Unidentified CIP, (£167k) additional CHS expenditure (Offset by other Income). (£122k) overspend on drugs, in line with increased A&E activity. £58k ahead of forecast due to various small variances

#### Surgery

**Income** - Clinical Income £1,654k adverse variance in month (£13,382k YTD) Cancellations remain high, 254 in February (233 M10) & 95 On The Day cancellations (70 in M10). The majority of cancellations are due to bed shortages.

Variance on DC £273k (YTD £2,689k), EL £250k (£4,407k), NEL £1,359k (£6,232k), OP £89k (£1,299k).

Specialities with the most significant variances were: General Surgery £545k (£3,871k), Urology £272k (£1,987k), T&O £258k (£2,804k), Ophthalmology £129k (£912k), Plastic Surgery £154k (£704k), Vascular £198k (£1,952k), Dermatology £53k (£522k), ENT £5k (£262k favourable)

YTD CIP failure of £3,316k

Spire over-performance has fallen to £591k YTD (£1,278k M8, £848k M9, £450k M10) as a result of the reduced Orthopaedic referrals. The reduction in activity is expected to be reflected in January's final income figures.

Variance to forecast £1,664 adverse in month (£4,233k adverse YTD) mainly due to Specialised block benefit reported in Central.

**Pay** - Overspend in month £266k (YTD £1,551k). Unidentified CIP of £197k (YTD - £1,941). Nursing overtime is overspent by £56k (a decrease from an overspend of £31k in M9) & is seeing an ongoing reduction month on month (£215k in M8 to £70k in M10). Agency nursing has decreased to £141k in M11 from £174k in M10. Substantive costs continue to increase each month. M1 substantive costs were £8,061k. They are now £8,334k.

YTD Premium Pay is £1,513k underspent, driven by a combination of medical & nursing pp underspends. Locums are underspent by £331k, WLI by £408k, agency by £1,094k. £370k adverse variance in relation to the Cancer Alliance costs recovered through income.

Provisional figures for Dec show an ongoing trend of high numbers of Medical Boarders, an average of 72, nearly two wards, in January, up from 37 in July.

Variance to forecast - £180k favourable in month (£404k favourable YTD).

**Non-Pay** - £543k underspent in month reflecting the reduced activity at Spire, referrals were reduced to 6 patients pw as part of the divisional CIP initiatives, this has risen to 16 pw to combat 52 Week breaches. Ophthalmic & Dermatology drugs continue to underspend reflecting both the under-performance on activity & the adverse variance in non-tariff drugs income.

Variance to forecast - £435k favourable variance in month (£939k favourable YTD).

DIRECTORATES INCOME & EXPENDITURE	Feb-20			Year to date		
	Actual £k	Budget £k	Variance F/(A) £k	Actual £k	Budget £k	Variance F/(A) £k
<b>MEDICINE</b>						
Total Income	19,636	19,669	(33)	221,998	222,684	(687)
Pay Costs	(9,373)	(8,713)	(659)	(98,676)	(94,961)	(3,714)
Non-Pay Costs	(7,359)	(7,570)	211	(81,958)	(82,886)	929
Total Expenditure	(16,732)	(16,283)	(448)	(180,633)	(177,848)	2,786
<b>SURPLUS/(DEFICIT)</b>	<b>2,905</b>	<b>3,386</b>	<b>(481)</b>	<b>41,364</b>	<b>44,837</b>	<b>(3,472)</b>
<b>EMERGENCY &amp; URGENT CARE</b>						
Total Income	1,618	1,649	(31)	19,611	19,092	519
Pay Costs	(2,140)	(1,886)	(253)	(23,246)	(21,032)	(2,215)
Non-Pay Costs	(336)	(228)	(107)	(3,681)	(3,121)	(560)
Total Expenditure	(2,475)	(2,115)	(361)	(26,928)	(24,153)	2,775
<b>SURPLUS/(DEFICIT)</b>	<b>(857)</b>	<b>(466)</b>	<b>(391)</b>	<b>(7,317)</b>	<b>(5,060)</b>	<b>(2,256)</b>
<b>SURGERY</b>						
Total Income	12,749	14,746	(1,996)	155,633	169,304	(13,671)
Pay Costs	(9,418)	(9,152)	(266)	(102,789)	(101,238)	(1,551)
Non-Pay Costs	(3,359)	(3,902)	543	(44,207)	(44,803)	596
Total Expenditure	(12,778)	(13,054)	277	(146,996)	(146,041)	955
<b>SURPLUS/(DEFICIT)</b>	<b>(28)</b>	<b>1,692</b>	<b>(1,720)</b>	<b>8,638</b>	<b>23,263</b>	<b>(14,625)</b>



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NHS Foundation Trust

February 2020

## Finance - Lead Director John Hennessey

### Core Slide 45

#### Summary by Division continued

##### Women's and Children's

**Income** - Clinical Income £0.2m adverse in month driven by lower activity levels in NICU and maternity. Drugs and other income are both up slightly in month. YTD income is adverse by £2.3m of which £1.3m is driven by NICU and the remainder within Gynae (£600k) mainly due to winter cancellations and sickness and Obstetrics (£500k)

**Pay Costs** are overspent in month by £63k. January included unidentified CIP of £20k as well as a £40k overspend within maternity and £24k of overspend within Obstetric and gynaecology Medical due to cover of 2 consultants on mat leave, vacancies within paediatric nursing is offsetting some of the overspends in month. YTD is now showing an overspend of £12k.

**Non Pay** - £96k overspent in month, £65k of which is unidentified CIP, remainder of overspend due to catch up of costs for BMI within Gynaecology and community midwifery rent.

##### Clinical Support

**Income** - Clinical Income £1,279k favourable, due to new HPV contract (£1,637k benefit), offset by reduced EPA income (£253k CIP not achieved) and reduced Radiology (£440k - Nuclear Med scanners closed). £1,640k HPV Mobilisation Income ahead of plan (offset by Costs). Cytology backlog work and other laboratory tests £208k ahead of plan. Drugs Income £1,028k adverse to plan (Offset by reduced costs - Cambridge Community Contract). £1,284k adverse to forecast, due to timing difference on HPV mobilisation (£878k) and clinical income (£510k).

**Pay** - (£720k) YTD variance includes (£238k) HPV Mobilisation, (£166k) New Staff in Cytology for new contract, (£207k) EPA overspend, mainly due to agency usage (JPUH), (£348k) overspend in Imaging, due to vacancy factors not met, all offset by £208k underspend in dietetics, as Community staff now TUPE to NCHC - Offset by reduction in Clinical Income Block. £470k favourable mainly due to HPV (both mobilisation and new staffing).

**Non-Pay**- YTD Variances include (£1,964k) HPV Mobilisation, (£108k) on Clinical Engineering items (Inc. new contracts like infusion pumps and Radiometer), (£367k) JPUH spoke site overspend, £121k overspend on Blood products, (£239k) on EPA consumables, (£262k) Outsourcing to SHS for Histology Reporting, (£190k) on CT Maintenance contract (New Siemens contract), (£151k) overspend on Histology Consumables, (£242k) additional MRI vans for recovery plan - offset by additional clinical income, (£71k) Additional mattress hire costs. Drugs costs underspend of £1,113k (offset by Drugs Income). £1,125k favourable variance against forecast, due to timing difference on HPV mobilisation

##### Services

**Income** - YTD is £137k adverse to plan due to CNST reimbursement now required to be shown as reduction in non pay £372k. Facilities car parking shortfall due to less spaces being available due to construction £28k These are partially offset by Quadrum income for IT equipment and additional STP support for IT of £275k

**Pay** - is overspent in month by £37k, £96k overspend due to unidentified CIP in month and an £18k additional cost in HR for temporary staffing project team. This is partially offset by an underspend within IT driven by capitalisation of project related agency costs. YTD pay is overspent by £137k, £448k of which is due to unidentified CIPS. This is offset by underspends in Finance, Nurse Management & Planning & Performance as well as IT.

**Non-Pay** - Is overspent by £219k in month, £60k of which relates to additional costs within IT, £70k due to catch up on water rate costs, £44k of additional Leaseguard costs and £25k finance office move costs due to AP service no longer being outsourced. YTD there is an overspend of £479k of which £307k relates to legal fees, £185k Quadrum IT installation, £60k additional IT maintenance overspend, £70k additional costs for water rates. This is partially offset by £180k reduced bad debt provision.

##### Other

**Income** - M11 adverse variance of £3.0m due to Specialised Block & N&W Block of £1.3 offset by unachieved PSF funding of £2.9m & Private Patient income of £1.2m. YTD £9.8m adverse due to PSF/FRF Funding offset by Specialised and N&W CCG Blocks

**Pay** - M11 adverse variance of £0.4k due CIP categorisation change of £0.6m, R&D £0.3m (offset by income) & CEA catch up £0.2m, offset by £0.6k of delayed service developments. YTD £2.1m adverse due to £3.9m of CIP categorisation change offset by 2.3m delayed Service Developments

**Non-Pay** - M11 favourable variance of £1.0m due to release of contingency £0.4m, delayed Ward Block opening £0.3m and delayed Dialysis Outsourcing £0.15m. YTD favourable variance £3.7m, contingency £3.3m R&D £0.7m and delayed service developments £1.0m offset by (£1.5m) due to unallocated non-pay CIP

**Non-Opex** - M11 favourable variance of £0.3m, being Contingent Rent £74k from RPI being less than assumed and depreciation of £134. YTD £1.6m of which Contingent rent £0.6m & Depreciation £0.7m

	Feb-20			Year to date		
	Actual £k	Budget £k	Variance F/(A) £k	Actual £k	Budget £k	Variance F/(A) £k
<b>DIRECTORATES INCOME &amp; EXPENDITURE</b>						
<b>WOMENS &amp; CHILDREN</b>						
Total Income	5,263	5,452	(188)	59,983	62,318	(2,334)
Pay Costs	(3,682)	(3,619)	(63)	(39,506)	(39,494)	(12)
Non-Pay Costs	(596)	(500)	(96)	(6,701)	(5,831)	(870)
Total Expenditure	(4,278)	(4,120)	(159)	(46,208)	(45,325)	883
<b>SURPLUS/(DEFICIT)</b>	<b>985</b>	<b>1,332</b>	<b>(347)</b>	<b>13,776</b>	<b>16,993</b>	<b>(3,217)</b>
<b>CLINICAL SUPPORT</b>						
Total Income	4,566	4,153	413	49,564	47,120	2,444
Pay Costs	(5,483)	(5,478)	(5)	(60,769)	(60,049)	(720)
Non-Pay Costs	(2,947)	(2,666)	(282)	(31,625)	(29,253)	(2,372)
Total Expenditure	(8,431)	(8,144)	(286)	(92,394)	(89,302)	3,092
<b>SURPLUS/(DEFICIT)</b>	<b>(3,865)</b>	<b>(3,992)</b>	<b>127</b>	<b>(42,830)</b>	<b>(42,182)</b>	<b>(648)</b>
<b>SERVICES</b>						
Total Income	648	643	6	6,931	7,068	(137)
Pay Costs	(2,146)	(2,109)	(37)	(23,540)	(23,427)	(113)
Non-Pay Costs	(5,657)	(5,438)	(219)	(59,570)	(59,091)	(479)
Total Expenditure	(7,804)	(7,547)	(257)	(83,110)	(82,518)	592
<b>SURPLUS/(DEFICIT)</b>	<b>(7,155)</b>	<b>(6,904)</b>	<b>(251)</b>	<b>(76,179)</b>	<b>(75,449)</b>	<b>(730)</b>
<b>OTHER inc. NON OPEX</b>						
Total Income	5,384	8,340	(2,956)	72,694	82,465	(9,771)
Pay Costs	(747)	(372)	(375)	(5,634)	(3,547)	(2,087)
Non-Pay Costs	(869)	(1,914)	1,045	(17,165)	(20,811)	3,645
Total Expenditure	(1,616)	(2,286)	670	(22,800)	(24,358)	(1,558)
<b>SURPLUS/(DEFICIT)</b>	<b>3,768</b>	<b>6,054</b>	<b>(2,286)</b>	<b>49,894</b>	<b>58,107</b>	<b>(8,213)</b>
<b>TOTAL</b>						
Total Income	49,866	54,651	(4,786)	586,414	610,052	(23,638)
Pay Costs	(32,989)	(31,330)	(1,659)	(354,161)	(343,748)	(10,413)
Non-Pay Costs	(21,124)	(22,218)	1,095	(244,907)	(245,796)	888
Total Expenditure	(54,113)	(53,549)	(564)	(599,068)	(589,544)	9,524
<b>SURPLUS/(DEFICIT)</b>	<b>(4,247)</b>	<b>1,103</b>	<b>(5,350)</b>	<b>(12,654)</b>	<b>20,508</b>	<b>(33,162)</b>



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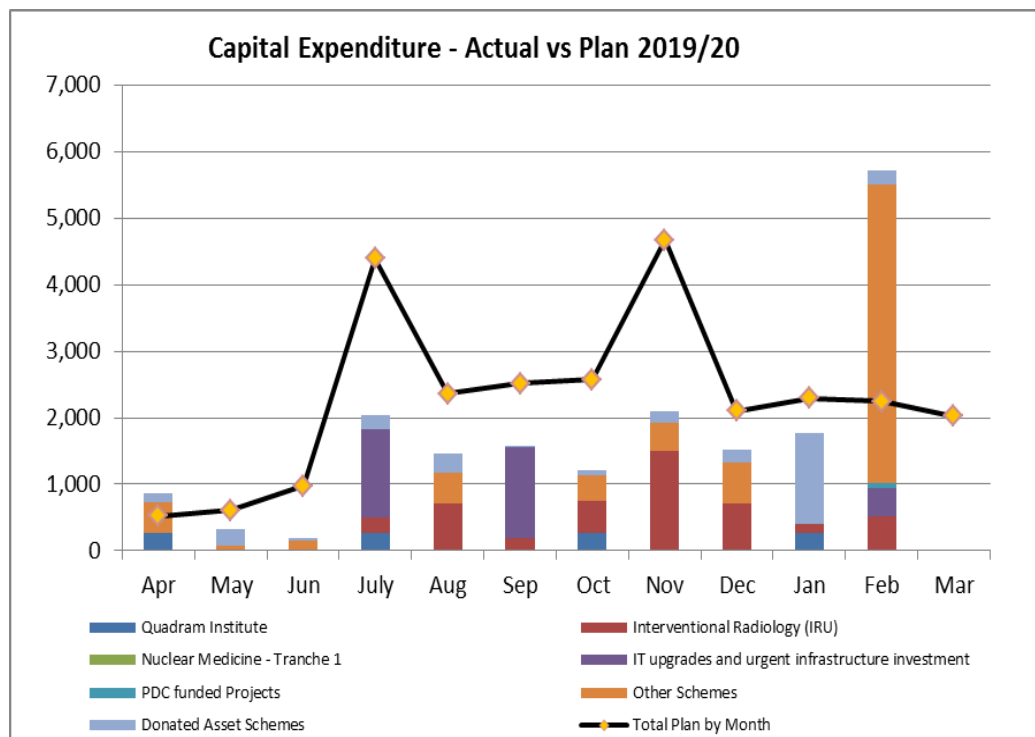


NHS Foundation Trust

February 2020

## Core Slide 46 Capital Progress Report

**Finance** - Lead Director John Hennessey



The capital plan for 2019/20 as submitted to NHSI on the 15<sup>th</sup> July 2019 is £27.305m. This is made up as follows:

- New loan funding £15.8m
- IRU approved loan funding £6.8m
- Internally funded schemes £2.4m
- Charitably funded schemes £2.3m

The related 5 year capital plan is £188.9m.

A drawdown of £0.4m was made in February against the approved IRU loan of £7m. Total drawdown is £4.6m.

An application for a capital loan was made to NHSI/DHSC which was confirmed as agreed on 21 October. The loan agreed is for £20.8m, with £15.8m relating to 2019/20.

A drawdown of £4.1m was made in February against the approved capital loan of £15.8m. Total drawdown is £8.0m.

An additional loan application was made to NHSI/DHSC for £4.6m to purchase the Aylsham Suite. This has been agreed and will be drawn in March.

In addition we have been awarded further capital – as PDC – to support 'Winter' & IT. This totals £5.7m and is expected to be spent by 31<sup>st</sup> March 2020.

