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Norfolk and Norwich University Hospitals
NHS Foundation Trust

MEETING OF THE TRUST BOARD IN PUBLIC
WEDNESDAY 7 APRIL 2021

A meeting of the Trust Board will take place at 9am on Wednesday 7 April 2021 by MS Teams and in Room 16 of the Bob Champion Research & Education building (BCRE)

Due to the Covid-19 pandemic attendance by members of public is by MS Teams only - details at www.nnuh.nhs.uk

AGENDA

	Item	Lead	Purpose	Page
1	Apologies, Declarations of Interest and Chairman's Introduction	Chair	Information	
2	Experience of Care – Patient/Family Story – 'James' Young Carer Story' https://youtu.be/CJXvROXEa3I *Amrita Kulkarni (Patient Experience Manager), Ruby Allen (Patient Engagement & Experience Facilitator) and Sarah Higson (Lead for Patient Engagement & Experience) attending*	NF	Information	**2**
3	Minutes of the Board meeting held in public on 03.02.21	Chair	Approval	**4**
4	Matters arising and update on actions	Chair	Discussion	**12**
5	Chief Executive's Report	CEO	Discussion	**Verbal**
6	Covid-19 pandemic update	CC	Information	**13**
7	**Reports for Information and Assurance:**		Information, Assurance and Approval as specified	
	(a) Audit Committee (31.03.21) – inc ToRs for Board and Audit Committee for approval	JF		**21** **24 & 30**
	(b) Quality and Safety Committee (30.03.21) (c) IPR – Quality, Safety and Patient Experience data	GOS ED/NF		**39** **41**
	(d) Finance, Investments and Performance Committee (22.03.21 & 31.03.21) (e) i) IPR – Performance and Productivity data ii) Finance – Month 11 report	TS CC RC		**58** **60** **81**
	(f) People & Culture Committee (29.03.21) (g) IPR – Workforce data	DR PJ		**101** **103**
8	Response to CQC report	NF	Information	**112**
9	Dementia Strategy	NF	Approval	**127**
10	Questions from members of the public	Chair	Discussion	
11	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 2 June 2021 – location/arrangements TBC

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REPORT TO THE TRUST BOARD OF DIRECTORS

Date	**7 April 2021**
Title	**Experience of Care – Patient/Family Story – 'James' Young Carer Story'**
Author & Exec lead	**Ruby Allen, Patient Engagement & Experience Facilitator & Professor Nancy Fontaine, Chief Nurse**
Purpose	**For Information, Discussion and Reflection**

1. Background/Context

1.1 A patient story is where a patient or family member describes their experience of healthcare in their own words. The idea is to gain an understanding of what it is like for them and or their family / carers; what was positive; what was sub-optimal and what would have make the experience more positive.

1.2 Listening to patient stories gives us the opportunity to learn about the things that we do well and consider where we can make improvements. It helps put patients at the heart of service development and improvements.

1.3 Today's story is about James – a young carer, presented by The Patient Engagement & Experience Team. It reflects on the experience of care for James, as a young carer of his mother during her admission, stay and at discharge. The board will be able to reflect on this experience with a view to understanding the support and communication required by young carers of patients at our hospital.

2. Key issues, risks and actions

2.1 Key learning:

- To embed within the development of electronic patient record, a way to identify/record carers, including young carers
- To improve staff awareness of who young carers are and the support we should be providing to enable them to continue their caring role whilst their cared for person is in the care of the hospital.
- To engage with the young carers within our local communities to understand their experiences and learn about the issues they face.

3. Conclusions/Outcome/Next steps

3.1 This experience and story provides valuable insight and learning which the organisation will use to drive forward improvements in identification and support for young carers- and all carers.

3.2 The short film was shared widely during Young Carers' Action Day (16 March) and will be used for training sessions for staff to raise awareness.

3.3 James and other young carers will work as partners to improve young carer identification and experience via the Patient Engagement & Experience Team and NNUH Carers' Forum.

Recommendation:

The Board is recommended to: listen to and reflect on the story presented, using that information to inform future strategies and improvement plans.

Experience of Care – Patient/Family Story – Board Meeting –	
Brief outline of the "story"	
James (17 years of age) is a young carer – and main carer - for his mother who has a range of physical and mental illnesses. James' mother was admitted to the NNUH in Sep 2020, through ED and stayed on a couple of wards. Throughout her stay, James felt his knowledge of his mother's needs and valuable insight he has into her health and wellbeing was not listened to. He was not given the opportunity to be involved in the discussions around her care, nor given accurate updates on the decisions made around his mother's care in his absence. The lack of communication with James as a carer for his mother resulted in anxiety and stress for both James and his Mum, which James has identified could have been allayed had there been a note on his Mum's file saying she had wanted clinical staff to communicate with James, as her carer. James was not properly acknowledged as a carer for his Mum, and he states this is a key reason for her poor experience of care, his poor experience of the hospitals' services, and for an incorrect care plan being provided upon discharge. James is worried about future admissions of his Mum to NNUH, as he fears he will not be listened to as a Young Adult Carer.	
What "point" it is trying to convey	
The story highlights the importance of having awareness of, and identifying, Young Carers of patients at NNUH. The action of identifying and involving young carers can improve the care and experience of both patients and carers alike. The story provides an opportunity to really understand the importance of communication and involvement of carers – including young carers – when a cared for person is admitted to NNUH. This example of an Experience of Care from a Young Carer's perspective highlights the need for the Trust to improve the process of identifying and supporting them, as part of the "triangle of care".	
Who will be "speaking"	
Family member	James via a short animated film
Staff	Patient Engagement & Experience Team
Time allocation for each element	
Film	5 – 7 minutes
Staff	5 mins
Questions	5 mins
Any Other Pertinent Information	

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MINUTES OF TRUST BOARD MEETING IN PUBLIC

HELD ON 3 FEBRUARY 2020

Present:	Mr D White	- Chairman
	Dr P Chrispin	- Non-Executive Director
	Mr R Clarke	- Chief Finance Officer
	Mr C Cobb	- Chief Operating Officer
	Prof E Denton	- Medical Director
	Ms S Dinneen	- Non-Executive Director
	Prof N Fontaine	- Chief Nurse
	Mr J Foster	- Non-Executive Director
	Mrs J Hannam	- Non-Executive Director
	Mr S Higginson	- Chief Executive
	Mr P Jones	- Chief People Officer
	Dr G O'Sullivan	- Non-Executive Director
	Prof D Richardson	- Non-Executive Director
	Mr T Spink	- Non-Executive Director
In attendance:	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 A Prem	- Associate Non-Executive Director
	Ms V Rant	- Assistant to Board Secretary
	Members of the press and public, including 7 governors	

21/001 **APOLOGIES, DECLARATIONS OF INTEREST AND CHAIRMAN'S INTRODUCTION**

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

Mr White indicated that we are in a challenging period as the number of patients requiring admission with Covid-19 is higher than in the pandemic First Wave. Patients are also experiencing a greater severity of illness requiring longer stays in hospital.

The Board paid tribute to our fantastic staff and expressed heart-felt thanks for their efforts in rallying round and showing great professionalism and dedication to patient care. Our staff have been flexible, working additional hours at a time when patient need is so high and staffing pressures are increased due to sick sickness absence or shielding/self-isolating. It is recognised that this is inevitably having a toll on staff and this picture is reflected nationally. As we move into the recovery phase, we will be looking at ongoing support for staff to optimise sustainable services for patients.

21/002 **MINUTES OF PREVIOUS MEETING HELD ON 4 NOVEMBER 2020**

The minutes of the meeting held on 4 November 2020 were agreed as a true record for signature by the Chairman.

21/003 **MATTERS ARISING AND UPDATE ON ACTIONS**

The Board reviewed the Action Points arising from its meeting held on 4 November 2020 as follows:

20/048(b) (Nov '20) – Carried forward - IPR format - Non-Executives noted that targets had not been included on IPR slides for pressure ulcers and falls and suggested that it would be helpful to include a line on the SPC chart to aid tracking of progress to achieve the target percentage reduction. Professor Fontaine confirmed that this would be reviewed with the Information Services team. **Action: Prof Fontaine**

20/048(d) (Nov '20) – IPR format - The definition for NSTEMI (Non-ST-elevation myocardial infarction) has been added to the IPR. Action closed.

20/049 (Nov '20) – The Modern Slavery Act statement has been updated as approved and uploaded to the website. Action closed.

21/004 **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.

On behalf of the Executive Team and Board Mr Higginson expressed sincere thanks to the Trust's staff for all their efforts and flexibility in responding to the pandemic. We have also received support from members of the community, military colleagues and system partners. The pandemic Second Wave has been a real challenge for the Trust and its staff but there are signs that the peak of pressure is beginning to lessen.

In our role as Regional Surge Centre, we have continued to provide support to the rest of the region receiving 38 critical care transfers and secondary transfers for adult major trauma patients during December and January.

The Board was informed that approximately 98% of staff have received a Covid vaccination and we are grateful to staff in the vaccine centre and pharmacy for supporting this effort. The vaccination centre has also been able to vaccinate members of the wider community (patients over 80 and health & social care workers). It has bene a huge effort.

Alongside caring for patients with Covid, we have been trying to maintain urgent and cancer services. We have recommenced surgery at the Spire Hospital and will resume surgery on the main site as soon as pressure eases. The operational position at the hospital continues to be fragile and we would urge the public to continue to maintain social distancing measures to keep each other safe.

The Health & Safety Executive undertook a 'spot' inspection visit to the Hospital in December to assess Covid compliance. There was positive feedback but an improvement plan has been put in place to address some issues that were identified in some areas which concerned social distancing; ventilation in an office; shared use of a printer; and donning and doffing of PPE.

The CQC also carried out an unannounced inspection of the Emergency Department in December. Improvements in culture and teamwork within the ED were noted. The CQC raised concerns regarding the triage system, compliance of infection prevention and control procedures and performance against the 4 hour target. An improvement plan is being put in place to address the associated Improvement Notice which was subsequently issued.

Mr Higginson explained that system of Committees in Common has been established to enhance collaboration with other acute Trusts in Norfolk and the Terms of Reference are on the website.

The financial position is a deficit of £5.7m against the revised forecast deficit of £11.4m. Good progress has been made with regard to actions arising from the Financial Governance Review with 34/65 actions complete and we remain on track to meet our end of year objectives.

We are launching our virtual ward which will enable patients to be monitored and looked after remotely in their homes. The EDMS project is also being rolled out and will facilitate conversion of paper records into a digital format which is a crucial step in our digital maturity.

Mr Higginson highlighted the work of our research team who recruited over 500 participants in the successful Novovax Covid vaccine trial.

Non-Executives reflected on the CQC criticism of nursing levels in the ED and data suggesting a deteriorating trend in safer staffing levels and asked what actions were being taken to address these issues. Mr Higginson explained that the Board will be holding a more in-depth discussion about the CQC findings once the final report has been published. We have made good progress to make improvements since the last inspection and a robust plan has been implemented to address the recommendations. This will be overseen by the Board's Quality & Safety Committee.

Professor Fontaine highlighted that the previous CQC report in 2019/20, had noted the improvement in staffing in the ED and our Registered Nursing vacancy rate has reduced significantly since 2018. On the day of the inspection, sickness absence meant that staffing levels were lower than usual but longer term data gives a more representative picture. We have also been focusing on medical recruitment.

Non-Executives asked for further information regarding the Health & Safety Executive visit. Mr Jones indicated that the inspectors had been impressed with infection prevention and control zoning in place and measures for maintaining hand hygiene, face masks wearing and social distancing. The inspection included the entirety of the site and an improvement programme is looking to widely share learning outcomes in relation to the four points identified by the inspectors.

21/005 **COVID 19 PANDEMIC UPDATE**

The Board received an update from Mr Cobb in relation to the Trust's operational response to the Covid pandemic.

Mr Cobb expressed gratitude for the support and response by our staff during this most challenging period of the pandemic. At the peak of this wave, there were 350 patients in hospital representing 40% of our total adult bed base the remaining 60% bed base being reserved for crucial services including children, maternity, stroke and cardiology.

Management of appropriate segregation processes has increased the frequency of patient moves, putting enormous pressure on staff to identify beds on yellow wards for those patients who are 'stepping down' from red wards and causing congestion on the flow of patients.

We were unable to continue to provide elective surgery in December because there was no capacity but this work has restarted within the last week. The hospital's Vaccine Centre was established in December and over 25,000 people have now received their vaccinations through the unit. This includes 10,000 staff, 10,000 health and social care workers, 4,000 people over 80 years and 1,600 care home workers. The work of the facility supporting Norfolk people has been exceptional.

Professor Denton reported that for patients in the second wave there are additional treatment options, with improved survival rates but patients are taking much longer to recover and many relatively young patients. The number of very sick patients is reflected in the high crude mortality rate. Mr Cobb reported that the impact on staff from the number of deaths in the hospital has been significant. Our critical care capacity was increased from 20 beds to 80 beds spread across four areas and we accepted critical care patient transfers from other hospitals, in our role as Regional Surge Centre.

Non-Executives noted the huge response and how rapidly things have been moving. Mr Cobb was asked about the supply of vaccination and the level of confidence in delivering our programme. It was explained that we have assurance that we will receive vaccine sufficient to deliver the second dose element of our cohort.

There was Non-Executive questioning with regard to the level of support that we can offer staff who are suffering distress and trauma through the pandemic. Professor Fontaine highlighted that the impact from patient deaths goes wider than our critical care teams and extends to a wide range of specialty ward doctors and nurses who do not usually experience this level of deaths in hospital. A package of interventions has been established including critical incident debriefings, pastoral care from the chaplains and formal psychology support service.

One of the biggest challenges has been encouraging staff to use support mechanisms before they get into difficulty. Mr Jones highlighted that through the psychological support service we are looking at ways to provide staff with an opportunity to talk about their experiences and will be encouraging staff to take annual leave, to rest and recuperate.

21/006 **REPORTS FOR INFORMATION AND ASSURANCE**

(a) Quality & Safety Committee (26.01.21)

The Board received an update from Dr O'Sullivan with respect to the work of the Quality & Safety Committee.

Dr O'Sullivan reported that the Committee noted the high acuity of patients in hospital, the increase in device related pressure ulcers which is indicative of how ill our patients are. The Committee also discussed the pressure on staffing numbers and the potential impact on ability to maintain quality of care.

The Committee was mindful of the operational pressures at the time of the CQC inspection in December but recognised that the inspection had picked up issues relating to triage of patients, waiting times and processes in ED and actions are being established to address these areas of concern.

The number of in-hospital deaths is low in comparison with other hospitals but there has been a recent increase which is thought to be related to Covid. Mortality rates continue to be closely monitored by the Committee and particular focus is being given to the SHMI rate.

The Committee considered that the patient experience improvement work being co-produced with patients is impressive. The Committee also reviewed the Ockenden Assurance Self-Assessment and recommends this to the Board.

(b) IPR – Quality, Safety and Patient Experience data

The Board received the performance data relating to Quality and Safety. With respect to mortality, the impact of Covid is apparent in terms of direct mortality in line with the

national picture. There will also be an indirect impact in terms of disruption to established patient pathways. We may be seeing an indication of excess deaths relating to non-covid patients and this is being closely monitored and assessed.

There was Non-Executive questioning in relation to the rate of pressure ulcers. An improvement programme and a 10% reduction target is being applied for pressure ulcers. A new Consultant Practitioner for wound care and tissue viability will be commencing in post in March and we are hoping to optimise systems for wound care through introduction of revised risk assessments and documentation.

(c) Finance, Investments & Performance Committee (27.01.21)

The Board was updated with respect to the work of the Finance, Investments & Performance Committee.

The Committee reviewed the operational position and the response to the pandemic from across the organisation. This is obviously having a significant impact on achievement of performance targets (both elective and emergency) as the Trust is required to focus on clinically urgent patients. The operational management of the crisis and all those members of the Trust involved were commended and the Committee was assured that appropriate priority is being given to coping with the pandemic. Further national guidance is awaited on the approach to be taken with respect to long-waiting elective patients.

The Committee was updated with regards to the restrictions on delivery of second-doses of vaccine to staff. This is obviously of concern at a time when staff need all the support that can be available and when staff availability is a crucial constraint.

The Committee was updated with respect to major capital and estates projects:

- following completion of the Ward-block buy out, the DPU/Paediatric theatres scheme is proceeding, with work on site due to start in the next month;
- a new staff rest area in the ED is also being built with central capital funds;
- by the end of March, the business case for the Pharmacy Production Unit should be available for review.

The Committee noted the improved position on CIP and increased confidence on outturn. Financial performance in the year to date is in line with the plan.

The Committee held initial discussions with respect to the Trust's Financial Strategy. This excellent piece of work recognises the financial challenges facing the Trust and will be the subject of further discussions, alongside our other strategies, working towards review by the Board. This Strategy will be an important foundation for ensuring sustainable performance in future years and the Committee was assured by the work led by Mr Clarke and the Finance team.

The Committee was updated on progress in implementing the Use of Resources Action Plan, which is largely on track with 34/65 actions completed. There is ongoing discussion on the optimal arrangement for the change teams in the Trust.

The Committee reviewed relevant elements of the Corporate Risk Register and, noting the very good progress that has been made, encouraged review of the timelines for achievement of some of the actions and targets to ensure that they are deliverable.

The process for reviewing the Corporate Risk Register at Committee level continues to strengthen. Mitigating actions and timelines for completion of work are now being identified for risks, assisting Committee oversight and assurance.

(d) IPR – Performance and Productivity data

Mr Cobb reminded the Board that for a period during December elective activity was reduced to life threatening surgery only. Our elective waiting list has grown to 57,000 and it will be significantly challenging to recover as we move out of the pandemic. We will be focused on the backlog of waiting patients and have plans in place to increase elective work but this will be challenging while the number of emergency Covid patients remains high.

Mr Cobb highlighted that the number of cancer patients waiting 104 days increased in the first wave reaching 250 patients in July 2020. Between July and September we were able to reduce that number and this has been maintained by utilising day case capacity.

The CQC Improvement Notice raised concerns around the time to initial assessment in the ED being impacted by triage and processes in the early part of the pathway. An action plan will address those issues but cannot be achieved by the ED alone and will require a hospital-wide effort.

(e) Finance – Month 9 Report

Mr Clarke reported that financial performance in the year to date is on track with Plan. The position is better than the forecast deficit of £5.8m and influenced by underspend in non-pay costs as a result of reduced elective activity and offset by accrual for untaken annual leave. Our forecast deficit remains in line with the Plan but this may improve further.

(f) People & Culture Committee (28.02.21)

The Board was updated on the work of its People & Culture Committee.

The Committee discussed the impact of the pandemic on our staff and recognised the importance of ensuring that appropriate process and structures are in place to provide a supportive environment – to enhance resilience and to aid healing and recovery. This is going to be a matter of real importance as we, hopefully, move into a recovery phrase following the acute pandemic.

The Committee received an update on the national NHS Staff Survey conducted in 2020. Early indications suggest a mixed picture but further information on the national profile is awaited. The Trust will receive data over the next couple of months and the national results are due for publication at the end of February. The Committee will review and monitor actions in response to the full results once received.

The Committee was informed that the Trust was one of approximately 14 Trusts visited by the HSE in December to assess Covid procedures and precautions. The visit was wide–ranging across clinical and non-clinical areas and resulted in only relatively minor findings. This was a credit to the staff and teams involved.

The Committee received a gap-analysis relating to the recommendations of the National NHS People Plan. Four key areas for focus in 2021/22 were suggested and agreed by the Committee, notably:

- management of violence & aggression against staff, to reduce this significantly, taking account of the new NHS Violence Reduction Standard;
- appointment of a Board level Wellbeing Guardian;
- deploy a new Medical Rostering System and improve the effectiveness of rostering on a collaborative basis with neighbouring organisations to enhance future workforce integration;

- take positive steps to ensure staffing reflects the diversity of the organisation, not just in relation to our community, but at more senior levels in the Trust.

Non-Executives highlighted that the Committee has been focusing on the potential risks for staff from stress and mental health issues and the actions to mitigate the risks. The Committee had been reassured to hear about the support from the palliative care team and the training and psychological support being put in place to help.

The Board **ratified** the proposal that the Chair of People & Culture Committee is the nominated Board level staff Wellbeing Guardian.

(g) IPR – Workforce data

Mr Jones highlighted achievement of the mandatory training target in November at 90.6% - but subsequent performance will have been adversely affected by suspension of non-essential training during the 'second wave' of the pandemic.

The Board was informed that the rate of sickness absence (excluding Covid related absences) was 3.8% and is one of the lowest in the region. There was non-executive questioning relating to staff sickness and the incidence of stress and anxiety in particular. Mr Jones explained that the impact of the pandemic is well recognised. Stress is the most common cause for which staff seek help from the Trust's counselling service. Options are being explored as to how we can support a period of recuperation following the pandemic whilst addressing pressures/demands to restore services.

21/007 **OCKENDEN REVIEW OF MATERNITY SERVICES**

The Board received a report from Ms Laura Schaffer (Operational Director – Women and Children), Ms Beth Gibson (Consultant Obstetrician and Lead for Antenatal Services) and Ms Kelly Stevens (Acting Divisional Midwifery Director).

Professor Fontaine informed the Board that the Ockenden Report was published in December setting out the findings of an independent review of maternity services at the Shrewsbury and Telford Hospitals, with concerning outcomes for women and births. Maternity units are required to review the report and to implement a number of immediate and essential actions.

Ms Schaffer indicated that the Maternity Team undertook a self-assessment review against 17 actions defined from the immediate and essential actions identified in the Ockenden Report. Self-assessment against the 17 actions showed compliance against 16 and 1 action requiring further work. The results have been reviewed through the Management Board and Quality & Safety Committee.

Mr Higginson thanked the maternity team for all their work and dedication in responding to the Ockenden Report. As the Designated NED for Maternity, Dr Chrispin informed the Board that this had been a helpful exercise and she and the Q&S Committee had been assured by all the processes in place and actions taken.

Mr White reflected that the Board is focused towards achieving an organisation-wide approach of patient engagement, co-production, listening and acting. The team were thanked for their work and will oversee progress towards implementation of the actions through its Board Assurance Committees.

21/008 **QUESTIONS FROM MEMBERS OF THE PUBLIC**

Board members were asked to provide additional explanation regarding the forecast and escalation plan on page 19 of the papers. Mr Cobb explained that the Trust is provided with a weekly forecast of the anticipated number of Covid admissions. An

escalation plan was developed in the event that the numbers of patients reached the potential number. In the event it was not necessary to implement the additional escalation capacity to its full extent.

21/009 **ANY OTHER BUSINESS**

Mr White highlighted that the Council of Governors will be meeting in public on 4 February.

21/010 **DATE AND TIME OF NEXT MEETING**

The next meeting of the Trust Board in public will be at 9.30am on Wednesday 7 April 2021 by MS Teams & in BCRE.

Signed by the Chairman: …… Date: ……
Confirmed and approved for signature by the Board on 07.04.21 [TBC]

Decisions Taken:

21/006 (f) – implementation of National People Plan	The Board **ratified** the proposal that the Chair of People & Culture Committee is the nominated Board level staff Wellbeing Guardian.

Action Points Arising:

	Action
21/003 – IPR tracking targets % reduction in pressure ulcers and falls	20/048(b) (Nov '20) – Carried forward - IPR format - Non-Executives noted that targets had not been included on IPR slides for pressure ulcers and falls and suggested that it would be helpful to include a line on the SPC chart to aid tracking of progress to achieve the target percentage reduction. Professor Fontaine confirmed that this would be reviewed with the Information Services team. **Action: Prof Fontaine**

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Action Points Arising from Trust Board meeting (public) – 03.02.21

Item	Action	Update – April 2021
21/003 – IPR tracking target % reduction in pressure ulcers and falls	20/048(b) (Nov '20) – Carried forward - IPR format - Non-Executives noted that targets had not been included on IPR slides for pressure ulcers and falls and suggested that it would be helpful to include a line on the SPC chart to aid tracking of progress to achieve the target percentage reduction. Professor Fontaine confirmed that this would be reviewed with the Information Services team. **Action: Prof Fontaine**	Patient Falls – target line included in IPR slide **Action complete** Pressure Ulcers – work in progress **Carried forward**

JPG 01.04.21

COVID-19 Update

March 2021

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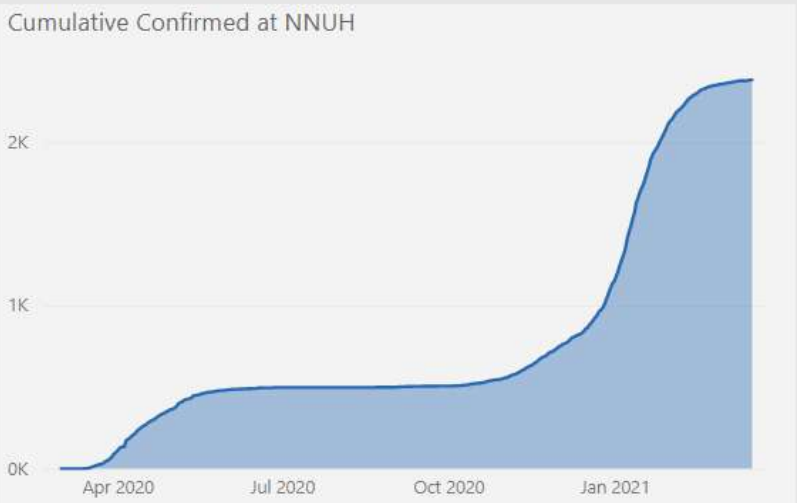
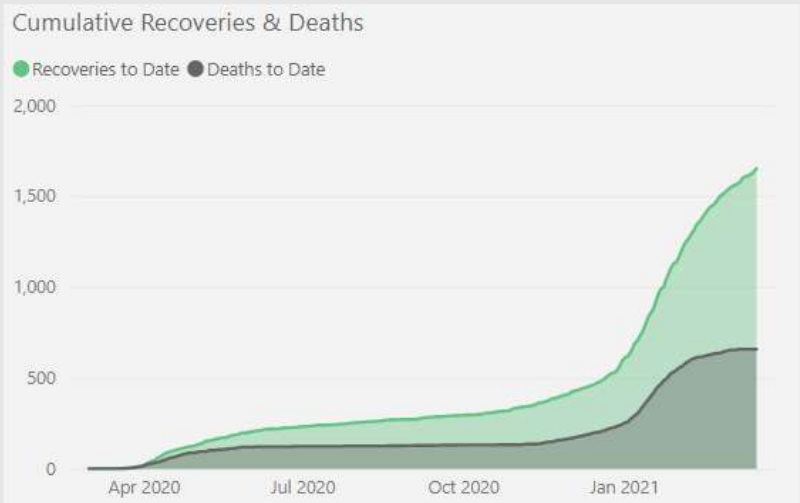
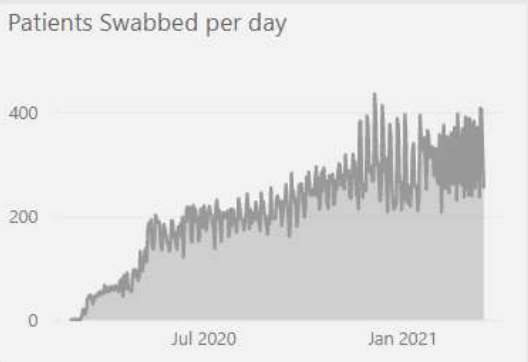
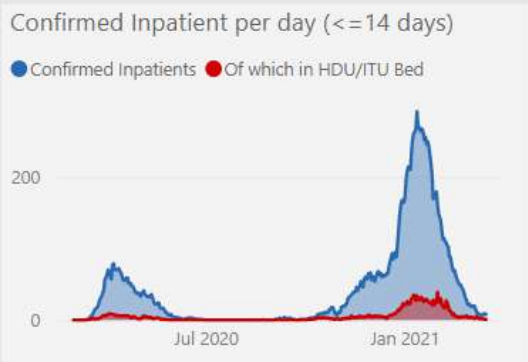
COVID-19 Report: Timeseries to 18th March 2021

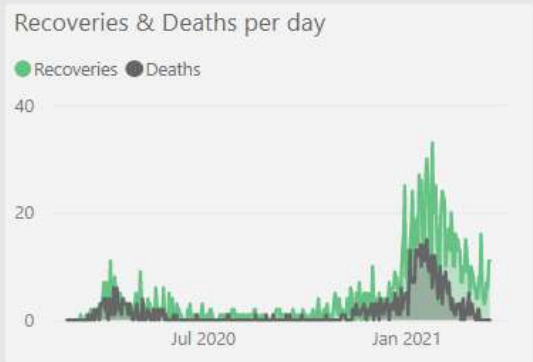
Cumulative	Total Swabs Taken	Patients Swabbed	Confirmed Cases	Recoveries	Deaths
01/03/20 - 18/03/21	82,524	32,996	2,380	1,649	657











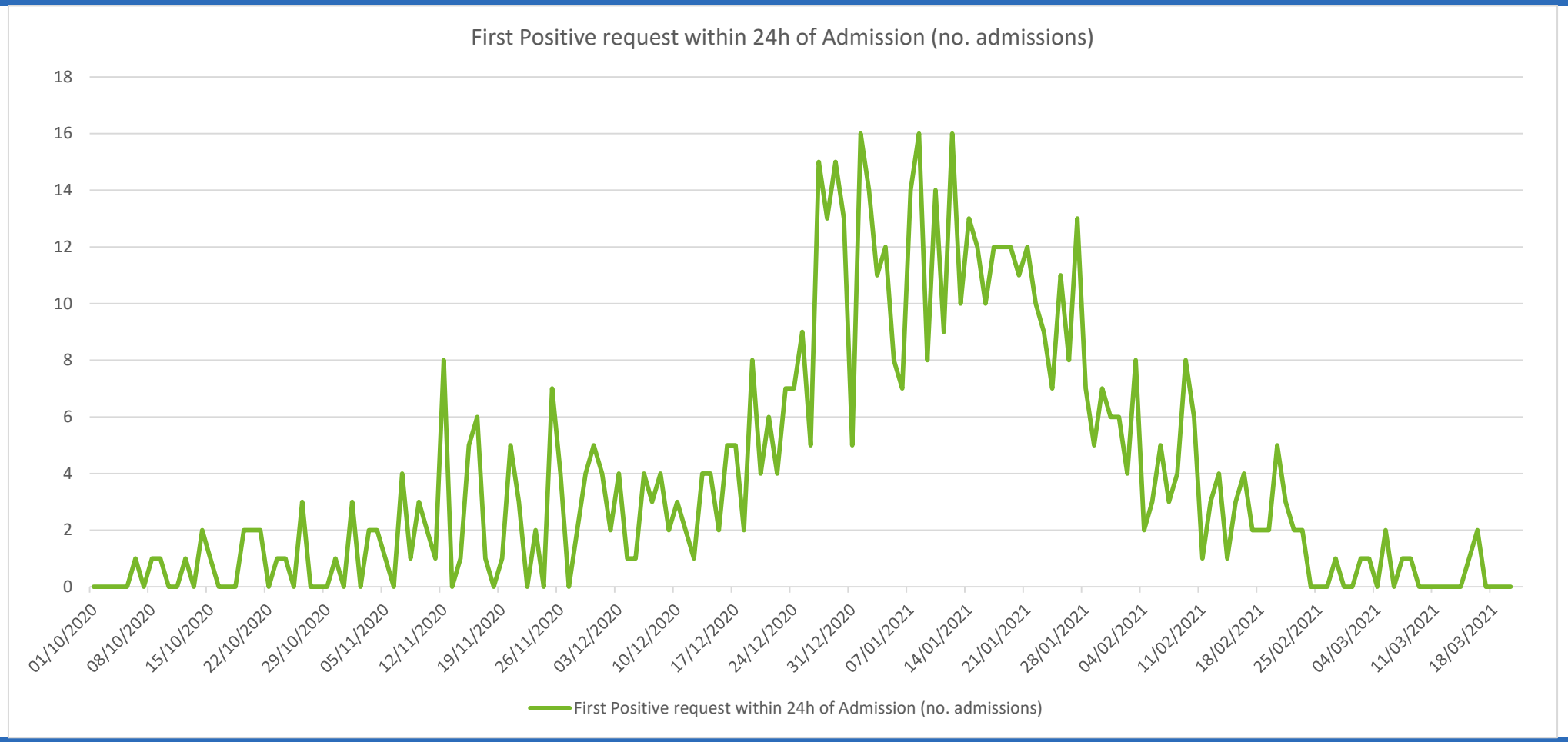
Commentary

The Pandemic Respiratory Diseases Plan, prepared alongside the Winter Plan for 2020/21, provided phased escalation plan to manage the ongoing COVID-19 Pandemic.