	Apr	Apr	May	May	Jun	Jun	July	July	Aug	Aug	Sep	Sep	Oct	Oct	Nov	Nov	Dec	Dec	Jan	Jan	Feb	Feb	Mar	TOTAL
	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Actual	Plan	Plan
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Quadram Institute	271	271	0	0	0	0	271	271	0	0	0	0	271	271	0	0	0	0	270	270	0	0	0	1,083
Interventional Radiology (IRU)	0	0	360	0	726	18	891	234	882	610	660	195	885	480	1,062	1,494	629	704	250	136	89	513	342	6,776
Nuclear Medicine - Tranche 1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2,273	0	0	0	0	0	0	0	0	2,273
IT upgrades & urgent infrastructure	0	0	0	0	0	0	2,664	1,315	0	0	370	1,369	470	0	370	0	370	0	370	0	370	422	150	5,134
PDC funded Projects	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	87	0	0
Other Schemes	251	453	252	84	246	140	212	0	1,227	556	1,363	0	924	385	924	433	1,053	627	1,145	0	1,175	4,478	923	9,695
Charitably Funded Schemes	0	148	0	238	0	38	359	225	250	292	125	9	25	78	50	168	50	192	261	1,364	612	222	642	2,344
<b>Total Plan by Month</b>	<b>522</b>		<b>612</b>		<b>972</b>		<b>4,397</b>		<b>2,359</b>		<b>2,518</b>		<b>2,575</b>		<b>4,679</b>		<b>2,102</b>		<b>2,296</b>		<b>2,246</b>		<b>7,067</b>	<b>27,305</b>
<b>Actual to Date</b>		<b>872</b>		<b>322</b>		<b>196</b>		<b>2,045</b>		<b>1,458</b>		<b>1,573</b>		<b>1,214</b>		<b>2,095</b>		<b>1,523</b>		<b>1,770</b>		<b>5,721</b>		<b>18,789</b>

February 2020

## Core Slide 47

**Finance** - Lead Director John Hennessey

### Statement of Financial Position at 29<sup>th</sup> February 2020

	Opening Balance as at 1 April 2019 £'000	Plan 31 March 2020 £'000	Plan YTD 29 Feb 2020 £'000	Actual YTD 29 Feb 2020 £'000	Variance YTD 29 Feb 2020 £'000
Property, plant and equipment	232,609	256,529	254,195	242,508	(11,687)
Trade and other receivables	78,154	84,918	84,333	84,173	(160)
Other financial assets	0	0	0	0	0
<b>Total non-current assets</b>	<b>310,763</b>	<b>341,447</b>	<b>338,528</b>	<b>326,681</b>	<b>(11,847)</b>
Inventories	10,438	10,574	10,574	10,850	276
Trade and other receivables	28,845	33,505	29,885	38,871	8,986
Non-current assets for sale	0	0	0	0	0
cash and cash equivalents	7,461	1,155	1,155	8,806	7,651
<b>Total Current assets</b>	<b>46,744</b>	<b>45,234</b>	<b>41,614</b>	<b>58,527</b>	<b>16,913</b>
Trade and other payables	(68,246)	(65,055)	(64,622)	(75,482)	(10,860)
Borrowing repayable within 1 year	(21,233)	(52,393)	(46,438)	(46,438)	0
Current provisions	(282)	(307)	(307)	(283)	24
Deferred Income	(5,851)	(4,764)	(4,764)	(18,805)	(14,041)
<b>Total current liabilities</b>	<b>(95,612)</b>	<b>(122,519)</b>	<b>(116,131)</b>	<b>(141,008)</b>	<b>(24,877)</b>
<b>Total assets less current liabilities</b>	<b>261,895</b>	<b>264,162</b>	<b>264,011</b>	<b>244,200</b>	<b>(19,811)</b>
Borrowings - PFI & Finance Lease	(190,764)	(187,406)	(187,919)	(187,935)	(16)
Borrowings - Revenue Support	(89,871)	(87,991)	(90,525)	(114,459)	(23,934)
Borrowings - Capital Support	(224)	(29,479)	(26,741)	(12,566)	14,175
Provisions	(2,131)	(1,702)	(1,717)	(2,083)	(366)
Deferred Income	(5,875)	(4,755)	(4,765)	(3,919)	846
<b>Total non-current liabilities</b>	<b>(288,865)</b>	<b>(311,333)</b>	<b>(311,667)</b>	<b>(320,962)</b>	<b>(9,295)</b>
<b>Total assets employed</b>	<b>(26,970)</b>	<b>(47,171)</b>	<b>(47,656)</b>	<b>(76,762)</b>	<b>(29,106)</b>
<b>Financed by</b>					
Public dividend capital	31,909	31,881	31,881	32,077	196
Retained Earnings (Accumulated Losses)	(73,852)	(94,025)	(94,510)	(123,739)	(29,229)
Revaluation reserve	14,973	14,973	14,973	14,900	(73)
<b>Total Taxpayers' and others' equity</b>	<b>(26,970)</b>	<b>(47,171)</b>	<b>(47,656)</b>	<b>(76,762)</b>	<b>(29,106)</b>

### Non-Current Assets

There is some slippage on the capital programme primarily due to a delay in receiving capital support from DHSC of £14.2m YTD.

### Trade and Other Receivables

This balance is £9.0m higher than plan YTD. The key driver is timing.

### Cash

Cash is £7.7m higher than plan at the end of February due to short term timing differences and operational performance. Loan drawdowns continue to be delayed as long as possible.

### Trade and other payables

This is £10.9m higher than plan YTD.

Increased levels of general trade payables and accruals – timing difference.

### Deferred Income

This balance is £13.2m higher than plan YTD. The key items are MRET income of £0.8m, other income re Region of £5.0m, income related to recharges for capital work not yet carried out of £0.2m, HPV mobilisation income of £3.2m. These are timing differences.

### Borrowings

Total overall support borrowings are £9.8m higher than plan.

In year revenue borrowings are £49.8m against a YTD plan of £25.9m. Being £23.9m higher than plan.

In year capital borrowings are £12.3m against a YTD plan of £26.5m. Being £14.2m lower than plan. The Trust has received the signed loan agreement for the 2019/20 capital loan and has begun the process of drawing against this.

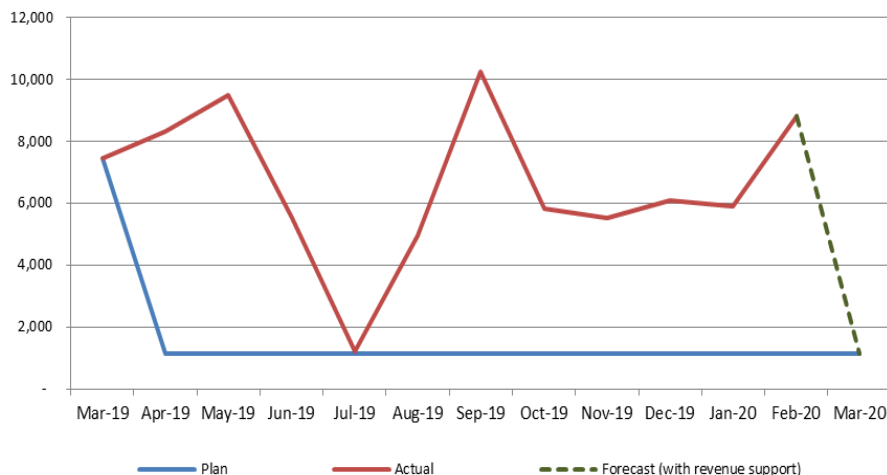


February 2020

## Core Slide 48

## Finance - Lead Director John Hennessey

Cash Balance actual and forecast versus plan



- The graph shows the cash levels since the end of March 2019. Short term timing differences drive the difference between actual and plan.
- The Trust is required to keep a minimum balance of £1 million, hence the closing cash plan every month is circa £1m.
- The future cash loan requirement on current projections is £2.2m in April.
- Without the revenue support of £2.2m in April, the cash position at the end of April is forecast to be minus £1.2m.
- Revenue borrowing of £160.9m at the end of February 2020 comprise: £16m in 2016/17, £36.4m in 2017/18, £58.7m in 2018/19 & £49.8m in 2019/20.
- Capital borrowing of £12.6m at the end of February 2020 comprise: £0.2m in 2018/19 & £12.4m in 2019/20.
- The interest rates are: 3.5% on £71.8m, 1.5% on £92.7m, 1.51% on £4.6m and 0.79% on the remainder of £8.0m.

### NOTE:

- The plan for 2019/20 assumed in year borrowings of £29.3m for revenue. At the start of the year it was £111.1m, bringing total forecast revenue borrowings to £140.4m.
- Capital Borrowings are forecast to be £26.9m following the latest capital submission to NHSI on the 16<sup>th</sup> February 2020.
- The Trust Board approved borrowing 'limit' is £175m revenue and £50m capital.
- The need for the funds is driven by our operational performance.

REVENUE	Opening	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
Revenue Borrowings-Plan	111,104	116,286	121,185	127,455	127,455	128,376	132,748	132,748	132,748	136,963	136,963	136,963	140,384
Revenue Borrowings-Actual	111,104	115,740	121,962	124,056	132,704	138,630	142,771	143,524	145,297	151,597	157,428	160,897	
Variance - (Adverse) / Favourable	0	546	(777)	3,399	(5,249)	(10,254)	(10,023)	(10,776)	(12,549)	(14,634)	(20,465)	(23,934)	

CAPITAL	Opening	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
Capital Borrowings-Plan	224	896	1,808	3,214	6,126	8,642	11,044	14,431	17,421	20,325	23,508	26,741	29,479
Capital Borrowings-Actual	224	224	224	224	224	1,258	1,508	1,852	2,249	7,392	8,091	12,566	24,588
Variance - (Adverse) / Favourable	0	672	1,584	2,990	5,902	7,384	9,536	12,579	15,172	12,933	15,417	14,175	

## Income Statement Comparison - for the Month of February 2020

	For the month			Variances Fav / (Adv)			
	Actual	Budget	Prior year	To Budget		To prior year	
	£'000	£'000	£'000	£'000	%	£'000	%
<b>INCOME</b>							
<b>NHS clinical income</b>							
Clinical Income	38,049	37,172	34,213	877	2%	3,836	11%
Clinical Income - Spire Contract	233	662	751	(429)	(65%)	(518)	(69%)
NT Drugs	5,336	5,893	5,050	(557)	(9%)	286	6%
<b>Total NHS clinical income</b>	<b>43,618</b>	<b>43,727</b>	<b>40,014</b>	<b>(109)</b>	<b>(0%)</b>	<b>3,604</b>	<b>9%</b>
<b>Non NHS clinical income</b>							
Private patients	(885)	318	90	(1,203)	(378%)	(975)	(1083%)
Other - RTA	128	110	153	18	16%	(25)	(16%)
<b>Total Non NHS clinical income</b>	<b>(757)</b>	<b>428</b>	<b>243</b>	<b>(1,185)</b>	<b>(277%)</b>	<b>(1,000)</b>	<b>(412%)</b>
<b>Other Income</b>							
R&D	1,817	1,809	1,795	8	0%	22	1%
Education & Training	2,087	1,976	2,387	111	6%	(300)	(13%)
PSF / FRF / MRET Income	762	3,621		(2,859)	(79%)	762	
Other non patient care income	2,337	3,090	2,973	(753)	(24%)	(636)	(21%)
<b>Total other Income</b>	<b>7,003</b>	<b>10,496</b>	<b>7,155</b>	<b>(3,493)</b>	<b>(33%)</b>	<b>(152)</b>	<b>(2%)</b>
<b>TOTAL OPERATING INCOME</b>	<b>49,864</b>	<b>54,651</b>	<b>47,412</b>	<b>(4,787)</b>	<b>(9%)</b>	<b>2,452</b>	<b>5%</b>
<b>EXPENDITURE</b>							
Employee benefit expenses	(32,993)	(31,330)	(30,397)	(1,663)	(5%)	(2,596)	(9%)
Drugs	(6,390)	(6,984)	(6,018)	594	9%	(372)	(6%)
Clinical supplies	(5,500)	(5,467)	(5,699)	(33)	(1%)	199	3%
Non clinical supplies	(7,093)	(7,644)	(7,497)	551	7%	404	5%
- Fixed	(1,833)	(1,833)	(1,785)		0%	(48)	(3%)
- Capacity	(488)	(424)	(505)	(64)	(15%)	17	3%
- Income Backed including Spire	(2,099)	(2,539)	(2,676)	440	17%	577	22%
- Variable	(2,673)	(2,848)	(2,531)	175	6%	(142)	(6%)
PFI operating expenses	(2,137)	(2,122)	(2,026)	(15)	(1%)	(111)	(5%)
<b>TOTAL OPERATING EXPENSES</b>	<b>(54,113)</b>	<b>(53,547)</b>	<b>(51,637)</b>	<b>(566)</b>	<b>(1%)</b>	<b>(2,476)</b>	<b>(5%)</b>
<b>Profit/(loss) from operations</b>	<b>(4,249)</b>	<b>1,104</b>	<b>(4,225)</b>	<b>(5,353)</b>	<b>(485%)</b>	<b>(24)</b>	<b>1%</b>
<b>Non-operating income</b>							
Interest	18	10	16	8	(80%)	2	13%
Profit/(loss) on asset disposals		(3)		3	100%		
<b>Total non-operating income</b>	<b>18</b>	<b>7</b>	<b>16</b>	<b>11</b>	<b>157%</b>	<b>2</b>	<b>13%</b>
<b>Non-operating expenses</b>							
Interest on PFI and Finance leases	(1,399)	(1,399)	(1,419)		0%	20	(1%)
Interest on Non Commercial Borrowing	(293)	(427)	(204)	134	31%	(89)	44%
Depreciation	(914)	(993)	(760)	79	8%	(154)	20%
PDC							
Other - Contingent Rent	(1,209)	(1,283)	(1,140)	74	6%	(69)	6%
<b>Total non operating expenses</b>	<b>(3,815)</b>	<b>(4,102)</b>	<b>(3,523)</b>	<b>287</b>	<b>7%</b>	<b>(292)</b>	<b>8%</b>
<b>Surplus (deficit) after tax from continuing operations</b>	<b>(8,046)</b>	<b>(2,991)</b>	<b>(7,732)</b>	<b>(5,055)</b>	<b>(169%)</b>	<b>(314)</b>	<b>(4%)</b>
Memo:							
Donated Asset Additions	13	400	35	(387)	(97%)	(22)	(63%)
<b>Surplus (deficit) after tax and Donated Asset Additions</b>	<b>(8,033)</b>	<b>(2,591)</b>	<b>(7,697)</b>	<b>(5,442)</b>	<b>(210%)</b>	<b>(336)</b>	<b>(4%)</b>

## Notes:

Calendar Days	29	29	28
Working Days	20	20	20

## Income Statement Comparison - Year to 29 February 2020

	Annual Plan £'000	Year to date			Variances Fav / (Adv)				Forecast		
		Actual	Budget	Prior year	To Budget		To prior year		Actual	Annual Plan	Variance
		£'000	£'000	£'000	£'000	%	£'000	%	£'000	£'000	£'000
<b>INCOME</b>											
<b>NHS clinical income</b>											
Clinical Income	470,145	432,660	429,784	399,121	2,876	1%	33,539	8%	472,916	470,145	2,771
Clinical income - Spire Contract	8,409	7,702	7,681	7,416	21	0%	286	4%	9,934	8,409	1,525
NT Drugs	70,716	60,611	64,826	60,553	(4,215)	(7%)	58	0%	65,560	70,716	(5,156)
<b>Total NHS clinical income</b>	<b>549,270</b>	<b>500,973</b>	<b>502,291</b>	<b>467,090</b>	<b>(1,318)</b>	<b>(0%)</b>	<b>33,883</b>	<b>7%</b>	<b>548,410</b>	<b>549,270</b>	<b>(860)</b>
<b>Non NHS clinical income</b>											
Private patients	3,913	2,043	3,295	1,411	(1,252)	(38%)	632	45%	3,582	3,913	(331)
Other - RTA	1,560	1,248	1,208	1,490	40	3%	(242)	(16%)	1,250	1,560	(310)
<b>Total Non NHS clinical income</b>	<b>5,473</b>	<b>3,291</b>	<b>4,503</b>	<b>2,901</b>	<b>(1,212)</b>	<b>(27%)</b>	<b>390</b>	<b>13%</b>	<b>4,832</b>	<b>5,473</b>	<b>(641)</b>
<b>Other Income</b>											
R&D	21,242	19,270	19,892	19,557	(622)	(3%)	(287)	(1%)	20,534	21,242	(708)
Education & Training	23,703	22,161	21,729	22,317	432	2%	(156)	(1%)	23,700	23,703	(3)
PSF / FRF / MRET Income	33,649	12,025	30,022	30,971	(17,997)	(60%)	12,025	(7%)	12,783	33,649	(20,866)
Other non patient care income	34,266	28,692	31,614	30,971	(2,922)	(9%)	(2,279)	(7%)	34,772	34,266	506
<b>Total other income</b>	<b>112,860</b>	<b>82,148</b>	<b>103,257</b>	<b>72,845</b>	<b>(21,109)</b>	<b>(20%)</b>	<b>9,303</b>	<b>13%</b>	<b>91,789</b>	<b>112,860</b>	<b>(21,071)</b>
<b>TOTAL OPERATING INCOME</b>	<b>667,603</b>	<b>586,412</b>	<b>610,051</b>	<b>542,836</b>	<b>(23,639)</b>	<b>(4%)</b>	<b>43,576</b>	<b>8%</b>	<b>645,031</b>	<b>667,603</b>	<b>(22,572)</b>
<b>EXPENDITURE</b>											
Employee benefit expenses	(374,007)	(354,164)	(343,748)	(326,479)	(10,416)	(3%)	(27,685)	(8%)	(388,660)	(374,007)	(14,653)
Drugs	(83,808)	(71,840)	(76,824)	(71,665)	4,984	6%	(175)	(0%)	(77,742)	(83,808)	6,066
Clinical supplies	(65,743)	(64,019)	(59,961)	(61,937)	(4,058)	(7%)	(2,082)	(3%)	(71,537)	(65,743)	(5,794)
Non clinical supplies	(93,934)	(85,839)	(85,747)	(82,059)	(92)	(0%)	(3,780)	(5%)	(96,252)	(93,934)	(2,318)
- Fixed	(22,339)	(19,617)	(20,109)	(19,581)	492	2%	(36)	(0%)	(21,560)	(22,339)	779
- Capacity	(5,956)	(5,347)	(5,398)	(5,743)	51	1%	396	7%	(5,964)	(5,956)	(8)
- Income Backed including Spire	(30,474)	(27,521)	(27,936)	(27,430)	415	1%	(91)	(0%)	(30,399)	(30,474)	75
- Variable	(35,165)	(33,354)	(32,304)	(29,305)	(1,050)	(3%)	(4,049)	(14%)	(38,329)	(35,165)	(3,164)
PFI operating expenses	(25,386)	(23,206)	(23,262)	(20,495)	56	0%	(2,711)	(13%)	(25,274)	(25,386)	112
<b>TOTAL OPERATING EXPENSES</b>	<b>(642,878)</b>	<b>(599,068)</b>	<b>(589,542)</b>	<b>(562,635)</b>	<b>(9,526)</b>	<b>(2%)</b>	<b>(36,433)</b>	<b>(6%)</b>	<b>(659,465)</b>	<b>(642,878)</b>	<b>(16,587)</b>
<b>Profit/(loss) from operations</b>	<b>24,725</b>	<b>(12,656)</b>	<b>20,509</b>	<b>(19,799)</b>	<b>(33,165)</b>	<b>(162%)</b>	<b>7,143</b>	<b>(36%)</b>	<b>(14,434)</b>	<b>24,725</b>	<b>(39,159)</b>
<b>Non-operating income</b>											
Interest	120	185	110	143	75	(68%)	42	29%	203	120	83
Profit/(loss) on asset disposals	(36)	42	(33)	15	75	227%	27	180%	(36)	(36)	
<b>Total non-operating income</b>	<b>84</b>	<b>227</b>	<b>77</b>	<b>158</b>	<b>150</b>	<b>195%</b>	<b>69</b>	<b>44%</b>	<b>167</b>	<b>84</b>	<b>83</b>
<b>Non-operating expenses</b>											
Interest on PFI and Finance leases	(16,841)	(15,441)	(15,443)	(15,666)	2	0%	225	(1%)	(16,843)	(16,841)	(2)
Interest on Non Commercial Borrowing	(3,971)	(3,194)	(3,523)	(1,683)	329	9%	(1,511)	90%	(3,553)	(3,971)	418
Depreciation	(10,649)	(8,950)	(9,634)	(9,472)	684	7%	522	(6%)	(9,726)	(10,649)	923
PDC											
Other - Contingent Rent	(14,802)	(12,920)	(13,524)	(12,170)	604	4%	(750)	6%	(14,131)	(14,802)	671
<b>Total non operating expenses</b>	<b>(46,263)</b>	<b>(40,505)</b>	<b>(42,124)</b>	<b>(38,991)</b>	<b>1,619</b>	<b>4%</b>	<b>(1,514)</b>	<b>4%</b>	<b>(44,253)</b>	<b>(46,263)</b>	<b>2,010</b>
<b>Surplus (deficit) after tax from continuing operations</b>	<b>(21,454)</b>	<b>(52,934)</b>	<b>(21,538)</b>	<b>(58,632)</b>	<b>(31,396)</b>	<b>(146%)</b>	<b>5,698</b>	<b>10%</b>	<b>(58,520)</b>	<b>(21,454)</b>	<b>(37,066)</b>
<b>Memo:</b>											
Donated Asset Additions	1,280	2,974	880	1,033	2,094	238%	1,941	188%	3,553	1,280	2,273
<b>Surplus (deficit) after tax and Donated Asset Additions</b>	<b>(20,174)</b>	<b>(49,960)</b>	<b>(20,658)</b>	<b>(57,599)</b>	<b>(29,302)</b>	<b>(142%)</b>	<b>7,639</b>	<b>(13%)</b>	<b>(54,967)</b>	<b>(20,174)</b>	<b>(34,793)</b>

The table below shows the position on a control total basis. The Trust is obliged to report against this on a monthly basis to NHSI.