The Trust escalated through Local COVID States, with Local Covid State 5 triggered on 18th December 2020 which remained until 18th February 2021. De-escalation throughout February occurred through LCS4 and LCS3 until 4th March where the Trust de-escalated to, and remains in Local Covid State 2. As of 23rd March there were 11 active COVID-19 patients of which 3 in Critical Care

The Pandemic Plan proved invaluable during the pandemic and will remain in place with minor modifications to incorporate learning and future proofing. The Incident Management Team (IMT) structure will be used to underpin the delivery of the recovery programme. The Trust Flow and Escalation Policy will be redesigned using this template and process.

COVID-19 Report: Diagnosed <24 Hours of Admission



Commentary

The number of patients testing positive for COVID-19 has continued to reduce to <2 per day March 2021. This correlates to the reduced presentations of patients with COVID-19 symptoms.

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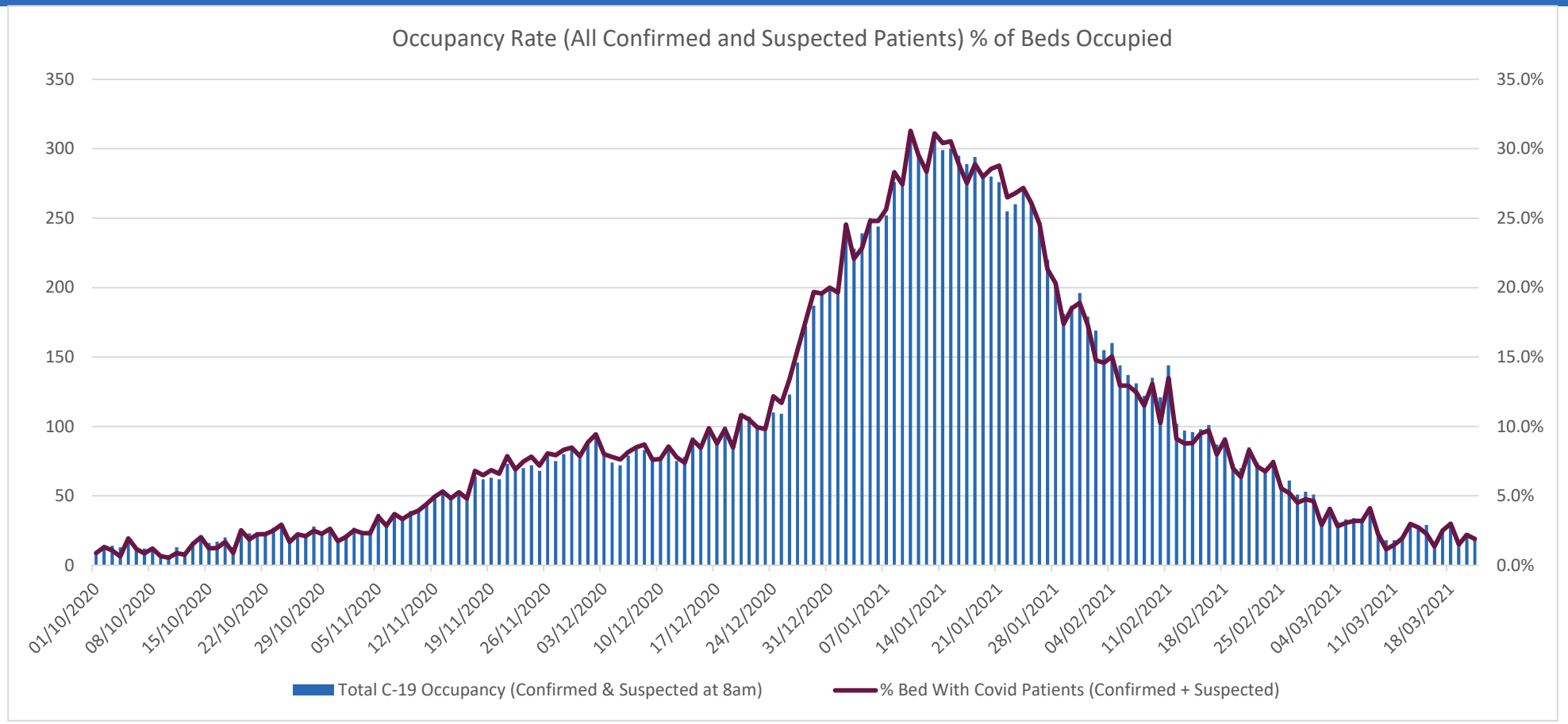
COVID-19 Report: Bed Occupancy



Commentary

Nearly 35% of the total adult beds were occupied by Covid-19 patients during peak in January. Occupancy has steadily reduced in down to <5% in March 2021. Currently only Cringleford ward is a designated as a red ward for patients requiring isolation. Contingent on the continued reduction in red admissions, this Covid isolation area will move to the Isolation Unit from 29th March 2021.

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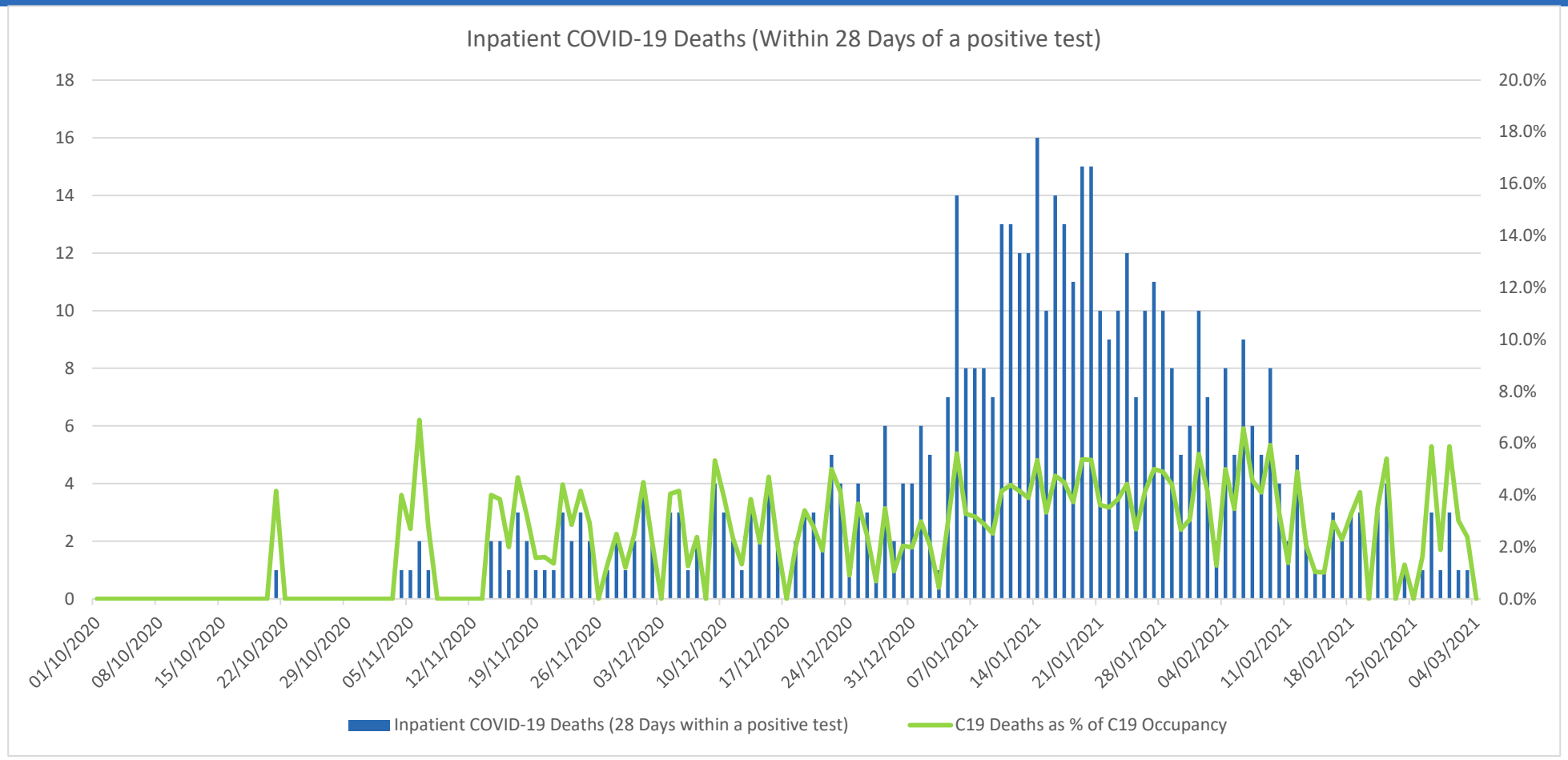
COVID-19 Report: Inpatient Deaths



Commentary

The percentage of Covid related deaths to Covid inpatient occupancy has reduced during February 2021 and to the start of March 2021.

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COVID-19 Report: De-Escalation to Local COVID State 2

LOCAL COVID STATE 2 (2-30 C-19 Patients)

Key:
- High Risk Pathway - Confirmed / Suspected C-19
- Medium Risk Pathway - Asymptomatic Awaiting Results
- Low Risk Pathway - Negative C-19 Confirmed

Level	West Block B	West Block C	Centre Block D	Centre Block E	Centre Block G	Centre Block H	East Block I	East Block K	East Block L	East Block M
4			Denton Ward 37 Low Risk Pathway - Negative C-19 Confirmed 4970 Orthopaedics	Earsham Ward 24 Medium Risk Pathway - Asymptomatic Awaiting Results 5955 Head & Neck / Ortho Surgery	Gateley Ward 24 Medium Risk Pathway - Asymptomatic Awaiting Results 5964 Orthopaedics					
3	Blakeney Ward 32 Medium Risk Pathway - Asymptomatic Awaiting Results 3237 Obs	Cley Ward Obstetrics 32 Medium Risk Pathway - Asymptomatic Awaiting Results 5953 Obs/Gyane	Dilham Ward 24 Medium Risk Pathway - Asymptomatic Awaiting Results 5957 General Surgery	Emergency Assesment Unit Surgical 24 Medium Risk Pathway - Asymptomatic Awaiting Results 2424 Surgical Assessment Area	Gissing Critical Care 24 Closed	Hethel Ward 37 Medium Risk Pathway - Asymptomatic Awaiting Results 5968 Respiratory	Critical Care Complex 20 High Risk Pathway - Confirmed / Suspected C-19 8661 Critical Care Intwood Critical Care 25 Medium Risk Pathway - Asymptomatic Awaiting Results 8681 CCC	Coronary Care Unit Medium Risk Pathway - Asymptomatic Awaiting Results Kilverstone Ward 37 Medium Risk Pathway - Asymptomatic Awaiting Results 5971 Cardiology	Jack Pryor Critical Care 16 Closed	Mattishall Ward 37 Medium Risk Pathway - Asymptomatic Awaiting Results OPM
2	Buxton Ward 33 Medium Risk Pathway - Asymptomatic Awaiting Results 3405 Paediatrics	Coltishall Ward 37 Medium Risk Pathway - Asymptomatic Awaiting Results 5954 Paediatrics	Docking Ward 36 Medium Risk Pathway - Asymptomatic Awaiting Results 2431 Vascular Surgery	Edgefield Ward 39 Medium Risk Pathway - Asymptomatic Awaiting Results 5962 Urology	Guist Ward 37 Medium Risk Pathway - Asymptomatic Awaiting Results 5966 Gastro	Heydon Neuroscience Ward 37 Medium Risk Pathway - Asymptomatic Awaiting Results 2484 Stroke	Ingham Ward 33 Medium Risk Pathway - Asymptomatic Awaiting Results Stroke	Kimberley Ward 38 Medium Risk Pathway - Asymptomatic Awaiting Results 5234 Endo	Loddon Ward 31 Medium Risk Pathway - Asymptomatic Awaiting Results OPM Short Stay	OPED / PAED ED Medium Risk Pathway - Asymptomatic Awaiting Results EUC
1	Brundall Ward 30 Medium Risk Pathway - Asymptomatic Awaiting Results 5276 OPM	Cringleford Ward 20 High Risk Pathway - Confirmed / Suspected C-19 7831 Respiratory	Dunston Ward 33 4068 Closed	Elsing Ward 37 Medium Risk Pathway - Asymptomatic Awaiting Results 5963 OPM	Gunthorpe Ward 35 Medium Risk Pathway - Asymptomatic Awaiting Results 3562 OPM	Acute Medical Unit (H) 34 Medium Risk Pathway - Asymptomatic Awaiting Results Assessment Area	Acute Medical Unit (I) 32 Medium Risk Pathway - Asymptomatic Awaiting Results Assessment Area	Acute Medical Unit (K) 32 Medium Risk Pathway - Asymptomatic Awaiting Results Assessment Area	Langley Ward 32 Medium Risk Pathway - Asymptomatic Awaiting Results 5974 Renal	Mulbarton Ward 35 Medium Risk Pathway - Asymptomatic Awaiting Results 5975 Onc/Heam

Commentary

The Trust escalated through Local COVID States, with Local Covid State 5 triggered on 18th December 2020 which remained until 18th February 2021. De-escalation throughout February occurred through LCS4 and LCS3 until 4th March where the Trust de-escalated to, and remains in Local Covid State 2.

Swift and efficient de-escalation of red wards occurred during February with the number of confirmed and suspected covid patients reducing. A series of clinical cleans to re-open wards back as yellow capacity were required. Dunston ward has remained closed as part of this process in order to add bay doors and conduct additional minor works during this time.

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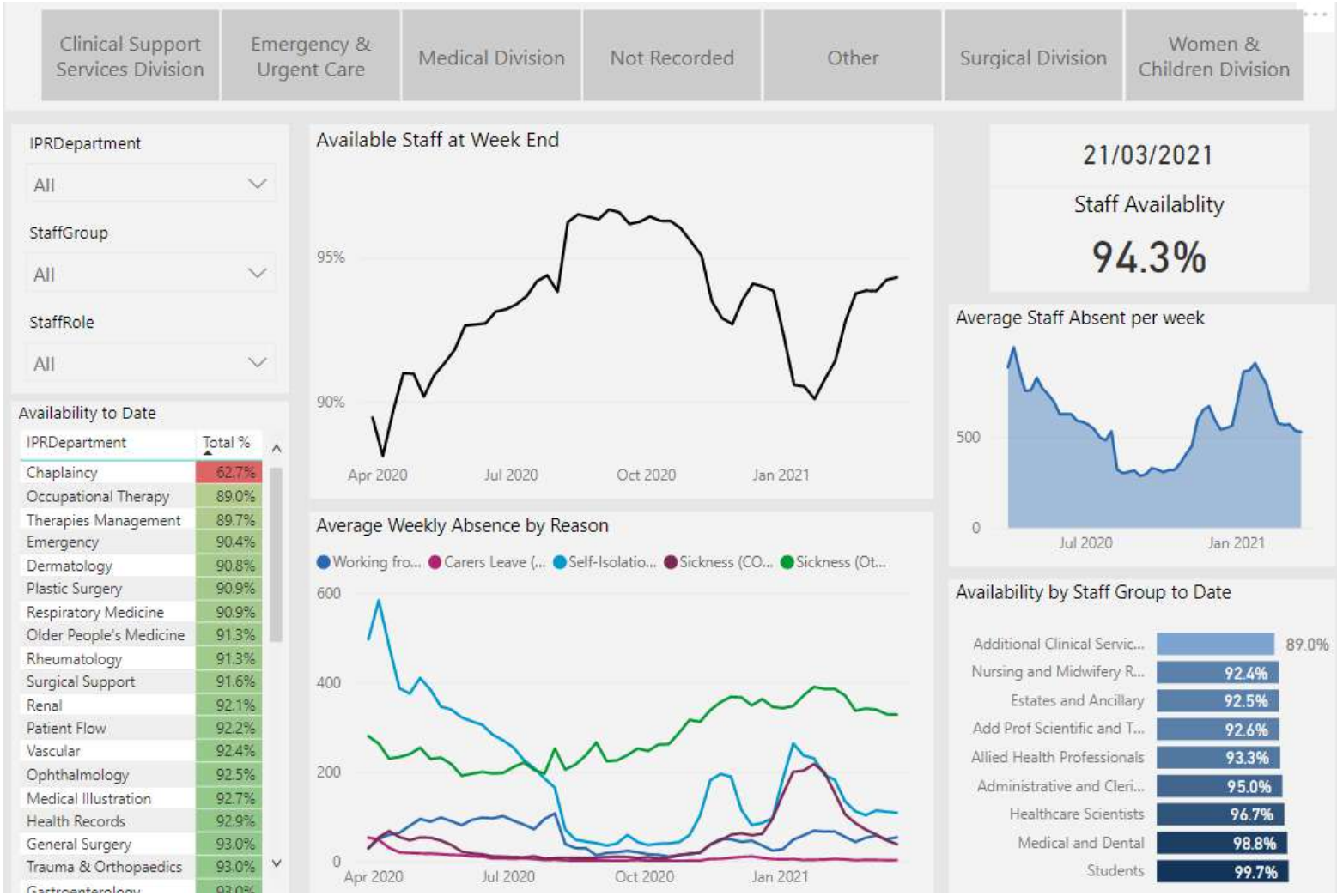
COVID-19 Report: Workforce



Commentary

Staffing alongside bed capacity proved extremely challenging to the organisation with Covid-19 related sickness and non-COVID sickness reaching above average levels for winter. As community and hospital prevalence of Covid-19 reduced, there has been increased levels of staff availability to a 'near-normal' seasonal level.

During the week of 14th Feb, an average of 529 substantive staff were absent and availability was at 94.3%.

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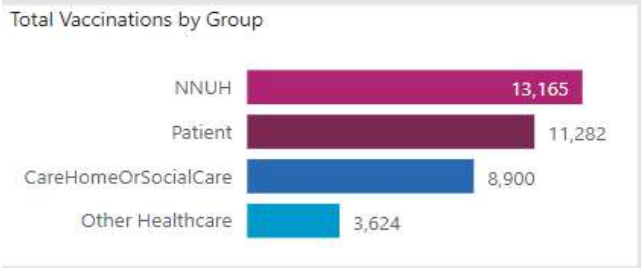
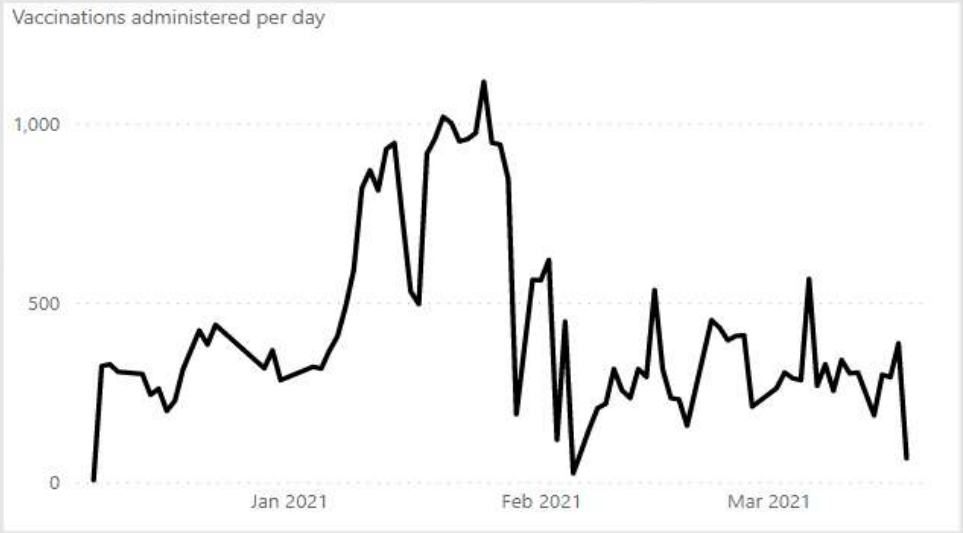
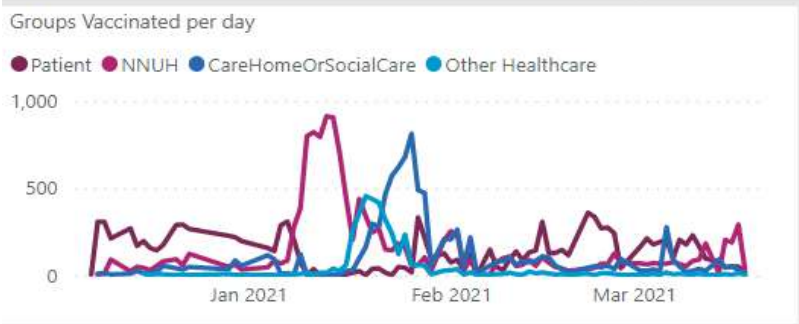
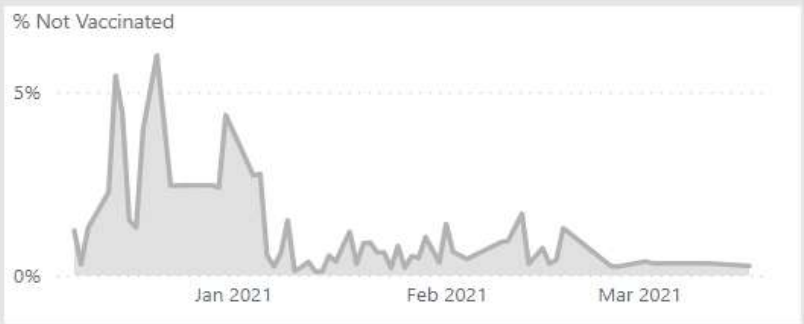
COVID-19 Report: Vaccination (As of 18th March)

Total Vaccinations	Patients	NNUH Staff	CareHome or SocialCare	Other Healthcare
36,971	11,282	13,165	8,900	3,624









The information shown is dependent on a daily extract from the National Immunisation Vaccination System (NIVS). Vaccinations up to and including 18/03/2021

Commentary

The NNUH Vaccination hub became operational on the 8th December 2020 and has subsequently delivered over 36,000 vaccinations to Over 80's, Care Home Staff, Healthcare Staff and Social Care Staff.

By the end of January, all NNUH Staff (including bank and Serco) had received an invite to receive a vaccination.

Second doses for patients have resumed from the W/C 22/02/2021 as planned with capacity flexed to align dates to when first doses were received.

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REPORT TO THE TRUST BOARD

Date	**7 April 2021**
Title	**Chair's Key Issues from Audit Committee Meeting on 31.03.21**
Lead	**Julian Foster – Non-Executive Director (Committee Chair)**
Purpose	**For Information, assurance and approval as specified**

1 Background/Context

The Audit Committee met on 31 March 2021. Papers for the meeting were circulated to all Board members for information in the usual way. The meeting was quorate and was held by MS Teams. Ms Jackie Hammond (Public Governor) attended as observer.

2 Key Issues/Risks/Actions

Issues to Highlight and escalate:		
1	Appointment of External Auditors	The Audit Committee and Council of Governors have worked together to oversee procurement of External Audit services for the Trust. Following an open tender process the Council of Governors agreed to re-appoint KPMG as External Auditors for 3 years with an option to extend by 2 years. The appointment was **ratified** by the Committee. Both this and the appointment of Internal Auditors involve significant increases in audit fees as a result of increased regulation of audit and a lessening of competition between audit firms.
2	Appointment of Internal Auditors	Following a competitive procurement exercise, the Committee was recommended to re-appoint RSM to provide internal audit services for a 3-year term from 1 April 2021. The Committee **agreed** reappointment as recommended.
3	Internal Audit Progress Report & Draft Head of Internal Audit Opinion	Because of the pandemic the IA programme has largely taken place during the second half of the year. Positive reports were received in relation to Business Continuity, Accounts Receivable, Accounts Payable, Elective Waiting List, Risk Management and Complaints. The Draft Head of Internal Audit Opinion looks across the whole year and shows a positive opinion on the basis that significant progress has been made in response to the Financial Governance Review and in implementing recommendations from previous IA reports. The Committee spent considerable time reviewing 4 Partial Assurance Internal Audit reports: - HR Policies - Agency & Bank Use - Payroll

		- ED SoPs These audits identified weaknesses in communicating and providing appropriate training in relation to some policies and procedures and the Committee held a wide ranging discussion on the absence of expected controls both within HR and in the divisions. While there may be mitigating factors on why some basic controls are not working effectively, concern was expressed about the need to strengthen management leadership in ensuring a culture of control over business as usual processes. A series of actions were proposed in following up the recommendations from these audits and to strengthen the control environment. The Committee considered a critical "advisory" report on the completion of the Data Security and Protection toolkit where a number of self- assessment confirmations were found to lack the expected evidence.
4	Draft Internal Audit & LCFS Plans for 2021/22	The Committee commented on the draft Internal Audit and Counter-Fraud Plans for 2021/22 which also need to be reviewed by HMB. Delegated authority to the CFO was given to commence these programmes in non-contentious areas prior to full Audit Committee approval at the May meeting.
5	Update on External Audit Plan & Final Accounts Timetable	The timetable for the 2021 audit was agreed. The proposed timetable assumes that Board approval will be given at the end of May (as in previous years). There is no requirement for a Quality report again this year but there will be VFM reporting in addition to last year's reporting requirements.
6	Risk Management Update & Quarterly CRR Review	The Committee reviewed the ongoing progress in developing the Trust's Risk Management processes. There is a clear annual reporting schedule for Board and Board Committees to receive and review the Corporate Risk Register. The Committee was assured that the requested updates had been made to the Board's Risk Appetite Statement and this will be reviewed again as part of concluding the operational and business planning cycle for 2021/22 in accordance with the recently released planning guidance.
7	FT Code of Governance Annual Review	The Committee received the output of a review against the Foundation Trust Code of Governance. The Committee noted that the Trust is assessed as compliant with all elements of the Code other than 3 exceptions where additional explanation of our approach was deemed necessary: - location of Schedule of Matters Reserved (i.e. appended to the Board's ToRs); - agreement to hold some Board meetings in private for specified purposes (e.g. commercial or personal confidentiality); - the approach to NED remuneration (follows recent national guidance rather than the now superseded approach of the Code). The associated explanations were **agreed** for inclusion in the Annual Report.
8	Governance Road Map update	The Committee received an update on implementation of the Governance Road Map actions agreed by the Board as part of the Organisational Governance Framework.
9	Trust Board – Terms of Reference review	The Committee reviewed the Terms of Reference for the Board of Directors (including the Schedule of Matters Reserved for Decision of the Board). No significant changes were indicated by the Board's annual review and only relatively minor updates were proposed to the Matters Reserved. The Committee **recommends the attached ToRs to the Board for approval.**

10	Committee annual evaluation.	The Committee reviewed the outputs of its annual review exercise. This has been multifaceted, involving member feedback, evaluation against HFMA templates and review of ToRs. On the basis of this evaluation, the Committee has agreed its Work Programme for the year ahead and recommends the **attached updated Committee ToRs to the Board for approval.**

3 Conclusions/Outcome/Next steps

The next Committee meeting is scheduled for 26 May 2021 and will review the Annual Report and Accounts in order to recommend these to the Board at its meeting later that same day

Recommendation:

The Board is recommended to:

- **note** the work of its Audit Committee;
- **approve** the updated Terms of Reference for i) Board of Directors (inc Schedule of Matters Reserved) and ii) Audit Committee.

TRUST BOARD

TERMS OF REFERENCE

1 CONSTITUTION

In accordance with its Constitution, the Trust has a Board of Directors, which comprises both executive and non-executive directors. As set out in Appendix 7 to the Constitution, the Trust has Standing Orders for the Practice and Procedure of the Board of Directors. For the avoidance of doubt, those Standing Orders take precedence over these Terms of Reference, which do not form part of the Trust's Constitution.

As determined and approved by the Board, these Terms of Reference are supplemented by a Schedule of Matters Reserved to the Board (attached as an Appendix to these Terms of Reference).

2 MEMBERSHIP

Membership of the Board is determined in accordance with Section 18 of the Trust's Constitution to ensure that at least half the members of the Board, excluding the Chairman, should be independent non-executive directors and the Board membership shall be as follows:

(a) an independent non-executive Chairman;
(b) no more than six other independent non-executive directors;
(c) no more than six executive directors; and
(d) a non-executive director nominated by the University of East Anglia.

3 ATTENDANCE

The Board may invite non-members to attend its meetings as it considers necessary and appropriate.

The Trust Secretary, or deputy, shall be Secretary to the Board and shall attend to take minutes of the meeting and provide appropriate advice and support to the Chairman and Board members.

4 MEETINGS and QUORUM

Meetings of the Board shall be held at such times as the Board may determine.

Routinely, meetings of the Board shall be held bi-monthly in public, on dates agreed with the Chairman. Dates of forthcoming meetings of the Board in public shall be posted on the Trust's website.

Agendas and papers for forthcoming public meetings of the Board, and minutes of previous public meetings of the Board, shall be posted on the Trust's website.

Additional meetings of the Board may be held in private for 'special reasons'[1] as determined by the Board.

No business shall be transacted at a meeting of the Board unless at least one third of the whole number of the directors is present, including at least one executive director and one non-executive director.

If an Executive Director is unable to attend a meeting of the Board, an alternate may be appointed to attend that meeting or part of it, if so requested by the Chairman. Any such alternate shall not be counted as part of the required quorum unless they have been formally appointed by the Board as an Acting Director, as set out at 6.24 of the Standing Orders. Attendance at the meeting may be by teleconference or videoconferencing at the discretion of the Chair.

The Front Sheet of any report to the Board should indicate its purpose, i.e. whether it is for decision or information only. In order to enable members of the Board to give proper consideration to all relevant matters, persons preparing papers for the Board should employ appropriate brevity commensurate with the subject matter.

5 PURPOSE

The purpose of the Board is to:

5.1 provide leadership to the Trust to promote achievement of the Trust's Principal Purpose[2] as set out in its Constitution, ensuring at all times that it operates in accordance with the Constitution and relevant operating licences;

5.2 set the values and strategic direction of the Trust and, to the extent appropriate, the strategies for each of the Trust's Divisions;

5.3 agree the Trust's financial and strategic objectives, including approval of the annual business plan and financial plan;

5.4 oversee the implementation of the Trust's strategic objectives;

[1] In accordance with the Health and Social Care Act 2012

[2] *"**2.1** The principal purpose of the Trust is the provision of goods and services for the purposes of the health service in England.*

***2.2** The Trust does not fulfil its principal purpose unless, in each financial year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purpose.*

***2.3** The Trust may provide goods and services for any purposes related to:*
- ***2.3.1** the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness; and*
- ***2.3.2** the promotion and protection of public health.*

***2.4** The Trust may also carry on activities other than those mentioned in the above paragraph for the purpose of making additional income available in order better to carry on its principal purpose. "*

5.5 monitor the performance of the Trust and ensure that the Executive Directors manage the Trust within the resources available in such a way as to:

(a) ensure the safety of patients and the delivery of a high quality of care;
(b) protect the health and safety of Trust employees and all others to whom the Trust owes a duty of care;
(c) make effective and efficient use of Trust resources;
(d) promote the prevention and control of Healthcare Associated Infection;
(e) comply with all relevant regulatory, legal and code of conduct requirements;
(f) maintain high standards of ethical behaviour, corporate governance and personal conduct in the business of the Trust;
(g) maintain the high reputation of the Trust both with reference to local stakeholders and the wider community;
(h) promote clinical research and teaching.

5.6 ensure that the Trust has adequate and effective governance and risk management systems in place;

5.7 review and approve the Trust's Annual Report and Accounts;

5.8 receive and consider high level reports on matters material to the Trust detailing, in particular, information and action relevant to the operation of the Management Board and including:

(a) human resource matters;
(b) operational performance;
(c) patient experience and clinical quality and safety;
(d) financial performance;
(e) the identification and management of risk;
(f) matters pertaining to the reputation of the Trust;
(g) strategic development;

5.9 promote teaching, training, research and innovation in healthcare to a degree commensurate with the Trust's 'teaching hospital' status;

5.10 promote and develop appropriate partnerships with other organisations in accordance with the Trust's values and strategic direction;

5.11 engage as appropriate with the Trust's Membership and Council of Governors;

5.12 act as corporate trustee for The Norfolk and Norwich University Hospitals NHS Foundation Trust Charitable Funds or equivalent successor funds;

5.13 oversee the role of the Trust as host for the NIHR Clinical Research Network (Eastern).

5.14 receive reports from committees of the Board concerning work undertaken within their Terms of Reference.

6 BOARD COMMITTEES

6.1 The Board may delegate powers to formally constituted committees, which may have executive authority in accordance with their Terms of Reference.

6.2 The Board has established the following Committees of the Trust:

- Audit Committee;
- Quality and Safety Committee;
- Finance, Investments and Performance Committee;
- People and Culture Committee
- Nominations and Remuneration Committee;
- Committee in Common (meeting as part of N&W Hospitals Group)
- Charitable Funds Committee.

Approved by the Trust Board of Directors on: 7 April 2021 (TBC)

Annual Review date: 30 April

APPENDIX TO BOARD OF DIRECTORS TERMS OF REFERENCE

SCHEDULE OF MATTERS RESERVED TO THE BOARD OF DIRECTORS

This Schedule constitutes the document referred to in the Standing Orders of the Board of Directors as *'Reservation of Powers to the Board and Delegation of Powers'.*

The following matters have been reserved to the Trust Board for its collective decision:

1 setting the values and strategic direction of the Trust and approving the Trust's Strategic Objectives;

2 agreeing levels of delegated authority and the Trust's Scheme of Delegation;

3 major changes to the Trust's corporate structure or governance arrangements;

4 establishment of Board Committees and review of their Terms of Reference and reports;

5 approval of the Trust's Annual Report and Accounts;

6 approval of the annual ~~business~~ operational plan and financial plan;

7 approval of the Trust's 'forward planning' documentation (or equivalent as NHS regulatory guidance may require) for submission to NHS England/NHS Improvement – (in accordance with sections 34.2 & 34.3 of the Trust's Constitution);

8 review and approval of the Trust's 'Speak-Up' policy;

9 review and approval of the Trust's Risk Management Strategy and Policy;

10 approval of contracts (other than individual contracts of employment), contract bids, joint ventures, partnerships, commitments, (including disposal of assets), and property documents including licences or leases, in all cases where the cumulative financial commitment is in excess of £2M (having regard to the requirement to seek NHSE/I agreement for commitments >£15m);

11 approval of appointment of members and Chairman of each of the Committees of the Board as listed in its Terms of Reference;

12 approval of appointment of the Senior Independent Director from amongst the Non-Executive Directors of the Trust;

13 approval of any proposals that the Constitution of the Trust should be amended, before they are submitted to NHS England/NHS Improvement;

14 approval of any substantive change to the Trust's insurance or indemnity arrangements in relation to Directors and Officers Liability;

15 specification of Qualifying Organisations as listed at Annex 2 to the Constitution (The Staff Constituency);

16 agreement to amend the Standing Orders of the Council of Governors, in accordance with section 9.3 of Annex 6 to the Constitution (Standing Orders For the Practice and Procedure of the Council of Governors);

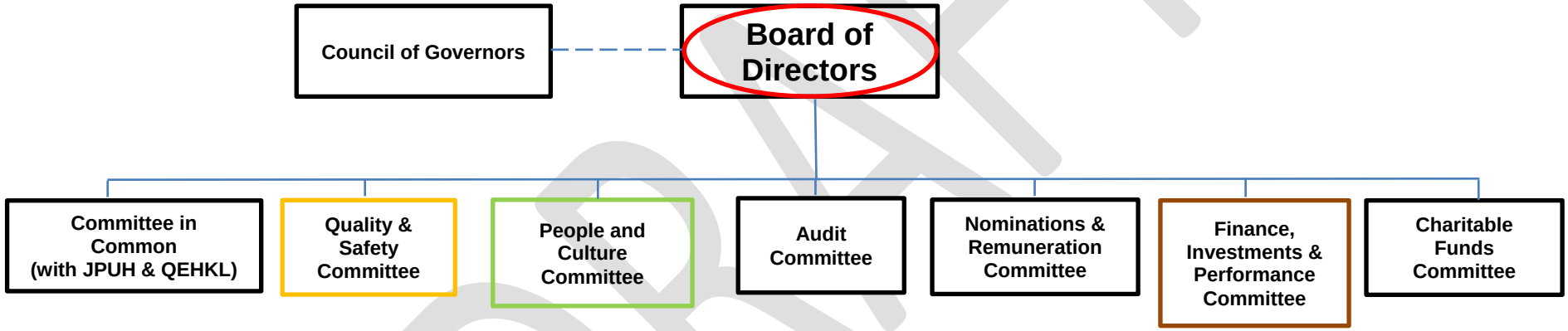
17 agreement to amend the Standing Orders of the Board of Directors, in accordance with section 6.33 of Annex 7 to the Constitution (Standing Orders for the Practice and Procedure of the Board of Directors);

18 in its capacity as Corporate Trustee, approval of the Charity's Annual Report & Accounts and expenditure of charitable and endowment funds >£100,000 per request;

19 award of 'naming rights' relating to any part of Trust property which may be associated ~~in association~~ with charitable or commercial sponsorship or gift;

20 review and revision of this Schedule of Matters Reserved to the Board.

Board of Directors
Committee Structure



As at January 2021

AUDIT COMMITTEE

TERMS OF REFERENCE[1]

1. CONSTITUTION AND PURPOSE

In accordance with the Constitution of the Trust, a Non-Executive Committee is established, to be known as the Audit Committee ("the Committee"). The Terms of Reference of the Committee shall reflect the requirements of NHSI documents - NHS Foundation Trust Code of Governance (July 2014) and 'Governance over audit, assurance and accountability: guidance for foundation trusts' (March 2015)

The **Purpose** of the Committee is to maintain oversight of and provide assurance to the Board with regard to:

- the integrity of the Trust's financial statements and reporting of financial performance;
- the relevance and robustness of governance structures; and
- the effectiveness of the Trust's systems of risk management and internal control.

2. AUTHORITY

The Committee has no executive powers, other than those specified in these Terms of Reference or otherwise requested by the Trust Board or in its Scheme of Delegation.

The Committee is authorised by the Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Board to obtain legal or other independent professional advice and to secure the attendance of persons with relevant experience and expertise from within or without the Trust as it considers necessary.

3. MEMBERSHIP

The Committee shall consist of not less than three Non-Executive members, appointed by the Board from amongst the independent Non-Executive Directors of the Trust. The Chairman of the Trust shall not be a member of the Committee.

One of the members will be appointed Chair of the Committee by the Board. The Committee Chairman may nominate one of the remaining members to act as deputy in his/her absence, failing which, in the absence of the Committee Chairman the remaining members shall elect one of themselves to chair the meeting. Members will be required to attend at least half of the meetings of the Committee each year. At least one member of

[1] These Terms of Reference are based on the model contained in the NHS Audit Committee Handbook 2011, updated to reflect the HFMA NHS Audit Committee Handbook 2018, but also reflect ~~the template in~~ the UK Corporate Governance Code (2018) ~~Combined Code Guidance on Audit Committees (2003)~~ and ICSA Guidance on Terms of Reference for Audit Committees (20~~07~~). They are informed by NHSI: Audit and assurance: a guide to governance for providers and commissioners (December 2019)

the Committee should have recent and relevant financial experience as determined by the Trust Board.

4. MEETINGS, ATTENDANCE AND QUORUM

The Committee must consider the frequency and timing of meetings necessary to allow it to discharge all its responsibilities. Meetings shall however be held not less than four ~~three~~ times a year at appropriate times in the reporting and audit cycle. The External Auditor or Head of Internal Audit may request that a meeting be held if they consider that one is necessary.

A quorum for the Committee shall be two members. Attendance at the meeting may be by teleconference or videoconferencing at the discretion of the Committee Chair. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions invested in, or exercised by the Committee.

At least once a year the Committee shall meet privately with the External and Internal Auditors. The Head of Internal Audit and representative of External Audit have a right of direct access to the Chair of the Committee.

Attendance at meetings of the Committee shall be as follows:

- Chief Finance Officer, Deputy Director of Finance and appropriate Internal and External Audit representatives shall normally attend meetings of the Committee;
- counter fraud specialist will attend a minimum of two committee meetings a year;
- Chief Executive is expected to attend at least one Committee meeting annually, to discuss the process for assurance that supports the Annual Governance Statement (AGS) and should attend when the Committee considers the draft AGS and the annual report and accounts;
- Medical Director shall attend two meetings per annum, timed to coincide with discussion and review of Clinical Audit in the Trust;
- Chief Nurse shall attend two meetings per annum, timed to coincide with discussion and review of matters relating to Risk Management in the Trust.

The Chairman of the Trust, Chief Executive and other executive directors may be invited to attend any meeting of the Committee, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director. The Executive responsible for Risk Management, or a deputy of appropriate seniority, will also be expected to attend meetings of the Committee that are considering matters relating to Risk Management.

The Committee may ask any or all of those who normally attend Committee meetings but who are not members to withdraw to facilitate discussion of any particular matters at the discretion of the Chair.

In exceptional circumstances when an executive member cannot attend Committee meetings, they must arrange for a fully briefed deputy of sufficient seniority to attend on their behalf with agreement of the Committee Chair.

5. SUPPORT ARRANGEMENTS

The Board Secretary will be responsible for providing secretarial support to the Committee and provide appropriate support to the Chair and committee members.

The Committee shall operate as follows:

- The Committee will establish an annual Work Programme, summarising those items that it expects to consider at forthcoming meetings.
- Agendas for forthcoming meetings will be based on the Work Programme, reviewed by the Committee and agreed with the Committee Chair.
- Papers for the meeting should be submitted to the Committee secretary a minimum of 6 working days prior to the meeting. Papers on other matters will be put on the agenda only at the request of or with the prior agreement of the Chair.
- Papers will be sent out by the Committee secretary at least 4 working days before each meeting.
- To facilitate oversight by the Board of Directors, papers for meetings of the Committee will be circulated for information to those members of the Board who are not members of the Committee.
- Minutes will be prepared after each meeting of this Committee within 14 days and circulated to members of the Committee and others as necessary once confirmed by the Chair of the Committee. A record of action points arising from meetings of the Committee shall be made and circulated to its members with the minutes.
- Following each meeting of the Committee, the Chair of the Committee shall make a report to the next meeting of the Board of Directors highlighting any issues that require its particular attention, or require it to take action.
- The Terms of Reference of the Committee will be reviewed annually and will only be changed with the approval of the Trust Board.

6. DECLARATIONS OF INTERESTS

All members must declare any actual or potential conflicts of interest relevant to the work of the Committee, which shall be recorded in the Minutes accordingly. Members should exclude themselves from any part of a meeting in which they have a material conflict of interest. The Chair will decide whether a declared interest represents a material conflict.

7. DUTIES

In furtherance of achievement of its Purpose, particular duties of the Committee are as follows:

7.1 Integrated Governance, Risk Management and Internal Control

The Committee shall review the implementation and ongoing quality and effectiveness of integrated governance, risk management and internal control, across the whole of the Trust's activities (clinical and non-clinical), that supports the achievement of the Trust's objectives.

In particular, the Committee will review the adequacy and effectiveness of:

7.1.1 the structures, processes and responsibilities within the Trust for identifying and managing key risks;

7.1.2 all risk and control related disclosure statements, (in particular the Quality Report and Annual Governance Statement), together with any accompanying Head of Internal Audit Statement, External Audit Opinion or other appropriate independent assurances, prior to endorsement by the Board;

7.1.3 the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks, the fitness for purpose of the Board Assurance Framework and the appropriateness of the disclosure statements identified at 7~~6~~.1.2;

7.1.4 the operational effectiveness of relevant policies and procedures for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications;

7.1.5 the policies and procedures relating to counter fraud, bribery and corruption;

7.1.6 the Trust's 'Speak-Up' procedures (FTSU) to ensure that arrangements are in place for Trust employees to raise concern (in confidence) about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters and for the proportionate and appropriate investigation and follow-up of allegations. In the Trust's governance structure, FTSU reports into the Board's People and Culture Committee and the Audit Committee may take assurance from the People & Culture Committee, in accordance with 7.5 below;

7.1.7 the structures, processes and responsibilities within the Trust with regard to Emergency Preparedness, Resilience and Response & Business Continuity.

In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these and may also seek reports and assurances from directors and managers as appropriate.

7.2 Internal Audit

The Committee shall ensure that there is an effective Internal Audit function that meets the Public Sector Internal Audit Standards (2017) and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:

7.2.1 monitoring ~~reviewing~~ the effectiveness of Internal Audit and carrying out an annual review, ensuring that the Internal Audit function has adequate resources, access to information and appropriate standing within the Trust;

7.2.2 approving the Internal Audit strategy and programme of work, ensuring that this is consistent with the audit needs of the Trust and there is co-ordination between the Internal and External Auditors to optimise audit resources. The Audit Committee shall take into account any recommendations made by other Committees of the Board in relation to matters falling within their Terms of Reference;

7.2.3 reviewing the major findings of Internal Audit work (and management response);

7.2.4 approving the audit fee and the appointment or dismissal of the Internal Auditors;

7.3 External Audit

The Committee shall review and monitor the independence and objectivity of the External Auditors (as appointed by the Council of Governors) and the effectiveness of the audit process. In particular, ~~T~~the Committee shall review the work and findings of the External Auditor ~~(as appointed by the Council of Governors)~~ and shall consider the implications of the External Auditor's work and the responses of Trust managers to it. This will be achieved by:

7.3.1 agreeing with the Council of Governors the criteria for appointment, reappointing and removing External Auditors, considering the performance of the External Auditor including agreement of the audit fees, making appropriate recommendations to the Council of Governors on appointment and reappointment of the External Auditor;

7.3.2 discussion and agreement with the External Auditor, before the audit commences, concerning the nature and scope of the audit;

7.3.3 discussing with the external auditors their evaluation of audit risks and assessment of the Trust and the impact on the audit fee;

7.3.~~4~~3 review of all External Audit reports, including agreement of the annual audit letter before its submission to the Board, and any work performed outside the annual audit plan, together with management responses;

7.3.~~5~~4 review and monitor the external auditor's independence and objectivity and effectiveness of the audit process, including the provision of any non-audit services, taking into consideration relevant UK professional and regulatory requirements;

7.3.~~6~~5 in the event of the external auditors resigning, making appropriate recommendations to the Council of Governors as required. It is for the Chairman of the Board to inform NHSI of the reasons for ceasing an auditor's appointment;

7.3.~~7~~6 developing and implementing a policy regarding the supply of non-audit services by the External Auditor, taking account of relevant ethical guidance, and monitoring that service, in accordance with the agreement of the Council of Governors.

The Committee shall also assess the effectiveness of the audit process by:

7.3.8 reviewing any representation letters requested by the external auditor before they are signed by management,

7.3.9 review and agree management's response to the auditor's findings and recommendations.

7.4 Counter Fraud

The Committee will satisfy itself that the Trust has adequate arrangements in place for counter fraud, bribery and corruption that meet the NHS Counter Fraud Authority's standards and will review the outcomes of work in these areas.

Specifically, it will:

- approve the Trust's Counter Fraud strategy and Local Counter Fraud Specialist annual work plan, including the resources allocated for the delivery of the strategy and work plan;
- receive and review progress reports of the Local Counter Fraud Specialist against the four principles of the overall NHS Counter Fraud Strategy;
- monitor the implementation of management actions arising from counter fraud reports;
- receive and discuss reports arising from quality inspections by the counter fraud service;
- make recommendations to the Trust Board as appropriate in respect of Counter Fraud at the Trust;
- receive, review and approve the annual report of the Local Counter Fraud Specialist.

7.5 Other Assurance Functions

Where appropriate the Audit Committee shall review the findings of other significant assurance sources ~~(for example Independent Inquiry reports)~~ and shall consider any implications for the governance of the Trust.

These will include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulation/inspectors – for example the CQC, NHS Resolution etc and professional bodies with responsibility for the performance of staff or functions – for example, Royal Colleges, accreditation bodies etc

In addition, as part of its approach to providing assurance to the Board, the Committee ~~may~~ will consider the work of other committees within the organisation (in particular the three other Board Assurance Committees), whose work can provide relevant assurance to the Audit Committee's overview of the systems and processes of integrated governance.

In reviewing issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the clinical audit function.

7.6 Financial Reporting

The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

The Committee should also ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

7.6.1 the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee;

7.6.2 changes in, and compliance with, accounting policies and practices and estimation techniques;

7.6.3 unadjusted mis-statements in the financial statements;

7.6.4 any unusual transactions and know they have been accounted for;

7.6.5 ~~major judgemental areas~~ significant judgements in preparation of the financial statements;

7.6.6 significant adjustments resulting from the audit

7.6.7 explanations for significant variances.

7.7 Charitable Funds[2]

7.7.1 With respect to the Trust's Charitable Funds, the Committee will report to the Trust Board of Directors (in its capacity as Corporate Trustee). With the support of Internal Audit and External Audit, the Committee will provide assurance with respect to the governance of the charitable funds including expenditure from charitable funds in accordance with the relevant objects.

7.7.2 The Committee will review the Annual Report and Accounts of the Trustees prior to its consideration and approval by the Corporate Trustee.

8. PROCESS FOR MONITORING COMMITTEE EFFECTIVENESS

8.1 The Committee shall submit an Annual Report to the Trust Board reporting on the work of the Committee in support of the Annual Governance Statement, specifically commenting on the completeness and embeddedness of risk management in the organisation and the integration of governance arrangements.

8.2 The Committee will report to the Council of Governors identifying any matters in respect of which it considers that action or improvement is needed and making recommendations as to the steps to be taken.

8.3 A separate section of the Annual Report should describe the work of the Audit Committee in discharging its responsibilities.

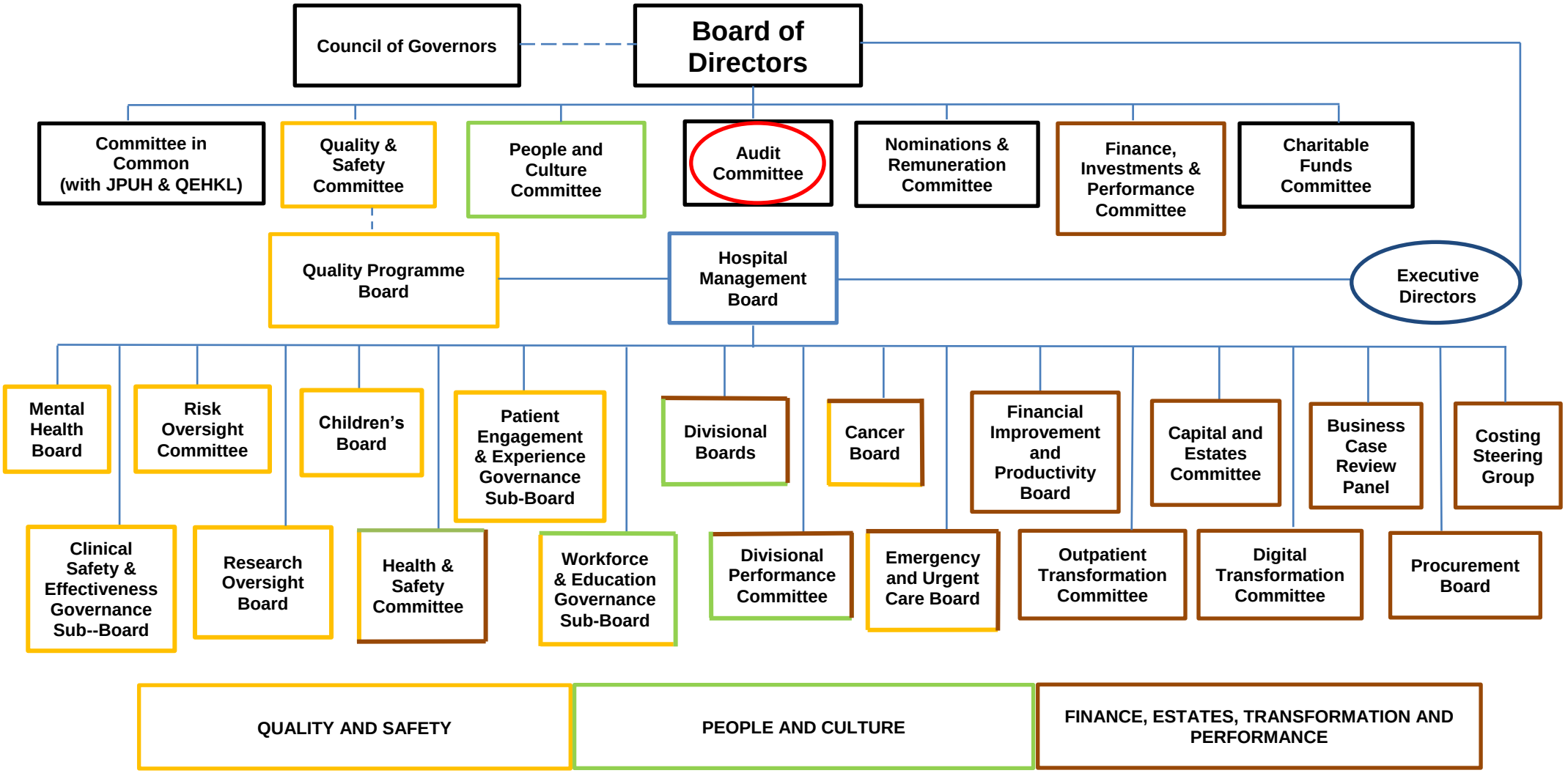
Approved by the Board of Directors on: 7 April 2021 (TBC)

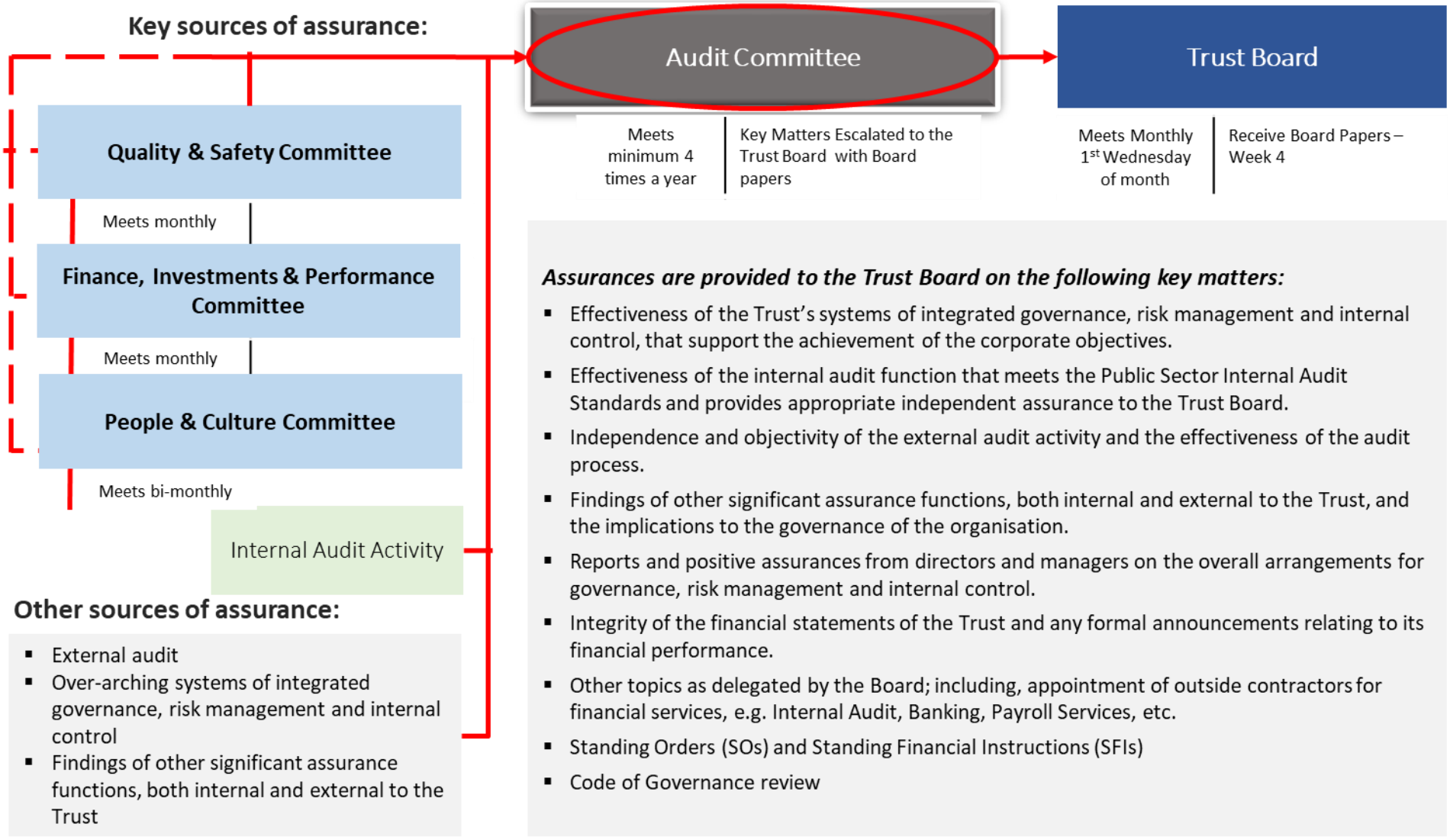
Annual Review date: 30 April

[2] Relevant guidance is found in
- Charity Commission document CC14 "Investment of Charitable Funds (2004);
- Charity Commission document CC10 "the Hallmarks of an Effective Charity (2008);
- National Audit Office – Charitable Funds Associated with NHS bodies (June 2000).

Norfolk and Norwich University Hospitals NHS Foundation Trust

Board of Directors and Management Board Reporting and Accountability Structure




Key sources of assurance:
Quality & Safety Committee
Meets monthly
Finance, Investments & Performance Committee
Meets monthly
People & Culture Committee
Meets bi-monthly
Internal Audit Activity
Other sources of assurance:
External audit
Over-arching systems of integrated governance, risk management and internal control
Findings of other significant assurance functions, both internal and external to the Trust
Audit Committee
Meets minimum 4 times a year
Key Matters Escalated to the Trust Board with Board papers
Trust Board
Meets Monthly 1st Wednesday of month
Receive Board Papers – Week 4
Assurances are provided to the Trust Board on the following key matters:
Effectiveness of the Trust's systems of integrated governance, risk management and internal control, that support the achievement of the corporate objectives.
Effectiveness of the internal audit function that meets the Public Sector Internal Audit Standards and provides appropriate independent assurance to the Trust Board.
Independence and objectivity of the external audit activity and the effectiveness of the audit process.
Findings of other significant assurance functions, both internal and external to the Trust, and the implications to the governance of the organisation.
Reports and positive assurances from directors and managers on the overall arrangements for governance, risk management and internal control.
Integrity of the financial statements of the Trust and any formal announcements relating to its financial performance.
Other topics as delegated by the Board; including, appointment of outside contractors for financial services, e.g. Internal Audit, Banking, Payroll Services, etc.
Standing Orders (SOs) and Standing Financial Instructions (SFIs)
Code of Governance review
Key:
Direct oversight by the committee:
Indirect oversight by the assurance committee:

REPORT TO THE TRUST BOARD

Date	**7 April 2021**
Title	**Chair's key Issues from Quality and Safety Committee Meeting on 30.03.21**
Lead	**Dr Geraldine O'Sullivan – Non-Executive Director (Committee Chair)**
Purpose	**For Information and assurance**

1 Background/Context

The Quality and Safety Committee met on 30 March 2021. Papers for the meeting were made available to all Board members for information in the usual way. The meeting was quorate and was held by MS Teams. It was attended by Mrs Erica Betts (Public Governor) as observer. Due to the Covid 19 pandemic, the meeting was not preceded by clinical/departmental visits.

2 Key Issues/Risks/Actions

Key issues to highlight to the Board were identified as follows:		
1	Quality and Safety – Current Performance – Extract from IPR	Current Q&S performance and issues were discussed. There is ongoing concern with regard to the commissioning of adequate mental health services particularly for vulnerable children & young people. Similarly there are concerns around safeguarding services for both children and adults. As these are system issues, Mr Higginson will be raising these at a system –level.
2	Quality Priorities – progress & plans for 2021/22	The Committee was updated on the progress against the 14 agreed Quality Priorities for 2020/21. Progress was disrupted by C19 with one priority (age appropriate patient & family feedback) being fully satisfied during 2020/21. In view of the disruption, the Committee agreed that the 13 other Quality Priorities from 2020/21 will be carried forward to 2021/22 and one new priority around improving patient-centred transfers of care has been added.
3	Clinical Audit priorities (2021/22)	The Committee received a report from Dr Stuart Williams (Consultant Radiologist & Lead for Clinical Audit) with regard to the Clinical Audit programme. It was disrupted by the pandemic during 2020/21 as staff were deployed to other activities. The Committee was apprised of the Audit Priorities for the year ahead. In terms of acting on outputs from audits, Audit facilitators are now embedded within directorates which helps with capturing actions arising from audits to improve services.
4	Emergency Dept Improvement Actions	The Committee reviewed the action plan developed by the Emergency Department (ED) team following the recommendations made by the CQC. Considerable progress has already been made in terms of enhanced focus on triage and auditing of the triage process; recruitment to the department; planned input from the patient panel. The Committee requested that the underlying principle of improving the patient experience in ED should underpin the improvement plan focusing on 'what Good looks like from a patient perspective'. The updated Improvement Plan is to be received by the Board at its meeting on 7 April.

5	Dementia Strategy Update	The Committee reviewed the updated Dementia Strategy following the incorporation of comments and changes requested by the Committee. The Committee **recommends** the Strategy to the Board for approval.
6	Committee Draft Annual Report (2020/21)	The Committee undertook an initial review of its Annual Report including identification of the most significant risks relating to Quality & Safety. The Committee will return to this at its next meeting but concern regarding prolonged waiting times will feature prominently.

3 Conclusions/Outcome/Next steps

The next Committee meeting is scheduled for 27 April 2021 with the aim of re- starting our practice of pre-meeting clinical visits.