<b>Deficit on a control total basis - reportable to NHSI:</b>											
Surplus (deficit) after tax and Donated Asset Additions	(20,174)	(49,960)	(20,658)	(57,599)	(29,302)	(142%)	7,639	(13%)	(54,967)	(20,174)	(34,793)
Remove: Donated Asset Additions	(1,280)	(2,974)	(880)	(1,033)	(2,094)	238%	(1,941)	188%	(3,553)	(1,280)	(2,273)
Add back: Donated Depreciation	763	779	699	781	80	11%	(2)	(0%)	763	763	
<b>Adjusted financial performance surplus/(deficit)</b>	<b>(20,691)</b>	<b>(52,155)</b>	<b>(20,839)</b>	<b>(57,851)</b>	<b>(31,316)</b>	<b>(150%)</b>	<b>5,696</b>	<b>(10%)</b>	<b>(57,757)</b>	<b>(20,691)</b>	<b>(37,066)</b>
<b>CONTROL TOTAL</b>	<b>(21,691)</b>	<b>(21,747)</b>	<b>(21,747)</b>	<b>8,001</b>			<b>0%</b>	<b>(29,748)</b>	<b>(21,691)</b>	<b>(21,691)</b>	
<b>Performance against control total</b>	<b>1,000</b>	<b>(30,408)</b>	<b>908</b>	<b>(65,852)</b>	<b>(31,316)</b>	<b>3449%</b>	<b>35,444</b>	<b>(54%)</b>	<b>(36,066)</b>	<b>1,000</b>	<b>(37,066)</b>

Notes:

Calendar Days	335	335	334
Working Days	232	232	232



## REPORT TO THE TRUST BOARD

<b>Date</b>	<b>1 April 2020</b>
<b>Title</b>	<b>Chair's Key Issues from People and Culture Committee Meeting on 27.03.20</b>
<b>Lead</b>	<b>Tim How – Non-Executive Director &amp; Chair of meeting</b>
<b>Purpose</b>	<b>For Information and assurance</b>

### 1 Background/Context

The People and Culture Committee met on 27 March 2020. Papers for the meeting were circulated to Board members for information in the usual way. The meeting was quorate and was held by tele/videoconference. It was attended by Carol Edwards and Diane DeBell (Public Governors) as observers.

Due to the Covid 19 pandemic, attendance at the meeting was kept to a minimum and the meeting was not preceded by clinical/departmental visits.

### 2 Key Issues/Risks/Actions

Items of note considered at the meeting included:

Items received for information and assurance:		
1	Covid 19 response – staff matters:	<p>The Committee received an update with respect to staff-related aspects of the pandemic, notably:</p> <ul style="list-style-type: none"> <li>- effective suspension of existing job plans with staff reallocated to areas of greatest need;</li> <li>- maintaining staff morale and resilience (seeking to enhance rest facilities, channelling of food etc donations through the Charity, enhanced provision of psychological care etc);</li> <li>- protection of staff (risk stratification of at risk staff, maximising home-working, PPE, working with UEA/NRP partners to enhance testing capacity);</li> <li>- maximising staffing capacity (refresher training, engaging medical and nursing students);</li> <li>- accommodation for staff who need rest between shifts or are unable to return home (with thanks to UEA);</li> <li>- communication (2x daily email updates to all staff), communication (multiple FAQs for staff), communication (weekly CEO webinar).</li> </ul>
2	Freedom to Speak Up	The Committee was assured that the existing FTSU arrangements remain in place for staff to raise concerns.

3	Staff Survey	The Committee considered the results of the Staff Survey and associated themes. The system of staff appraisals has been suspended during the pandemic and will be relaunched once the operational pressures have lessened.
4	Premium pay controls	The Committee received a report with respect to actions arising from the Internal Audit on premium pay controls. The Committee emphasised the need to maintain appropriate control where we can even in the pandemic situation and was informed that where it is possible to implement the audit recommendations without adversely affecting frontline we will continue to do so.
5	Relevant risks from the Corporate Risk Register	A report on the CRR was received. The Risk Register will be updated to document and reflect the risks associated with the pandemic prior to review by the Board next month.

#### Issues to highlight and escalate:

6	Workforce IPR metrics	The standard workforce metrics have been 'overtaken by events'. Depending on how long the current extraordinary circumstances persist, we may need to establish some revised metrics to measure staffing, sickness, self-isolation etc.
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### 3 Conclusions/Outcome/Next steps

The next Committee meeting is scheduled for 28 May 2020

#### Recommendation:

The Board is recommended to **note** the work of its People and Culture Committee.



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Norfolk and Norwich University Hospitals



NHS Foundation Trust

# Integrated Performance Report (Workforce Section)

March 2020 (February 2020 data)



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# Norfolk and Norwich University Hospitals



NHS Foundation Trust

INTEGRATED  
PERFORMANCE  
REPORT

## Workforce

Chief People Officer  
Paul Jones



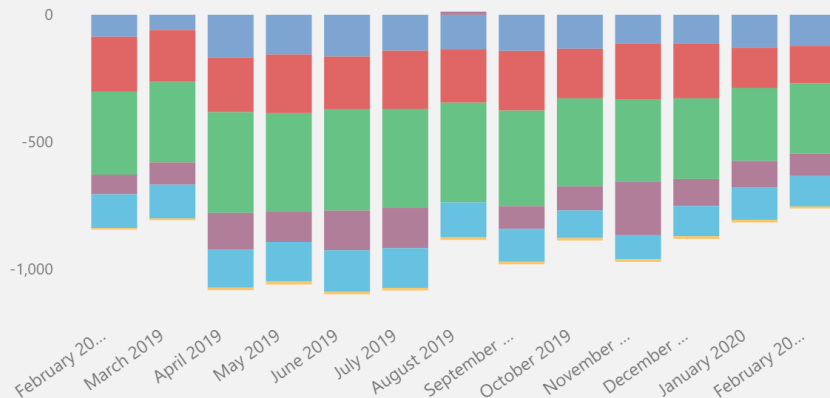
Month Selector

Most Recent ▼

An overview of the workforce at NNUH - Substantive Vacancies (WTE) by Staff Group, with supplementary financial information including the GBP variance between actual spend and pay cost budget, as well as the proportion of pay costs paid to temporary staff. All workforce information shown is provided by Finance.  
NB. Regarding Variance: Actual to Budget (GBP): a negative value = overspend, a positive value = underspend.

### Substantive Vacancies (WTE)

● A&C ● Clin. Support ● Reg. N&M ● M&D ● S,T &T ● Other



### Vacancies

Month	A&C	Clin. Support	Reg. N&M	M&D	S,T &T	Other	Total
February	-123	-146	-276	-88	-119	-8	-761

### Spend Variance % Temp Spend

M	2020	M	2020
Feb	-1.66M	Feb	11.6%

### Data Observations

Overall, in the last twelve months to 29th February 2020, there are 484.0 additional staff (7,640.6 staff in post 29-Feb-20), an increase of 6.8% across NNUH as a result of service developments and capacity and quality investments.

Since April 2017 there has been an increase of 1,193.0 WTE (6,447.6 staff in post 31-Mar-17) and since April 2018 there has been an increase of 853.5 WTE (6,787.1 staff in post 31-Mar-18)

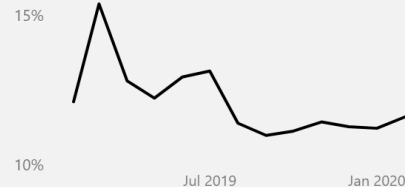
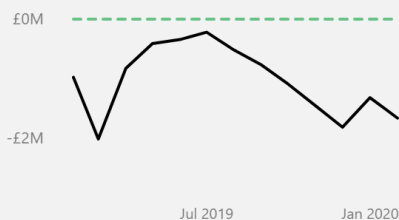
### Management Comments and Actions

The biggest increase in staffing is the clinical support staff category, which is attributable to our success in recruiting healthcare assistants (125.5 additional support staff since February 2019).

The vacancy gap widened in April 2019 due to increases to the establishment, but the trend is downward.

### Variance: Actual to Budget (GBP)

### Pay Costs: % Temporary Staff (GBP)





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## Safer Staffing

Chief Nurse  
Nancy Fontaine

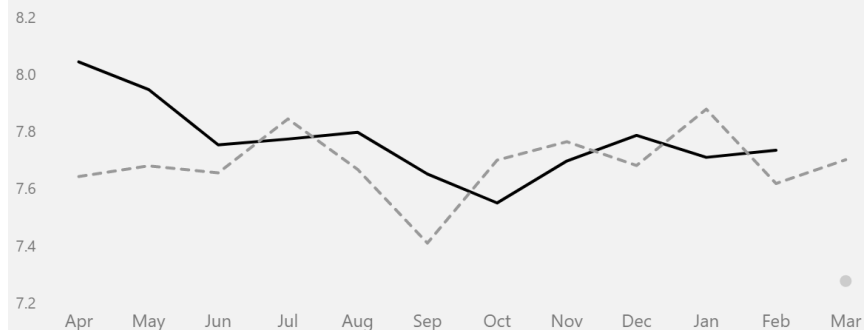


### Month Selector

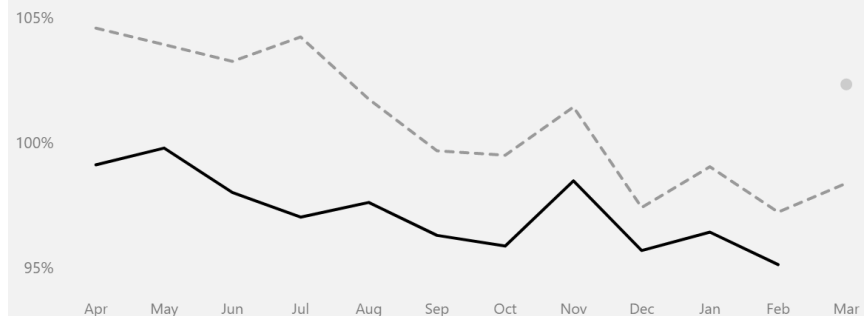
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### Safe Staffing CHPPD Average

● Current Year ● Last Year ● Preceding Year



### Safe Staffing Fill Rates Percentage



### CHPPD Avg.

Month	2019	2020
February	7.6	7.7

### Fill Rates %

M	2019	2020
Feb	97.2%	95.1%

### Data Observations

The average Care Hours Per Patient Day (CHPPD) for Feb 2020 has remained static at 7.7, with 4.1 being delivered by RN and 3.6 by Unregistered nurses. Overall RN fill rates for Feb fell below 90% to 88.4%; a decrease of 1.1% Jan 2020 (89.5%). RN/RM fill rates for night shifts have reduced further in Feb by 0.4% to 90.7, however an increase of 0.3% from Feb 19. Average fill rate for Unregistered nurses decreased in Feb to 104.2%, a 1.6% decrease from Jan. In January, RN fill rates fell below 90% in 18 of 33 areas on day shifts and 7 on night shifts. Red flags (inc W&C) have increased to 1053, which is 424 above our average over the last 12 months, indicating improving escalation.

### Management Comments and Actions

Review and mitigation of RED FLAGS is improving, however, NHSi have postponed their acuity training visit due to Covid-19. Nursing allocation policy remains in draft; due to the current operational pressures but aims for delivery as soon as practicable. Temporary Staffing Transformation continues with positive strategic and operational aims. Action planning developing regarding temporary workforce during COVID-19.



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## Sickness & Turnover Rates

**Chief People Officer**  
**Paul Jones**

**NNUH Digital Health**  
business intelligence

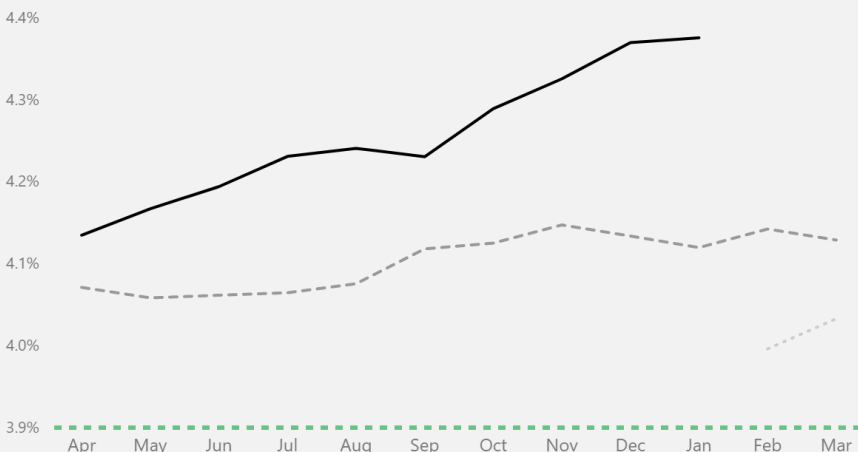
Month Selector

Most Recent ▼

Staff wellbeing and retention is an important factor in the long-term workforce picture for the NHS. The measures below show annualised sickness rates (recorded on ESR) and staff turnover. Turnover is shown both annualised (showing the level of staff leavers over the preceding twelve month period) and well as a monthly figure to highlight trends or seasonality. Sickness absence is reported one month in arrears, all information is shown up to the same point in time to provide a cohesive picture.

### Annualised Sickness Absence

● Current Year ● Last Year ● Preceding Year



### Annualised Sickness Absence

Month	2019	2020
January	4.1%	4.4%

### Annualised Turnover

M	2019	2020
Jan	10.9%	12.2%

### Monthly Turnover

M	2019	2020
Jan	0.9%	1.0%

#### Data Observations

For sickness, the Operating Plan for 2019/20 has set a challenging 12 month rolling average target of 3.9% for sickness. As at 31 January 2020, the rate is 4.37%.

Please note that the turnover rates are inflated for the NNUH and CSS Division due to 38 leavers as a result of TUPE implementation (21 with regard to HPV, and 17 in respect of Community Dietetics). The impact is to inflate the turnover figure for the NNUH by 0.44% per month and for CSS Division specifically by 2.2% per month. This staff alignment will remain in the monthly turnover figures until November 2020.

The turnover rate for the 12 months to February 2020 is 12.1% (when adjusted for HPV and Community Dietetics the rate would be 11.66%). Promisingly, the annual turnover rate has reduced from 12.2% in January 2020. The monthly turnover rate of 0.77% is actually the lowest monthly rate since May 2018.

#### Management Comments and Actions

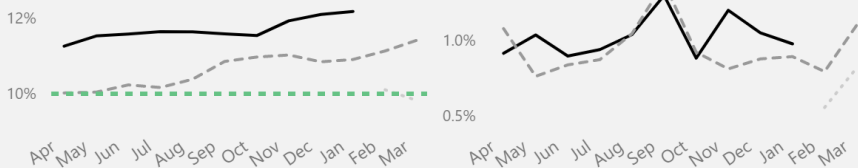
The most significant indicator is the rolling 12-month average sickness rate. For the 12 months to end of January 2020 this is 4.37%. This deteriorating 12 month performance reflects increases when compared to last year.

However, there are signs that the seasonally adjusted rate is stabilising with expectations that February 2020 will see the third consecutive month where the rate has not increased. It should also be noted that 60% of lost days are due to staff absent for more than 28 days. Furthermore, during 2019, 2% of all episodes of sickness accounted for 35% of all lost sick days. Accordingly, efforts are required to reduce and minimise the occasions for longer term sickness.

We recognise that with the Covid-19 pandemic we should expect to see an increase in absences from the Hospital. Not all absences will be due to sickness, but it would be reasonable to expect an unseasonable increase in sickness absence.

### Annualised Turnover

### Monthly Turnover





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## Appraisals & Mandatory Training

Chief People Officer  
Paul Jones

**NNUH Digital Health**  
business intelligence

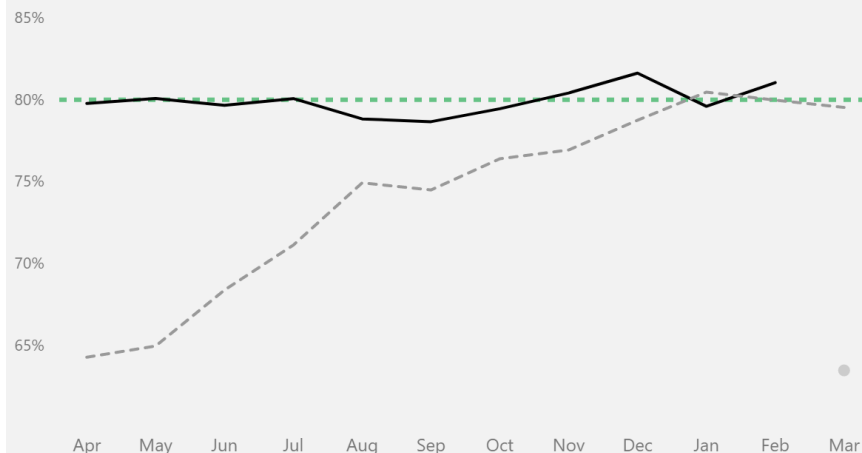
An insight into the proportion of non-medical staff who have received appraisals (of those eligible), alongside the proportion of staff meeting their Mandatory Training requirements.

Month Selector

Most Recent ▼

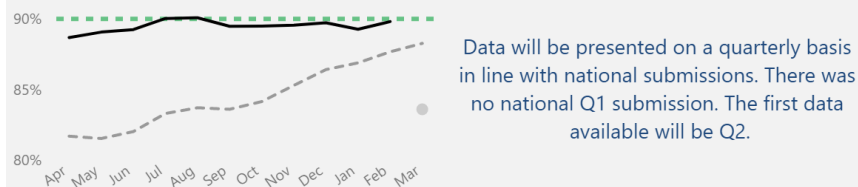
### Non-Medical Appraisals

● Current Year ● Last Year ● Preceding Year



### Mandatory Training

### Medical Appraisals



Data will be presented on a quarterly basis in line with national submissions. There was no national Q1 submission. The first data available will be Q2.

### Non-Medical Appraisals

Month	2019	2020
February	80.0%	81.0%

### Mandatory Training

M	2019	2020
Feb	87.7%	89.8%

### Medical Appraisals

M
---

#### Data Observations

For appraisals, the Operating Plan for 2019/20 reflects an aspiration for 90% compliance but accepting that consistently exceeding 85% compliance would represent excellent progress.

81.0% of eligible staff (Non-Medical appraisals) had an appraisal during the last 12 months. Just one division is above 85% (Clinical Support).

For information, the 2019 Staff Survey reports that 87.8% of staff had an appraisal. However, just 18.4% indicated that the appraisal experience helped them to improve their job.

For Mandatory Training, the compliance rate hovers just below 90%, three areas (Women & Children, Clinical Support and Corporate areas) have compliance rates which exceed 90%.

#### Management Comments and Actions

For appraisals, management effort is required to support the completion of appraisals in order to increase the compliance rate. As a result of the 2019 Staff Survey, a review of the appraisal experience and process is to take place in order to improve engagement, participation and value.

A series of improvements and interventions are in place to support enhanced mandatory training compliance. The number of Mandatory training events is increasing with more topics available to staff. Additional support is offered to staff to maximise mandatory training with a range of support options for staff accessing eLearning.

A new mandatory training report was launched in February, providing improved visibility and accessibility for all staff, to help raise our Mandatory Training compliance. This report has been well received by Managers and staff alike.

## REPORT TO TRUST BOARD

<b>Date</b>	<b>1 April 2020</b>
<b>Title</b>	<b>National Institute of Health Research (NIHR) Clinical Research Network (CRN) Eastern: Annual Plan 2020/21</b>
<b>Author(s)/Exec Lead</b>	<b>Helen Macdonald, Chief Operating Officer/ Erika Denton, Host Executive Accountable Officer, NNUHFT</b>
<b>Purpose</b>	<b>Approval</b>

### 1. Background

The NIHR CRN contract extension between the Department of Health and Social Care (DHSC) and Norfolk and Norwich University Hospitals Foundation Trust (NNUHFT) started on 1 April 2019 and will run until 31 March 2022.

The Performance and Operating Framework (POF) for 2020/21 continues many of the requirements that have been in place over the initial contract period (2014-2019). Since 2019 this has broadened to include research in Public Health and Social Care and there has been a greater emphasis on placing research in underserved populations.

In 2019/20, the Coordinating Centre's annual business plan incorporated 6 new strategic improvement priorities including: driving research in all health and social care settings; innovative engagement activities for patients, carers and the public; ensuring rapid access to learning and development opportunities; working with life science partners to develop the global research system; greater use of digital assets; and evidencing the impact of the activity of the CRN on the health and care system. These priorities will stay in place for the duration of the remaining contracting period and inform LCRNs' annual plans.

The performance of the local networks will continue to be measured against a set of overarching High Level Objectives (HLOs), which maintain a primary focus on delivering recruitment to time and target for commercial and non-commercial studies.

For 2020/21, Speciality Objectives have been removed and replaced by a single additional HLO relating to increasing recruitment in 10 specialities of the Local CRN's choosing, which will sit alongside the 9 DHSC priority disease topics. However, as the final details of this and the other HLOs have not yet been confirmed by the DHSC, the annual plan has been predicated on meeting the draft guidance where appropriate.



## **2. Key issues, risks and actions**

Each financial year, the DHSC requires a detailed plan from the network through the Host Organisation to achieve contractual compliance with the POF.

The plan is split into the following sections:

- Host Organisation approval
- POF requirements, containing details of the LCRN's governance and management arrangements, strategic work streams and key projects to be delivered by the network in order to fulfil its mandatory requirements
- High Level Objectives – cross-regional and divisional access and performance targets
- Local Initiatives – projects and activities to be delivered by the LCRN either in isolation, or in collaboration with other LCRNs and/or other parts of the NIHR
- Financial Management, including details of local processes and allocation of funding for the 2020/21 financial year and details of any strategic initiatives and funding e.g. 'Green Shoots' scheme to develop the next generation of PIs

For 2020/21, CRN Eastern has received flat funding and a balanced financial plan has been sent to all Partner Organisations based on the new local funding model, which was implemented for the first time in 2019/20. Partners have been asked to submit line by line financial returns.

The CRN Coordinating Centre requires a detailed action plan of all activities to be completed to achieve or maintain compliance with mandatory requirements as detailed in the POF requirements section, which includes links to additional supporting documents. For 2020/21 these activities have been planned in collaboration with POs, including detailed recruitment forecasts.

The key measures for the 2020/21 financial year and the likelihood of achieving them are as follows (please note, HLOs and their numbering, and acceptance of CRN Eastern targets by the Coordinating Centre are not yet confirmed):

**High Level Objective 1A:** Number of participants recruited to NIHR CRN Portfolio studies.

The predicted number for 2020/21 collated from all Partner Organisations, Primary Care, Public Health and Social Care is 45,000 recruits. In common with other LCRNs and reflecting a wider national trend, targets (the Coordinating Centre's nomenclature refers locally to targets and nationally to ambitions) for HLO1a for 2019/20 are unlikely to be met, so an increase in recruitment for 2020/21 has not been forecast. The risk of not meeting this measure is medium.

In addition to ensuring that we recruit sufficient numbers of participants and deliver a balanced portfolio, we will continue our focus on widening access to clinical and non-clinical research in underserved populations. This will help to reduce the mismatch in particular regions where disease prevalence is high and access to research studies is low.

**High Level Objective 1B:** Number of participants recruited to commercial contract NIHR CRN Portfolio studies –we are awaiting confirmation of the number, but in 2019/20 CRN Eastern had a strong showing on this objective that we would hope to match. The risk of not meeting this measure is low.

**High Level Objectives 2A and 2B:** Performance on recruitment to time and target (RTT) for commercial studies (HLO 2a) has steadily increased over the past 2 years, but is nonetheless unlikely to meet the national target of 80% for 2019/20. For 2020/21 we shall continue to embed processes for sharing best practice between POs to further increase our outturn on this measure and aim to meet the national target. RTT for non-commercial studies has traditionally been strong within CRN Eastern and is likely to exceed the national target. The risk for not meeting these measures for the 2020/21 financial year is likely to be medium for HLO 2A and low for HLO 2B.

**High Level Objective 3:** Increase the number of studies delivered for the commercial sector with support from the NIHR Clinical Research Network. Plans are in place to support national requirements and improve our performance. The local target has not yet been set. The risk of not meeting this measure is medium.

**High Level Objective 6 A,B,C,D:** Plans in place to meet previous measures (widen participation in research by enabling the involvement of a range of health and social care providers) and new measure of HLO 6D - Number of Non-NHS sites recruiting into NIHR CRN Portfolio studies. The risk of not achieving all measures is low.

**High Level Objective 7:** Deliver significant levels of participation in NIHR CRN Portfolio Dementias and Neurodegeneration (DeNDRoN) studies. CRN Eastern will meet greater than one fifteenth of the national requirement for this measure. The risk of not meeting this measure is medium.

**High Level Objective 8:** Demonstrate to people taking part in health and social care research studies that their contribution is valued (number of NIHR CRN Portfolio study participants responding to the Patient Research Experience Survey (PRES) each year). CRN Eastern has traditionally been very strong on this metric. However, due to an increased focus on this mandate from the DHSC, we are expecting the Coordinating Centre to set a very challenging target (TBC) and therefore the risk of not meeting this measure is medium.

**High Level Objective 9:** (replaced previous HLOs 4 and 5) Reduce intra-study site set-up times for NIHR CRN Portfolio studies. The risk of not meeting measure is medium.

**New High Level Objective:** Improve access to research by increasing recruitment in priority specialties (including difficult to reach groups). This new objective will enable LCRNs to select 10 of their own speciality areas. The risk of not meeting this measure is low.

**Work streams:**

Plans are in place to meet contractual requirements for all work streams (as detailed in the POF and Local Initiatives sections). This includes plans for Patient and Public Involvement and Engagement (PPIE), including Research Ambassadors, Communications, Business Intelligence, Workforce Development and Wellbeing (we have an Early Career Researcher initiative incorporating research training into regional medical school training programmes), Commercial and

Academic Research Delivery and Business Development and Marketing.

**Recommendations:**

The Trust Board is recommended to:

Approve the annual plan on 1 April 2020.

The plan was submitted in draft to the NIHR Co-ordinating Centre on 27 March 2020 and will be confirmed once the NNUHFT Host Trust Board has approved.

The plan was approved by the CRN Eastern Partnership Group on 9 March 2020 and went to the NNUH Management Board on 24 March 2020

Update (19/03/2020). This plan, including its milestones and risks was written before the Covid-19 pandemic. The Coordinating Centre has advised that LCRNs should submit their plans based on this original information, which will be subject to revision.

## Requirements for 2020/21 Annual Plan, Mid Year Progress Report and Annual Report

### LCRN Planning Queries

This document contains a list of queries from LCRN colleagues and CRNCC responses.  
This is being updated as queries are received.

#### Introduction

This 2020/21 Annual Plan, Mid Year Progress Report and Annual Report Template (hereafter referred to as 'Template') is provided to enable LCRNs to Plan / Report at three time points. The purpose of providing an integrated Template is to enable LCRNs to have visibility and early access to a single template per financial year containing the available planning and reporting requirements. It is hoped that this will minimise duplication of effort. The CRNCC will endeavour to make minimal changes during the operational year.

The Template has been created for each LCRN to complete in 2020/21. Section 4 (HLOs) has been populated with the available information on the proposed High Level Objectives and associated measures for 2020/21. Please note, the HLOs are still to be approved by the DHSC. We will confirm final objectives as soon as we are able by email or in the LCRN Bulletin. Please ensure that edit permissions for 'LCRN Support' and 'PM Team' are not amended locally. If you make local copies of this Template, please ensure that this information is communicated and local systems are in place to forward the pending requirements.

The main points to note for the completion of the Annual Plan elements of the Template can be found below. Further specific guidance / details for specific elements have also been included in parentheses [ ] within individual tabs.

Please direct any queries on this Template or the 2020/21 Annual Plan, Mid Year Progress Report and Annual Report to [crncc.performance@nihr.ac.uk](mailto:crncc.performance@nihr.ac.uk)

An optional call has also been scheduled on Thursday 30 January between LCRN COOs / Deputy COOs and SMT colleagues to discuss the template and clarify expectations.

#### 1 How to complete the Annual Plan:

Submission of Annual Plan

\* The LCRN Annual Plan must be agreed by the LCRN Partnership Group and formally approved by the LCRN Host Organisation Board. Confirmation of review and agreement / approval by the LCRN Partnership Group and LCRN Host Organisation Board, respectively, should be provided under the Host Organisation Approval tab of the Template. Guidance on expectations and completion of the Template is provided in sections 2-9, below.

\* The LCRN Annual Plan should be submitted to the CRNCC Performance Management Team by 5pm on **Friday 27 March 2020** by giving the LCRN Support email account ([lcnn.support@nihr.ac.uk](mailto:lcnn.support@nihr.ac.uk)) edit permission to a copy of all relevant files on the NIHR Hub (Google Drive).

Submission of LCRN Annual Financial Plan

\* The LCRN Annual Financial Plan should be submitted separately via the CRN Finance Tool by 5pm on **Friday 27 March 2020**. In case of queries in the interim, please contact [crnfinance@nihr.ac.uk](mailto:crnfinance@nihr.ac.uk).

The LCRN Annual Plan should set out the specific activities and strategic initiatives to support achievement of the NIHR CRN performance objectives as documented in Section 2 (Part B) of Appendix A of the DHSC/LCRN Host Organisation Agreement. The LCRN Annual Plan should be developed in collaboration with the governance, management and influencing groups set out in Part C of the 2020/21 Performance and Operating Framework (POF); including but not limited to the LCRN Operational Management Group and the LCRN Partnership Group. LCRNs are encouraged to engage with colleagues in CRNCC Directorates and Research Delivery Divisional teams, and National Specialty Leads for support and specialist advice and expertise, as required. The LCRN Host Organisation is asked to ensure that plans for 2020/21 are informed by and build upon local performance, successes, challenges and priorities from 2019/20. Plans should reflect the working principles of the NIHR CRN, set out in A.3 of the 2020/21 POF, should address the NIHR CRN Priorities set out in A.4 of the 2020/21 POF (where applicable locally), and the CRN Performance Indicators, set out in Sections 2 and 4 of Part B of the POF.

Tab-by-tab guidance is provided below:

**Coverpage:** Please add the 'Date of Annual Plan submission'

**1. Host Organisation Approval:** The LCRN Annual Plan must be agreed by the LCRN Partnership Group and formally approved by the LCRN Host Organisation Board. Confirmation of review and agreement / approval by the LCRN Partnership Group and LCRN Host Organisation Board respectively should be provided under Section 1A of the Host Organisation Approval sheet. Section 1B and 1C should not be completed at this time.

**2. Annual Performance Highlights:** Section 2 of the Template is for information only at this stage and should not be completed as part of the Annual Plan.

**3. Part C: POF requirements:** Section 3 of the Template should be used to describe the actions that your LCRN plans to undertake in order to achieve or maintain compliance with the mandatory POF requirements in 2020/21. Please include actions and projects delivered locally, in collaboration with other LCRNs (as part of regional LCRN Supra-network collaborative activities or other LCRN collaborations), nationally / CRN-wide led locally by the LCRN, and in collaboration with other parts of the NIHR and / or other external organisations.

The rows in this section of the Template are based on mandatory requirements within Part C: Operating Framework of the 2020/21 POF

For each mandatory requirement please:

- \* provide a description of the actions you will take to achieve / maintain compliance with the specified mandatory requirements in column E
- \* provide the name of the individual responsible for the actions in column F
- \* enter the date when full compliance is expected in column G. If your LCRN is already compliant please enter 1/04/2020
- \* enter the expected date of completion of the actions in column H
- \* where requested and additionally, where relevant, provide a link / URL in column I

The use of bullet points and cross-referencing between projects / sections of the plan, as relevant, is encouraged. Please provide sufficient contextual detail within the description of actions to ensure that the description can be understood by readers from across the NIHR CRN.

**12/03/2020** - The 2019/20 national funding model required LCRNs to ring-fence 2% of its 2019/20 allocation on initiatives to improve CRN activity in the ten health areas identified by DHSC as priorities in 'targeting local health needs'. However with the national model for 2020/21 reflecting LCRN performance in targeting local health needs, DHSC are content that CRNCC are not prescriptive regarding the proportion of funding allocated to support the targeting local health needs strategy. Therefore, there is no longer a requirement to spend a certain proportion of funding and the allocation of necessary funding to support local strategy is to be determined locally.

**4. High Level Objectives:** In Section 4 of the Template, under column F 'LCRN Target', please enter the respective local forecast contributions / proposed targets for your LCRN for the Participant Recruitment Objective measures A&B and Dementia and Neurodegeneration Recruitment Objective (cells F13, F14 and F21, respectively). In column G of the associated rows, please describe how the target has been determined and provide the supporting rationale. For all HLOs, please complete columns H-J as needed to describe any special projects or initiatives planned to contribute to the Objectives not already captured in Section 3 'Part C: POF requirements. Column H can also be used to cross-reference as relevant to rows in Section 3.

**5. Local initiatives:** Section 5 should be used to detail local initiatives and projects to be delivered in 2020/21 that the LCRN would like the CRNCC and other LCRNs to be aware of, including those to be delivered in collaboration with other parts of the NIHR CRN / NIHR or other organisations. In the case of Supra-network projects or collaborative projects with other LCRNs the project should be included in the Annual Plan of each participating LCRN.