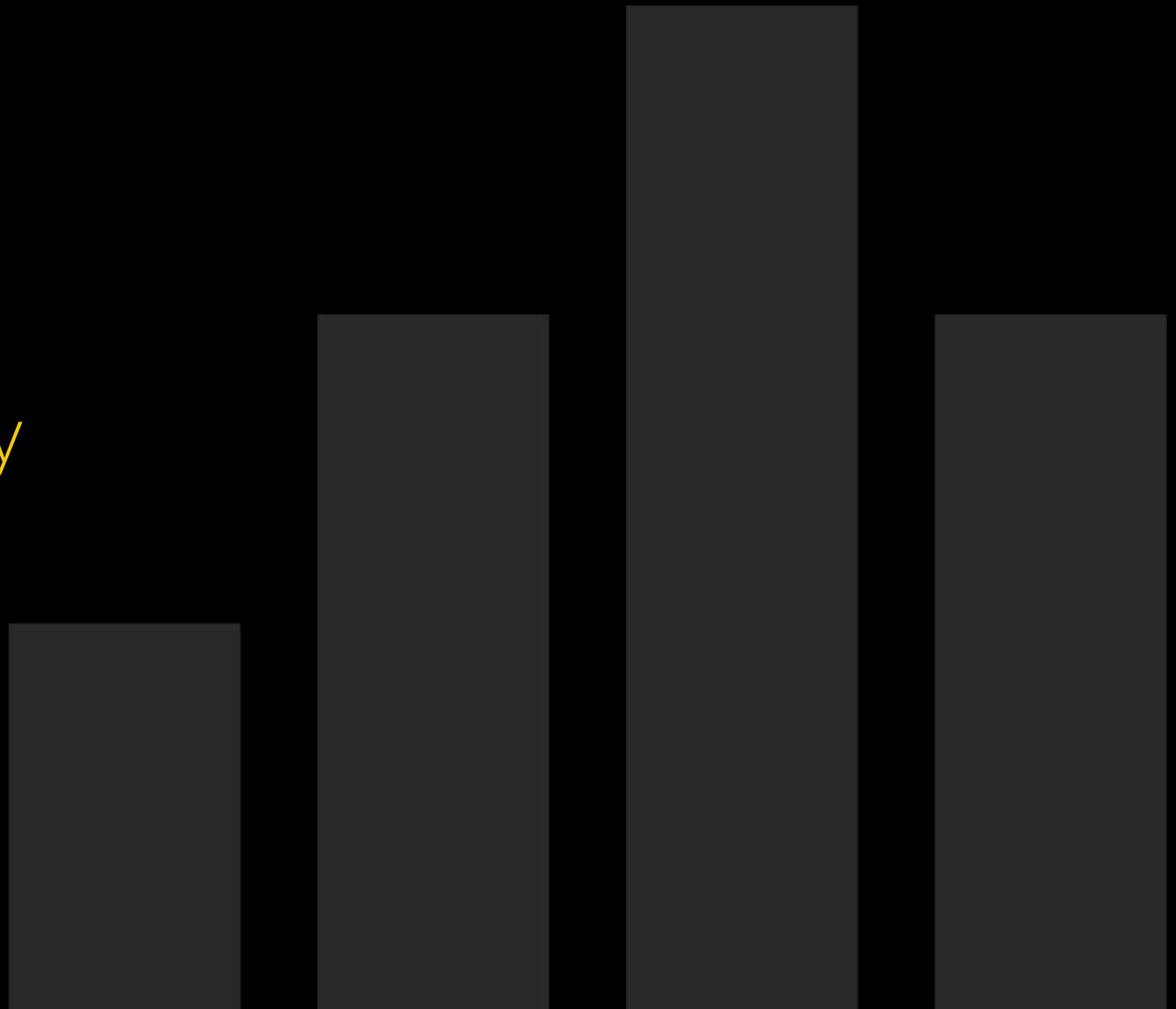
Recommendation: The Board is recommended to **note** the work of its Quality & Safety Committee and in particular agreement of the Quality Priorities 2021/22 and the recommendation of the Dementia Strategy.

Microsoft | Power BI

Quality & Safety

View in Power BI

Last data refresh:
18/03/2021 12:39:11 GMT Standard Time
Downloaded at:
18/03/2021 14:46:31 GMT Standard Time



Quality Summary

All metrics designated as Trust IPR Metrics, where the variation for the latest month of data was not common cause.

NNUH Digital Health
business intelligence

Topic	Metric Name	Date	Result	Variation	Assurance
Children & Midwifery Safeguarding	Safeguarding Children and Midwifery	Feb 2021	28	Concern (High)	No Target
Mortality Rate	Crude Mortality Rate	Jan 2021	10.30%	Concern (High)	No Target
Patient Concerns	PALS Enquiries	Jan 2021	602	Improvement (High)	No Target
Patient Experience	Compliments	Feb 2021	113	Concern (Low)	No Target
Patient Safety	Incidents	Feb 2021	3,730	Concern (High)	No Target
Pressure Ulcers	Hospital Acquired Pressure Ulcers per 1,000 bed days	Feb 2021	2.7	Concern (High)	No Target
Safer Staffing	Safe Staffing Fill Rates	Feb 2021	77.20%	Concern (Low)	Not capable
Saving Babies Lives	CTG Training and Human factors situational awareness compliance	Feb 2021	81%	Concern (Low)	Unreliable

SPC Variation Icons

Common Cause | Concern (High) | Concern (Low) | Improvement (High) | Improvement (Low)

SPC Assurance Icons

Capable | Not capable | Unreliable

Patient Safety

NNUH Digital Health
business intelligence

Serious Incidents

Feb 2021

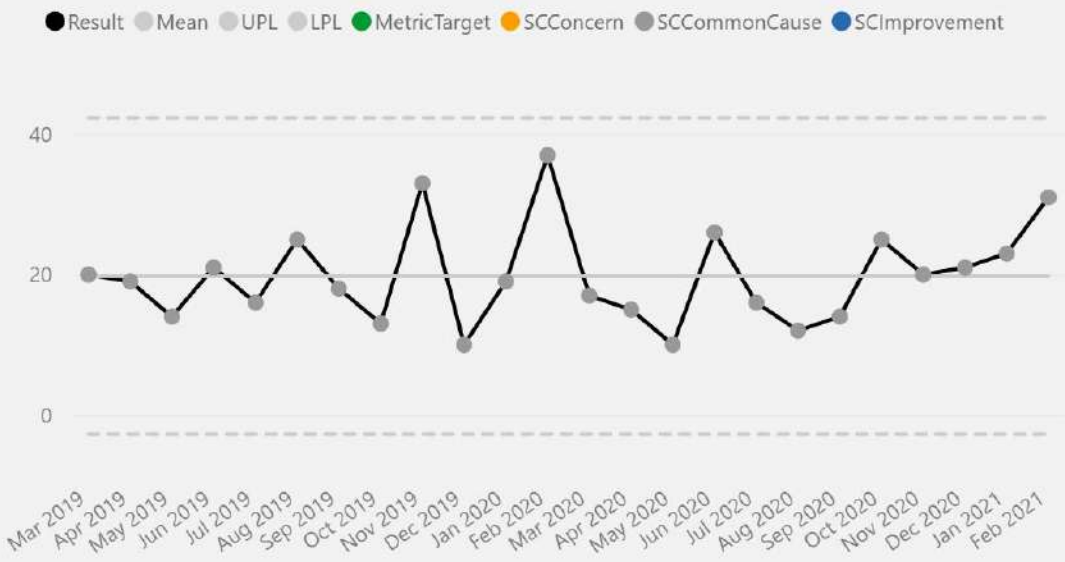
Variation	Assurance

31 Result	42 UPL
N/A Target	20 Mean
	-3 LPL

Analytical Commentary

Variation is Common Cause

Serious Incidents



Assurance Commentary

31 SI's were reported in February: 2 Ambulance handover delays, 15 DTA breaches, 2 falls, 5 delay in treatmet, 4 Cat 3 HAPU, 2 Maternity incidents, 1 HCAI Covid.
3730 Datix incidents were reported. This number continues to increase driven by the number of 52wk RTT breaches. 97% of all incidents are reported as causing no or low harm.
A high number of reported incidents indicates a good safety reporting culture.

Improvement Actions

Reporting safety incidents is encouraged.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Duty of Candour Compliance	Feb 2021	92%		Common Cause		Unreliable
Incidents	Feb 2021	3,730		Concern (High)		No Target

Pressure Ulcers

NNUH Digital Health
business intelligence

Hospital Acquired Pressure Ulcers per 1,000 bed days

Feb 2021

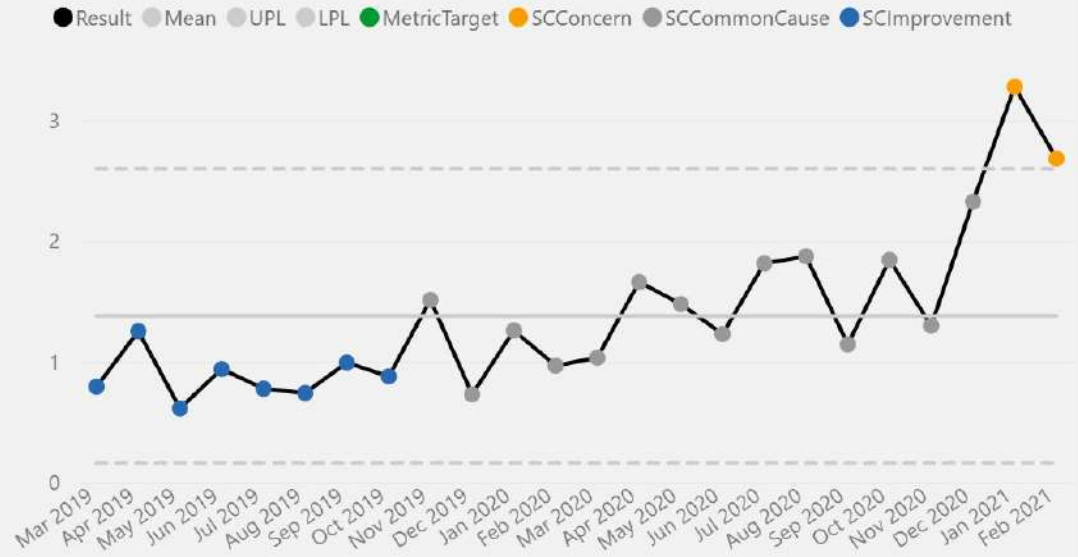
Variation | Assurance

2.7 Result	2.6 UPL
N/A Target	1.4 Mean
	0.2 LPL

Analytical Commentary

Data point fell outside of process limits, and therefore the variation is Special Cause Variation - Concern (High)

Hospital Acquired Pressure Ulcers per 1,000 bed days



Assurance Commentary

Deteriorating performance in Category 2- 4 PU is highlighted by a special cause of a concerning nature in January and February. This is mainly driven by the increasing number of category 2 pressure ulcers being reported .

Improvement Actions

The Pressure Ulcer Improvement Programme will be focussing on the following areas to achieve a 20% reduction in the number of hospital acquired pressure ulcers. These include:
Increasing awareness among staff of the importance of reducing pressure ulcer incidence
Reviewing equipment ordering processes to identify where delays may occur
Improving grading and reporting systems
Ensuring all documentation and information relevant to pressure ulcer prevention includes the SSKIN care bundle
Reviewing staff education and providing training where gaps are identified

Patient Falls

NNUH Digital Health
business intelligence

Patient falls per 1,000 bed days (moderate harm or above)

Feb 2021

Variation

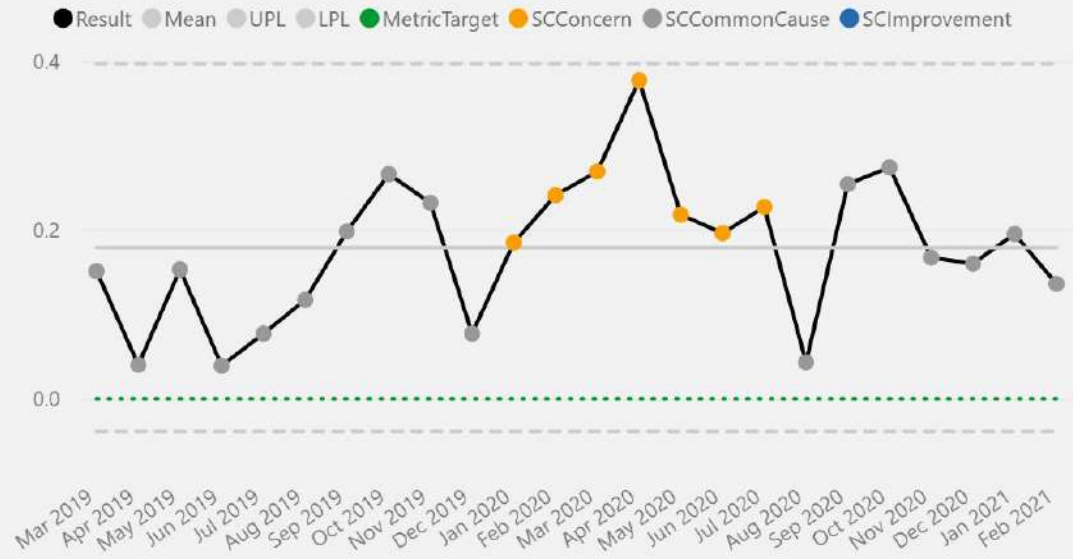
Assurance

0.1 Result
0.0 Target
0.4 UPL
0.2 Mean
0.0 LPL

Analytical Commentary

Variation is Common Cause

Patient falls per 1,000 bed days (moderate harm or above)



Assurance Commentary

176 falls reported in month. 98% of these were no or low harm.
x2 severe harm injurous falls reported as serious incidents.

Improvement Actions

The Trust-wide Falls QI project aims to :
Reduce the number of Trust wide falls by 25% by July 2021.
Reduce the rate of harms from falls (moderate, severe and catastrophic) by 20% by July 2021
By developing and implementing :
Person centred falls risk assessment and care planning that is based on the patients clinical conditions, health needs and care setting
Promoting mobilisation and meaningful activity to enhance physical and cognitive functioning.

Patient Experience

NNUH Digital Health
business intelligence

Friends & Family Score

Feb 2021

Variation | Assurance

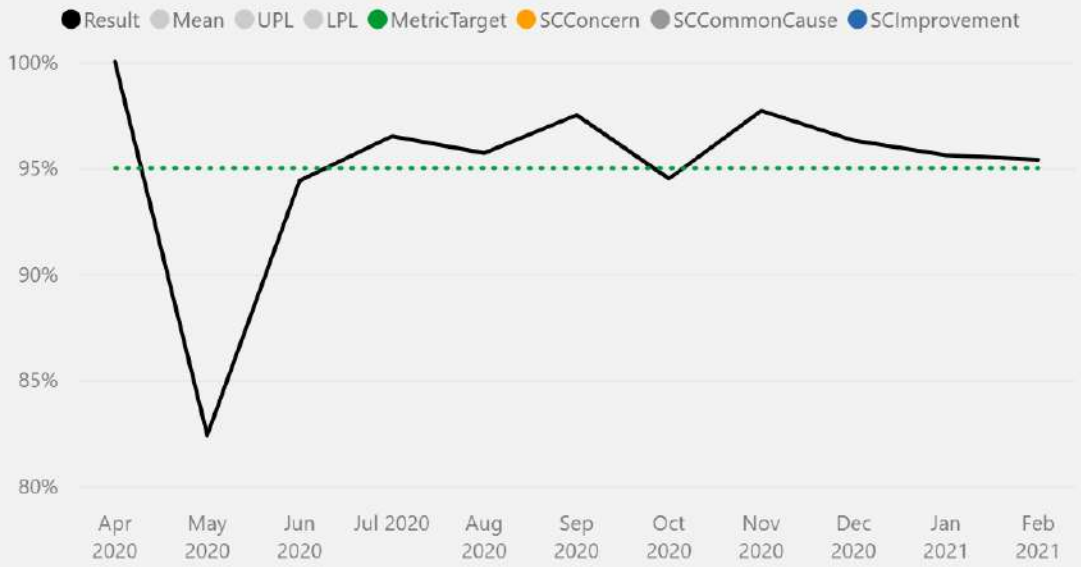
95.40% Result
95.00% Target

UPL
Mean
LPL

Analytical Commentary

Metric does not meet SPC criteria

Friends & Family Score



Assurance Commentary

The FFT score for satisfaction with the services has remained at or around the target of 95% however numbers of surveys completed remains lower due to impact of Covid restrictions and despite implementation of virtual offers

Improvement Actions

SMS forms part of new FFT provider contract starting in April for ED and then rolling out into OP, which will help improve responses rate.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Compliments	Feb 2021	113		Concern (Low)		No Target

Patient Concerns

NNUH Digital Health
business intelligence

PALS % Closed within 48hours

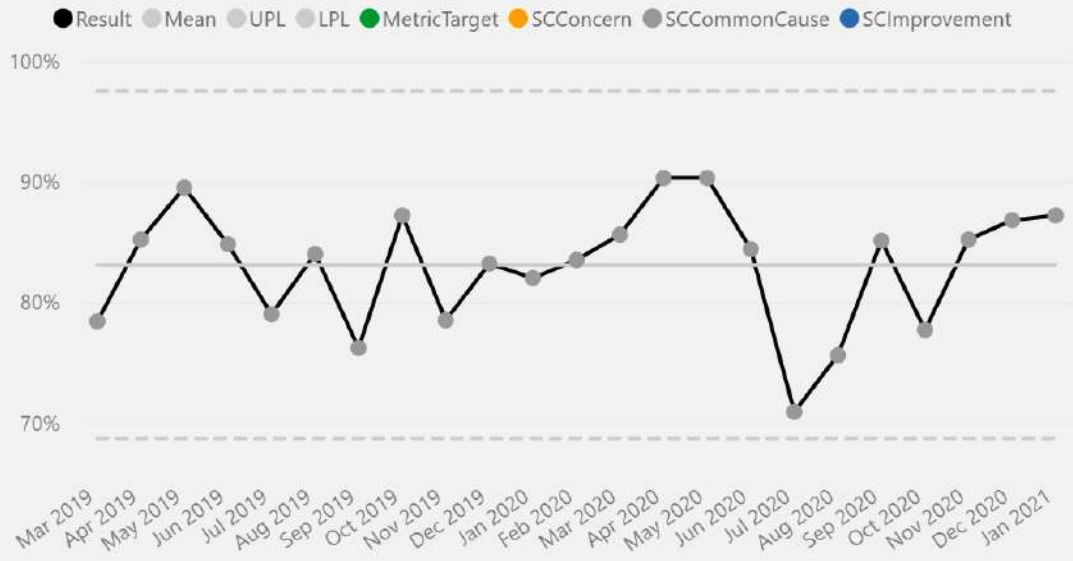
Jan 2021

Variation	Assurance
87.2% Result	97.5% UPL
N/A Target	83.1% Mean
	68.7% LPL

Analytical Commentary

Variation is Common Cause

PALS % Closed within 48hours



Assurance Commentary

PALS responsiveness to all contacts remains high.
This month total PALS matters received – 481 (602) Concerns = 175, Enquiries = 117, Signposting = 86 (of which 26 are formal complaints), Best Wishes = 101
Main Subjects
Communications – lack of patient updates, unable to get through to wards. Appointment delays and cancellations – Chasing TCI dates, rescheduling and cancelling of appointments, not able to attend, want to postpone.

Improvement Actions

Divisions provide reports to PEEG covering their local actions.
The Relatives Liaison Team (RLT) re-established and to date 120 families supported. PALS are able to hand over to RLT on the same day to ensure support offered immediately.
Critical Care has also established a bespoke RLT which is proving successful in managing family contacts and updating information board - 182 (incl 53 out of area transfers)

Supplementary Metrics

Metric Name	Date	Result	Variation	Assurance
PALS Enquiries	Jan 2021	602	Improvement (High)	No Target

Complaints

NNUH Digital Health
business intelligence

Complaints - Trust

Feb 2021

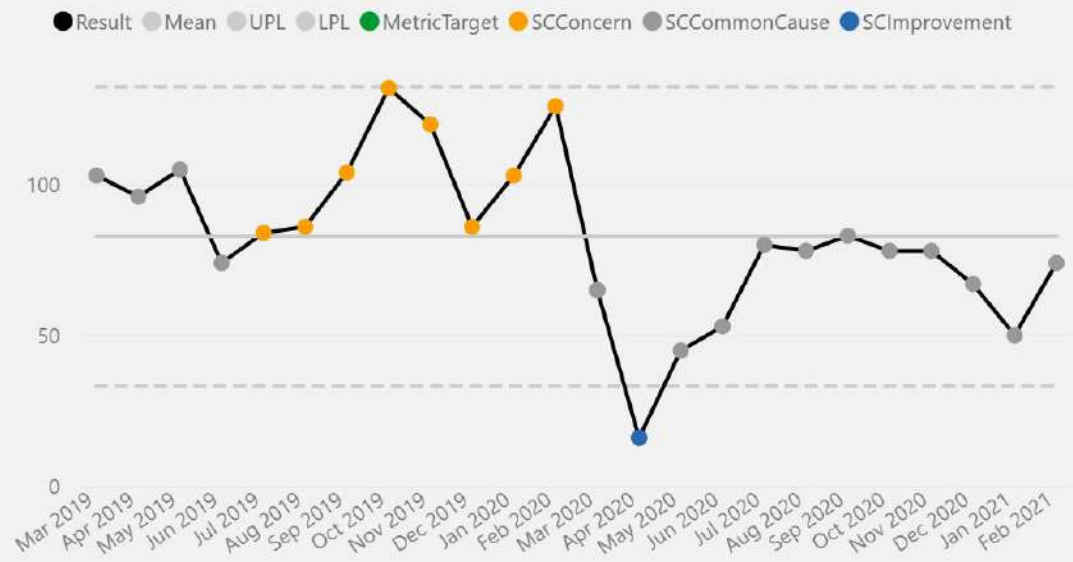
Variation | Assurance

74 Result
N/A Target
132 UPL
83 Mean
33 LPL

Analytical Commentary

Variation is Common Cause

Complaints - Trust



Assurance Commentary

All response targets met.

Internal Audit review concluded - Reasonable Assurance Opinion.

Improvement Actions

Supplementary Metrics

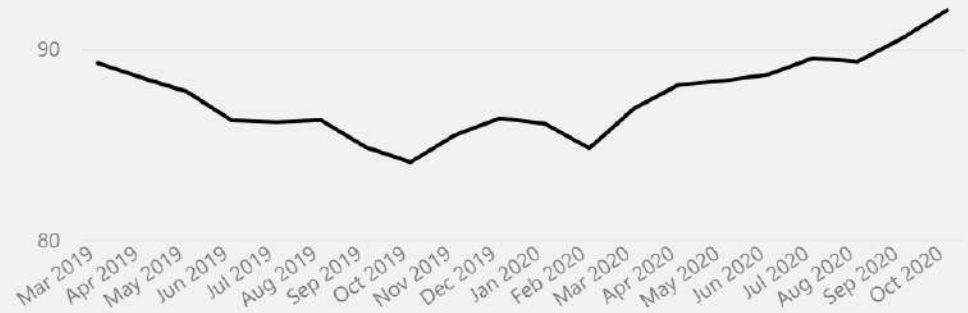
Metric Name	Date	Result		Variation		Assurance
Complaints - Acknowledgement	Feb 2021	100%		Common Cause		Unreliable
Complaints - Response Times - Trust	Feb 2021	95%		Not Applicable		Not Applicable
Post-investigation enquiries	Feb 2021	8		Not Applicable		Not Applicable

Mortality Rate

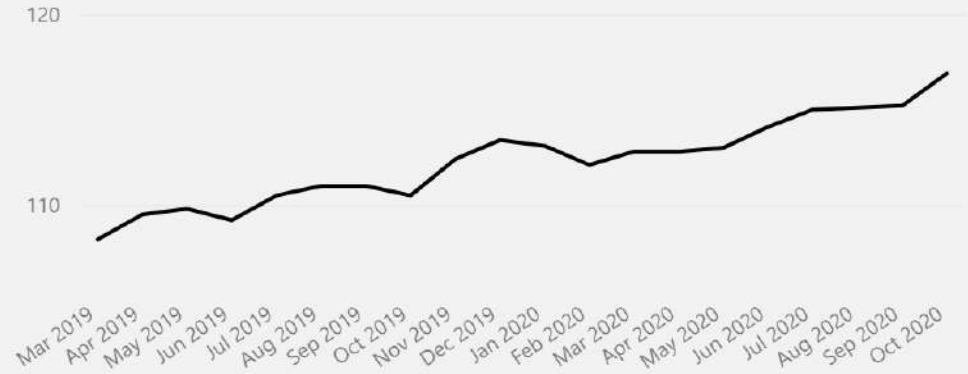
NNUH Digital Health
business intelligence

MetricName	Date	Result
HSMR	Oct 2020	92.03
SHMI	Oct 2020	117

HSMR



SHMI



Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Crude Mortality Rate	Jan 2021	10.30%		Concern (High)		No Target

Assurance Commentary

All SHMI outlier, CUSUM and HSMR/SMR alerts are investigated in detail, with recommendations made to appropriate areas/persons to action. A recent HSMR/SMR alert (essential hypertension) was triggered following the death of 1 patient, which will be reviewed through the SJR process.

Improvement Actions

- NNUH SHMI action plan development in progress to address increased trend reported over recent months.
- Clinical Coding Clinicians are now in post and will act as the liaison between clinical coding and medical staff, facilitating sharing learning regarding coding and mortality data.
- A Cohort review of Covid Deaths for the second wave will be completed.
- Work continues with improvement groups which include #NOF pathway and palliative care.

Safer Staffing

NNUH Digital Health
business intelligence

Safe Staffing Fill Rates

Feb 2021

Variation	Assurance
L	F

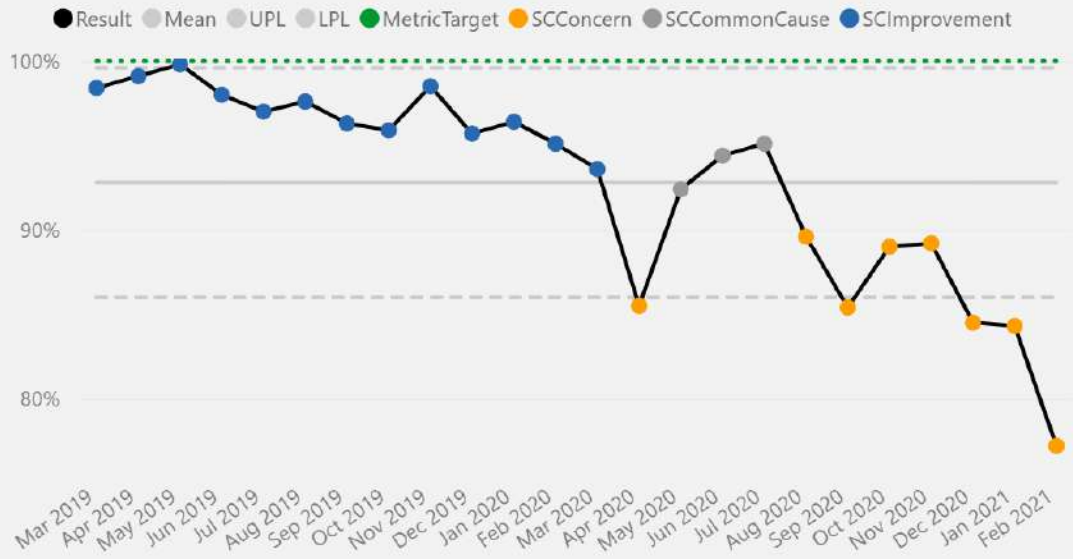
77.20% Result
100.00% Target

99.60% UPL
92.80% Mean
86.00% LPL

Analytical Commentary

Data point fell outside of process limits, Data is consistently below mean, and therefore the variation is Special Cause Variation - Concern (Low)

Safe Staffing Fill Rates



Assurance Commentary

During February the Trust de-escalated from Local Covid State 5 to 3. The elective "Green Pathway" resumed and "Red Wards" reduced from 10 to 2 in-patient areas. Critical Care capacity did not de-escalate at the same rate and remained at between 100% to 50% higher than the normal bed base. A total of 8.8 CHPPD was delivered in month with 4.8hrs being delivered by RN. Hours worked vs Planned reduced significantly to 77.2%. These quality measures should continue to be interpreted with caution due to a modification in the baseline of required CHPPD relating to the demand in critical care beds, the re-purposing of inpatient wards and reduced bed occupancy in month of 87%. 779 Red flags were raised in Feb, with 473 remaining open, 179 of these were raised for shortfall of RN on night shifts diluting RN to patient ratios to 1:18 across some areas. Reduced temporary staffing fill rates and increased CCC capacity therefore impacted on the ability to maintain safer staffing levels on nights in February.

Improvement Actions

To maintain safest staffing across all clinical areas 2,337 redeployments occurred in February; (214 less than December) with 892 of these to critical care. During the repurposing of the rosters for yellow areas, twilight shifts were implemented to mitigate the risk for part nights that assisted with RN tasks. Our Combat medics deployment ended on the 28th Feb and our Care Assistant transition to HCA continue to develop through the practice development and education training.

Supplementary Metrics

Metric Name	Date	Result	Variation	Assurance
Safe Staffing CHPPD	Feb 2021	8.8	Common Cause	No Target

Infection Prevention & Control

NNUH Digital Health
business intelligence

MetricName	Date	Result	Target	Mean
C. difficile Cases Total	Feb 2021	3	35	6
CPE positive screens	Feb 2021	1	N/A	1
E. Coli trust apportioned	Feb 2021	7	N/A	4
HOHA C. difficile Cases	Feb 2021	0	0	1
Hospital Acquired MRSA bacteraemia	Feb 2021	0	0	0
Klebsiella trust apportioned	Feb 2021	3	N/A	2
MSSA HAI	Feb 2021	5	N/A	2
Pseudomonas trust apportioned	Feb 2021	1	N/A	1

Assurance Commentary

A Period of Increased Incidence for C.difficile on Elsing ward concluded on 09/03/21 following supportive measures. These involved the IP&C team working closely with staff in the area to support, educate and audit, with the aim to prevent further transmission. Antibiotic ward rounds were undertaken and an antibiotic prescribing alert was communicated across the Trust to guide antibiotic prescribing. There have been no further cases on Elsing. There were 22 Covid outbreaks between November and March and only Langley remains on countdown to closure. Outbreak meetings were held to discuss cases. The IP&C team worked closely together with the staff in the clinical areas, the CCG and NHSE to address learning points to promote a reduction in transmission.

Improvement Actions

Work is ongoing to embed day 0, day 3 and day 6 Covid screening across the Trust. A screening Icon is available on ward view, dates are populated on patient handover and daily emails sent. It will also be added to Red to Green meetings.

Hospital Acquired MRSA bacteraemia

E. Coli trust apportioned

C. difficile Cases Total

HOHA C. difficile Cases

MSSA HAI

Klebsiella trust apportioned

CPE positive screens

Pseudomonas trust apportioned

Maternity: Mothers

NNUH Digital Health
business intelligence

Caesarean Deliveries

Feb 2021

Variation | Assurance

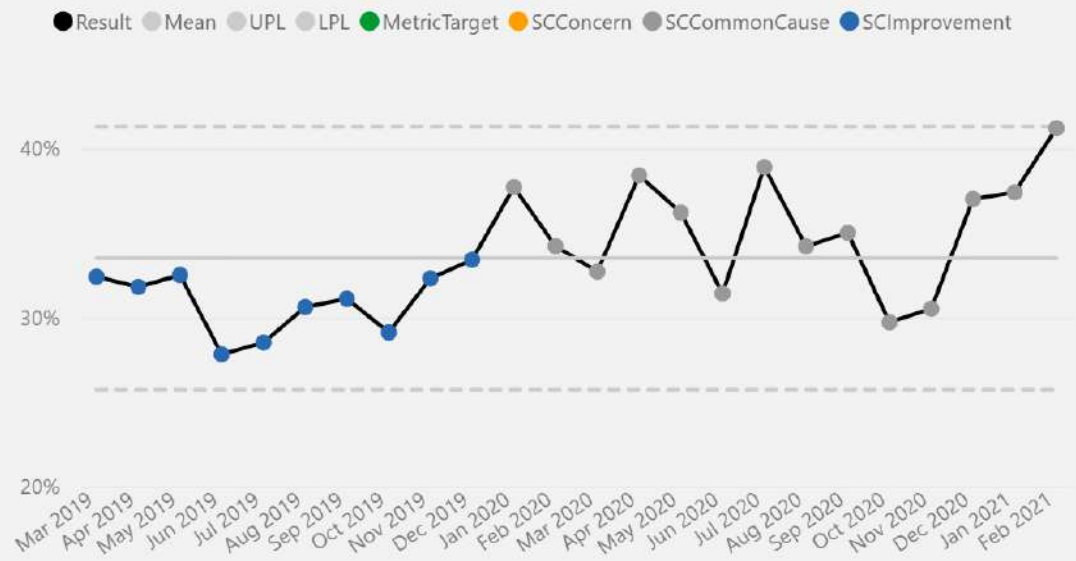
41.2% Result
N/A Target

41.3% UPL
33.5% Mean
25.7% LPL

Analytical Commentary

Variation is Common Cause

Caesarean Deliveries



Assurance Commentary

381 babies delivered to 376 mothers.1:1 care in labour was 100%. A review of the 4 unplanned homebirths (BBA's) in February identified that 3 women had called too late, due to rapid progression of labour. Therefore a midwife was unable to get to their home before the birth of the baby, but Paramedics were in attendance for all deliveries and all women received appropriate care. 1 BBA could potentially have been prevented. The woman lived locally to the Hospital, and this occurred mid-week, during the day when staff would have been available to attend. English was not this patients first language, and she was not aware to call for community midwives to attend her home. Caesarean deliveries accounted for 41.2% of all deliveries, this is an increase from 37.4% in January.