For each project or initiative, please:

- \* provide a title and brief description of the project or initiative in column B
- \* enter the intended outcome of the project or initiative in column C
- \* confirm whether the project is Specialty specific, and if so, specify the applicable Specialty or Specialties in column D
- \* enter the expected completion date in column E
- \* download and populate the A3 CRN initiatives template linked in cell F3. Please name the template file based on the initials of your LCRN or LCRN Supra-network, followed by the relevant Section number, starting from 5.1 e.g. 'EM5.1' for East Midlands first local initiative or 'SNB5.1' if the first local project East Midlands plan to deliver will be delivered collaboratively across their LCRN Supra-network, Supra-network B. Enter the link URL for this document in column F.

**6. Financial Management:** Section 6 should only be completed as part of the LCRN Annual Plan. It should not be completed as part of the LCRN Mid Year Progress Report or Annual Report.

Section 6.2 relates to the local funding model. Rows 8-16 should be amended to reflect the local funding elements. Cell F17 will become white when the 9 cells above total 100%.

In section 6.7, the date of the internal audit, if not specified in the internal audit report, should be taken as the last working day of the fieldwork.

**7. Appendices:** As a minimum, Section 7 of the Template should include a link to AP Appendix 1 - Risk and Issues Log - please include a link to an updated copy of your Risk and Issues Log.

Additional appendices may be added at the discretion of the LCRN, by completing row 5 and inserting additional rows below 5 as needed. For any additional appendices, please complete columns A, B and C with the Appendix number, Title and document link.

#### 2 Contract Support Documents

**8. CSDs:** This reference tab has been included to provide ready access to the LCRN Contract Support Documents for 2020/21. This sheet provides the links to the finalised Contract Support Documents. It will be updated by the CRNCC Performance Management team as soon as the remaining documents become available, and we will also provide notification via the LCRN Bulletin of newly added links. Please note that the LCRN Contract Support Documents currently available via the LCRN Hubsite are those for 2019/20. We will be adding the CSDs for 2020/21 to the LCRN Hubsite in the near future and will advise LCRNs when this has been done.

#### 3 How to complete the Mid Year Progress Report:

Specific guidance on expectations will be provided as needed by the CRNCC ahead of the 2020/21 Mid Year Progress Report

#### 4 How to complete the Annual Report:

Specific guidance on expectations will be provided as needed by the CRNCC ahead of the 2020/21 Annual Report

Clinical Research Network  
CRN Eastern

## 2020/21 Annual Plan, Mid Year Progress Report and Annual Report

Date of Annual Plan submission: 27 March 2020

Date of Mid Year Progress Report submission: XX

Date of Annual Report submission: XX

## Section 1. Host Organisation Approval

### 1A. Annual Plan

Confirmation that this Annual Plan has been reviewed and agreed by the LCRN Partnership Group:	Yes
Date of the LCRN Partnership Group meeting at which this Annual Plan was agreed:	
Confirmation that this Annual Plan has been formally approved by the LCRN Host Organisation Board:	Yes
Date of the LCRN Host Organisation Board meeting at which this Annual Plan was (or will be) approved:	01/04/20

### 1B. Mid Year Progress Report

Host Organisational approval and LCRN Partnership Group agreement is not required for the Mid Year Progress Report

### 1C. Annual Report

Confirmation that this Annual Report has been reviewed and agreed by the LCRN Partnership Group:	
Date of the LCRN Partnership Group meeting at which this Annual Report was agreed:	
Confirmation that this Annual Report has been reviewed and approved by the LCRN Host Organisation Board	
Date of the LCRN Host Organisation Board meeting at which this Annual Report was (or will be) approved:	

If this Annual Plan / Annual Report has not been approved by the LCRN Host Organisation Board at the time of submission to CRNCC, then the LCRN Host Organisation Nominated Executive Director should provide that confirmation by email to the CRNCC once the Board has approved the Plan / Report to [crncc.performance@nihr.ac.uk](mailto:crncc.performance@nihr.ac.uk)



## Section 2. Annual Performance Highlights (Annual Report only) - maximum 1 page of A4 (portrait)

Section 2. Annual Performance Highlights should only be completed as part of the Annual Report submission. For the Annual Report, please complete the Table below, entering key performance highlights, successes and challenges from 2020/21

<b>1. Summary of performance against the national performance indicators</b>		
<b>1.1 Performance against the HLOs, LCRN Partner Satisfaction Survey Indicators, LCRN Customer Satisfaction Indicators and LCRN Patient Experience Indicators</b>		
<b>2. Please summarise 3 local or Supra-network initiatives that your LCRN has delivered or been involved in during 2020/21. Section 2.1 should relate to targeting research to meet the health needs of the local population. This section is an opportunity to highlight excellent performance, successes and or challenges and associated learning. The intention is to enable opportunities to showcase these examples as case studies, opportunities for regional or national roll-out and sharing of best practice</b>	2.1	
	2.2	
	2.3	

### Section 3: Part C POF Requirements

Section 3 of the template should be used to detail the key projects to be delivered by the network in 2020/21 to fulfil the mandatory requirements of the Performance and Operating Framework. Please include local network projects and activities, projects to be delivered in collaboration with other LCRNs (as part of regional LCRN Supra-networks or other LCRN collaborations), and projects to be delivered nationally/CRN-wide led locally by the LCRN. Projects to be delivered in collaboration with other parts of the NIHR and/or other external organisations should also be included. Columns A-G should be completed as part of the 2020/21 Annual Plan. In column G, if your LCRN is already compliant with the requirement please enter '1/04/2020'. Otherwise, please enter the earliest date in 2020/21 by which you expect to achieve full compliance with the requirement. Columns H-J should be completed as part of the 2020/21 Mid Year Progress Report. Columns K-L should be completed as part of the 2020/21 Annual Report.

#### Progress Status Information:

Colours in the Status column are automated. Please select Complete, Red or Green from the drop-down menu in column J or L and the colour will update automatically.

<b>Complete</b>	Fully compliant.
<b>Red</b>	Actions off-track or full compliance has not or will not be achieved by the date originally anticipated.
<b>Green</b>	Actions on-track and full compliance expected to be achieved by the date originally anticipated.

Plan Ref	POF Section	CSD	POF requirement	To complete at Annual Plan stage		Lead	Anticipated date of full compliance	Expected date of completion	Link URL (where applicable)	To complete at Mid Year Progress Report stage		To complete at Annual Report stage	
				Description of actions to achieve / maintain compliance with the requirement	Status					Status	Commentary	Status	Commentary
1. General Management													
3.1.1	C.2.1	CSD003	Provide LCRN Host Organisation corporate support services for LCRN management. These should include risk management, finance management, Human Resources, Information and Communication Technology, high-quality office premises and facilities, and legal and contracting support.	• Corporate support services in place.	HM	April 2020							
3.1.2	C.2.1	CSD003	Maintain an LCRN leadership team comprising Nominated Executive Director, LCRN Clinical Director and LCRN Chief Operating Officer (the 'LCRN Leadership Team') in compliance with the requirements and role outlines set out in CSD003.	• The LCRN leadership team is fully established and in place. In the event of any mandated posts becoming vacant, the Host Organisation would take all necessary steps to make re-appointments in adherence with CSD003.	HM	April 2020							
	C.2.1	N/A	Maintain an LCRN management team that includes an identified manager for each of the functions listed below, who have relevant management experience and who have sufficient capacity to manage the full range of activities in the area. The role outlines / job descriptions for these posts must be consistent with National CRN Coordinating Centre role outlines, where provided: • Business Intelligence • Communications • Continuous Improvement • Finance • General Administration • Human Resources • Industry Operations • Information and Communications Technology • Patient and Public Involvement and Engagement • Study Support Service (including management of Divisional Research Delivery, Cross-divisional Research Delivery, and Industry Operations) • Workforce Development	• The LCRN has a management team with identified managers for each function. The role of Industry Operations Manager (IOM) is now part of the function of one of our Research Delivery Managers (RDMs), while Information and Communications Technology is covered by the dCOO and Business Intelligence (BI) Manager.	HM	April 2020							
3.1.3													
3.1.4	C.2.1	CSD088	Convene an LCRN Partnership Group that will meet a minimum of three times per year and in line with the model Terms of Reference as provided by the National CRN Coordinating Centre.	• Partnership Group meetings are held 3 times per year. The Partnership Group is chaired by Tracey Dowling, CEO Cambridge and Peterborough NHS Foundation Trust.	HM	April 2020							
3.1.5	C.2.1	CSD007	Maintain a fully executed contract with each LCRN Partner organisation using the Category A, Category B, or Category C LCRN Partner form of contract as included within the DHSC / LCRN Host Organisation contract.	• A process is in place to issue and manage Category A, Category B and Category C contracts.	HM	April 2020							
3.1.6	C.2.1	N/A	Maintain an LCRN Business Continuity and Disaster Recovery Plan, and test this plan a minimum of once per year.	• LCRN Business Continuity and Disaster recovery plan in place. Test date will be scheduled for 2020/21.	MB	April 2020							
2. Financial Management													
3.2.1	C.3.1	CSD007	Implement and maintain measures that provide evidence and assurance that LCRN funding provided to LCRN Partners is used solely for the Work Programme as set out in the Category A, B and C contracts.	• The LCRN finance team has robust processes in place to seek assurances over LCRN funding. Detailed budgets are prepared by Partner Organisations (POs) and scrutinised by LCRN Finance. Quarterly returns are run through rigorous checking processes. POs are required to sign and submit a quarterly checklist alongside their finance return. At year end, prior to signing our LCRN financial return declaration, all POs are required to sign and submit an annual declaration to confirm adherence to the contractual requirements (see URL link). • The LCRN has a PO monitoring SOP and workplan, involving an annual programme of PO visits, involving sample testing of reported costs and commercial income. The suite of SOPs will be further developed in Q1.	NH	April 2020	July 2020						
3.2.2	C.3.1	CSD004	Ensure that LCRN funding that is 'top-sliced' to support the delivery of national initiatives is spent specifically on these initiatives. The LCRN must notify the National CRN Coordinating Centre of any underspend arising from this top-sliced funding at the earliest opportunity to allow funding to be appropriately redistributed by the National CRN Coordinating Centre.	• At budget setting, detailed plans are obtained for top-sliced RITA and NSL funding. POs are expected to break even on these funding streams. At each quarter, POs report top-sliced funding within their finance returns, which is subject to the standard LCRN checking processes. Any identified underspend would be reported to the Co-ordinating Centre.	NH	April 2020							
3.2.3	C.3.1	CSD007	Set out an annual local funding distribution model which will clearly describe the basis on which LCRN funding is allocated to LCRN Partners. The local funding model must be publicly available in a stand-alone document.	• A CRN Eastern funding model working group was convened in 2018, comprising representatives from 7 POs. The new funding model was instigated for the first time for the 2019/20 financial year following sign off from Partnership Group. The funding model is publicly available on our Hub website (see link in Column L) and will be added to the LCRN website by the end of Q1 2020/21.	MB	April 2020	June 2020	<a href="https://lcrn.gov.uk/commercial-income/">https://lcrn.gov.uk/commercial-income/</a>					
3.2.4	C.3.1	CSD007	Ensure that all payments made to distribute LCRN funding to LCRN Partners are valid, complete, accurate and appropriately authorised.	• POs are advised to raise monthly invoices for 1/12th of their approved allocation. Invoices are subject to LCRN Finance checks and the Host Organisation's (HO) authorisation and processing rules. The HO enforces authorisation rights and limits, such that only the COO/dCOO have authority to approve LCRN expenditure. Invoices are processed via the Host online approval and payment system.	NH	April 2020							
3.2.5	C.3.1	CSD007	Implement a budgetary control system to monitor actual expenditure against the LCRN Annual Financial Plan, and ensure that a forecast is produced at least quarterly for the remainder of the financial year. This forecast must be managed to ensure a breakeven position at year end.	• Quarterly returns and reports are used as a basis for budgetary control. During the reporting process, CRN Eastern finance review and amend forecasts to ensure an accurate financial position is reflected. A monthly vacancy monitoring process is also operated in order to establish any vacancy dipper that might arise in the period. Each quarter, the financial position is reported to LCRN Executive and strategic decisions are made in terms of any in-year investments or overhead allocations to POs.	NH	April 2020							
3.2.6	C.3.1	CSD007	Implement a system to ensure that financial reports provided to the National CRN Coordinating Centre are accurate, complete and up to date.	• CRN Eastern Finance operate a timetable, workplan and suite of work instructions to ensure that all financial reports provided to the National CRN Coordinating Centre are accurate, complete and up to date.	NH	April 2020							
3.2.7	C.3.1	CSD004	Report to the National CRN Coordinating Centre: • the forecast outturn for the financial year which agrees to the Annual Financial Plan together with quarterly financial returns, via the NIHR CRN Finance Tool or any other system specified by the National CRN Coordinating Centre to agreed deadlines • all LCRN funding and expenditure, for all organisations in receipt of that funding, and agree to the year-end figures in LCRN Partners' accounts by the deadlines specified by the National CRN Coordinating Centre • each end-of-year financial return including a signed disclosure statement from the LCRN Host Organisation Director of Finance and LCRN Chief Operating Officer as specified by the National CRN Coordinating Centre.	• All processes in place and referenced in other finance sections.	NH/MB	April 2020							
3.2.8	C.3.1	CSD007	Obtain written assurance that the financial information provided by LCRN Partners is accurate and complete and that all costs are valid and appropriately authorised, including a signed disclosure statement from each LCRN Partner organisation signed by the Director of Finance (or equivalent authority) of the LCRN Partner organisation.	• At year end, prior to signing our LCRN financial return declaration, all POs are required to sign and submit an annual declaration to confirm adherence to the contractual requirements (see URL in Column L).	NH	April 2020							
3.2.9	C.3.1	CSD007	Implement and maintain Standard Operating Procedures (specifically to ensure that NIHR CRN funding is not used to subsidise commercial contract research delivery in the LCRN Host and Partner Organisation, and that commercial research is supported on a full cost recovery basis.	• CRNE prepared Commercial Income Distribution Guidance in November 2017, which was issued to Partners and agreed at April 2019's Partnership Group (See Column L). • As part of CRN Eastern's finance team's annual monitoring visits, POs are required to provide evidence of reinvestment of any commercial income attributable to CRN funding to support non-commercial portfolio studies. • The SOP will be finalised by end Q1.	NH/MB	April 2020	July 2020	<a href="#">Commercial Income Distribution Guidance</a>					
3.2.10	C.3.1	CSD007	Understand an internal audit at least once every three years in respect of LCRN funding to review the LCRN Minimum Financial Control standards. The costs incurred by the LCRN Host Organisation in undertaking an internal audit can be charged against LCRN funding.	• An internal audit in respect of LCRN funding was carried out by RSM Risk Assurance Services in September 2018, with clear objectives identified in line with the minimum scope requirements specified by the Coordinating Centre. See further details in Section 6.7.	NH	April 2020							
3. CRN Specialities													
3.3.1	C.4.1	CSD080	Put in place a named Local Specialty Research Lead (LSRL) for each National Specialty Group (NSG). The LSRL role must conform to the NSG Terms of Reference.	• CRN Easterns has a LSRL in place for each speciality, there is an interim LSRL in place for hepatology. Processes are in place to promptly seek new appointments where vacancies arise. • The role conforms to the Terms of Reference.	JPV/JT	April 2020							
3.3.2	C.4.1	CSD081	Inform the National CRN Coordinating Centre of any changes to LSRLs, and involve the CRN National Specialty Leads in the appointment or replacement of LSRLs prior to confirmation of appointment.	• The CC are advised of new appointments and an additional process has been added to ensure that the National Specialty Lead is involved in new appointments in 2020/21.	HM	April 2020							
3.3.3	C.4.1	CSD003	Maintain a documented mechanism locally to ensure LSRLs deliver their role in accordance with the role description. LCRNs are expected to report on SRL involvement in the following as part of the LCRN Annual Plan: • Attendance at NSG meetings • Contribution to NSG strategic projects locally and nationally • Mentoring, training and communication of local investigators, particularly those new to research • Promotion of the CRN and its activities • Engagement with external stakeholders including Royal Colleges and professional bodies	• All LSRLs have a link senior manager who provides support to allow each LSRL to carry out their responsibilities effectively, both locally and nationally. • Information will be collated centrally to evidence these activities for each Speciality. This is the responsibility of the SMT link.	d/RDMS (C/Ds)	April 2020	March 2021						
3.3.4	C.4.1	CSD082	Support LSRLs to complete expert feasibility reviews for which they receive requests and ensure their compliance with the study support process (minimum 50% of agreed LSRL reviews completed within the required timeline).	• RDM with dedicated industry management capacity during 2019/20 Q4 will provide capacity in 2020/21 to monitor requests for feasibility reviews and to track responses. Liaising with the Cluster offices, the manager will compile a record of reviews completed which will contribute towards evidence of activities undertaken by LSRLs. Failure to participate in this aspect of the role will be addressed during performance reviews.	HP	October 2020	March 2021						
3.3.5	C.4.1	N/A	Undertake analyses to identify disparities between local health and care needs and the local research portfolio in all CRN Specialities, and, in consultation with the Specialty Cluster / National Specialty Leads / LSRLs, develop plans to address any such disparities. Any projects undertaken in this area should be reported through the LCRN Annual Report.	• Our Public Health consultant will support population health profiles, data collection and analysis. • Each Specialty Lead has a link senior manager who will develop plans to address local disparities with particular reference to identified specialties (see 4.15) and the national priorities. • Please also refer to the Local Initiative: Equality, diversity and inclusion project • Local researchers have developed CRN Portfolio studies in COPD rehabilitation which will recruit in 2020/21. Delivery sites will be selected in geographical hotspots identified through use of the COPD Disease Mapping tool. • Research opportunities within the Reproductive Health and Childbirth portfolio will be offered to women living in areas of high deprivation. Postcode data will be collected from healthcare records and sent to the LCRN for analysis on a quarterly basis. • Reporting of these activities will highlight local impacts and ensuring these are shared with all POs.	BH	March 2021		<a href="#">Equality, diversity and inclusion project</a>					
					HP/HC	March 2021							
					HP/HC	October 2020							
3.3.6	C.4.1	N/A	Develop and support national and local initiatives to expand research in multimorbidity. Any projects undertaken in this area should be reported through the LCRN Annual Report.	• We have established links with the NIHR ARC East of England Ageing and Multi-Morbidity theme through our Ageing LSG, and Research Delivery Manager. • New Eastern led multi-morbidity studies are expected to come onto the portfolio in 2020/21.	BH	March 2021							
3.3.7	C.4.1	N/A	All LCRN Partner organisations must report participant year of birth within LPMs for all studies.	• A plan is in place. • We are fully engaged with national programmes to build year of birth into LPMs recruitment recording processes, and have advised Partners that we will require this to give them time to resolve any IG issues.	DW/MB	March 2021		<a href="#">Year of Birth Plan</a>					
3.3.8	C.4.1	Gd086	Establish a process to identify and communicate with those new to research, and report through the LCRN Annual Report how those new to research have been mentored and supported to increase involvement in NIHR CRN Portfolio research.	• The NIHR's 'Your Path in Research' campaign will be fully supported from an Eastern angle, used in promotion to Early Career Researchers and those new to research throughout the year. Plans include focused initiatives around International Nurses Day on 12 May and James Lind's birthday on 4 October. • Research engagement events held in collaboration with partner organisations will be used to connect with those new to research. • The Greenhous scheme provides dedicated funding (in the form of PA or sessions time) for clinicians and others who will become Principal Investigator for the first time in order to grow the region's research capability and recruitment activity. Awardees have a suitable, named NIHR Portfolio experienced research mentor and are supported by Partner Organisation Research and Development Teams and Research Delivery Managers. Training is provided for them and they are required to report progress to the Specialty Lead during the reward period. • The establishment of the workforce profile, see section 10.1, will provide opportunities to identify and communicate with those new to research. • Research naive staff are also able to access locally delivered training courses provided by the workforce team. • See Early Career Researcher (ECR) Initiative for more information about how we are engaging with research naive trainees.	ET/ER	March 2021							

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3.5.6	C.6.1	N/A	When sharing or citing LCRN performance data (e.g. in LCRN Annual Reports, plans, and local communications) the data used must be the official data as produced or issued by the National CRN Coordinating Centre.	<ul style="list-style-type: none"><li>All shared and published data is extracted from national systems (ODIP/CNHS) and cross-checked to guard against errors in processing or definition. This is underpinned by ongoing education and training given to significant or influential users, such as RDMs, SDOs and R&amp;D teams. Further support is provided alongside reports in areas of potential confusion, such as managing/supporting speciality and confirmed/provisional data, with dedicated simple guides to understanding these.</li></ul>	DW	April 2020					
3.5.7	C.6.1	N/A	Provide appropriate business intelligence (BI) tools and systems to allow the Business Intelligence Lead and supporting staff to provide a modern BI Service to the Host Organisation, LCRN staff and Partners.	<ul style="list-style-type: none"><li>Alongside CDR, which we encourage staff to use, we have amalgamated CDR and LCRN data to build intuitive, interactive reporting in Power BI, published to Google Sites. With a common style, multiple different reports have been built for different audiences and purposes. Processes for reporting problems or requesting new content are signposted in the reports, and are managed through Google Forms. Feedback on these new reports has been very positive and we continue to drive further developments.</li></ul>	DW	April 2020					
6. Communications											
3.6.1	C.7.1	N/A	Promote research opportunities to patients and public in line with the NHS Constitution for England (available at <a href="https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/NHS-Constitution_WELL.pdf">https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/480482/NHS-Constitution_WELL.pdf</a> on page 8), including informing patients about research that is being conducted within the LCRN area. Engagement opportunities offered by the National CRN Coordinating Centre-managed services such as Join Dementia Research (JDR) and Be Part of Research should be communicated to all appropriate stakeholders.	<ul style="list-style-type: none"><li>Research opportunities will continue to be promoted to patients and the public in line with the NHS Constitution for England, informing patients about research being conducted within the LCRN region, maintaining accessibility to all, with transparency, equality and equity of messaging. In line with the CRN Eastern Strategy 2019-2022 (see Column I), CRN Eastern Communications will focus efforts on raising awareness of research in research deprived localities and populations, promoting research studies according to population health needs and in under-developed areas including Reproductive Health, and Mental Health.</li></ul>	ER	April 2020	Ongoing	<a href="#">LCRN Eastern communications Strategy</a>			
3.6.2	C.7.1	CS0016	Develop and deliver a local communications plan that recognises the LCRN's position as part of a national system, and that supports: <ul style="list-style-type: none"><li>the development and maintenance of the LCRN's positive reputation</li><li>transparency of local performance on research delivery</li><li>strong external and internal stakeholder relationships including effective working with other parts of the NIHR</li><li>clinical delivery of national NIHR and CRN campaigns and initiatives.</li></ul>	<ul style="list-style-type: none"><li>In line with the 2020/21 CRN Eastern Communications Plan (see Column I), we aim to deliver SMART (specific, measurable, achievable, realistic and timely) communications objectives. This will include nurturing strong relationships with all stakeholder groups, from regional media to NIHR colleagues, in order to ensure brand continuity and reputation enhancement.</li></ul>	ER	April 2020	Ongoing	<a href="https://docs.google.com/presentation/d/1uEm8Ez9d4F5y6d431u6hL18181624wLdUd4d4V7Y7d4d4p4131321665d4">https://docs.google.com/presentation/d/1uEm8Ez9d4F5y6d431u6hL18181624wLdUd4d4V7Y7d4d4p4131321665d4</a>			
3.6.3	C.7.1	CS0016	Ensure the whole LCRN operates in line with the brand guidelines, operational requirements, website and social media guidelines and national messaging as advised by the National CRN Coordinating Centre.	<ul style="list-style-type: none"><li>We will ensure adherence of stakeholders to NIHR and CRN branding, operational requirements and national messaging by continuing to support CRN and wider NIHR colleagues around the country, providing guidance, and cascading and sharing communications.</li></ul>	ER	April 2020	Ongoing	CRN Eastern website: <a href="https://local.nhr.ac.uk/form/eastern">https://local.nhr.ac.uk/form/eastern</a> CRN Eastern Hub Home: <a href="https://sites.google.com/nhr.ac.uk/cr-eastern-hub/home">https://sites.google.com/nhr.ac.uk/cr-eastern-hub/home</a> A Guide to CRN Eastern: <a href="https://drive.google.com/file/d/1u8d4d4V7Y7d4d4p4131321665d4/view">https://drive.google.com/file/d/1u8d4d4V7Y7d4d4p4131321665d4/view</a>			
3.6.4	C.7.1	CS0016	Promote the acknowledgement of NIHR support in publications and press releases in communications with local researchers and LCRN Partners in receipt of funds or support from the NIHR.	<ul style="list-style-type: none"><li>Through the continuation of the CRN Eastern Communications Manager undertaking the additional role of NIHR Regional Communications Link for the East of England, we will continue to support other NIHR colleagues in the region and strengthen business relationships with partner organisations' communications stakeholders, to drive visibility of the NIHR in publications and press releases.</li></ul>	ER	April 2020	Ongoing				
7. Patient and Public Involvement and Engagement (PPIE)											
3.7.1	C.8.1	CS0058	Create an annual Patient and Public Engagement (PPIE) Plan, to be included as a section within the LCRN Annual Plan.	<ul style="list-style-type: none"><li>PPIE work plan in place for 2020/21 to be RAG rated and monitored by the PPIE Steering Group and through regular updates to the Executive Committee</li></ul>	HC/DC/AR	April 2020		<a href="#">PPIE Work Plan for 2020/21</a>			
3.7.2	C.8.1	CS0058	Assign appropriate resources, including the minimum of a 1.0 Whole Time Equivalent (WTE) PPIE lead, to enable effective delivery of the PPIE Plan.	<ul style="list-style-type: none"><li>0.1 WTE PPIE lead</li><li>0.1 WTE PPIE Manager</li><li>0.5 WTE PPIE Administrator</li></ul>	HC	April 2020					
3.7.3	C.8.1	CS0058	Ensure representation at the PPIE Leads Forum by a relevant LCRN representative(s).	<ul style="list-style-type: none"><li>PPIE representative attends each Forum meeting</li><li>Appropriate member of team takes part in the monthly PRES and RC icons</li></ul>	AR/DC	April 2020					
3.7.4	C.8.1	CS0058	Ensure engagement in National CRN Coordinating Centre PPIE initiatives by relevant local representative(s).	<ul style="list-style-type: none"><li>The CRN Eastern PPIE Team engage with all National initiatives to deliver at local level including the new Research Champions and PRES processes. Continue to engage with National T-cons and events as well as developing initiatives at a local level.</li></ul>	HC/DC/AR	April 2020					
3.7.5	C.8.1	CS0074	Implement the improvements to the PRES delivery system as introduced by National CRN Coordinating Centre throughout the year.	<ul style="list-style-type: none"><li>The RC initiative is in place and details of how it will be delivered are set out in the CRN Eastern PPIE work plan. The scheme has over 40 PRAs in post at one time, working with 11 of our 16 Hospital Trusts over the course of the year. This will be extended to a further 2 PCs in 2021. The programme of work comprises:<ul style="list-style-type: none"><li>Two Public Contributors within the CRN as Lay reps on the PG and Exec.</li><li>Trust PRA and JDR Champions posts which help ensure sustainability of the PRA programme and promote culture change within the R&amp;D Team. JDR Champions will be supported by the JDR coordinator and outcomes will be reported by the PPIE Manager via the Impact Framework.</li><li>Some examples of RC activities planned by Trusts in 2020/21 include:<ul style="list-style-type: none"><li>ESNETT aim to deliver a patient cafe in 19/20 and use this as a springboard for PRA activity in 2020/21. This was funded by the CRN from our PPIE budget.</li><li>BEAT will deliver a training session for patients and the public in 2020/21, from which they intend to develop an Ambulance Trust appropriate PRA role. CRN Eastern has committed to fund this and give staff time (PPIE Manager).</li><li>PRA Led Learning disabilities access project as detailed in 3.7.14. Also see 3.7.13</li></ul></li></ul></li></ul>	AS	April 2020		<a href="#">PPIE Work Plan for 2020/21</a>			
3.7.6	C.8.1	CS0070	Conduct the Participant in Research Experience Survey (PRES) with Partners, providing quarterly data returns to the National CRN Coordinating Centre.	<ul style="list-style-type: none"><li>Annual delivery of the PRES is in place. Details of how the survey will be delivered are set out in the CRN Eastern PPIE work plan.</li><li>Continue work with POs and SGs to feedback PRES results and identify improvements to research delivery. Share the PRES results with the wider NIHR family, in particular the RDS, so that they can be used to inform and improve research design.</li></ul>	DC	April 2020		<a href="#">PPIE Work Plan for 2020/21</a>			
3.7.7	C.8.1	CS0070	Develop and implement a PRES Action Plan showing how PRES results have been acted upon by Partners. Progress against the PRES Action Plan should be tracked and reported via the National CRN Coordinating Centre PPIE Impact Framework.	<ul style="list-style-type: none"><li>The 2020/21 PRES Action Plan will build on the 2019/20 PRES Action Plan setting out improvements to be taken forward by POs and the CRN Eastern core team in response to the 19/20 survey results.</li><li>Progress will be reported as specified.</li></ul>	DC	April 2020		<a href="#">2020/21 PRES Action Plan</a>			
3.7.8	C.8.1	CS0070	Implement the improvements to the PRES delivery system as introduced by National CRN Coordinating Centre throughout the year.	<ul style="list-style-type: none"><li>Continue to implement improvements to the PRES delivery system locally, as and when introduced by the Coordinating Centre.</li><li>Ensure effective, regular updates with partner organisations to ensure they fully understand any changes.</li></ul>	DC	April 2020					
3.7.9	C.8.1	CS0072	Deliver the National CRN Coordinating Centre PPIE Impact Framework, ensuring the return of all required data by quarterly deadlines.	<ul style="list-style-type: none"><li>Ensure required quarterly data is provided on time to the Coordinating Centre.</li><li>These updates and the PPIE Work Plan will be monitored by the PPIE Steering Group.</li></ul>	AS/DC	April 2020					
3.7.10	C.8.1	CS0058	Promote the Be Part of Research service to patient groups and the public.	<ul style="list-style-type: none"><li>Promote Be Part of Research through all patient and public facing initiatives including the Rebo (interactive game) Schools Project, when using PRES to promote research and through the CRN's Flagship (Red Letter Day) Events. More detail is set out in the PPIE Work Plan (Ref: 3.6.1)</li></ul>	AS/DC	April 2020		<a href="#">PPIE Work Plan for 2020/21</a>			
3.7.11	C.8.1	CS0058	Support the involvement of local Research Champions and other public contributors with national opportunities within the NIHR as such opportunities arise.	<ul style="list-style-type: none"><li>All National opportunities will be shared with local RCs via email and where possible via the POs so that they can disseminate via their communication channels, as is currently the practice in the LCRN.</li></ul>	AS	April 2020					
3.7.12	C.8.1	CS0058	Put in place a structure for involving public contributors in the governance and leadership of their LCRN.	<ul style="list-style-type: none"><li>Two Public Contributors are in post within the CRN as Lay reps on the PB and Exec.</li><li>Lay representatives chair the CRN's quarterly PPIE Steering Group meetings and monitor the PPIE Work Plan.</li></ul>	AS/DC	April 2020					
3.7.13	C.8.1	CS0074	Develop PPIE capacity building activities, to Research Champions and any other public contributors, as specified in the Research Champions Contract Support Document.	<ul style="list-style-type: none"><li>The CRN supports PO PRA and staff as one, in terms of capacity building, as detailed in the work plan (Ref: 3.7.5)</li></ul>	AS		<ul style="list-style-type: none"><li>We already have activities and structures in place to support this. We are also planning to deliver additional activities. Therefore the date varies according to activity (see workplan). Full compliance with new CSD and associated activities by October 2020</li></ul>	<a href="#">PPIE Work Plan for 2020/21</a>			
3.7.14	C.8.1	CS0058	Deliver a programme of PPIE capacity building activities to Partners.	<ul style="list-style-type: none"><li>Further develop the CRN's Research Event Resource and Planning Pack to assist research staff to deliver patient facing events.</li><li>Continue to offer guidance and support to partners who plan and deliver PPIE events</li><li>Continue to offer and further develop the offering of Rebo's Research Adventure as a PPIE engagement activity.</li><li>Provide information/reporting on all events on the CRN's Hub Home site so that research staff and the public can continue to access the information after the event.</li><li>Continue to offer PPIE support to CRN Eastern's key studies to help ensure delivery to time and target whilst promoting a PPIE ethos within R&amp;D departments.</li><li>Share the outcomes of E&amp;D projects with partners to embed learning into current practice.</li><li>Deliver 2 E&amp;D projects identified in the PPIE work plan (equality of access subject to resources and Learning Disabilities and community involvement of all)</li></ul>	AS/DC	March 2021	April 2020 April 2020 April 2020 April 2020 March 2021 March 2021	<a href="#">PPIE Work Plan for 2020/21</a>			
8. NHS Engagement											
3.8.1	C.9.1	CS0078	Develop and deliver a Local NHS Engagement Plan for continued engagement of LCRN Host and Partner organisation staff in line with the Care Quality Commission (CQC) Well Led Framework, the NHS 10 Year Plan, and the NHS Constitution for England. The Local NHS Engagement Plan should involve CRN Local Research Specialty Leads and LCRN Partners' Research and Development Directors and teams.	<ul style="list-style-type: none"><li>Details of our proposed plan are outlined via the attached link. The Champion will liaise with the PPI team, Workforce and development, training and communication team to deliver the plan.</li></ul>	JMP	March 2021		<a href="#">Work Plan NHS Engagement and CQC Inpatient Experience</a>			
3.8.2	C.9.1	CS0078	Support the role of the LCRN Well Led Champion(s) in catalysing high quality collaborations that help fulfil the Local NHS Engagement Plan.	<ul style="list-style-type: none"><li>The role of the LCRN Well Led Champion is fully supported within CRN Eastern from within the core team and the partnership group.</li><li>Two Trusts (CUH and NCH&amp;C) have agreed to assist the champion in the development and implementation of the plan (see attached link).</li></ul>	JMP	March 2021		<a href="#">Work Plan NHS Engagement and CQC Inpatient Experience</a>			
3.8.3	C.9.1	CS0078	Develop an LCRN Action Plan based on the results of the research question in the 2019 CQC equivalent experience survey as it applies to supporting partnership organisations to improve patient access to research.	<ul style="list-style-type: none"><li>Details of the proposed action plan are outlined in the attached link. In addition to the two partner organisations listed in 3.8.2 the champion will work with all the R&amp;D managers and propose recommendations.</li></ul>	JMP	March 2021		<a href="#">Work Plan NHS Engagement and CQC Inpatient Experience</a>			
9. Workforce Learning and Organisational Development											
3.9.1	C.10.1	N/A	Develop and implement a comprehensive LCRN Workforce Plan for LCRN staff ensuring a responsive and flexible workforce to deliver NIHR CRN Portfolio studies.	<ul style="list-style-type: none"><li>A comprehensive plan is in place, with a named Workforce Development Lead responsible for Workforce Planning. This plan will be reviewed and updated. (Details of how the plan will be implemented are linked in Column I.)</li></ul>	ET	September 2020		<a href="#">WFD Workplan</a>			
3.9.2	C.10.1	N/A	Establish, maintain and report on a profile of NIHR CRN funded staff employed within the LCRN geography.	<ul style="list-style-type: none"><li>A workforce profile will be captured, maintained and reported on (see Column I).</li></ul>	ET	September 2020					
3.9.3	C.10.1	N/A	Nominate a senior leader as Wellbeing Lead with identified responsibility for the wellbeing of all LCRN-funded staff, having oversight of wellbeing initiatives across the LCRN.	<ul style="list-style-type: none"><li>Esther Thomas, Workforce Development and Wellbeing Lead is the named lead responsible for the wellbeing of all CRN funded staff and has oversight of wellbeing initiatives within the Eastern region (see Wellbeing Strategy link in Column I).</li></ul>	ET	April 2020					
3.9.4	C.10.1	N/A	Provide LCRN-funded staff with opportunities to engage with the strategic initiatives of the NIHR CRN, including the continuing development of learning resources in support of the NIHR CRN.	<ul style="list-style-type: none"><li>CRN Eastern will continue to provide opportunities for its staff to be involved with local and national strategic initiatives, including development and delivery of learning resources for the region. We will work with our supernetwork colleagues from East and West Midlands on projects to achieve these aims (see Column I).</li></ul>	ET	March 2021					
3.9.5	C.10.1	CS0025	Identify a Good Clinical Practice (GCP) Programme Lead who is a suitably qualified individual responsible for the strategic oversight of GCP education across the LCRN.	<ul style="list-style-type: none"><li>Esther Thomas and Debbie Campbell are joint GCP Programme Leads and are suitably qualified to perform this role.</li></ul>	ET	Ongoing					
3.9.6	C.10.1	CS0026	NIHR Learn must be used to manage all GCP and NIHR learning directory courses.	<ul style="list-style-type: none"><li>All local learning is managed using NIHR Learn</li><li>A slide set with presentation notes has been developed for speciality group and other face-to-face meetings highlighting how to use NIHR Learn and what is available. This is constantly being updated and will continue to be delivered across the region in 2020/21.</li></ul>	ET	Ongoing					