Improvement Actions

Learning has been shared with the teams for the appropriate advice to be given in the antenatal period, with extra consideration for non-English speakers.
Heads of Midwifery in the region have been approached to ask for the % of Lower Segment Caesarean Section (LSCS) deliveries in their units to observe trends and compare where the NNUH sit in comparison to other Trusts.

Supplementary Metrics

Metric Name	Date	Result	Variation	Assurance
1:1 Care in Labour	Feb 2021	99.6%	Common Cause	No Target
3rd & 4th Degree Tears	Feb 2021	3.6%	Common Cause	Unreliable
Births Before Arrival	Feb 2021	4	Common Cause	No Target
Post Partum Haemorrhage ≥1500mls	Feb 2021	4.3%	Common Cause	No Target

Mothers Delivered

376

Babies Delivered

381

Maternity: Babies

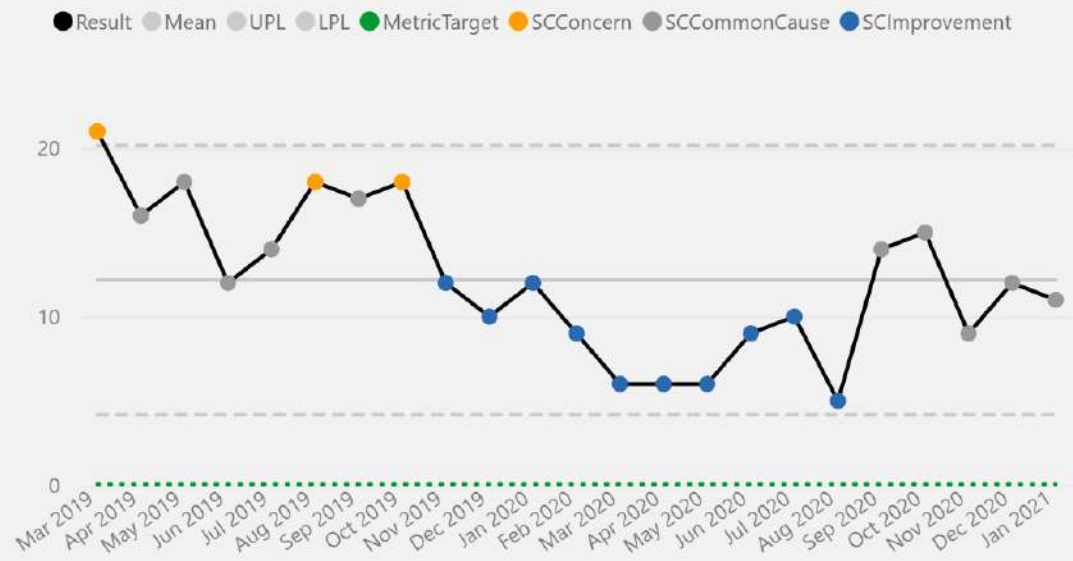
NNUH Digital Health
business intelligence

Unplanned NICU ≥37 week Admissions (E3)

Jan 2021

Variation	Assurance		
	F	11 Result	20 UPL
		0 Target	12 Mean
			4 LPL

Unplanned NICU ≥37 week Admissions (E3)



Analytical Commentary

Variation is Common Cause

Assurance Commentary

In February, due to a high volume of patients requiring inducion of labour, delays in care and high acuity, one patient was transferred to JPUH to deliver there.
There were 11 unexpected admissions to the Neonatal Unit in February 2021, 8 of the 11 cases had Respiratory Distress Syndrome (RDS). 10 of the 11 cases all have a datix completed. In 9 of the 11 cases, care was deemed to have been appropriate. 1 case is under review by HSIB as baby required cooling. The last case has identified some concerns with CTG monitoring, case has been discussed at MDT intrapartum care meeting. This baby was transferred to GOSH for ECMO secondary to pulmonary haemorrhages but was not required prior to transfer back to NNUH. Baby has been discharged home with follow up plan.

Improvement Actions

Concerns have been identified within the maternity department that datix's are not completed in a timely manner. A band 7 Maternity and Gynaecology Governance and Risk facilitator has commenced in post and is currently leading on datix improvements.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Adjusted Still Births	Feb 2021	0		Not Applicable		No Target
Apgar score <7 @5, ≥37 weeks	Feb 2021	11		Common Cause		No Target
Early Neonatal Death	Feb 2021	0		Not Applicable		No Target
Mothers Transferred Out of Unit	Feb 2021	1		Not Applicable		No Target

Saving Babies Lives

NNUH Digital Health
business intelligence

Topic	Metric Name	Date	Result		Variation		Assurance
Smoking Awareness	Smoking Status at Delivery	Feb 2021	8.8%		Common Cause		Unreliable
Fetal Growth Restriction	Less Than 3rd centile born > 37+6 weeks	Feb 2021	2%		Common Cause		Unreliable
Fetal Growth Restriction	SGA detected Antenatally	Feb 2021	63%		Common Cause		No Target
Reducing Preterm Birth	Singleton Births Preterm	Feb 2021	7%		Common Cause		Unreliable
Reducing Preterm Birth	Singleton live births < 34 wks (AN corticosteroids within 7 days PN)	Feb 2021	29%		Common Cause		Unreliable
Effective Fetal Monitoring	CTG Training and Human factors situational awareness compliance	Feb 2021	81%		Concern (Low)		Unreliable

Assurance Commentary

This is the first month IPR commentry has been provided against Saving Babies Lives metrics.
CTG compliance is improving month on month and has been mantained over 80% for 2 months now. National smoking average is 9.9% for this population with a national target › 6% by March 2022.

Improvement Actions

Monoxide monitoring has been recommenced and very brief advice training is being delivered to all maternity staff.
Local Maternity & Neonatal System (LMNS) are putting together regional Saving Babies Lives training facilitated through blended learning which should contribute to an improvement in training compliance.

Adult Safeguarding

NNUH Digital Health
business intelligence

Safeguarding Adults

Feb 2021

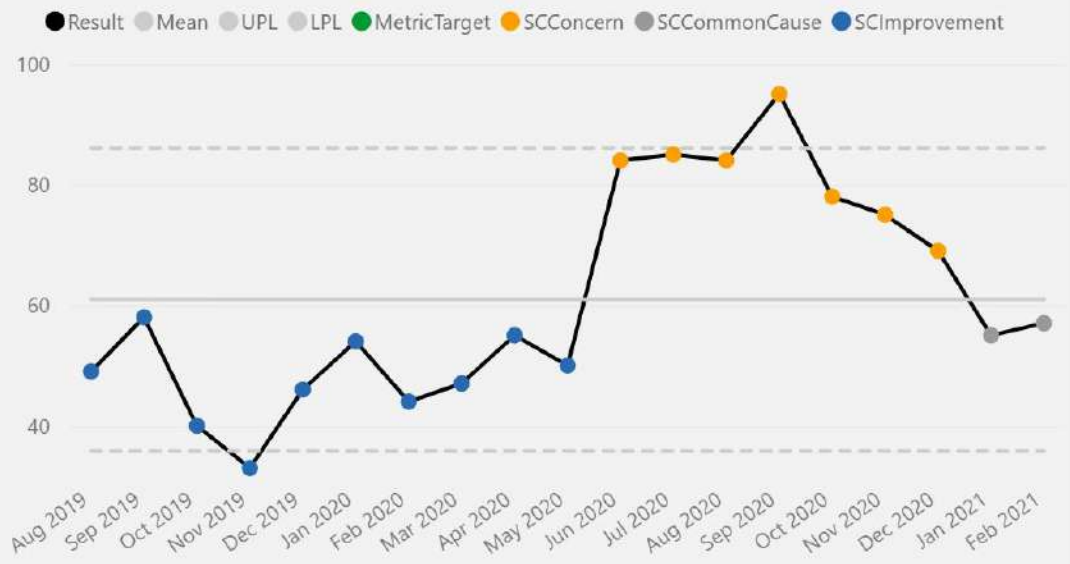
Variation	Assurance

57 Result
N/A Target
86 UPL
61 Mean
36 LPL

Analytical Commentary

Variation is Common Cause

Safeguarding Adults



Assurance Commentary

It is evidence of good practice that despite the current pandemic and pressure on frontline staff, Safeguarding Adult concerns continue to be recognised and reported.

Improvement Actions

Children & Midwifery Safeguarding

NNUH Digital Health
business intelligence

Safeguarding Children and Midwife...

Feb 2021

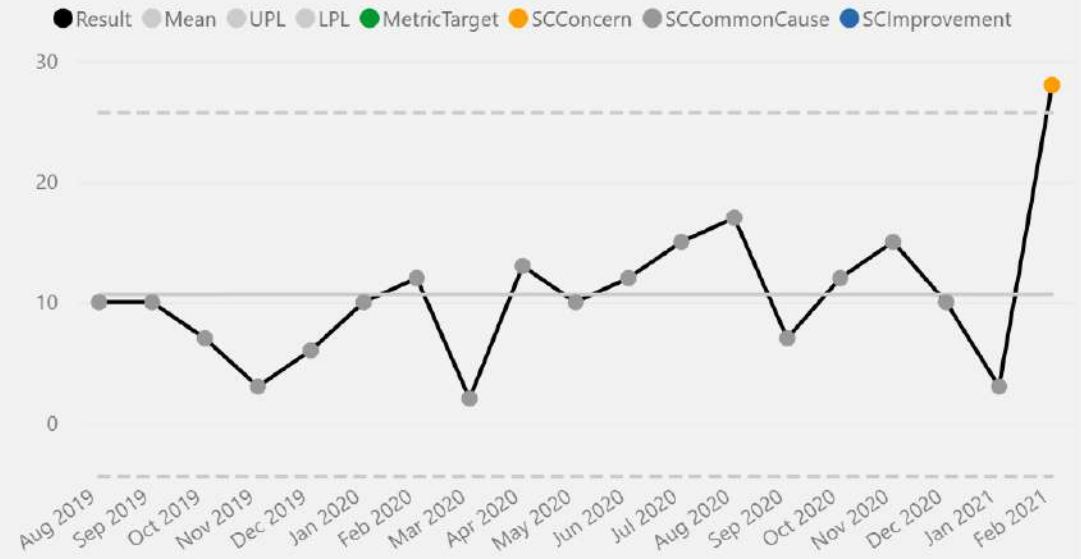
Variation	Assurance
H	

28 Result	26 UPL
N/A Target	11 Mean
	-4 LPL

Analytical Commentary

Data point fell outside of process limits, and therefore the variation is Special Cause Variation - Concern (High)

Safeguarding Children and Midwifery



Assurance Commentary

Following on from targeted training/communication to W&C division the increase in recorded CADS referral this month is felt to be a more accurate representation of how many safeguarding referrals NNUH are making to the Local Authority. It is evidence of good practice that the increased numbers of safeguarding concerns are recognised and reported by staff.

Improvement Actions

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Safeguarding Children	Feb 2021	14		Common Cause		No Target
Safeguarding Midwifery	Feb 2021	14		Not Applicable		No Target

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

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NHS Foundation Trust

CNST Maternity Incentive Scheme
Summary Position – March 2021

Safety Action	Safety Action description	Action Status	Key commentary for CNST programme
1	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	BLUE	All CNST safety actions have been taken to Evidence group at least once since 03 Dec 2020 and allocated the BRAG rating accordingly.
2	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	BLUE	All recommendations are due to return for an update in Mar /Apr 2021.
3	Can you demonstrate that you have transitional care services to support the recommendations made in the Avoiding Term Admissions into Neonatal units Programme?	BLACK	In December NHS Resolution confirmed the submission deadline for board declaration forms has been extended with a from Thursday 20 May 2021 to noon on Thursday 15 July 2021, and some of the sub-requirements of the safety actions will be revised.
4	Can you demonstrate an effective system of clinical* workforce planning to the required standard?	BLUE	Key updates on safety actions that are yet to be evidenced (i.e. Green / Amber / Red):
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	GREEN	- Action 5 – Bi annual staffing review completed and submitted to CNO 30 Dec 2020
6	Can you demonstrate compliance with all five elements of the Saving Babies' Lives care bundle Version 2?	GREEN	- Action 6 – Fetal Monitoring midwife post commenced in post late Feb 2021
7	Can you demonstrate that you have a mechanism for gathering service user feedback, and that you work with service users through your Maternity Voices Partnership to coproduce local maternity services?	BLACK	- Action 8 - On track for Compiance based on an offline spreadhset which does not match ESR data. Work ongoing to ensure ESR matches offline records before we can evidence as complete
8	Can you evidence that at least 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	GREEN	Action 9 - All on track for completion.
9	Can you demonstrate that the Trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?	GREEN	
10	Have you reported 100% of qualifying cases to HSIB and (for 2019/20 births only) reported to NHS Resolution's Early Notification (EN) scheme?	BLUE	

BLACK	Archived
BLUE	Complete and evidenced
GREEN	On track to Deliver
AMBER	At risk to delivery
RED	Not on track to deliver

Our Values People focused Respect Integrity Dedication Excellence

REPORT TO THE TRUST BOARD	
Date	**7 April 2021**
Title	**Chair's Key Actions from Finance, Investments and Performance Committee meeting on 22 March and 31 March 2021**
Lead	**Tom Spink – Non-Executive Director (Committee Chair)**
Purpose	**For Information and assurance**

1 Background/Context

The Finance, Investments and Performance Committee met on 31 March 2021. It also held an Extraordinary Meeting on 22 March, to provide additional time for consideration of our elective care strategy. Both meetings were quorate and were attended by Ines Grote (Public Governor) as observer. Papers for the meetings were circulated to Board members for information in the usual way and all Board members were invited to attend the Extraordinary Meeting held on 22 March, to participate in the strategy discussion.

2 Key Issues

The following issues were identified to highlight and escalate to the Board		
Meeting of 22 March:		
1	Update on Electronic Patient Record	The Committee was scheduled to review the refreshed Strategic Outline Case for the Electronic Patient Record. Issues remain unresolved however with respect the affordability of the scheme and the Committee was updated on ongoing discussions with the regional team which need to be concluded before the SOC can be finalised. Risks relating to prolonged delay in replacing our Patient Administration System were highlighted and will be monitored and reported through the Risk Management system.
2	Developing the draft Theatres/Elective Strategy	The Committee discussed the Trust's historical challenges with regard to delivering its elective programme, alongside the need to meet emergency demand, which have been significantly exacerbated by the pandemic. The impact on our waiting lists is evident and there is an increasing level of risk to patients who are waiting for treatment. Five interventions were proposed to improve the position, including optimisation in use of existing capacity. The imperative to act is clear and the Committee **agreed** that each of the interventions should be developed with a report back to the Committee at its next meeting. In the meantime, the Committee requested that a surgical productivity dashboard be developed to incorporate targets, utilisation, cancellations and patient harm.

Meeting of 31 March:		
3	Performance & Productivity - IPR	The Committee was updated on the improving position with regard to the Covid pandemic. It was noted that improvements to the narrative in the IPR have been initiated as requested by the Committee. The next step is for this to be more forward looking, as opposed to focus on past performance and the Committee requested additional commentary on our plans to improve.
4	Month 11 YTD Financial Position	The Committee received an update on the M11 Financial position and Forecast Outturn. It was again pleasing to note the improved financial position, albeit due to reduced activity. The Committee discussed factors influencing the Outturn and **confirmed delegated authority** to the Executive to revise the Outturn position.
5	Use of Resources update	The Committee reviewed progress made in implementing the Use of Resources Action Plan. The positive position was noted, not least in implementing the Financial Governance Review actions and the assurance received by the Audit Committee in this regard was noted. Although 45 actions have been completed and 14 are on track, eight have fallen overdue against the Trust's targets. Of these, most relate to people management and the Committee was informed that the Executive are looking to see what additional support may be helpful to complete these actions.
6	CIP update & workforce opportunities	As reported in the Finance Report, there is more to be done in developing Cost Improvement Plans and at the next meeting the Committee will give particular focus to workforce opportunities and what additional support may be necessary to make progress with the outstanding audit and UoR recommendations.
7	Operational Plan Cycle 3 and Finance Strategy update	The Committee received an update with respect to processes for development of the Trust's Operational Plan and Financial Strategy. The Committee **agreed to recommend** the next steps in each process as proposed elsewhere in the Board Agenda.
8	Network and Information Systems (NIS) Directive	The Committee was updated by the CIO with respect to our plans strengthen the Trust's Digital infrastructure and complete implementation of this Directive. The Trust has requested central funds to facilitate acceleration of these plans. In the meantime the assessment of the Management Board is that, taking all the circumstances into account and in the face of the Trust's underlying financial deficit and Licence Undertakings, the Trust does not have the funds available to expedite the current plan. Noting that efforts will continue to source funds to expedite the current timetable, the Committee supported the decision of the Management Board.
9	Corporate Risk Register – FI&P Extract	The Committee reviewed the relevant elements of the Corporate Risk Register, noted its continued evolution and encouraged regular review to ensure that target conclusion dates are kept up to date.

3 Conclusions/Outcome/Next steps

The next Committee meeting is scheduled for 28 April 2021.

Recommendation: The Board is recommended to:

- **note** the work of its Finance, Investments and Performance Committee.

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NHS
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NHS Foundation Trust

Integrated Performance Report:

Performance & Activity Domains

February 2021

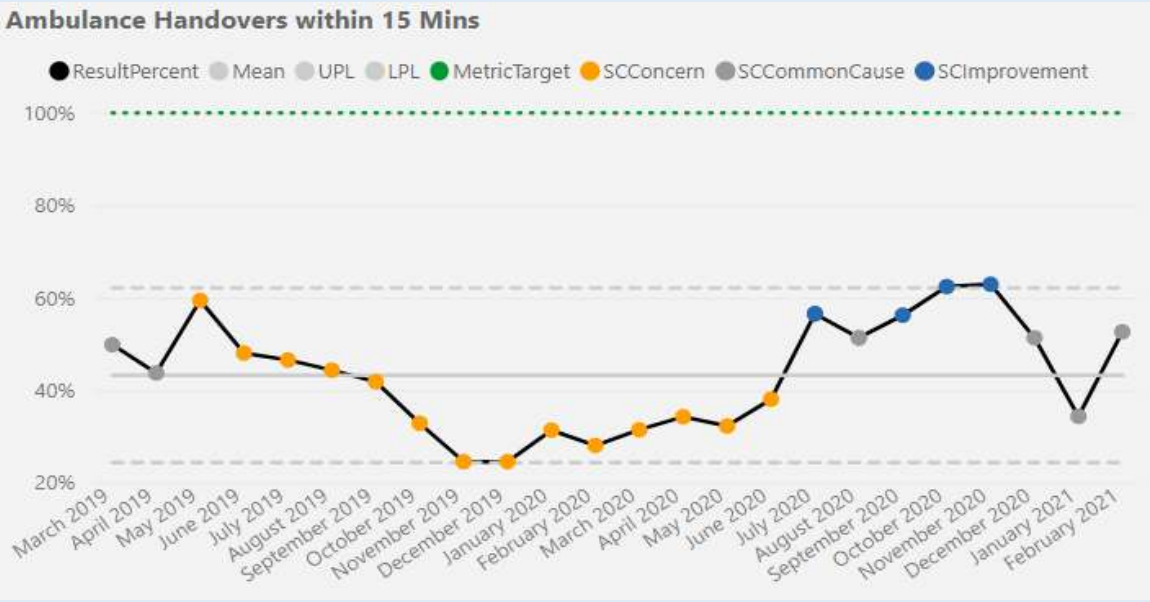
Our Values People focused Respect Integrity Dedication Excellence

Winter Plan Metrics

Non-Elective	Standard for Phase III /Winter 2020	February 2021 Performance
Ambulance Handovers < 15 mins	70%	52.6%
Ambulance handover delays >60 mins	1%	0.94%
Average minutes arrival to assessment in ED	15 mins	25.3 mins
Mean Time in ED non-admitted patients	200 mins	200 mins
Weekly Average Time DTA to admission	75% <15 Mins	1.1%
Bed Occupancy	92%	87%
Elective		
Cancer 2-week wait	80%	83.1%
Cancer 62 Day	70%	62%
Cancer 104 Day	<20	100
Waiting List Size	<81,000 on 31 March	60,944 (19 March 2021)
Remote Outpatients	25% New 60% Follow-Up	53% Total – NEW (35.6) FU (59.3%)

Performance – Ambulance Handovers <15 mins

NNUH Digital Health
business intelligence



Improvement Actions

1. *When* COVID presentations reduce further, reinstate single handover location

2. Reinstate Safer Better Faster (SBF) Programme with dedicated workstream on improving flow throughout ED and wider Trust. This will help to ensure ambulance handover capacity is available. EUC team is involved and helping to lead improvement as part of these workstreams.

Analytical Commentary

Variation is Common Cause

Assurance Commentary

Explanations for improvement:

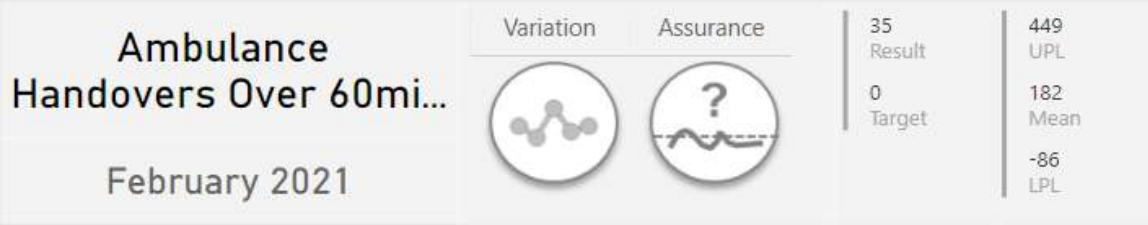
- Re-assessed ED areas zoning split with reduced presentations of patients with COVID-19 symptoms
- Re-established ambulance handover space and flipped to provide additional non-covid (yellow) handover space
- RATS area of ED has switched back to non-yellow.

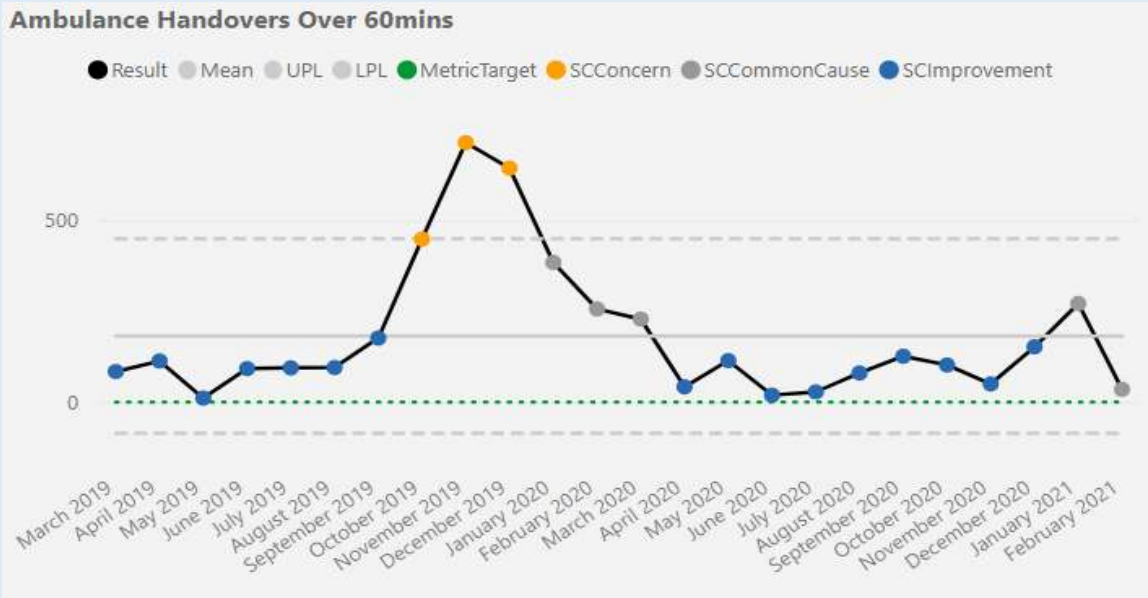
The improvement in February's ambulance handover performance directly correlates with the performance for the 'Average Time from DTA to Admission' data, demonstrating the relationship and impact that good and effective flow has upon the front door.

In addition with the above interventions to improve flow and align capacity to the correct covid-19 pathways, the additional clinical cleans still required between patients within ED cubicles remains impactful upon available space and time for patients to be offloaded.

Performance – Ambulance Handovers >60 mins

NNUH Digital Health
business intelligence





Improvement Actions

1. Continued adherence to early escalation to Executive On-Call if >60 min breach may occur. Plans made with Site Manager, Gold on Call and Exec.

Analytical Commentary

Variation is Common Cause

Assurance Commentary

The improvement and variation directly correlates with the performance for the 'Average Time from DTA to Admission' data, demonstrating the relationship and positive impact that effective flow out of ED has on front door performance.

24 out of the 35 >60 min handover breaches occurred on 1st Feb 2021. This was due to Edgefield Ward moving from Red to Yellow as part of the de-escalation from the COVID peak during mid January 2021. This was a known risk when attempting to flex inpatient bed spaces between red/yellow combined with decanting of a whole ward and subsequent multiple clinical cleans; however, this was a necessary step to enable improved flow.

The above change and plan subsequently improved performance and flow as it provided ample yellow capacity and supported the consolidation of the red bed base. The changes introduced through the Prism and SOS work have continued to be embedded during the winter period and are sustaining.

Performance – ED Assessment Within 15 Mins

NNUH Digital Health
business intelligence

ED Assessed Within 15mins

February 2021

Variation	Assurance
H	

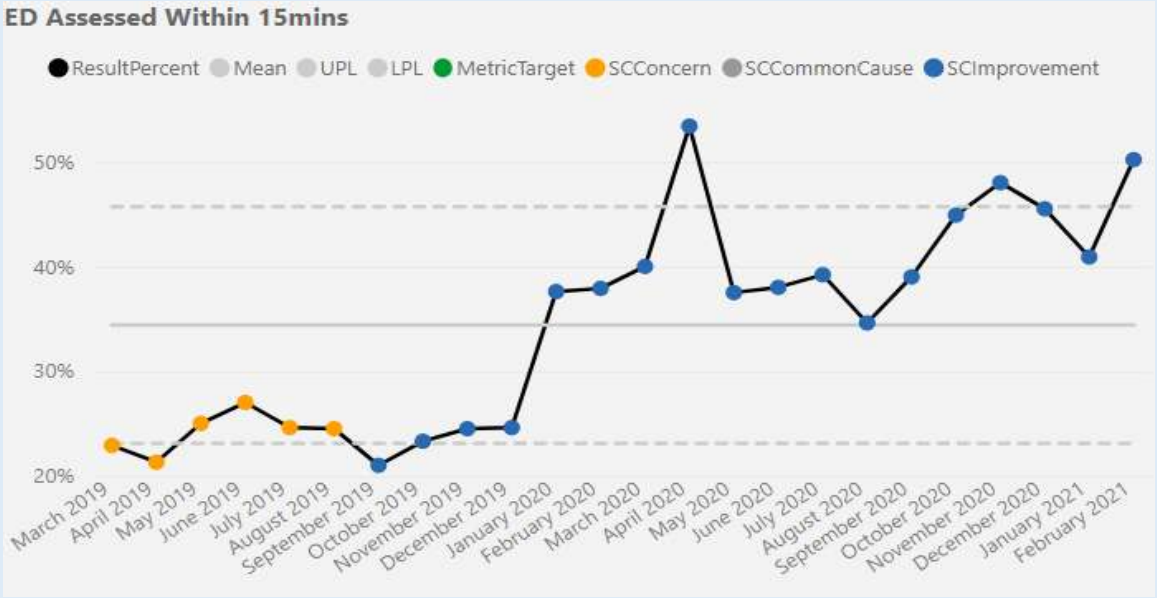
50.20% Result

N/A Target

45.70% UPL

34.40% Mean

23.10% LPL



Improvement Actions

1. Estates support in reconfiguring and developing additional triage capacity within ED – work is currently ongoing with facilities teams.

2. Removing blood and ECG from Triage process and into overall assessment and diagnostics pathways.

3. Developing prioritisation criteria and space for those in need of urgent triage

Analytical Commentary

Data point fell outside of process limits. Data is consistently above mean, and therefore the variation is Special Cause Variation – Improvement (High)

Assurance Commentary

As part of the Emergency Access Standards Consultation, it has been confirmed that this will be a key metric measured alongside the 4 hour quality standard.

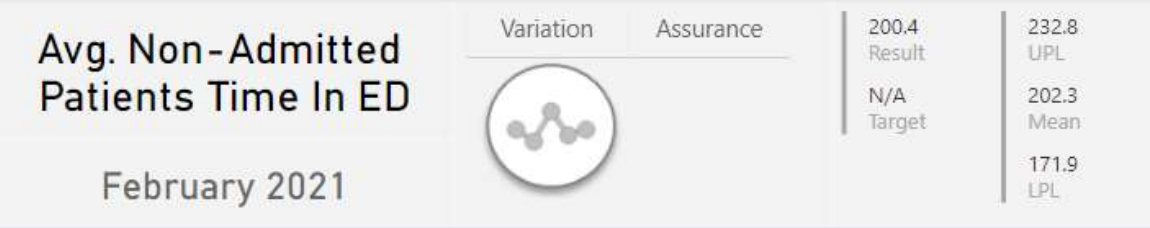
As a result, daily reviews of the time to initial assessment are in place via both the SBF programme and IMT Command & Control meetings with supportive actions initiated as required.

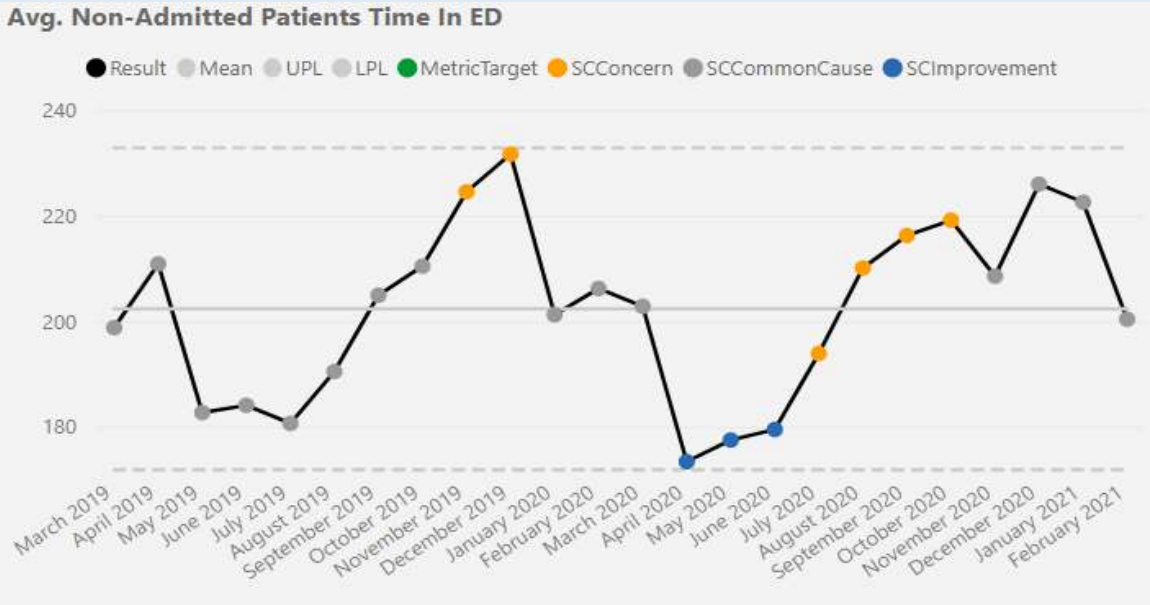
Initial assessment wait continues to be monitored and actioned on a live basis and at each safety huddle in ED. Work is underway with the BI Team and EUC/Operations Centre to refresh the Emergency Department Live Dashboard to reflect the new quality standards.