[illegible]

Section 4: High Level Objectives												
Columns F-J should be completed as part of the 2020/21 Annual Plan. The greyed out cells do not require completion. Columns K and L are expected to be completed as part of the 2020/21 Mid Year Progress Report. Columns M and N should be completed as part of the 2020/21 Year End Report. Columns in the Status column are automated. Please select Complete, Green or Red from the drop-down menu in columns K or M and the colour will update automatically												
Complete		Compliant with Objective and additional initiative(s) complete. Commentary is optional.										
Red		Not compliant with Objective or additional initiative(s) are off track. Commentary is mandatory and should clarify the issue and action being taken to address.										
Green		Compliant on target to achieve compliance with the Objective and all additional initiative(s) are on track.										
Plan Ref	Objective	Measure	Ambition	To complete at Annual Plan stage					To complete at Mid Year Progress Report stage		To complete at Annual Report stage	
				LCRN Target	How target has been determined and supporting rationale	Additional initiatives to achieve the Objective	Lead	Link URL (where applicable)	Status	Commentary	Status	Commentary
4.1	Efficient Study Delivery	Deliver NHR CRN Portfolio studies to recruitment target within the planned recruitment period	80%	80%			HP / MB					
4.2		(A) Proportion of commercial contract studies achieving or surpassing their recruitment target during their planned recruitment period, at agreed CRN sites (B) Proportion of non-commercial studies achieving or surpassing their recruitment target during their planned recruitment period	80%	80%								
4.3	Participant Recruitment	Deliver significant levels of participation in NHR CRN Portfolio studies	TBC	42,000	Partner Organisations have assessed their portfolio and pipeline and given ambitious, but realistic numbers by area (S)							
4.4		(A) Number of participants recruited to commercial contract NHR CRN Portfolio studies (B) Number of participants recruited to commercial contract NHR CRN Portfolio studies	TBC	TBC	Partner Organisations have assessed their portfolio and pipeline and given ambitious, but realistic numbers by specialty.		HP / MB					
4.5	New Commercial Studies	Increase the number of studies delivered for the commercial sector with support from the NHR CRN Research Network	750	N/A			HP / MB					
4.6		(A) Number of new commercial contract studies entering the NHR CRN Portfolio (B) Number of new commercial contract studies entering the NHR CRN Portfolio as a percentage of the total commercial NHR CTA approach for Phase II-IV studies	75%	N/A			HP / MB					
4.7	Provider Participation	Widen participation in research by enabling the involvement of a range of health and social care providers	99%	99%								
4.8		(A) Proportion of NHS Trusts recruiting into NHR CRN Portfolio studies (B) Proportion of NHS Trusts recruiting into NHR CRN Portfolio commercial contract studies	70%	70%			HP / MB					
4.9		(C) Proportion of General Medical Practices recruiting into NHR CRN Portfolio studies	45%	45%			HJ					
4.10		(D) Number of non-NHS sites recruiting into NHR CRN Portfolio studies	TBC	Provisionally 20% increase on 2019/20								
4.11	Dementia and Neurodegeneration Recruitment	Deliver significant levels of participation in NHR CRN Portfolio Dementia and Neurodegeneration (DeNDiRN) studies on the NHR CRN Portfolio, each year	TBC	1,600	Input from all Partner Organisations has supported HLO7 target setting. We have looked at current and pipeline studies expected to run in 2020/21.		BH					
4.12	Participant Experience	Demonstrate to people taking part in health and social care research studies that their contribution is valued	12,000	3,000			OC/HC					
4.13	Site Set-up (A)	Reduce intra study site set-up times for NHR CRN Portfolio studies	TBC	As per CRN Ambition			ST					
4.14		(B) Median intra study site set-up time for non-commercial studies (days)	TBC	As per CRN Ambition								
4.15	Local Specialities	Improve access to research by increasing recruitment in priority specialities (including underserved groups)	5%	5%			ROMS, BH, HC, KT					
4.16		(A) Percentage increase in the number of participants recruited to NHR CRN Portfolio studies within local priority areas (B) Proportion of LCRN local priority areas with an increased recruitment of 5% or more	80%	80%								
Calculation notes			Local Priorities - New HLO									
4.1	Efficient Study Delivery (A)	Ambition value 80% - unchanged from 2019/20 Ambition value	<p>Each LCRN will select between 5 and 10 'local priority research areas' for 2020/21 from a 'menu' list produced by the CRN National Specialty Leads. These 'local priority research areas' will be the focus of increased research engagement and activity in 2020/21, the purpose being to expand research activity in 'underserved' populations and research areas locally. The objective for each LCRN will be to increase research activity in recruitment in each of these 'local priority research areas' by at least 5%.</p> <p>The HLO will have two measures: (A) the actual % increase in recruitment in 'local priority research areas', and (B) the proportion of all LCRN local priority research areas in which recruitment has been increased by at least 5%.</p>									
4.2	Efficient Study Delivery (B)	Ambition value 80% - unchanged from 2019/20 Ambition value										
4.3	Participant Recruitment (A)	Ambition value TBC - will be the mean of the annual out-turn values for the 5 year period 2015/16 to 2019/20										
4.4	Participant Recruitment (B)	Ambition value TBC - will be the mean of the annual out-turn values for the 5 year period 2015/16 to 2019/20										
4.5	New Commercial Studies (A)	Ambition value 750 - unchanged from 2019/20 Ambition value										
4.6	New Commercial Studies (B)	Ambition value 75% - unchanged from 2019/20 Ambition value										
4.7	Provider Participation (A)	Ambition value 99% - unchanged from 2019/20 Ambition value										
4.8	Provider Participation (B)	Ambition value 70% - unchanged from 2019/20 Ambition value										
4.9	Provider Participation (C)	Ambition value 45% - unchanged from 2019/20 Ambition value										
4.10	Provider Participation (D)	Ambition value TBC - will be the 2019/20 out-turn value plus 5%										
4.11	DeNDiRN Recruitment	Ambition value TBC - will be the mean of the annual out-turn values for the 5 year period 2015/16 to 2019/20										
4.12	Participant Experience	Ambition value 12,000 - an increase of 2,000 on the 2019/20 Ambition value										
4.13	Site Set-up (A)	Ambition value TBC - will be the 2019/20 out-turn value less 5%										
4.14	Site Set-up (B)	Ambition value TBC - will be the 2019/20 out-turn value less 5%										
4.15	Local Priorities (A)	Ambition value 5% - an LCRN level baseline for each local priority research area will be calculated, this will be the mean of the equivalent annual out-turn values for the 2 year period 2018/19 to 2019/20. The ambition is to recruit at least 5% more participants in each local priority research area in 2020/21. If a CRN had recruited a mean average of 40,000 participants to Ambition value 80% - the ambition is that 80% of all LCRN local priority research areas achieve the 5% increase in recruitment. So, if each LCRN selects 5 priority areas, that will be 65 (13 x 5) local priority areas identified in total across the CRN. The ambition is to achieve a 5% increase in at least 80% of these, i.e. in at least 32 local priority areas in 2020/21.										
4.16	Local Priorities (B)	Ambition value 80% - the ambition is that 80% of all LCRN local priority research areas achieve the 5% increase in recruitment. In a CRN which selects 5 priority areas, that will be 45 (5 x 9) local priority areas identified in total across the CRN. The ambition is to achieve a 5% increase in at least 80% of these, i.e. in at least 32 local priority areas in 2020/21.										

## Section 5: Local Initiatives

Section 5 of the template should be used to detail local initiatives and projects to be delivered in 2020/21, that the LCRN would like the CRNCC and other LCRNs to be aware of. Please include local network projects and activities, projects to be delivered in collaboration with other LCRNs (as part of regional LCRN-Supra-network collaborative activities or other LCRN collaborations), and projects to be delivered nationally/CRN-wide led locally by the LCRN. Projects to be delivered in collaboration with other parts of the NIHR and/or other external organisations should also be included.

In order to communicate the rationale for initiatives and projects planned, their scope, impact and anticipated outcomes, LCRNs are asked to make a copy and populate the following linked template which will capture progress of delivery and learning to be shared on an ongoing basis. Please provide a link to the completed template in column G including the relevant Annual Plan project reference. This name the template file based on the initials of your LCRN or LCRN Supra-network, followed by the relevant Section number, starting from 5.1 e.g. 'EM5.1' for East Midlands first local initiative or 'SNBS.1' if the first local project East Midlands are planning will be conducted across their Supra-network, Supra-network B. In the case of Supra-network projects or collaborative projects with other LCRNs the project should be included in the Annual Plan of each participating LCRN.

[Link to A3 CRN Initiatives template](#)

Columns A-F should be completed as part of the 2020/21 Annual Plan.  
Columns G-H should be completed as part of the 2020/21 Mid Year Progress Report.  
Columns I-J should be completed as part of the 2020/21 Annual Report.

### Progress Status Information:

Colours in the Status column are automated. Please select Complete, Red or Green from the drop-down menu in column G or I (as relevant) and the colour will update automatically.

Complete		Initiative/project complete. Commentary is optional.							
Red		Initiative/project off-track or incomplete. Commentary is mandatory.							
Green		Initiative/project on-track and will be delivered by the expected completion date. Commentary is optional.							
To complete at Annual Plan stage						To complete at Mid Year Progress Report stage		To complete at Annual Report stage	
Plan Ref	Title and brief description of Project or Initiative	Intended outcome	Speciality specific? (Please specify)	Expected completion date	Please add link URL to A3 template	Status	Commentary	Status	Commentary
E5.1	Improving Site Setup - HLO9 Engagement Project	Improved engagement with partner organisations around the challenges and strategies for reducing site setup times (Supra Network)	No	March 2021	<a href="#">5.1 Improving Site Setup - HLO9 Engagement Project</a>				
E5.2	Digital Project - automated datafeed	Automated extraction of information obviating the need for manual data manipulation	No	January 2021	<a href="#">5.2 Digital Project</a>				
E5.3	Equality, diversity and inclusion project	To develop a resource pack that will support greater equality, diversity and inclusion in health research. To support Partner Organisation initiatives that aim to increase access to health research. (One NIHR)	No	March 2021	<a href="#">5.3 Equality, diversity and inclusion project</a>				
E5.4	PRES Delivery Improvement Project	Increase PRES returns by exploring delivery methods (Supra Network)	No	March 2021	<a href="#">5.4 HLO8 PRES Delivery Improvement Project</a>				
E5.5	Early Career Researcher Initiative - Working with NIHR Partners	To provide and embed research training into the education of Foundation Year Medics and Specialty Medics as well as training for medics and non medics who are in receipt of ARC fellowships	No	August 2021	<a href="#">5.5 ECR Initiative - Working with NIHR Partners</a>				



Section 6: Financial Management			
6.1	Please provide details of the plans that you anticipate impacting on the allocation of LCRN funding for 2020/21. (For example particular studies that require large investment, concentration on a particular Specialty)		CRN Eastern has a fully devolved model of funding in which Partner Organisations (POs) are expected to deliver within their funding envelope, derived from the local financial model developed during 2018/19 and outlined in section 3.2.3. Any studies that might result in significant variance from POs' allotted allocation will be reviewed on case by case basis and additional funding may be granted according to their strategic importance. The decision to adjust a PO's funding will be ratified by the Exec and Partnership Group where necessary.
6.2	In respect of the LCRN 2020/21 local funding model, please complete the following table* by entering the proportion of LCRN funding (%) within the funding elements detailed. If there are any other elements to the model please describe what this is for and the proportion of funding allocated to this		
*Notes	1. It is assumed that the Local Funding Model is net of any National Top Slice as these are pass through costs 2. If the funding element category is not applicable to your Local Funding Model, please enter 0% 3. The percentages (%) entered in the table should equate to 100%		
Funding Element	Examples	Description of model	% of Total CRN Funding Budget 2020/21 Budget (Please note that these should total 100%)
Host Top sliced element	Core Leadership team, Host Support costs, LCRN Centralised Research Delivery team	Top sliced (RTTQA and NSL) paid as passthrough to POs. Consultant PAs (following full PA review), reduced by 50% in 2020/21. Hosted staff, Core Leadership team and Host Support costs. Note that Eastern has 2 RDMs hosted at POs. PPIE, Comms and workforce are hosted at NNUH.	%
Block Allocations	Primary care, Clinical support services (i.e. pharmacy), R&D contributions	Primary Care Per patient and RSI costs, Clinical support services (Pharmacy, Pathology, Radiology etc).	%
Activity Based	Recruitment HLO 1, number of studies, activity weighting	50% fixed element (based on 2019/20 delivery funding) plus ABF weighted recruitment & HLO1 raw recruitment - no. of studies.)	%
Historic allocations	PO funding previously agreed	No element based on Historic allocations.	%
Performance Based	HLO performance, value for money metric	HLO 2a Commercial RTT.	%
Population Based	Adjustments for NHS population needs	No adjustment for Population Based element	%
Project Based	Study start up	No funding attributed as Project Based	%
Contingency / Strategic funds	Funds to meet emerging priorities during the year, including targeting local health needs	Investment funding to be allocated to priority areas ones these are finalised - see also 6.5 - minimum of 2%	%
Other funding allocations		None	%
<b>Total</b>			<b>0.00%</b>
Cap and Collar	Please provide your upper and lower limits if applicable	Cap and collar applied to individual PO allocations of +/- 10%	10% CAP 10% COLLAR
<b>Comments</b>			
6.3	If the 2020/21 local funding model methodology has changed since 2019/20, please give a brief description of the changes and the implications for Partner organisations' allocations		No changes to 2019/20 funding model (PG agreed a 2 year model).
6.4	Please confirm whether monitoring visits will be taking place over the course of 2020/21. If yes, please provide details of which Partner organisations will be covered and the rationale behind this decision. Please also indicate what proportion (by spend) of your Category A Partner organisations are being monitored		CRNE will carry out an annual visit to POs during 2020/21, except for those with minimal funding where there are no particular areas of risk or concern. This is in line with guidance issued by the NIHR CRN (Minimum Controls version 4.1 issued August 2019), and in accordance with the CRNE SOP established January 2018.  CRNE has taken the approach that "minimal funding" represents < 2% of the total annual allocation. On this basis there are 7 Category A POs who fall below this limit. As there are currently no significant risks or concerns surrounding these POs for 2020/21, they will fall outside the current requirements but will be continually monitored. Thus, CRNE will perform monitoring visits for 61% of our total Category A Partners (11 POs) in 2020/21, which represents coverage of 76% of our total AFP.  Dates and attendance of monitoring visits have been set out in the CRNE PO Monitoring SOP and workplan.
6.5	Please confirm if an amount of funding is being set aside to address local health needs and if so which applicable diseases will be prioritised. This should be highlighted as 'strategic funding' in the CRN Finance Tool		A minimum of 2% of the network's funding will be allocated. Further details will follow once the finalised list of priority specialties has been confirmed.
6.6	What are the key financial risks and mitigations for 2020/21? Please include cost saving initiatives / measures		The key risks to achieving a balanced plan are similar to those of previous years. The plan has been set with a vacancy factor of £1.0 m, which is in line with 2019/20. CRNE operates a central monitoring process for all vacancies held across the Network. This process enables us to maintain tight control over Network resources and to monitor achievement of the vacancy target during the year. At AFP stage there is likely to be some uncertainty as to the level of required payments to Primary Care Contractors due to the potential for delays in study delivery and the difficulty in calculating robust forecasts. These forecasts are reviewed quarterly and in
6.7	In which financial year did your previous internal audit take place? Have all of the auditor's recommendations been implemented and, if not, when will they be implemented?		An internal audit in respect of LCRN funding was carried out by RSM Risk Assurance Services in September 2018, with clear objectives identified in line with the minimum scope requirements specified by the CC. Audit opinion was 'reasonable assurance', with 1 medium and 1 low priority action point.
6.8	If the next internal audit is due in 2020/21, please give the estimated date of the audit		Not applicable.

Section 6: Appendices		
Ref no	Title	Link URL
<b>Annual Plan Appendices</b>		
AP Appendix 1	Risk and Issues Log	<a href="#">Appendix 1: CRN Eastern 2019-20 Risks and Issues Register</a>
AP Appendix 2	Workforce and Wellbeing Survey Report 2019	<a href="#">Appendix 2: Workforce and Wellbeing Survey Report 2019</a>
AP Appendix 3	Business Marketing Profile	<a href="https://drive.google.com/a/nhr.ac.uk/file/d/1n7kWFdKhIU3EhOk4g7-6aL6OXEFpkfzE/view?usp=sharing">https://drive.google.com/a/nhr.ac.uk/file/d/1n7kWFdKhIU3EhOk4g7-6aL6OXEFpkfzE/view?usp=sharing</a>
[Please add additional appendices/rows as needed]		
<b>Mid Year Progress Report Appendices</b>		
MYPR Appendix 1	Risk and Issues Log	
[Please add additional appendices as needed]		
<b>Annual Report Appendices</b>		
AR Appendix 1	LCRN Fact Sheet	
AR Appendix 2	Finance section for the LCRN Fact Sheet	
AR Appendix 3	LCRN Category B Providers	
AR Appendix 4	Non-Supported Non-Commercial Studies	
[Please add additional appendices as needed]		

Document Ref.	Document Link	Contract Support Document Name	POF Section Ref.
CSD002		NIHR CRN High Level Objectives Data Point Grid	B.2
CSD003	<a href="https://drive.google.com/open?id=1vggFLOnQJuohe5Vvs_xEyZYoe">https://drive.google.com/open?id=1vggFLOnQJuohe5Vvs_xEyZYoe</a>	NIHR CRN Governance, Leadership and Management	C.2
CSD004	<a href="https://drive.google.com/open?id=1xJP1dJpVMw2vHFOkTPJO_rAI">https://drive.google.com/open?id=1xJP1dJpVMw2vHFOkTPJO_rAI</a>	CRN Funding Reporting	C.3
CSD006	<a href="https://drive.google.com/open?id=1tGZLu4S8tkpYAXycXTKm5uUc">https://drive.google.com/open?id=1tGZLu4S8tkpYAXycXTKm5uUc</a>	Income distribution from NIHR CRN Industry Portfolio Studies	C.5
CSD007	<a href="https://drive.google.com/open?id=1qaHgkhdqIvYtbs7Qa8hMiwADx">https://drive.google.com/open?id=1qaHgkhdqIvYtbs7Qa8hMiwADx</a>	LCRN Minimum Financial Controls	C.2, C.3
CSD010	<a href="https://drive.google.com/open?id=11YzgEsHuxKJBGO-zaBGNDwnI">https://drive.google.com/open?id=11YzgEsHuxKJBGO-zaBGNDwnI</a>	NIHR CRN Urgent Public Health Research: Set-up	C.5
CSD011	<a href="https://drive.google.com/open?id=1jeIHnYt5iF3gVSPKT1zz9Nalzti">https://drive.google.com/open?id=1jeIHnYt5iF3gVSPKT1zz9Nalzti</a>	NIHR CRN Urgent Public Health Research: Initiation	C.5
CSD012	<a href="https://drive.google.com/open?id=1hn56nsc61Ei56Eug8IBY4nngkF5">https://drive.google.com/open?id=1hn56nsc61Ei56Eug8IBY4nngkF5</a>	NIHR CRN Urgent Public Health Research: Delivery	C.5
CSD013	<a href="https://drive.google.com/open?id=1DdbTDodm8irr1rI27JEA1uhipG-k">https://drive.google.com/open?id=1DdbTDodm8irr1rI27JEA1uhipG-k</a>	NIHR CRN Urgent Public Health Research: Reporting	C.5
CSD014	<a href="https://drive.google.com/open?id=16AKA44RtZFcCKz-75iOFGkyfNI">https://drive.google.com/open?id=16AKA44RtZFcCKz-75iOFGkyfNI</a>	NIHR CRN Urgent Public Health Research: Urgent Public Health Champion Role Outline	C.5
CSD016	<a href="https://drive.google.com/open?id=140_32ROWndnUgbEiO09vV4TiZ">https://drive.google.com/open?id=140_32ROWndnUgbEiO09vV4TiZ</a>	Communications	C.7
CSD021	<a href="https://drive.google.com/open?id=15RZsp3zz_6U8pFtXtQ5ffdn0D">https://drive.google.com/open?id=15RZsp3zz_6U8pFtXtQ5ffdn0D</a>	Confidential Information Arrangements for the Life Sciences Industry Feasibility Services – Confidential Disclosure Agreement (CDA) process v3.2 January 2019	C.5
CSD022	<a href="https://drive.google.com/open?id=1jjOE1XOy4DnxuQQnBgAnsCi">https://drive.google.com/open?id=1jjOE1XOy4DnxuQQnBgAnsCi</a>	Provision of Infrastructure Support for Research Delivery in Primary Care Settings	C.5
CSD023	<a href="https://drive.google.com/open?id=1uJP2EZ7ODqVld3OaKd4YAtuob1">https://drive.google.com/open?id=1uJP2EZ7ODqVld3OaKd4YAtuob1</a>	Provision of Good Practice in Assessing, Arranging and Confirming Local Capacity and Capability for Participating Organisations Delivering NIHR CRN Portfolio Studies	C.5
CSD024	<a href="https://drive.google.com/open?id=1QV6wHQQdagykPF659QXBLnJ">https://drive.google.com/open?id=1QV6wHQQdagykPF659QXBLnJ</a>	Provision of Good Practice for Sponsors to Enable Assessing, Arranging and Confirming Local Capacity and Capability for Participating Organisations Delivering NIHR CRN Portfolio Studies	C.5
CSD025	<a href="https://drive.google.com/open?id=1i557XKCCqZe1Kam4FI5rs_SUfL">https://drive.google.com/open?id=1i557XKCCqZe1Kam4FI5rs_SUfL</a>	NIHR CRN Good Clinical Practice Programme	C.10
CSD026	<a href="https://drive.google.com/open?id=10ME82Xb8e5JUV689aFJRlmyZUf">https://drive.google.com/open?id=10ME82Xb8e5JUV689aFJRlmyZUf</a>	National Learning and Development Programmes	C.10
CSD027	<a href="https://drive.google.com/open?id=1oMvBzJqDhtmaCn1M8AAle5fJk">https://drive.google.com/open?id=1oMvBzJqDhtmaCn1M8AAle5fJk</a>	Eligibility Criteria for NIHR Clinical Research Network Support: Policy (January 2018) Implementation Guidance Document ANNEX A: Frequently Asked Questions	C.5
CSD031		NIHR CRN Performance Management Framework and Risks and Issues Log Requirements	B.3
CSD032	<a href="https://drive.google.com/open?id=1lV7zfcOIM5zNknO_Uhl3dxgYya">https://drive.google.com/open?id=1lV7zfcOIM5zNknO_Uhl3dxgYya</a>	Business Development & Marketing	C.11
CSD040	<a href="https://drive.google.com/open?id=1bvbLxW1laVOpGQ1dL580sV-o-0r">https://drive.google.com/open?id=1bvbLxW1laVOpGQ1dL580sV-o-0r</a>	Eligibility criteria for NIHR CRN support - Implementation	C.5
CSD042	<a href="https://drive.google.com/open?id=1vt_rjftN-jhhu4AQFvWbuAju3Bai">https://drive.google.com/open?id=1vt_rjftN-jhhu4AQFvWbuAju3Bai</a>	NIHR CRN Study Support Service: Principles and Process for Setting and Amending Study and Site Targets	C.5
CSD043	<a href="https://drive.google.com/open?id=18g5PeTp7QIQxUSJGDO-iac_ZuD">https://drive.google.com/open?id=18g5PeTp7QIQxUSJGDO-iac_ZuD</a>	Principles for Local NIHR CRN Site Identification Process for Commercial Studies SOP	C.5
CSD045	<a href="https://drive.google.com/open?id=1YdXINeJ4BppE7Dly4vUQkeExI">https://drive.google.com/open?id=1YdXINeJ4BppE7Dly4vUQkeExI</a>	Annex B Policy and Principles for New Non-Commercial Studies Applying Outside of IRAS	C.5
CSD046	<a href="https://drive.google.com/open?id=1Lq0hIUx2vATK9b5W8CfRPk6H">https://drive.google.com/open?id=1Lq0hIUx2vATK9b5W8CfRPk6H</a>	Annex C: Policy and Principles for Open Studies	C.5
CSD048	<a href="https://drive.google.com/open?id=1E-vRQjBdNhHtl_gkF_BHixWGXgo">https://drive.google.com/open?id=1E-vRQjBdNhHtl_gkF_BHixWGXgo</a>	Annex D Policy and Principles for Non-Commercial Studies Taking Place in Non-CRN NIHR Infrastructure Sites That require CRN Support	C.5
CSD049	<a href="https://drive.google.com/open?id=1KfGUHfFmCl_fUlrIsMFJ9ktdDyaC">https://drive.google.com/open?id=1KfGUHfFmCl_fUlrIsMFJ9ktdDyaC</a>	NIHR CRN Study Support Service: For Activity Attribution Support and Review SOP	C.5
CSD050	<a href="https://drive.google.com/open?id=1G-mvkID6BIMyMpWLIJ-mJsxVPL">https://drive.google.com/open?id=1G-mvkID6BIMyMpWLIJ-mJsxVPL</a>	CRN Study Support Service Early Contact and Engagement SOP	C.5
CSD051	<a href="https://drive.google.com/open?id=1vXpG_Z957spntyZqsQOOhwQhI">https://drive.google.com/open?id=1vXpG_Z957spntyZqsQOOhwQhI</a>	CRN Study Support Service Industry Costing Template Validation SOP	C.5
CSD052	<a href="https://drive.google.com/open?id=1K5Jc5LlTM7Uyrvvqg8GObcepBuzL">https://drive.google.com/open?id=1K5Jc5LlTM7Uyrvvqg8GObcepBuzL</a>	CRN Study Support Service Study Performance Monitoring	C.5
CSD053	<a href="https://drive.google.com/open?id=1Y6f-zA1Z9S8l33yF_eH-_ZZUBLI">https://drive.google.com/open?id=1Y6f-zA1Z9S8l33yF_eH-_ZZUBLI</a>	CRN Study Support Service Non Commercial Feasibility Process: National Study Delivery Assessment SOP	C.5
CSD054	<a href="https://drive.google.com/open?id=14d3nM5pyKe2hIT23wg7HTL19Gf">https://drive.google.com/open?id=14d3nM5pyKe2hIT23wg7HTL19Gf</a>	NIHR CRN Study Support Service for Effective Start-up SOP Commercial Study Milestone Schedule Process (Principles and Process for Setting and Amending Study and Site Targets)	C.5
CSD055	<a href="https://drive.google.com/open?id=1XRYk-m3fU3BMAxAPK3OT_Uq">https://drive.google.com/open?id=1XRYk-m3fU3BMAxAPK3OT_Uq</a>	Study Support Service Helpdesk SOP	C.5
CSD056	<a href="https://drive.google.com/open?id=10p17hop-klX5NFgQpCGJnCo7e">https://drive.google.com/open?id=10p17hop-klX5NFgQpCGJnCo7e</a>	Commercial Eligibility and Feasibility Process SOP	C.5
CSD057	<a href="https://drive.google.com/open?id=1Ah7b9waVTq_BRkBQz6benG-Q">https://drive.google.com/open?id=1Ah7b9waVTq_BRkBQz6benG-Q</a>	Public Engagement and Involvement	C.8
CSD058	<a href="https://drive.google.com/open?id=1jGDomyZnDpzbEJSq4JU9K2glL">https://drive.google.com/open?id=1jGDomyZnDpzbEJSq4JU9K2glL</a>	Local Portfolio Management System Minimum Data Set	C.5
CSD059	<a href="https://drive.google.com/open?id=1r17L-D4mCdpzHj3QhriMm3uImQ">https://drive.google.com/open?id=1r17L-D4mCdpzHj3QhriMm3uImQ</a>	NIHR CRN Teenage and Young Adult Cancer Strategy	C.5
CSD063	<a href="https://drive.google.com/open?id=10-niYqu-f2-o3Gr5v-nWBWoE0CI">https://drive.google.com/open?id=10-niYqu-f2-o3Gr5v-nWBWoE0CI</a>	NIHR CRN Cancer: Teenage and Young Adult Cancer Research Nurse role outline	C.5
CSD064	<a href="https://drive.google.com/open?id=1bMMy_WaXML_XOOHme87IA95">https://drive.google.com/open?id=1bMMy_WaXML_XOOHme87IA95</a>	NIHR CRN Support for Research in Wider Health and Social Care Settings	C.5
CSD069	<a href="https://drive.google.com/open?id=1Tk1mBBKv-uGuc-VXpDxm_Ps">https://drive.google.com/open?id=1Tk1mBBKv-uGuc-VXpDxm_Ps</a>	NIHR CRN Recruitment Policy	C.5
CSD070	<a href="https://drive.google.com/open?id=1T5CyRichl8j-Qw_bqKP6OhSvqjv">https://drive.google.com/open?id=1T5CyRichl8j-Qw_bqKP6OhSvqjv</a>	Participant in Research Experience Survey	C.8
CSD071	<a href="https://drive.google.com/open?id=1n3OJughi8oAeyIpf7FvKXhCbwxZ">https://drive.google.com/open?id=1n3OJughi8oAeyIpf7FvKXhCbwxZ</a>	Principles for provision of a support service for non-NHS settings, including local set-up activities	C.5
CSD072	<a href="https://drive.google.com/open?id=1UJGAgzPw6dvnbtI8OwWfzxHmZ">https://drive.google.com/open?id=1UJGAgzPw6dvnbtI8OwWfzxHmZ</a>	CRN PPIE Impact Framework	C.8
CSD073	<a href="https://drive.google.com/open?id=1dys07B2BqOHdOqYdYGTGNq">https://drive.google.com/open?id=1dys07B2BqOHdOqYdYGTGNq</a>	Embedding Continuous Improvement across the NIHR CRN	C.10
CSD074	<a href="https://drive.google.com/open?id=1Fus3IKhsUq8BtQc_NCJvUjIT8x">https://drive.google.com/open?id=1Fus3IKhsUq8BtQc_NCJvUjIT8x</a>	Research Champions	C.8
CSD078	<a href="https://drive.google.com/open?id=1MFU4oSO84cW9xv1zgFvHbXz">https://drive.google.com/open?id=1MFU4oSO84cW9xv1zgFvHbXz</a>	NHS Engagement	C.9
CSD080	<a href="https://drive.google.com/open?id=1i0ITVnQSP5esmePlieQkRZP9Tr">https://drive.google.com/open?id=1i0ITVnQSP5esmePlieQkRZP9Tr</a>	National Specialty Group Terms of Reference	C.4
CSD081	<a href="https://drive.google.com/open?id=120Q1UBMVuDeDj.QgoQo0M5ba">https://drive.google.com/open?id=120Q1UBMVuDeDj.QgoQo0M5ba</a>	Process for the appointment of Specialty Research Leads	C.4
CSD083	<a href="https://drive.google.com/open?id=1BQQZm_5SMSnAvuMZOHZj8">https://drive.google.com/open?id=1BQQZm_5SMSnAvuMZOHZj8</a>	Eligibility Routes: Guidance and Principles Document Annex E: Policy and Principles for non- commercial studies which are led by a Devolved Administration but have English sites	C.5
CSD084	<a href="https://drive.google.com/open?id=1G8D-oZkZKHMhmtWxZRb1jq2o">https://drive.google.com/open?id=1G8D-oZkZKHMhmtWxZRb1jq2o</a>	Local Priorities High Level Objective	C.5
CSD085		LCRN Governance and Management Terms of Reference	C.4
CSD088	<a href="https://drive.google.com/open?id=1okrixPIX6l9VftoPULkdATHXabJ">https://drive.google.com/open?id=1okrixPIX6l9VftoPULkdATHXabJ</a>	LCRN Governance and Management Terms of Reference	C.2
CSD089	<a href="https://drive.google.com/file/d/10L0gPtOezQnST9f8MnNBFDhFWfXf">https://drive.google.com/file/d/10L0gPtOezQnST9f8MnNBFDhFWfXf</a>	Local Imaging Champion	C.4

## Section 10. Glossary

Abbreviation	Definition
AHSN	Academic Health Sciences Network
APOMP	Anaesthesia, Perioperative Medicine and Pain Management
ARIP	Advanced Research in Practice
BD&M	Business Development and Marketing
BI	Business Intelligence
CI	Chief Investigator
CIm	Continuous Improvement
COO	Chief Operating Officer
CPMS	Central Portfolio Management System
CPWR	Cost Per Weighted Recruit
CRNCC	Clinical Research Network Coordinating Centre
CSL	Clinical Specialty Leads
CUH	Cambridge University Hospitals NHS Trust
CQC	Care Quality Commission
dCOO	Deputy Chief Operating Officer
DHSC	Department of Health and Social Care
dRDM	Deputy Research Delivery Manager
ECE	Early Career and Engagement
ECR	Early Career Researchers
ENT	Ear, Nose and Throat
EOI	Expression of Interest
ETC	Excess Treatment Costs
GCP	Good Clinical Practice
GDPR	General Data Protection Regulations
HLO	High Level Objective
I&I	Improvement and Innovation
LCRN	Local Clinical Research Network
LIMC	Local Imaging Champion
LPMS	Local Portfolio Management System
LSRL	Local Specialty Research Lead
MDS	Minimum Data Set
MHRA CTA	Medicines and Healthcare products Regulatory Agency Clinical Trial Authorisation
NIHR	National Institute for Health Research
NNUH	Norfolk and Norwich University Hospitals NHS Foundation Trust
ODP	Open Data Platform
PA	Programmed Activity
PG	Partnership Group
PH	Public Health
PI	Principal Investigator
PO	Partner Organisation
PPIE	Patient and Public Involvement and Engagement
PRA	Patient Recruitment Ambassador
PRES	Patient Research Experience Survey
POF	Performance and Operating Framework
QA	Quality Assurance
R&D	Research and Development
RAG	Red, Amber, Green
RC	Research Champion
RDM	Research Delivery Manager
RDS	Research Design Service
RTT	Recruitment to Time and Target
SDO	Study Delivery Officer
SGL	Specialty Group Leads
SME	Small and Medium sized Enterprises
SMT	Senior Management Team
SSS	Study Support Service
STP	Sustainability Transformation Plan
TOR	Terms of Reference
TYA	Teenage and Young Adult

WFD	Workforce Development		
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