When the assessment area is broken down it demonstrates that the average time is almost on target at 16 mins in the waiting room for the main triage. The overall position is affected by Resus and ambulance assessments where the patients are often more complex and space is more restricted. A targeted approach will be used to address this and it will correlate with the ambulance handover improvement trajectory.

Performance – Average non admitted patient time in ED

NNUH Digital Health
business intelligence





Analytical Commentary

Variation is Common Cause

Assurance Commentary

The improved flow of admitted patients enabled assessment and treatment capacity for non-admitted patients, which combined with increased uptake of locum shifts improved total capacity and reduced waits.

This ensured patients were seen, assessed and treated in a timely manner. Reduction in demand during Feb 2021 also allowed for more timely patient care.

Dedicated ED transport throughout winter has helped outflow from the department with a lack of discharge suite. EUC are currently seeking procurement support to sustain this service with the most appropriate supplier.

Improvement Actions

1. Dedicated transport for ED provisioned in Jan & Feb 2021 between 12pm – 12pm daily to reduce patients waiting in ED for transport.

2. Ongoing recruitment to clinical staffing vacancies at all levels. Additional Medical Staff recruited, all cons due to be in post by September

3. Seeking to implement metrics as part of Live ED Reports and process where it is discussed at patient flow meetings and ED safety huddles. Currently provided at IMT daily

Performance – Average Time DTA to Admission

NNUH Digital Health
business intelligence

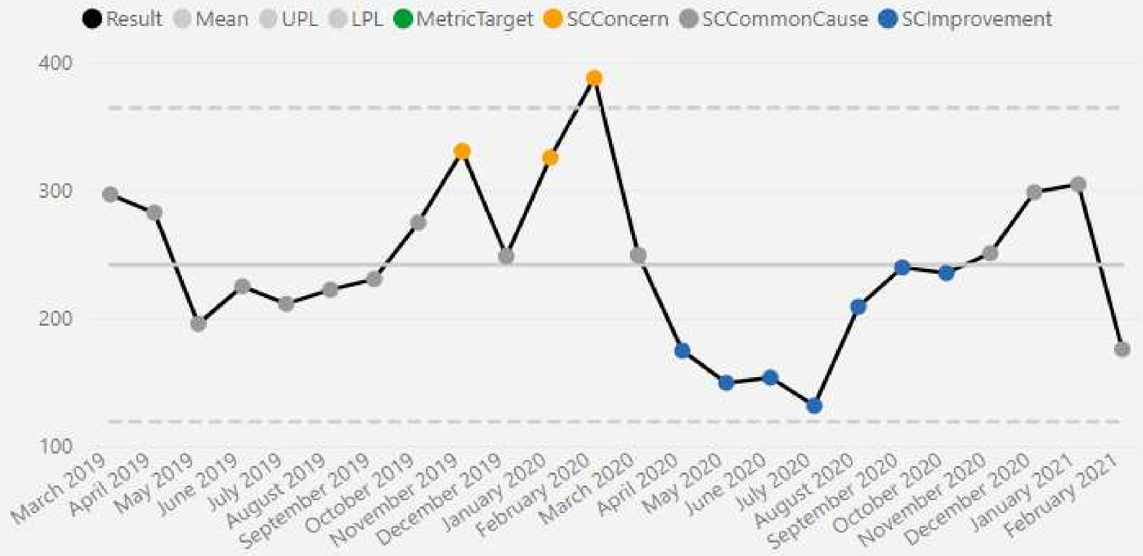
Average Time From DTA to Admission

February 2021

Variation	Assurance
	

175.7 Result	364.1 UPL
N/A Target	241.7 Mean
	119.3 LPL

Average Time From DTA to Admission



Improvement Actions

1. COVID Virtual ward introduced to help improve flow and discharge as well as better patient outcomes and experience. This will be monitored through IMT and transformational meeting. Engagement and buy in

2. Establish enhanced Same Day Emergency Care (SDEC) Unit on Loddon Ward to assist with flow from ED by 1st April 2021

Analytical Commentary

Variation is Common Cause

Assurance Commentary

In February 2021 there was an improvement in the average time from DTA to admission to 175.7 minutes. This was due to better flow and bed availability within base wards and assessment areas.

Reduced prevalence of COVID-19 in conjunction with an increasing number of wards flipping back to expand the yellow bed base provided additional capacity to admit into.

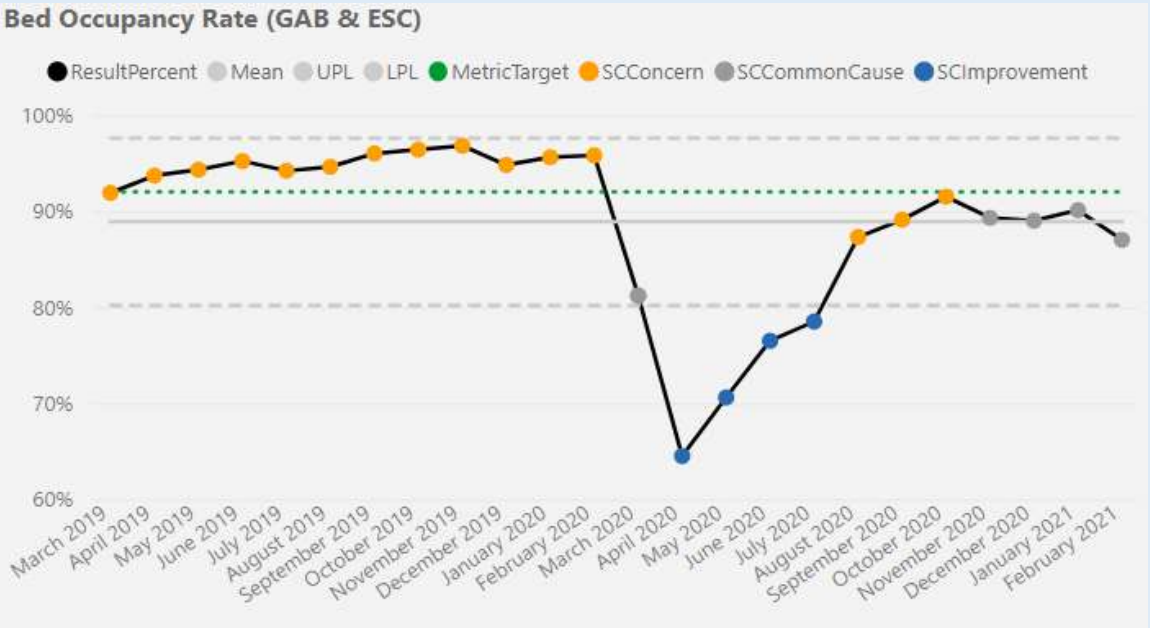
The time from DTA to admission is a key metric in the revised Emergency Access standards, which are currently out for national consultation. The standard will be the % of patients admitted within 1 hour of being 'Safe to Admit'. The EUC teams, Medicine, Surgery and W&C divisions will work together to improve performance as covid presentations decline.

Performance – Bed Occupancy

NNUH Digital Health
business intelligence

Bed Occupancy Rate (GAB & ESC)

February 2021



Analytical Commentary

Variation is Common Cause

Assurance Commentary

Bed occupancy rate in February in both General & Acute and Escalation beds decreased slightly to 87%.

This was due to a combination of factors including and not limited to:

- A number of 'red wards' decanting and remaining empty during clinical cleans in order to convert and re-open as yellow pathway capacity.
- Reducing COVID-19 prevalence within the Trust. Data indicates that COVID positive inpatients had an average LoS of 11.5 days in Jan 2021 (excluding 0 LoS data and based upon only emergency admissions) against a non-covid average of 6.4 days Total.

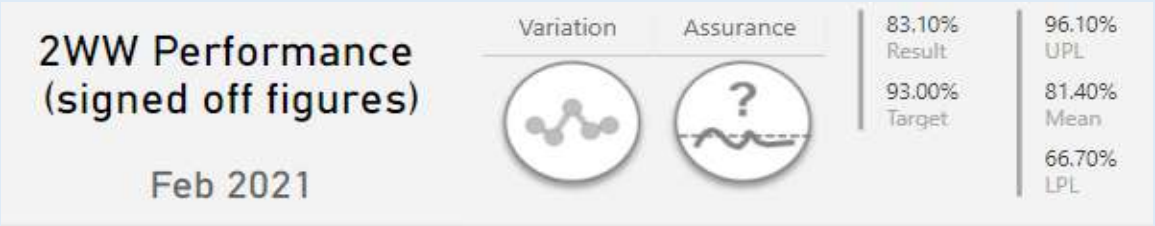
Improvement Actions

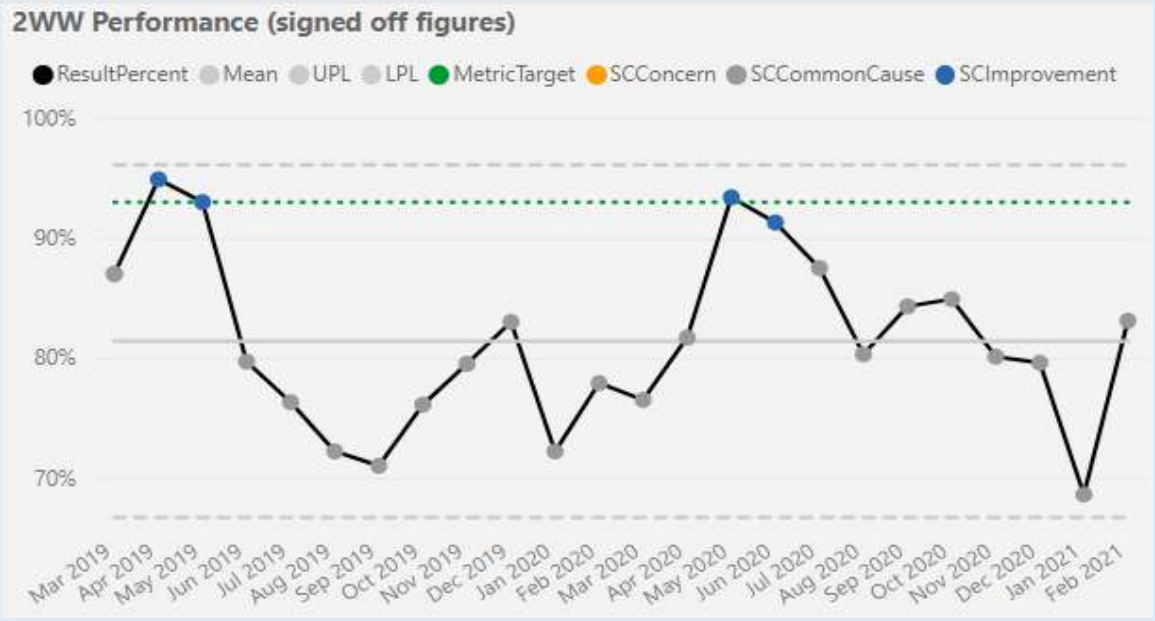
1. Review and plan drafted for re-basing of wards with all divisions in March 2021 to ensure appropriate co-location of services.

2. Daily monitoring of non-elective metrics including Bed Occupancy both GAB & HDU as part of daily IMT meetings

Performance – Cancer 2WW Performance

NNUH Digital Health
business intelligence





Analytical Commentary

Variation is Common Cause

Assurance Commentary

February Performance is Provisional due to national Cancer Reporting being 1 month in arrears.

Large upturn in performance in month as Breast continue to work through their backlog of referrals from pre Christmas. The number of patients waiting over 14 days for their Breast OPA has reduced from 575 on 31/12/20 to 70 as at 28/02/21

Improvement Actions

1. Additional Breast clinics continued to be provided on weekends throughout February to address the outstanding backlog and to book within 14 days.

2. Breast referral pathway reviewed at STP level to ensure appropriate placement of patients on referral.

Performance – Cancer 2WW Waiting List Profile

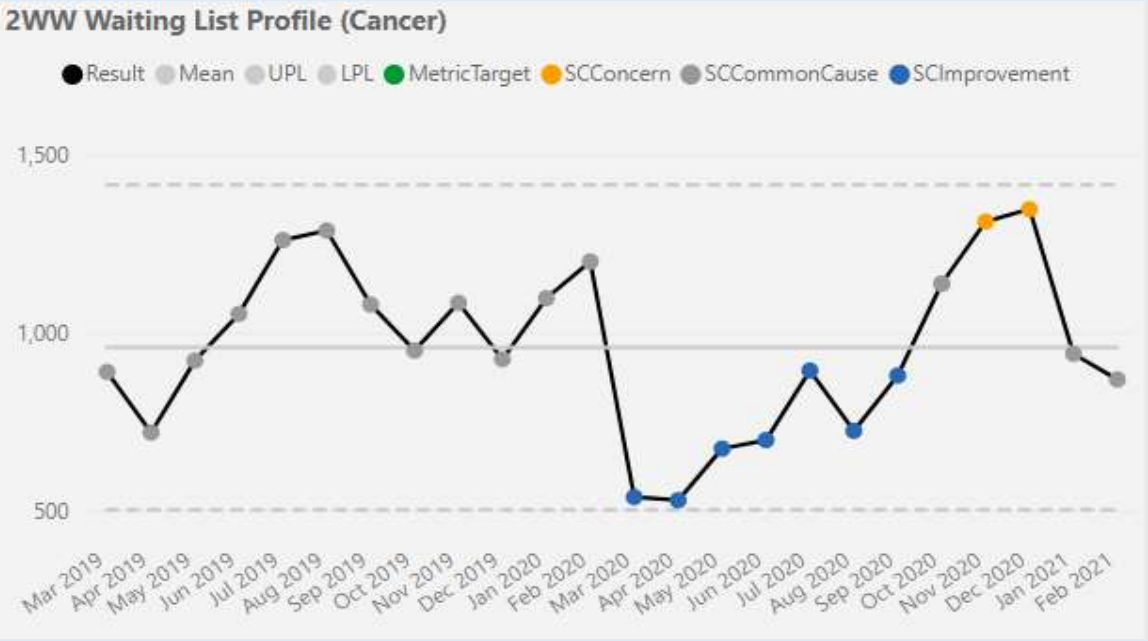
NNUH Digital Health
business intelligence

2WW Waiting List Profile (Cancer)

Feb 2021

Variation | Assurance

868 Result
N/A Target
1,414 UPL
958 Mean
502 LPL



Analytical Commentary

Variation is Common Cause

Assurance Commentary

Reduction in the two week wait waiting list is a direct correlation to the additional clinics being provided in Breast

Improvement Actions

1. Additional Breast clinics continued to be provided on weekends throughout February to address the outstanding backlog and to book within 14 days.

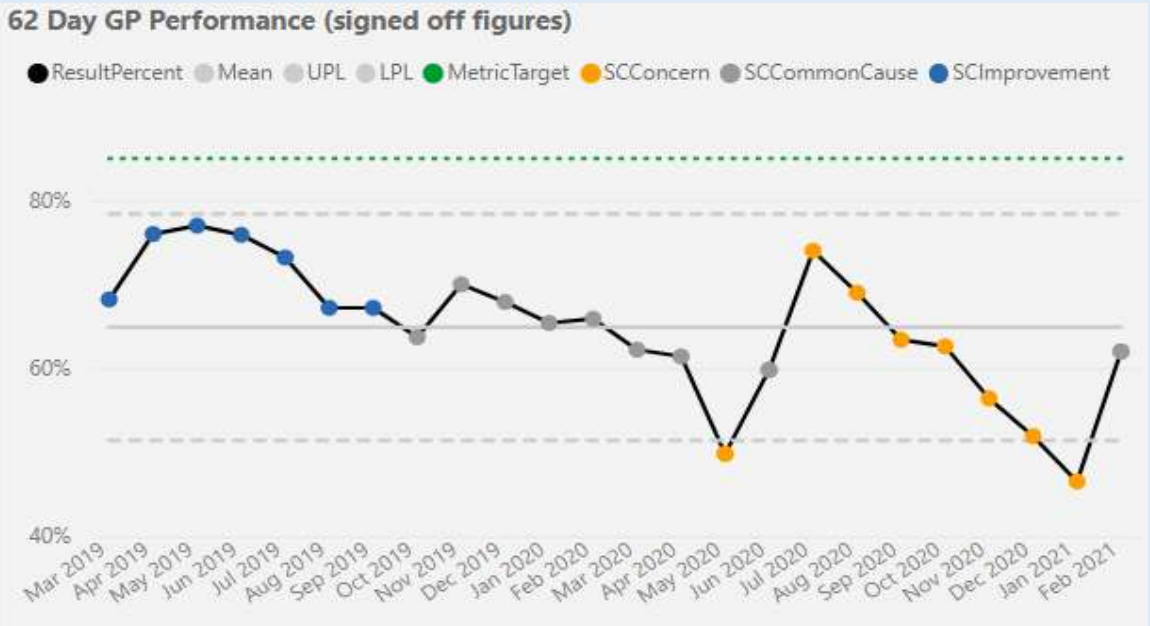
2. Breast referral pathway reviewed at STP level to ensure appropriate placement of patients on referral.

Performance – Cancer 62 Day Performance

NNUH Digital Health
business intelligence

62 Day GP Performance (signed off figures)

Feb 2021



Analytical Commentary

Variation is Common Cause

Assurance Commentary

Performance has started to improve in February as the Trust continues to reduce the backlog of patients over 62 days. Reducing the number waiting over 62 days from 329 on 26/01/21 to 219 as of 28/02/21. This is due to the continuation of diagnostic services through the current Covid wave, and the continued provision of Surgery at SPIRE Norwich

Use of Spire Norwich ends on 12th March 2021 on termination of the National Surge clause and contract.

Improvement Actions

1. Staged opening of further Surgical Theatres through March to provide additional P2 capacity.
2. Additional Diagnostic sessions through March to reduce any delays for diagnosis.
3. Mutual Aid process utilised for patients delayed for Surgery in Upper GI (3 Patients) and Head and Neck Cancer (1 Patient)

Performance – Cancer 62 Day Waiting List Profile

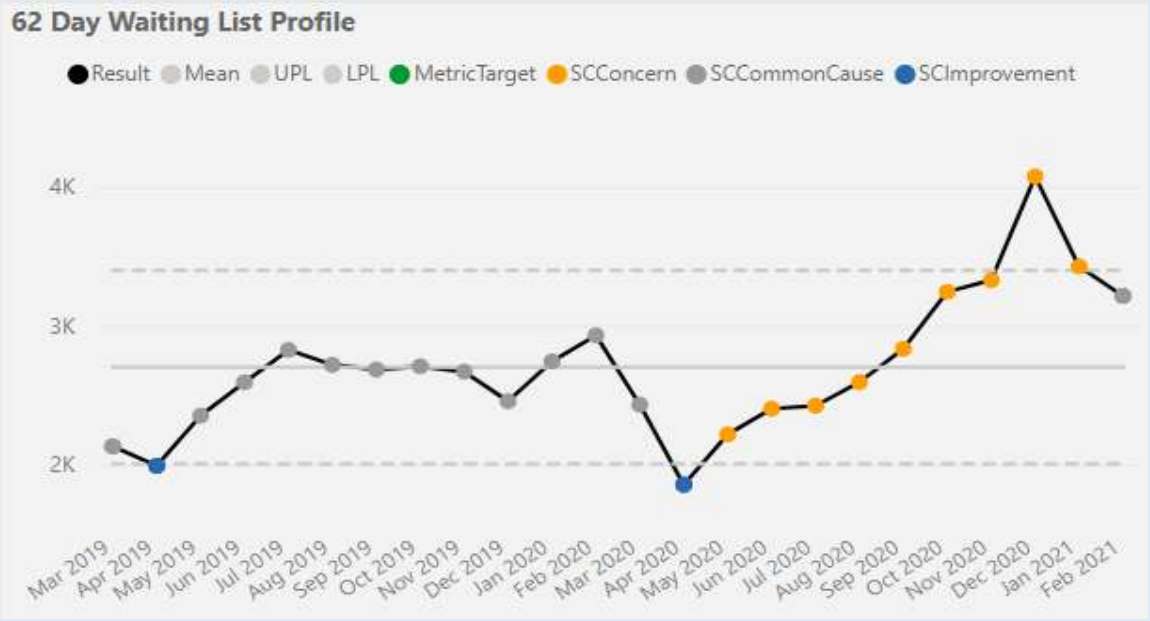
NNUH Digital Health
business intelligence

62 Day Waiting List Profile

Feb 2021

Variation | Assurance

3,214 Result	3,397 UPL
N/A Target	2,702 Mean
	2,006 LPL



Analytical Commentary

Variation is Common Cause

Assurance Commentary

Waiting list profile monitored weekly via PTL meetings with speciality leads and divisional check and challenge. Anticipated continued reduction in numbers as theatre and diagnostic activity increases.

Improvement Actions

1. Additional Template Biopsy, Cystoscopy, CTC and Endoscopy services continue to be provided to reduce time to diagnosis in Urology, Lower and Upper GI. Additional sessions provided until EO March 21.

2. Major Cancer work to be increased as we de-escalate our covid state providing more staffing for theatre and HDU capacity.

3. Week of 5 all day lists for Upper GI in March to clear majority of their Surgical backlog.

Performance – Cancer 62 Day Waits over 104 Days

NNUH Digital Health
business intelligence

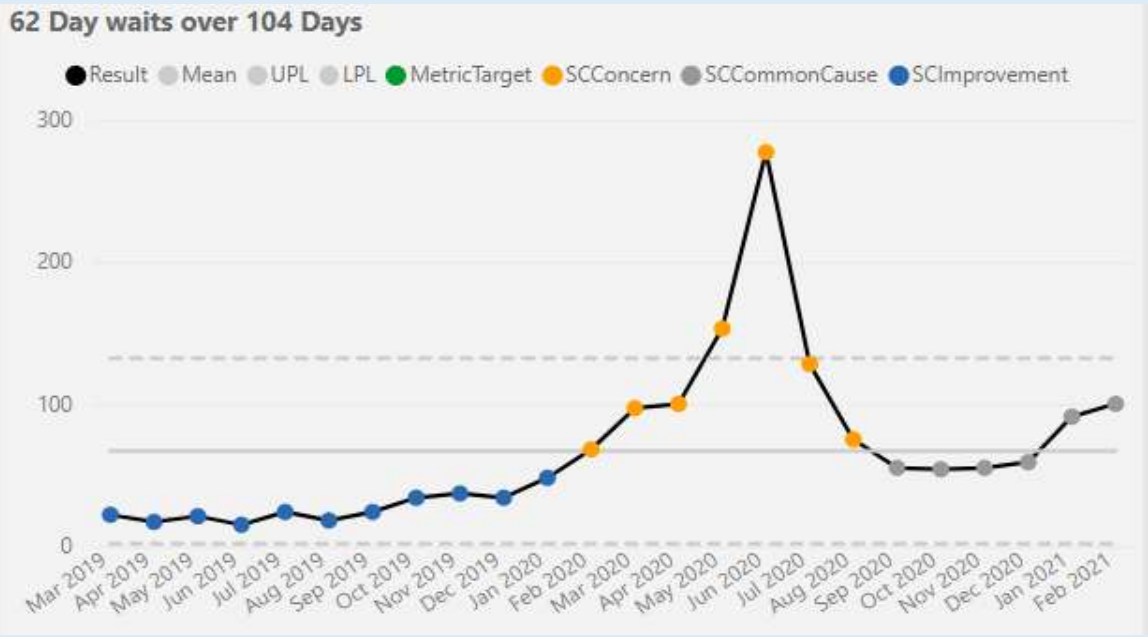
62 Day waits over 104 Days

Feb 2021

Variation | Assurance

100.0 Result
N/A Target

132.1 UPL
66.9 Mean
1.7 LPL



Analytical Commentary

Variation is Common Cause

Assurance Commentary

Slight increase in 104 day waits at the end of February due to delays to Surgery, Patient choice and complex patient pathways. Only Urology (40) and Skin (13) have over 10 patients waiting more than 104 days for treatment. Continued monitoring of improvement actions with divisions reporting into the IMT daily meetings .

Improvement Actions

1. Staged opening of further Surgical Theatres through March to provide additional P2 capacity
2. Additional Diagnostic sessions through March to reduce any delays for diagnosis.
3. Mutual Aid process utilised for patients delayed for Surgery in Upper GI (3 Patients) and Head and Neck Cancer (1 Patient)

Performance – RTT Waiting List

NNUH Digital Health
business intelligence

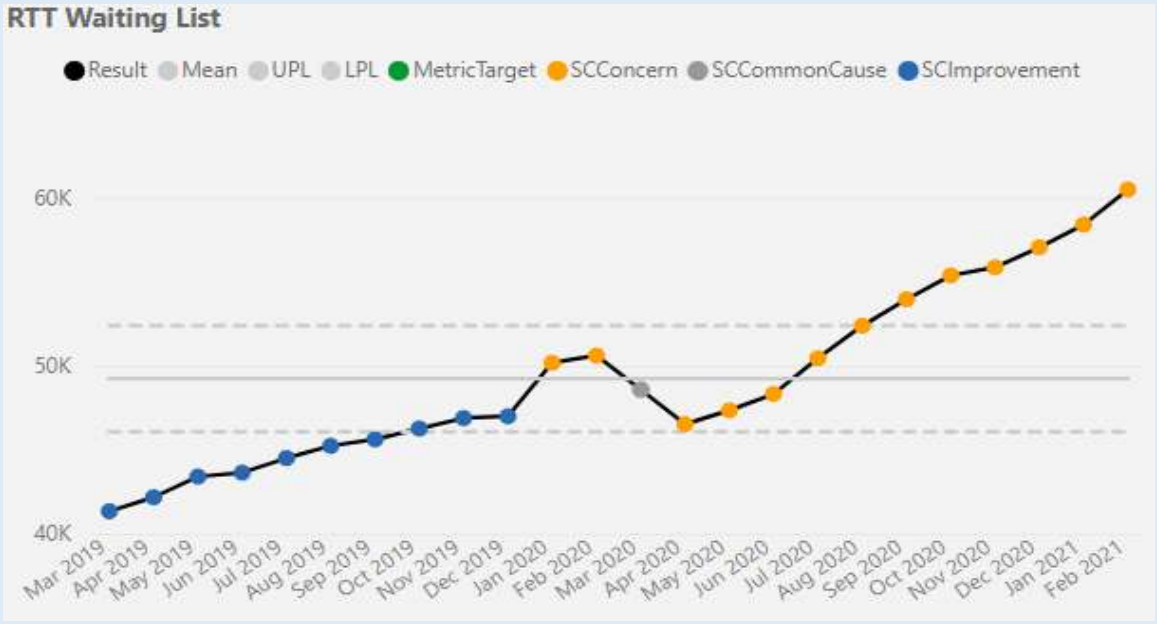
RTT Waiting List

Feb 2021

Variation | Assurance

60,499 Result
N/A Target

52,392 UPL
49,231 Mean
46,070 LPL



Improvement Actions

1. Divisions and Specialities are working on Activity Plans and Trajectories using P code data to clinically prioritise patients
2. Speciality level solutions are being developed for those with the biggest challenge , and include use of funded independent sector and insourcing where agreed.
3. Specialities involved in Acute Services Integration are using capacity at JPUH where it is appropriate to do so.
4. Discussions on load levelling of treatment has commenced across the SPT.

Analytical Commentary

Data point fell outside of process limits. Data is consistently above mean. Data point is part of an upwards trend, and therefore the variation is Special Cause Variation – Concern (High)

Assurance Commentary

Total numbers of patients waiting continues to grow due to the cessation of routine activity during the recent wave. Whilst the referrals during Jan and Feb were 27% lower than previous levels the reduction in activity was much greater therefore resulting in increased waiting list numbers.

Undoubtable there will be further growth during March. The impact of the 2nd covid wave is now significantly reduced however a combination of significant outstanding annual leave being undertaken and the required focus on priority patients will mean reductions in the overall waiting list are unlikely in Q1 of 2021/22.

Weekly PTL meetings provide assurance to the Head of Access via divisions that the waiting lists are being managed and P codes applied .

Performance – RTT 52 Weeks Wait

NNUH Digital Health
business intelligence

RTT 52 Weeks Wait

February 2021

Variation | Assurance

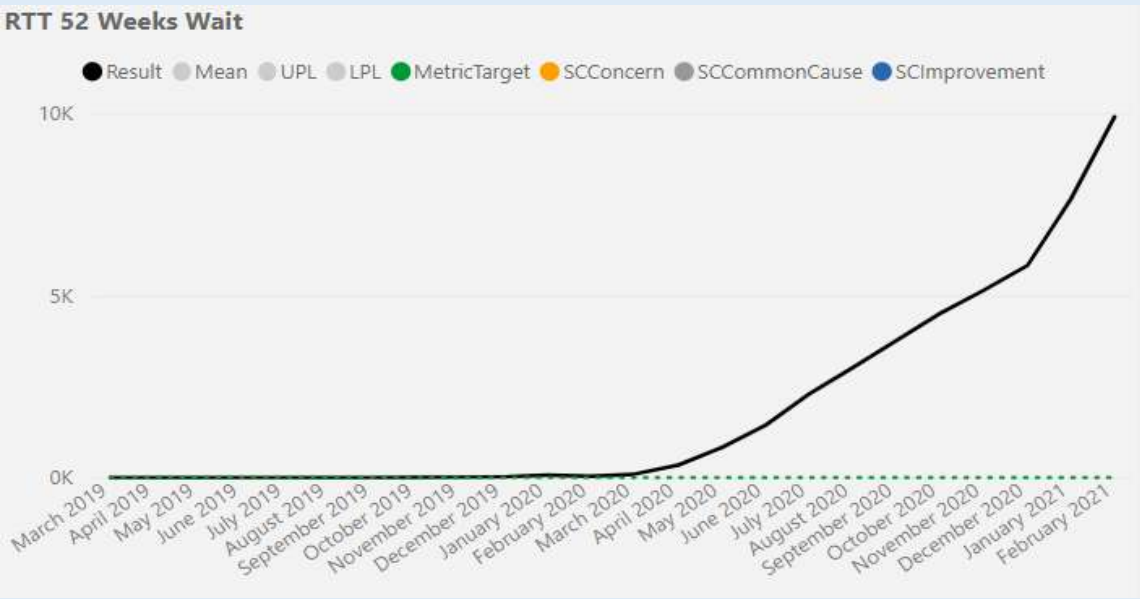
9,893 Result

0 Target

UPL

Mean

LPL



Analytical Commentary

This metric does not meet the requirements to generate an SPC Chart

Assurance Commentary

The number of patients waiting over 52 weeks has increased in February to 9,893.

The majority of these patients are P4, routine waiting for Surgery. With reduced surgical capacity and focus upon Cancer, Urgent (P1 & P2 Surgery) these patients with a lower clinical priority have waited longer and will continue to wait.

Continued internal oversite and assurance of waiting list management is via the weekly PTL meetings and check and challenge meetings

At a system level the Elective recovery cell has provided ongoing oversight to the elective position and are formulating a system-wide recovery plan for Norfolk & Waveney.

Improvement Actions

1. All patients on the admitted waiting list have been clinically validated in line with the NHSE requirement and allocated P codes .

2. Speciality level solutions continue to be developed for those with the biggest challenge which may include funded independent sector capacity or an insourcing provider .

3. Divisions and Specialities are working on Activity Plans and Trajectories across all elective and diagnostic waiting lists. National Planning guidance is expected on 26th March and will provide details of the National expectations for 21/22.

Performance & Activity – Remote Outpatients

NNUH Digital Health
business intelligence

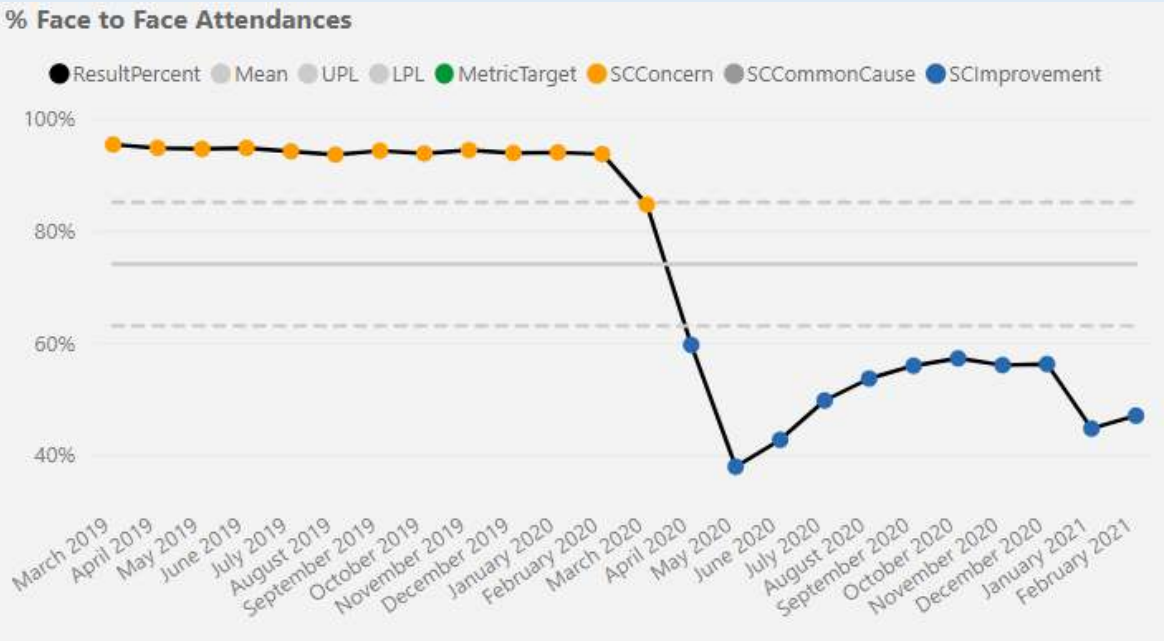
% Face to Face Attendances

February 2021

Variation	Assurance
L	

47.0% Result
N/A Target

85.0% UPL
74.0% Mean
63.0% LPL



Improvement Actions

1. Daily monitoring of outpatient activity via method of delivery and remote outpatients via IMT Command & Control.

2. Ongoing transformation initiatives to review National best practice models for delivering remote care in each speciality. Plans are then developed with divisions to implement best practice and new initiatives for delivering remote activity safely and effectively

Analytical Commentary

Data point fell outside of process limits. Data is consistently below mean, and therefore the variation is Special Cause Variation – Improvement (Low)

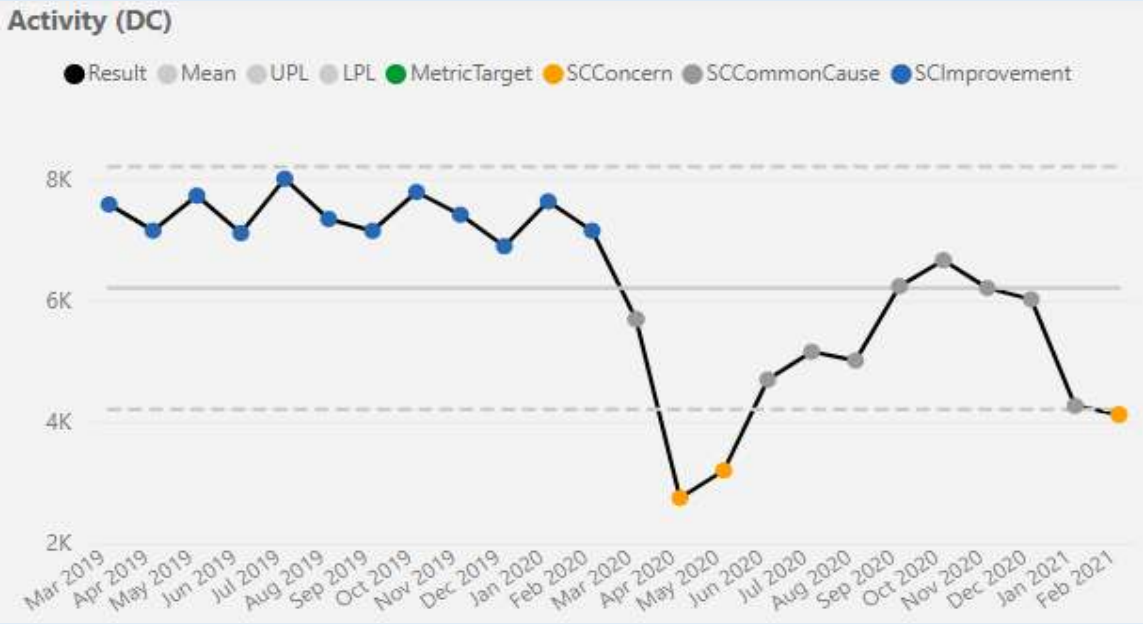
Assurance Commentary

The Trust continued to deliver over 50% of outpatient attendances remotely via telephone or video during February 2021.

Outpatient activity remained focused on Cancer (2WW) and Urgent appointments. Routine outpatient appointments were temporarily suspended in line with the Pandemic Infectious Respiratory Diseases Plan and escalation at Local Covid State 5 (Surge).

As de-escalation occurred in February down to Local Covid State 3 on 19th February, some routine outpatient services and appointments were restated. The de-escalation occurred noting that many staff remained re-deployed to critical care areas and that wellbeing of staff remained a high priority.

Activity – Daycase



Improvement Actions

1. Divisional plans under development to increase activity back towards Pre-covid Levels and reduce waiting times

2. Plans to be linked where appropriate to P code system and clinical priority

Analytical Commentary

Data point fell outside of process limits, and therefore the variation is Special Cause Variation – Concern (Low)

Assurance Commentary

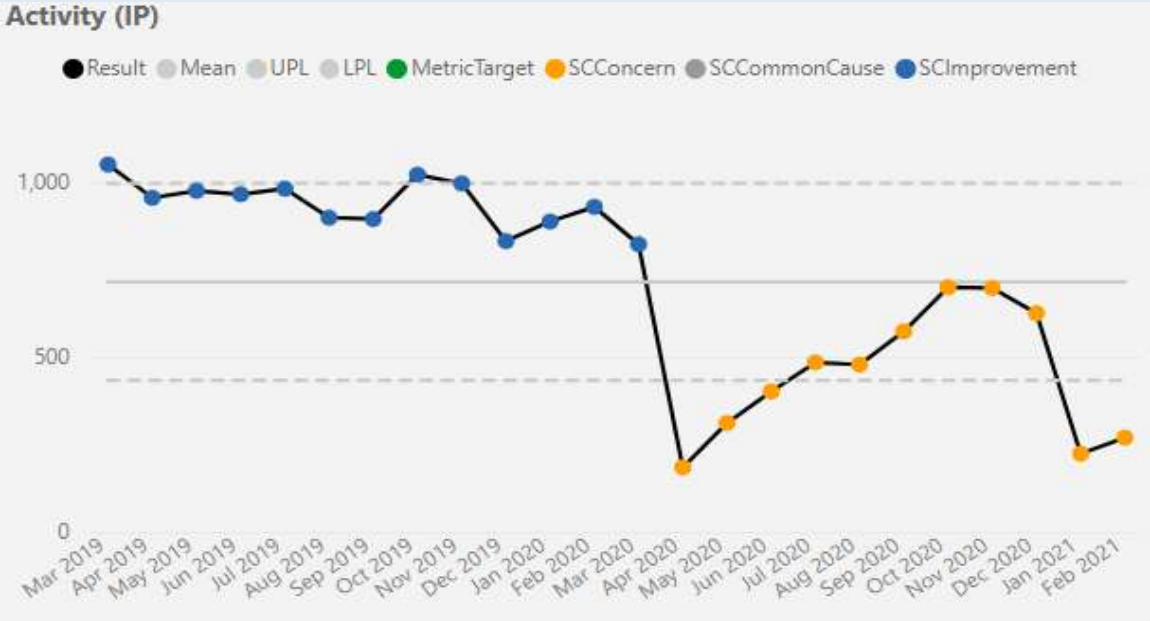
There were a total of 4,118 day cases in February 2021, which is 56% of the average monthly number in 2019/20.

Activity within Medicine was 1,638 less than February 2020 (primarily Gastro), whilst surgery were 1,276 cases behind (mostly Ophthalmology, Pain and Urology). W&C activity were 118 down on prior year, driven by gynaecology.

During February the day case activity was primarily P2 activity delivered via Spire or within a Covid Clean pathway at NNUH No Routine work was undertaken as directed by NHSE/I

As Covid numbers have reduced the activity numbers are increasing in March but still mainly focused on P2 activity

Activity – Elective Inpatient



Analytical Commentary

Data point fell outside of process limits. Data is consistently below mean, and therefore the variation is Special Cause Variation – Concern (Low)

Assurance Commentary

There were a total of 269 elective inpatient discharges in February 2021, which equates to 29% of average monthly number in 2019/20.

Activity within Medicine was 81 less than February 2020 (driven by Haematology/Oncology) whilst surgery were 496 cases behind (mostly T&O/Spinal, General Surgery and Urology). W&C were 83 less than prior year due to underperformance in Gynaecology.

The majority of elective activity in February took place at Spire, although some of the more complex surgical activity did take place these numbers were limited due to staffing and the numbers of Covid patients within Critical care

Moving into March the numbers are increasing as the numbers of covid patients significantly reduce and elective activity increases

Improvement Actions

1. Divisional plans under development to increase activity back towards Pre-covid Levels and reduce waiting times

2. Plans to be linked where appropriate to P code system and clinical priority

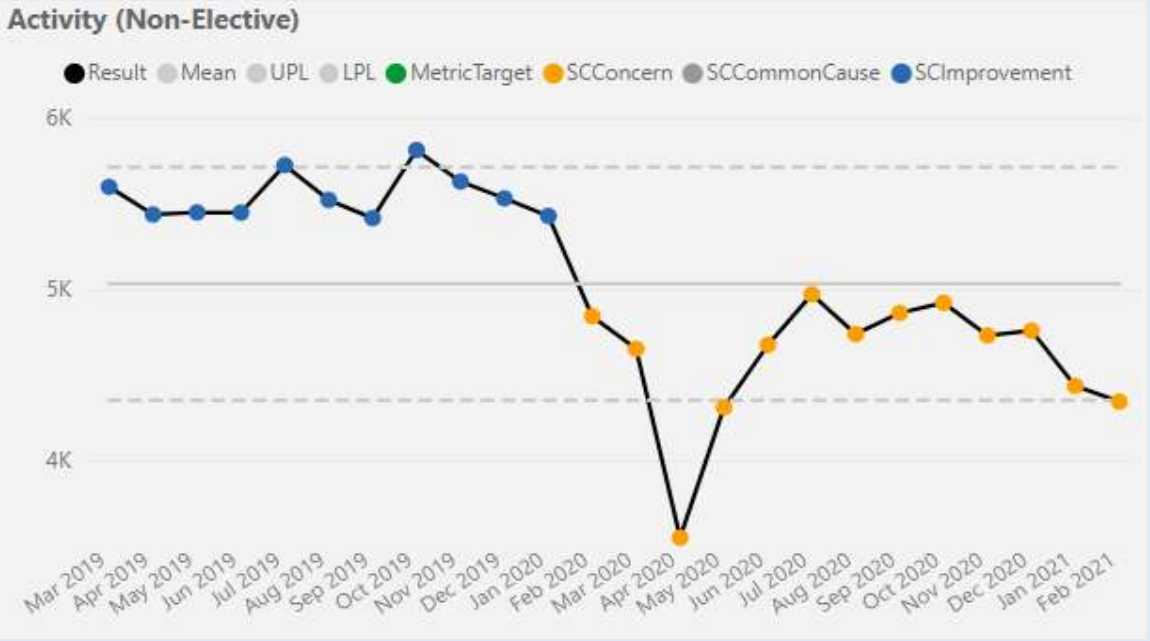
Activity – Non-Elective Discharges

NNUH Digital Health
business intelligence

Activity
(Non-Elective)

Feb 2021

Variation	Assurance	4,343 Result	5,712 UPL
		N/A Target	5,031 Mean
			4,350 LPL



Analytical Commentary

Data point fell outside of process limits. Data is consistently below mean, and therefore the variation is Special Cause Variation – Concern (Low)

Assurance Commentary

There were a total of 4,343 non elective discharges in February 2021 (Including maternity activity), which equates to 80% of average monthly number in 2019/20, and 498 less than February 2020.

Medicine were 158 down compared to February 2020 (primarily OPM and Respiratory), whilst Surgery were 294 cases behind although much of this is driven by changes in EAUS where activity is now being recorded as outpatients. W&C were 46 cases down, driven by Paediatric medicine/surgery.

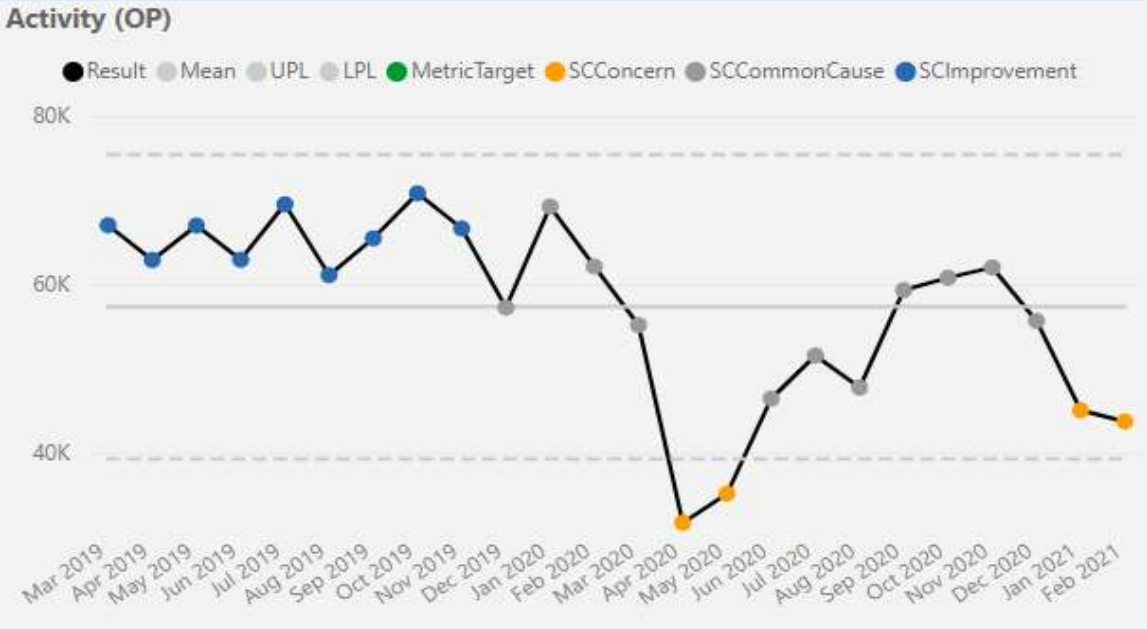
Performance did not meet the phase 3 plan submission target of 4,787.

Improvement Actions

N/A

Activity – Outpatient

NNUH Digital Health
business intelligence



Improvement Actions

1. Divisional plans under development to increase activity back towards Pre covid Levels and reduce waiting times

2. Plans to be linked where appropriate to P code system and clinical priority

Analytical Commentary

2 out of 3 data points have been close to the process limits, and therefore the variation is Special Cause Variation – Concern (Low)

Assurance Commentary

There were 9,782 new consultant led appointments in Feb 2021 (60% of Feb 2020). 3,453 [35%] were telephone/video, compared to an average of 888 [5%] in 2019/20. Activity fell short of the Phase 3 plan submission of 14,275.

There were 28,066 follow up consultant led appointments in Feb 2021 (75% of Feb 2020). 16,331 [58%] were telephone/video, compared to an average of 3,503 [9%] in 2019/20. Activity fell short of the phase 3 plan submission of 32,489.

There were 5,887 non-consultant appointments in Feb 2021 (69% of Feb 2020). 4,028 [68%] were telephone/video, compared to an average of 1,130 [12%] in 2019/20. Activity fell short of the phase 3 plan submission of 7,251.

There were 6,792 outpatient procedures in Feb 2021, falling short of the NHSE National Compliance of 11,669 (90% of Feb 2020)

There were 36,943 attendances (excluding procedures) and non face to face appointments, falling short of the NHSE national compliance of 49,166 (100% of Feb 2020).

Activity – ED Attendances

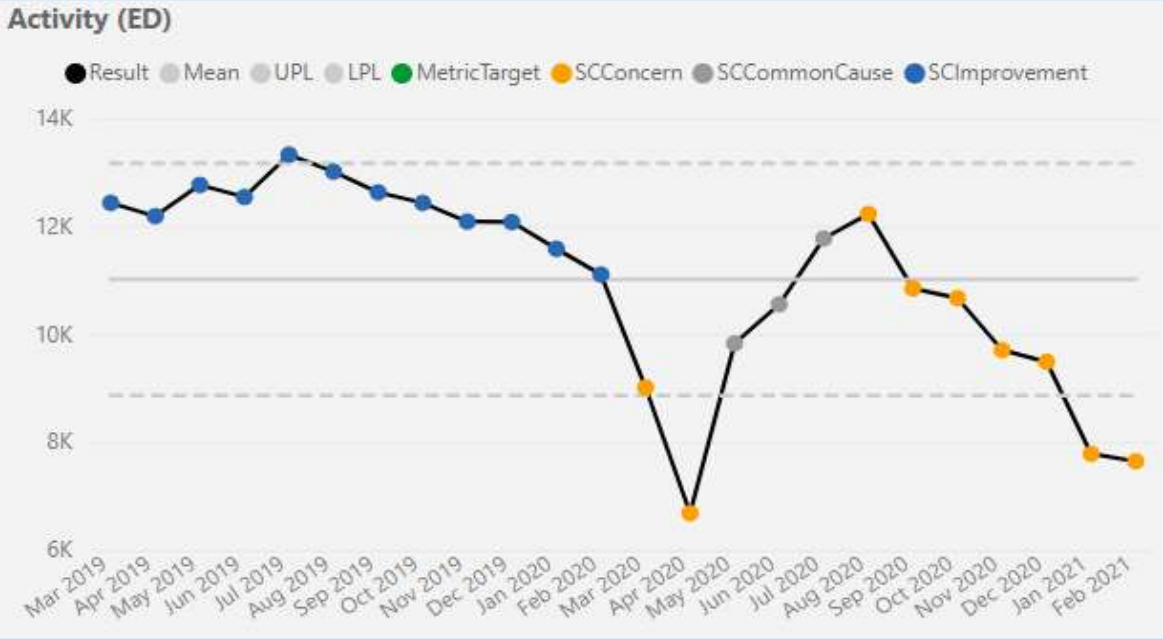
NNUH Digital Health
business intelligence

Activity (ED)

Feb 2021

Variation	Assurance
L	

7,641 Result
N/A Target
13,161 UPL
11,011 Mean
8,860 LPL



Analytical Commentary

Data point fell outside of process limits. Data point is part of a downwards trend, and therefore the variation is Special Cause Variation – Concern (Low)

Assurance Commentary

There were 7,641 A&E attendances in February 2021, compared to 11,100 in February 2020. 701 (9%) were for Children (CHED).

Improvement Actions

N/A

Norfolk and Norwich University Hospitals NHS Foundation Trust

Finance Report February 2021

23 March 2021

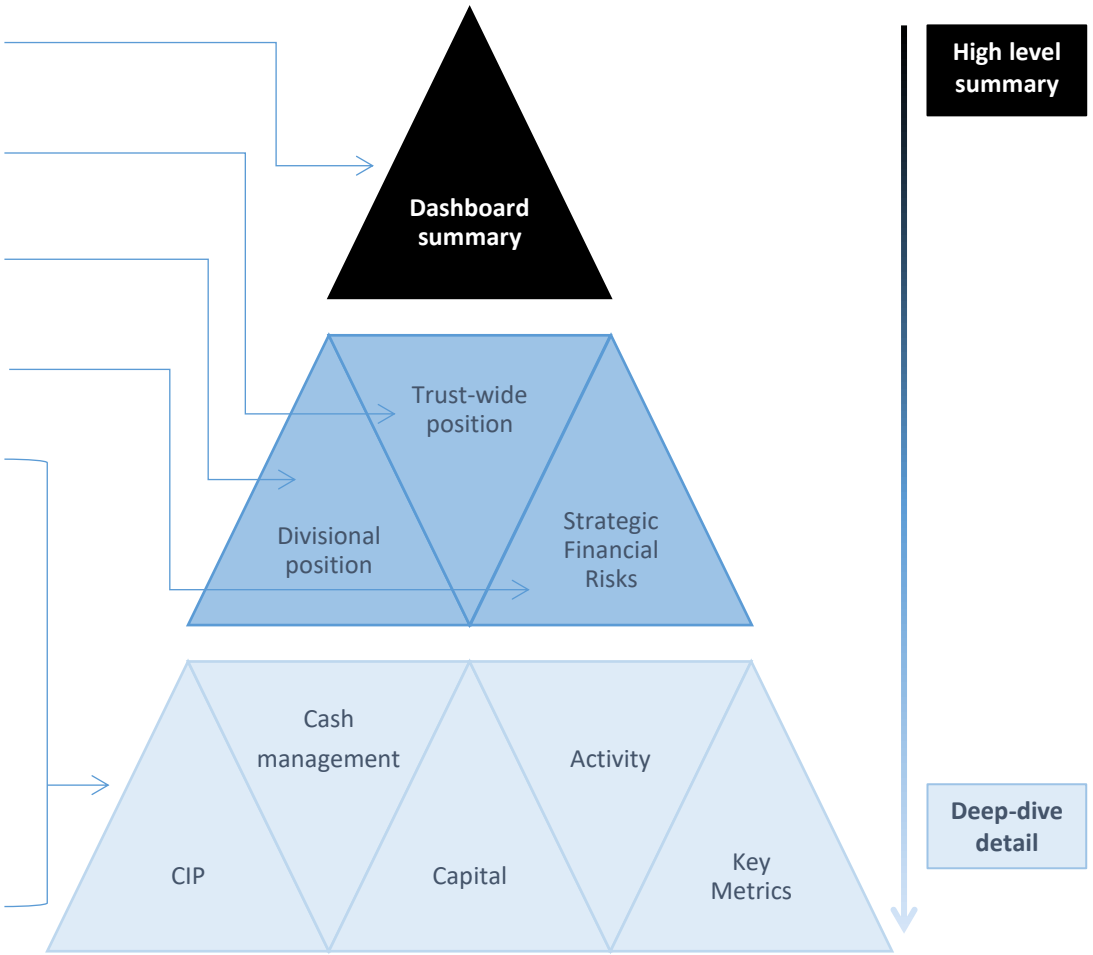
Roy Clarke, Chief Finance Officer

Norfolk and Norwich University Hospitals NHS Foundation Trust

Contents

This report sets out the Trust's financial performance and forms part of the Trust's performance reporting suite.

The report has been structured to provide the reader with an overview of the Trust's financial performance using the following framework



Norfolk and Norwich University Hospitals NHS Foundation Trust

1.1 Executive Dashboard

The year to date position as at 28 February 2021, is a £2.3m surplus on a control total basis which is £11.8m favourable to plan. The favourable variance of £11.8m is made up of an operational underspend of £14.1m, a COVID underspend of £5.0m offset by the accrual for untaken annual leave of £7.3m.

For the month of February 2021, the position is an operational surplus of £2.5m. This is a £4.3m favourable variance to plan.

The operational favourable variance of £14.1m is predominantly as a result of the reduced activity levels, due to a £1.0m favourable Pay variance predominantly due to lack of available locum staff for ED and slower than planned recruitment for the new ward. There was a £10.0m underspend across variable costs including clinical supplies and drugs relating to activity – this represents a 9.7% underspend compared to a 13.7% under delivery of Inpatient activity against the NHSE Compliance target. There was a £3.0m favourable performance in Other income due to additional ASI, R&D & WH&B Income all offset by additional expenditure.

The Trusts adjusted forecast year end outturn has moved favourably to a forecast breakeven position from a planned deficit of £11.4m. This is £11.4m favourable against plan. The Trust forecast after national adjustment funding for untaken annual leave accruals and lost other income is £9.4m. That would be £7.3m if the lost other income was subject to claw back due to the Trusts surplus.

The forecast improvement of £11.4m results from a forecast operational underspend of £13.7m, an underspend on COVID of £5.0m offset by accrual of untaken annual leave of £7.3m. The £13.7m operational underspend is predominantly due to our inability to deliver our elective pathway as a result of surge.

Provisional activity numbers for February continue to reflect the known pressures the hospital has faced as a result of Covid. Day Case and Elective Inpatient activity were only c.58% and c.29% of 2019/20 levels, against the NHSE Compliance target of 90%. Outpatient activity was also greatly reduced with restrictions on face to face activity, particularly outpatient procedure activity being only c.48% of 2019/20 levels. Outpatient attendances were also impacted, with activity for new appointments being c.67% of 2019/20 levels, and c.80% for follow up appointments. Further guidance has now been published that confirms the Elective Incentive Scheme has been suspended, and that no penalties will be imposed.

Cash at 28 February is £99.8m reflecting the one month in advance payment arrangement. This will unwind in March 2021. The cash position at 31st March using current 'run rates' is forecast to be £21.2m. This is likely to improve with finalisation of national settlements around annual leave and other income.

As at 28 February 2021 the Trust has underspent is capital plan by £24.4m. Each scheme within the Plan has been subject to review in regard to in year delivery. Overall, the Trust has high confidence of £89.2m (89%) of the forecast plan as being deliverable in year.

The Trust cash and capital position is under regular review due to the uncertain operational environment. The revised capital forecast outturn of £100.7m has been notified to NHSE&I.

Month 11 (Feb-2021)	Apr-Sep	October - February 2021			October20 - March21			RAG
	Actual £m	Actual £m	Plan £m	Variance £m	Forecast Outturn £m	Plan £m	Variance £m	
Clinical Income	282.4	233.1	232.9	0.2	279.4	279.4	0.0	
Other Income	74.4	74.6	71.6	3.0	91.1	86.0	5.1	
Pay	(203.5)	(181.7)	(175.4)	(6.3)	(217.7)	(210.4)	(7.3)	
Non Pay	(86.2)	(76.3)	(85.0)	8.7	(94.3)	(101.8)	7.5	
Net Drugs Cost	(38.8)	(32.3)	(32.5)	0.3	(38.0)	(39.0)	1.0	
Non Opex	(22.3)	(20.2)	(21.0)	0.8	(25.4)	(25.4)	0.0	
Surplus / (Deficit)	6.0	(2.7)	(9.5)	6.8	(5.0)	(11.3)	6.3	
COVID Expenditure	(15.8)	(6.9)	(18.2)	11.3	(9.3)	(31.3)	22.0	
COVID Income	9.8	11.9	18.2	(6.3)	14.3	31.3	(17.0)	
Reported Surplus / (Deficit)	0.0	2.3	(9.5)	11.8	0.0	(11.3)	11.3	
Headline Surplus / (Deficit)*	(0.6)	0.2	(5.8)	6.0	1.3	(6.9)	8.2	
Cash at Bank (before support funding)	74.7	99.8	1.2	98.6	21.2	(6.8)	28.0	
Capital Programme	27.2	75.4	99.8	(24.4)	100.7	106.4	(5.7)	
CIP	1.2	6.6	7.2	(0.5)	7.6	11.3	(3.7)	
Inpatients** (000's)	56.5	53.2	61.7	(8.5)	66.7	75.2	(8.5)	
Outpatients** (000's)	270.3	262.6	313.1	(50.5)	332.6	383.1	(50.5)	
A&E** (000's)	61.9	45.3	63.2	(17.9)	58.2	76.1	(17.9)	

** Headline surplus / (deficit) reflects impact of donated income and donated asset depreciation in line with statutory reporting*

*** Apr-Sep: Plan is 2019/20 Actual in line with financial plan*

*** Oct-Mar: FOT is 'Trust Recovery Plan', Plan is NHSEI Phase III Trajectory*

Norfolk and Norwich University Hospitals NHS Foundation Trust

1.2 Executive Dashboard

Risks

There are currently 17 risks on the strategic financial risk register, three risks have decreased in value as a result of continued delivery ahead of financial plan.

Strategic Financial Risks	Extreme (15-25)	High (8-14)	Moderate (4-6)	Low (1-3)
Total This Month	5	8	4	0
Total Last Month	5	11	1	0
Overall Trend	↔	↓	↑	↔

Divisional Performance

The operational divisions with the exception of Emergency have reported favourable positions against plan for the period October to date. This is due to the much reduced levels of activity compared to the Phase III plan, due to COVID.

With the exception of Emergency, all other operational divisions reported favourable positions against plan predominantly due to the reduced activity levels against the NHSE Compliance Target and Phase III plan. However, this includes the benefit of the Trust's CIP hedge.
Because actual activity is significantly lower than prior year and the reduced expenditure is not proportional to this, all divisions are RAG rated either amber or red.

'Other' shows an overspend of £8.3m being a £7.3m accrual for untaken annual leave and the balance relating to Trust CIP and other movements in provisions.

Divisional Performance Oct-2020 to Date Excl. COVID	Medicine		Emergency & Urgent Care		Surgery		Women's & Children's		CSS		Corporate		Other		Total	
	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m
Oct to Date Surplus / (Deficit)	(90.1)	4.0	(12.5)	(0.1)	(59.2)	5.4	(22.3)	0.6	(37.3)	3.7	(38.1)	1.6	256.8	(8.3)	(2.7)	6.8
FOT (M7-12)	(112.8)	0.0	(14.8)	0.0	(77.5)	0.0	(27.4)	0.0	(49.2)	0.0	(47.7)	0.0	324.6	11.4	(5.0)	11.4
Actual (M1-6)	(102.8)	1.7	(14.1)	0.7	(68.9)	4.7	(25.9)	0.3	(43.6)	2.6	(46.8)	0.6	308.1	(1.6)	6.0	9.0
Inpatients*	33.7	(3.4)	0.0	0.0	11.8	(4.8)	7.7	(0.3)	0.0	0.0	-	-	-	-	53.2	(8.5)
Outpatients*	105.7	(5.4)	0.1	(0.1)	117.3	(38.4)	25.9	1.8	13.6	(8.3)	-	-	-	-	262.6	(50.5)
A&E*	0.0	0.0	45.3	(17.9)	0.0	0.0	0.0	0.0	0.0	0.0	-	-	-	-	45.3	(17.9)
CIP RAG																
FINANCE RAG**																
PAF RAG**																

Above table excludes COVID Income and expensditure
**Activity variance NHSEI Phase III Compliance*
*** Prior Month PAF Rating*

Cost Improvement Programme

The Trust has delivered £6.62m of CIPs against a FIP Board approved plan of £7.16m. The risk adjusted forecast outturn CIP delivery is currently £7.6m against a CIP target of £11.3m.

The Trust has delivered £6.62m of CIPs against a FIP board approved plan of £7.16m, an under-performance of £0.54m arising through adverse performance in procurement initiatives linked to national procurement improvement schemes; a reduction in activity throughput impacting efficiency delivery; and premium pay schemes as a result of staffing requirements in relation to the Trust's response to the ongoing COVID-19 pandemic.

As at 12 March 2021, the programme consists of £8.3m of Gateway 2 approved schemes (of which £0.4m is contractually guaranteed) and £1.8m of Gateway 1 approved schemes. The initiatives that comprise these values are subject to revision as a result of any revisions to COVID-19 restoration planning guidance.

FY20/21 CIP Plan - Divisional Breakdown	FY20/21 Indicative Target £m	FY20/21 FIP Board Approved £m	Gap £m	FY20/21 RAG Adj. Forecast Delivery £m	Gap £m
Medicine	3.1	3.1	(0.0)	2.6	(0.5)
Emergency & Urgent Care	0.2	0.2	0.0	0.2	0.0
Surgery	3.3	2.6	(0.7)	2.4	(0.9)
Women's & Children's	1.2	0.9	(0.2)	1.2	0.0
CSS	1.8	1.0	(0.8)	0.8	(0.9)
Corporate	1.8	0.5	(1.3)	0.4	(1.4)
Total	11.3	8.3	(3.0)	7.6	(3.7)

Cycle 2 of the 2021/22 budget has a £26.4m CIP planning target with a forecast delivery value of £12.6m CIP requirement. Delivery plans remain significantly adrift of the £26.4m target with a total £1.1m at G2 and £11.8m at G1.

Norfolk and Norwich University Hospitals NHS Foundation Trust

2.1 Financial Performance – February 2021

The position for February 2021 is a surplus of £2.5m. This is a £4.3m favourable variance to plan. COVID-19 Expenditure for February, was £1.9m being £2.5m below plan of £4.4m.

Clinical Income:
Clinical Income is reporting a small favourable variance in February 2021 due to increased High Cost Devices recharged based on usage

Other Income:
There is a £0.5m favourable variance to plan for February 2021. Of this £0.1m is due to retrospective E&T tariff uplift advised by LDA in November, £0.1 favourable performance on private patients and RTA. The remaining £0.4m is due to variances across R&D, WH&B & ASI activity, all offset by additional costs.

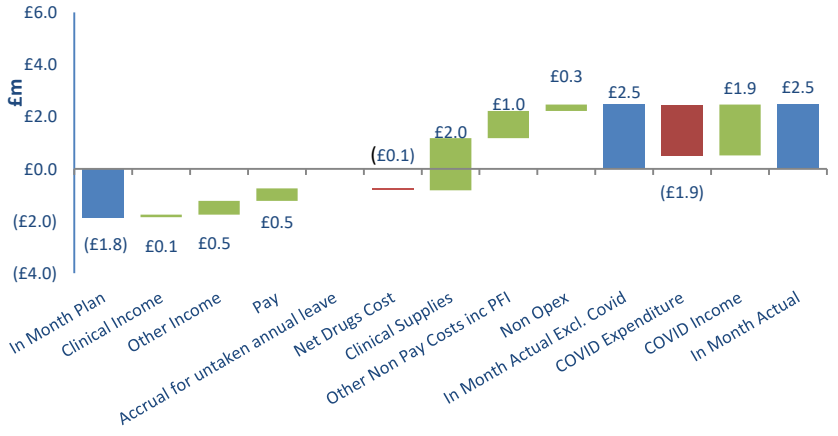
Pay:
There is a £0.5m favourable position against plan for February 2021. This is predominantly due to the lower levels of activity in Medicine and Surgery.

Non Pay incl. Net Drugs Cost:
There is a £3.0m favourable variance in February 2021. Clinical supplies & Drugs were £2.1m favourable due to reduced activity (Elective activity was c. 55% of 2019/20 actual activity v NHSEI Phase III plan of 90% and outpatients c. 70% of 2019/20 actual activity v NHSEI Phase III plan of 90%). Reduced capacity support for gastroenterology (Medinet), Theatres (SHS) and histopathology activity combined to create an underspend of £0.4m.

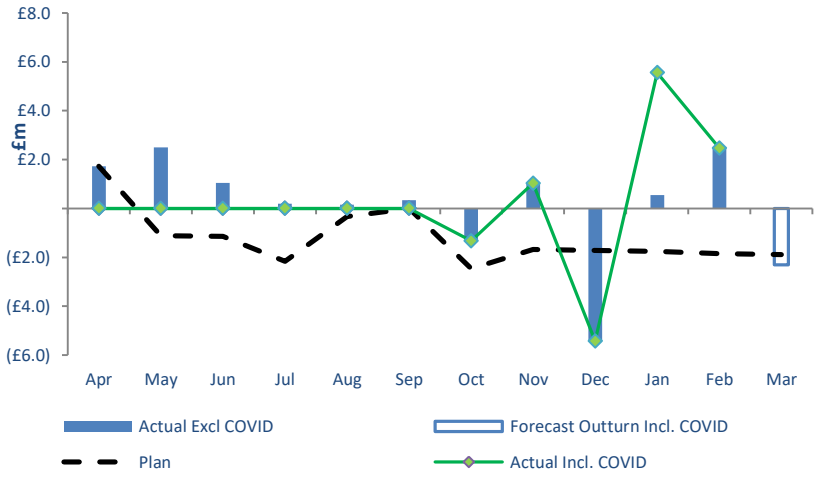
Non Operating Expenditure:
The Trust is reporting a favourable position of £0.3m as a result of the capitalisation of the New Ward Block and lower than planned depreciation charges

COVID 19 Expenditure:
The Trust is reporting £1.9m of COVID-19 Expenditure for February, being £2.5m below plan of £4.4m. This is mainly due to Trust staff being redeployed on COVID activity negating the requirement for additional external surge staffing. The planned spend for October to February was £18.2m against which £6.9m has been incurred. Of the favourable variance of £11.3m, £5m was recognised in January as an underspend. The income associated with remaining £6.3m forms part of an income repatriation to the ICS.

In Month Variance to Plan



Monthly Actual/Forecast Surplus/(Deficit)



Norfolk and Norwich University Hospitals NHS Foundation Trust

2.2 Financial Performance – April – February 2021

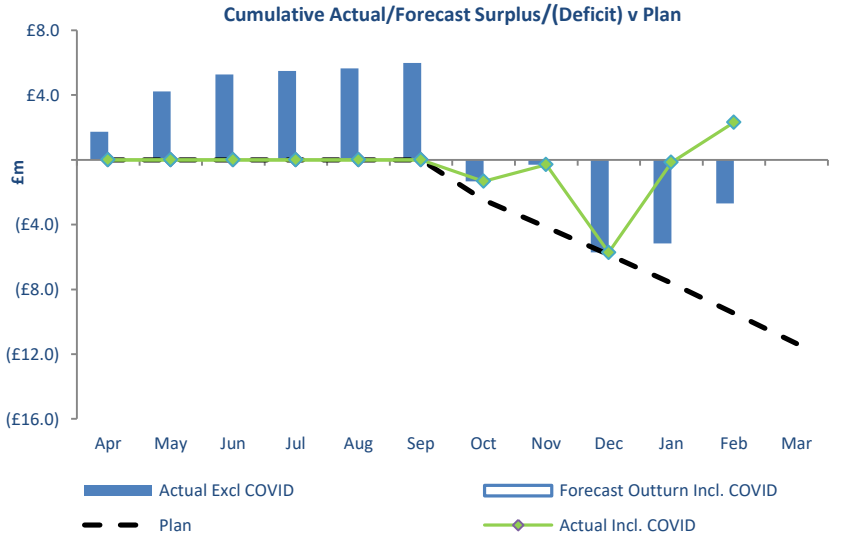
The YTD reported position for the period April to February is a surplus of £2.3m.
The Position for April – September 2020 was breakeven.

October to date the Trust is reporting a surplus of £2.3m, this is a favourable position of £11.8m against the planned deficit of £9.5m.
The surplus of £2.3m consists of a £4.6m operational surplus, a £5m COVID surplus and a revised £7.3m accrual for untaken annual leave linked to the COVID response.
The favourable variance of £11.8m is made up of an operational underspend of £14.1m, a COVID underspend of £5.0m offset by the accrual for untaken annual leave of £7.3m.

①The Position for April– September 2020 was breakeven. This consisted of a £6.0m operating surplus before COVID, COVID costs of £15.8m and top up income of £9.8m. The £6.0m operating surplus before COVID expenditure and top up income was £9.0m favourable against the planned deficit of £3.0m. The main drivers behind the £9.0m favourable position are £6m reduced expenditure on clinical supplies as a result of the reduced activity, most notably in Surgery.

②October to Date Performance:
October to date the Trust is reporting a surplus of £2.3m, this is a favourable position of £11.8m against the planned deficit of £9.5m.

The main drivers behind the £11.8m favourable position are shown in graph to the top right. The operational favourable variances total £14.1m, due to a £1.0m favourable Pay variance predominantly due to lack of available locum staff for ED and slower than planned recruitment for the new ward. There was a £10.0m underspend across variable costs including clinical supplies and drugs relating to activity – this represents a 9.7% underspend compared to a 13.7% under delivery of Inpatient activity against the NHSE Compliance target. There was a £3.0m favourable performance in Other income due to additional ASI, R&D & WH&B Income all offset by additional expenditure.
COVID expenditure is £6.9m against planned spend for October to February of £18.2m, a favourable variance of £11.3m. Of the favourable variance of £11.3m, £5m was recognised in month 10 as an underspend. This is mainly due to Trust staff being redeployed on COVID activity negating the requirement for additional external surge staffing.



The Trusts adjusted forecast year end outturn has moved favourably to a forecast breakeven position from a planned deficit of £11.4m. This is £11.4m favourable against plan. The Trust forecast after national adjustment funding for untaken annual leave accruals and lost other income is £9.4m. That would be £7.3m if the lost other income was subject to claw back due to the Trusts surplus.

The forecast improvement of £11.4m results from underspends to date and an expectation that non COVID activity will increase in the final of the year. Clearly this is dependent upon COVID, restoration plans and related resources. It assumes a further £3m of COVID underspend along with a £5m underspend on Independent Sector Capacity Support which will be offset with matching reduced income from the System. The breakeven forecast is set out in slide 2.3.

Norfolk and Norwich University Hospitals NHS Foundation Trust

2.3 Forecast Outturn

The Trusts forecast year end outturn has moved favourably to a forecast breakeven position from a planned deficit of £11.4m. Thus an improvement of £11.4m. The forecast improvement of £11.4m results from a forecast operational underspend of £13.7m, an underspend on COVID of £5.0m offset by accrual of untaken annual leave of £7.3m. The £13.7m operational underspend is predominantly due to our inability to deliver our elective pathway as a result of surge.

1 **M7-11 Actual / M12 Fcst:** Total £13.6m favourable variance, comprising of:

- Actual favourable operational variance to plan for October to February of £14.1m, a breakdown of this is provided in Section 2.2
- Accrual for annual leave of (£7.3m)
- Actual favourable In System COVID variance to plan for October to January of £5.0m
- Current underlying run rate assumed for March creates a favourable variance of £1.8m.
- Run rate driven underspend on COVID Independent Sector Capacity Support £8.0m
- Reallocation of underspend on COVID Independent Sector Capacity Support (£8.0m) with in Trust/System

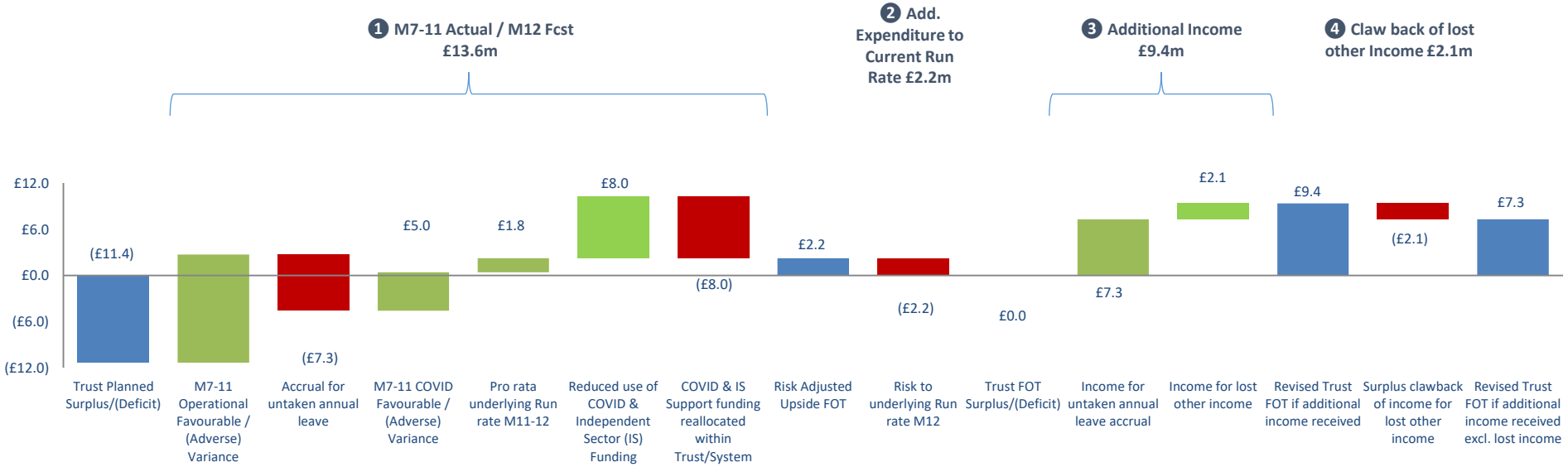
This results in a risk adjusted upside forecast outturn of a £2.2m deficit, £12.5m favourable to the operational plan of £11.4m

2 **Additional expenditure to current Run Rate: Total £2.2m** additional expenditure over the current underlying run rate in March.

This results in a risk adjusted forecast outturn of a breakeven, £11.4m favourable against the operational plan of £11.4m

3 **If the Trust is to receive a national funding adjustment of £7.3m for the accrual for untaken annual leave and £2.1m for lost other income the revised Trust forecast would be a surplus of £9.4m**

4 **Assuming the income for lost other income is subject to a clawback due to the Trust's surplus position the revised Trust forecast would be a surplus of £7.3m**

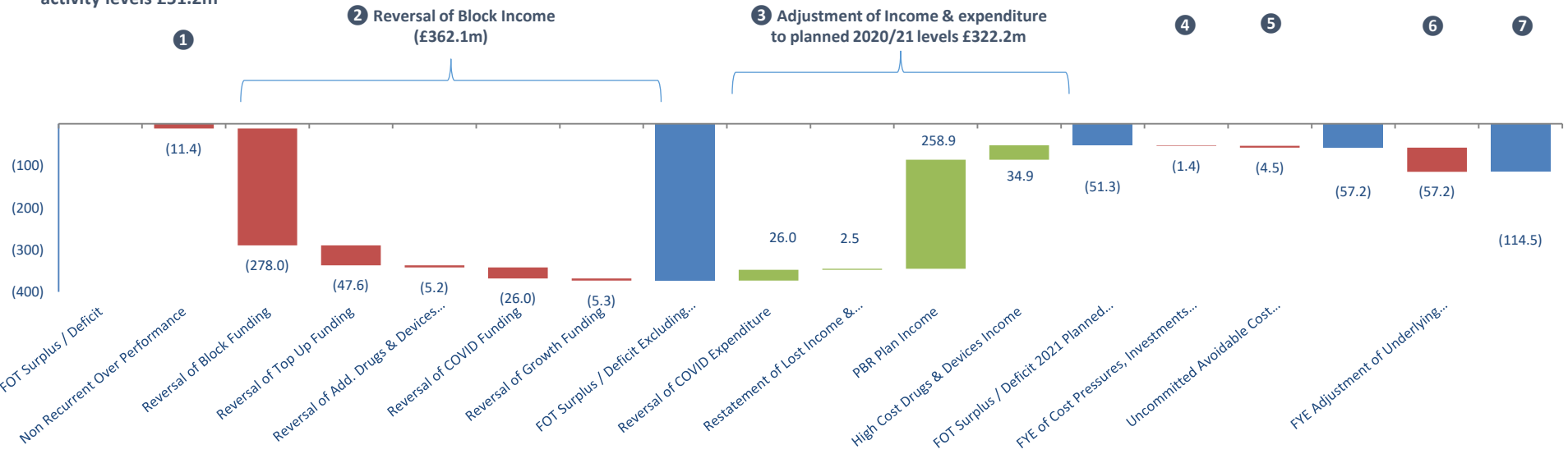


Norfolk and Norwich University Hospitals NHS Foundation Trust

2.4 Underlying Run Rate Analysis

The Trusts forecast outturn has moved favourably to a forecast deficit of breakeven from a planned deficit of £11.4m, being a £11.4m improvement. The annualised underlying deficit for the Trust is £114.4m as a result of reversing block income to the previously planned PbR income, removing COVID expenditure and including FYE of 2020/21 service developments and service developments held as a part of Intervention 2 of the Trust plan for October 2020-March 2021.

1. **Reversal of Non Recurrent 2020/21 Forecast over performance: Total £11.4m** removed due to underspend as a result of reduced Non COVID activity levels & non Recurrent CIP, annual leave accrual and COVID Income.
2. **Reversal of Block Income: Total £362.1m** removed from the plan for Clinical income Block (£278.0m), Top Up Funding (£47.6m), additional funding for High Cost Drugs & Devices (£5.2m), In & Out system COVID support funding (£26.0m) and Growth Support funding of £5.3m. **Underlying deficit excluding Block income of £373.4m**
3. **Adjustment of Income & expenditure to planned 2020/21 levels: Total £322.2m** added back due to the reversal of planned COVID expenditure including testing (£26.0m) , reinstatement of lost Non NHS Income e.g. private patients & car parking £2.5m), PbR income based on planned 2020/21 activity and tariff (£258.9m) and High cost Drugs and devices income on planned 2020/21 activity and tariff (£34.9m). **Underlying deficit adjusting income and relating expenditure to planned 2020/21 activity levels £51.2m**
4. **Full year 2020/21 Cost Pressures, Investments and CIP: Total £1.4m** from full year effect of 2020/21 cost pressures e.g. recruitment of Mental Health Nurses, HPV Contract and other recruitment to establishment. Full Year effect recurrent and non recurrent CIP. Offset by Contingency Reserve.
5. **Cost Pressures held as part of Intervention 2: Total £4.5m** predominately from delayed recruitment into establishment with no offsetting premium pay reduction, along with investments in IT, EDMS, Paediatric safer staffing and other 2020/21 cost pressures on hold due to COVID Pandemic
6. **Additional six months of underlying deficit to reflect a full year plan: Total £57.2** The above adjustments move the Trust plan for the six month period October – March. A further £57.2m is added to reflect a full 12 month period
7. **Annualised Underlying Deficit of £114.4m**



Norfolk and Norwich University Hospitals NHS Foundation Trust

3.1 Divisional Performance - Summary

With the exception of Emergency, all other operational divisions reported favourable positions against plan for February 2021 predominantly due to the reduced activity levels against the NHSE Compliance Target and Phase III plan. However, the Trust's Plan includes a hedge against CIP and therefore no CIP targets have been allocated to Divisional budgets which supports the favourable positions.
Due to actual activity being significantly lower than prior year and the reduced expenditure not being proportional to this, all divisions are RAG rated either amber or red.

The below commentary is against October to date performance in line with the NHSEI reporting period.

Clinical Income: Clinical Income subject to the block agreement has not been allocated to the divisions and therefore the divisional positions do not reflect the value of work done. The Clinical Income Block is reflected in 'Other'

Medicine:
Net expenditure of £90.1m, £4.0m favourable against plan. Pay has contributed savings of £1.3m, predominantly due to nursing vacancies, not fully covered by temporary staffing. Non Pay of £2.7m, predominantly as a result of a reduction in expenditure on drugs and clinical supplies, particularly in January and February, driven by a reduction in activity due to Covid, and non-recurrent savings in non-clinical supplies due to a reduction in capacity support costs - Bowel Cancer Screening not currently taking place at Dersingham, and slippage on the full implementation of the Siemens managed service contract.

Emergency:
Net expenditure of £12.5m, £0.1 adverse variance against plan.

Surgery:
Net expenditure of £59.2, £5.4m favourable against plan. Reduced activity during the period has impacted clinical supplies usage seeing a favourable non-pay position of £4.6 against plan. Due to current restrictions Day Case & elective activity are both trending below the activity plan. 0.6m underspent on pay due to less reliance on premium expenditure in the period.

Women's & Children's:
Net expenditure of £22.3m, £0.6m favourable against plan. £0.4m is driven by savings within Pay due to nursing vacancies within paediatrics. This, alongside lower levels of activity in January and February 2021 due to the pandemic has meant lower levels of Clinical Supplies, also contributing to the favourable position

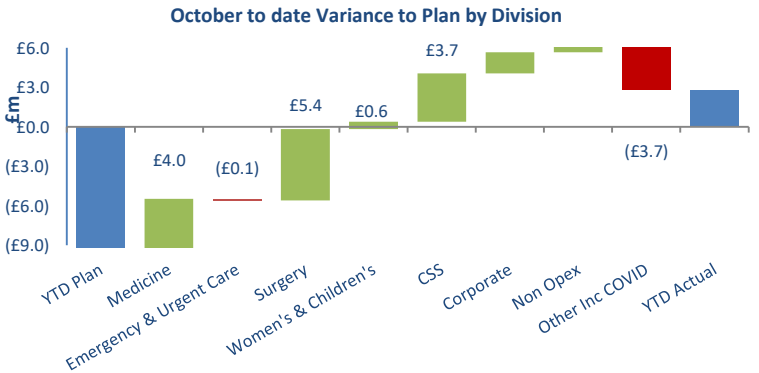
Clinical Support:
Net expenditure of £37.3m, £3.7m favourable against plan. This is driven by £2.3m underspend in clinical supplies (slippage in the new IRU managed service contract, reduced activity within new IRU suites and all laboratories) and £0.8m underspend due to Histopathology outsourcing not currently being required and reduced discretionary spend across the division.

Corporate:
Net expenditure of £38.1m, £1.6m favourable against plan

Other:
Other includes Clinical Income block and Top up funding along with R&D and the Trust Reserves including unallocated CIP. Net overspend of £8.3m being £7.3m accrual for untaken annual leave and balance relating to Trust CIP and other movements in provisions.

Divisional Performance Oct-2020 to Date Excl. COVID	Medicine		Emergency & Urgent Care		Surgery		Women's & Children's		CSS		Corporate		Other		Total	
	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m
Clinical Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	233.1	0.2	233.1	0.2
Other Income	1.1	(0.1)	0.1	0.0	3.3	0.9	0.5	0.1	5.6	0.4	3.6	0.4	60.5	1.4	74.6	3.0
Pay	(49.1)	1.3	(11.2)	(0.1)	(49.4)	0.2	(19.4)	0.4	(29.6)	0.0	(13.4)	(0.1)	(9.5)	(8.1)	(181.7)	(6.3)
Non Pay	(14.3)	1.9	(1.2)	(0.0)	(9.2)	4.1	(1.3)	0.3	(12.7)	3.1	(28.2)	1.3	(9.4)	(1.9)	(76.3)	8.7
Net Drugs Cost	(27.7)	0.8	(0.2)	0.0	(3.9)	0.3	(2.0)	(0.2)	(0.7)	0.1	(0.1)	(0.0)	2.3	(0.8)	(32.3)	0.3
Non Opex	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(20.2)	0.8	(20.2)	0.8
Oct to Date Surplus / (Deficit)	(90.1)	4.0	(12.5)	(0.1)	(59.2)	5.4	(22.3)	0.6	(37.3)	3.7	(38.1)	1.6	256.8	(8.3)	(2.7)	6.8
FOT (M7-12)	(112.8)	0.0	(14.8)	0.0	(77.5)	0.0	(27.4)	0.0	(49.2)	0.0	(47.7)	0.0	324.6	11.4	(5.0)	11.4
Actual (M1-6)	(102.8)	1.7	(14.1)	0.7	(68.9)	4.7	(25.9)	0.3	(43.6)	2.6	(46.8)	0.6	308.1	(1.6)	6.0	9.0
CIP	2.2	(0.2)	0.2	(0.0)	2.0	(0.2)	1.1	0.2	0.8	(0.1)	0.4	(0.1)	0.0	(0.1)	6.6	(0.5)
Inpatients*	33.7	(3.4)	0.0	0.0	11.8	(4.8)	7.7	(0.3)	0.0	0.0	-	-	-	-	53.2	(8.5)
Outpatients*	105.7	(5.4)	0.1	(0.1)	117.3	(38.4)	25.9	1.8	13.6	(8.3)	-	-	-	-	262.6	(50.5)
A&E*	0.0	0.0	45.3	(17.9)	0.0	0.0	0.0	0.0	0.0	0.0	-	-	-	-	45.3	(17.9)
CIP RAG																
FINANCE RAG**																
PAF RAG**																

Above table excludes COVID Income and expensditure
**Activity variance NHSEI Phase III Compliance*
*** Prior Month PAF Rating*



Norfolk and Norwich University Hospitals NHS Foundation Trust

3.2 Divisional Performance - Service Line Reporting 2020/21

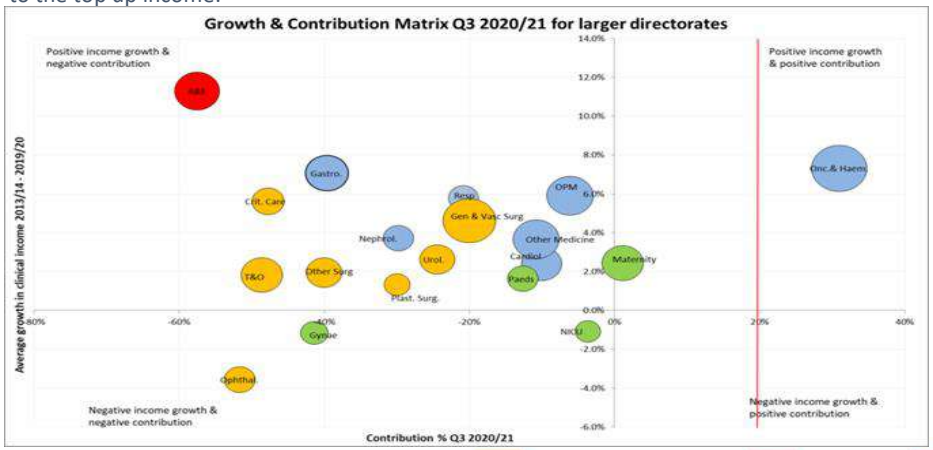
SLR data for the period April-December 2020/21 reflects the impact of COVID. All Divisions reported a deficit for contribution (Income less controllable costs) for the year to date due to reduced activity levels within the same cost base.

The impact of COVID was a fall in activity and income of more than a third in Q1, with Surgery most affected. During Q2 & Q3 there was some recovery, but remaining below 19/20 levels. Thus levels of contribution by division are as follows:

Division	% of 'PbR' Activity Income	19/20	Q1 20/21	Q2 20/21	Q3 20/21	20/21 Contribution
Medicine	6.4%	14%	(26%)	(4%)	1%	(14%)
Emergency	47.0%	(35%)	(92%)	(35%)	(52%)	(60%)
Surgery	27.4%	6%	(77%)	(29%)	(13%)	(48%)
Women & Children's	18.9%	5%	(25%)	(5%)	1%	(14%)
Clinical Support	0.4%	(61%)	(203%)	(100%)	(84%)	(142%)

It is hard to compare with pre-COVID performance, so trends from quarter to quarter will be a better indicator of recovery. Income has been priced under PBR; the top up from PBR-priced to income received is not allocated to divisions in these SLR reports.

The tables below show how the Divisions' activity, costs and income are reflected in SLR, prior to the top up income:



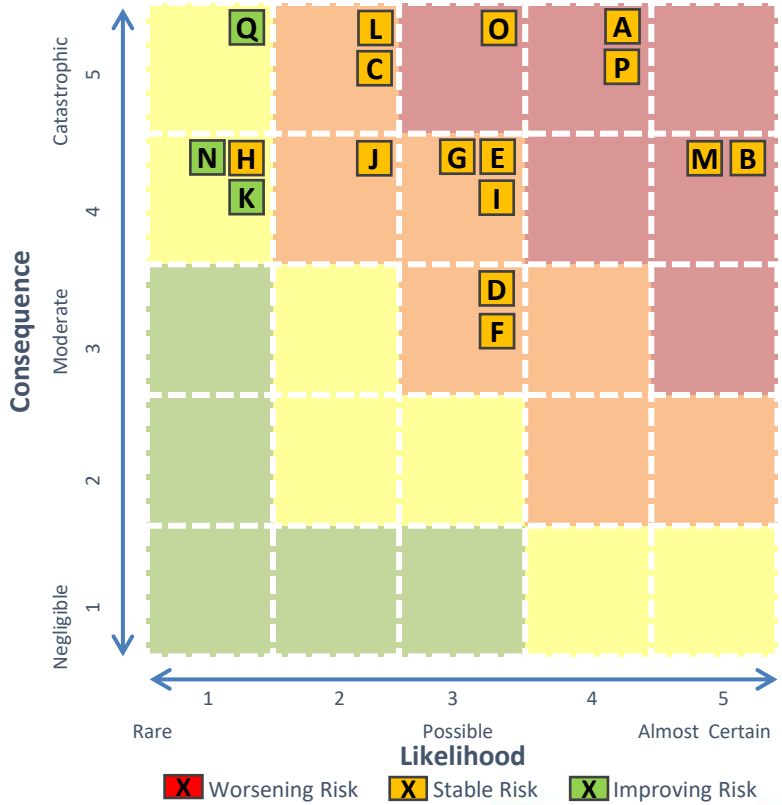
Norfolk and Norwich University Hospitals NHS Foundation Trust

4. Strategic Financial Risks

There are currently 17 risks on the strategic financial risk register, which is subject to review on a monthly basis. Three risks have improved in the month.

The Trust continues to formally review the Financial Risk Register, on a monthly basis, refreshing all risks and adding new risks which have been identified across the finance portfolio.

As part of the monthly review of Financial Risk Register, seven risks have decreased in value as a result of continued delivery ahead of financial plan, as a result of a reduction in activity levels, an improved forecast cash position and the cessation of the Elective Incentive Scheme (EIS).



	ID	Description	Risk Score	*Prior Month*
A	624	IF the Trust does not have a detailed financial strategy in place to deliver financial sustainability THEN the Trust will fail to achieve its strategic and operational priorities.	20	*20*
B	1034	IF the efficiency requirement is not identified and delivered THEN the Trust is at risk of significantly failing its I&E and cash plans, alongside delivery of the Trust's Operational Plan.	20	*20*
C	1223	IF the trust fails to achieve the interventions reflected in the draft M5-M12 operating plan, THEN budget will not be achieved, distressed funding will be required and reputation will be damaged.	10	*10*
D	1155	IF the Trust fails to coordinate restoration plans in a collaborative and system wide approach, THEN there is a risk of failure to meet regulatory guidance and pose a risk to financial performance.	9	*9*
E	1211	IF coding staffing levels remain as they currently are THEN there is a risk that national coding monthly deadlines (which drive clinical income and contractual processes) are not met or that the depth of coding is reduced, adversely impacting on future tariffs and mortality indicators.	12	*12*
F	1212	IF standards are not maintained in Trust wide processes to record all patient complexities, procedures and co-morbidities, THEN there is a risk that the full depth of coding is reduced. This can adversely impact on future tariffs; benchmarking data and mortality indicators.	9	*9*
G	1217	IF the Trust is unable to approve Consultant Job Plans, THEN this provides a risk of costs being in excess of planned levels.	12	*12*
H	1219	IF the Trust does not achieve its Financial Recovery Trajectory (FRT) THEN it will lose any Financial Recovery Fund (FRF) funding available and this will result in Distress Funding being required.	4	*4*
I	1221	IF the Trust's capacity plan does not reflect the available clinical space, THEN there is a risk that activity assumptions underpinning the FY20/21 plan are not valid, potentially leading to lower levels of income or higher levels of costs than planned through the use of expensive third party capacity, e.g. Spire, SBS.	12	*12*
J	1222	IF the Trust is unable to manage its financial performance in line with the Operational Plan, THEN there is a risk that it will be unable to maintain its planned cash balance and require Distress Funding.	8	*8*
K	1224	IF the national standards require greater throughput of activity than in the Trust's indicative activity plan THEN the Trust will be unable to meet those standards.	4	*12*
L	1225	IF the directorates do not control their establishment costs in line with the plan (including the reduction of COVID-19 absence), i.e. escalation into areas such as JPU THEN the Trust will be unable to meet a breakeven position.	10	*10*
M	1226	IF capital funding applications are not approved in good time by NHSE/I or the programme suffers operational slippage THEN the Trust will fail to deliver the capital programme in 20/21. This would adversely impact operational capacity, Trust reputation and ultimately patient care.	20	*20*
N	1229	IF the Trust delivers the budgetary plan with an associated cash shortfall of £6.8m, THEN the Trust will fail to meet its commitments should it be unsuccessful in obtaining revenue support PDC funding of £6.8m plus minimum £1m headroom.	4	*8*
O	1233	IF the Trust delay recruitment of overseas nurses THEN the Trust may fail to meet Safer Staffing levels.	15	*15*
P	1235	IF the directorates deliver the July 2020 planned activity over the remainder of the period with a fixed capacity THEN the Trust's waiting list will increase due to the continued loss of productivity.	20	*20*
Q	1387	IF the Trust enters a surge or super-surge scenario THEN under current arrangements in line with National Guidance, any additional costs arising will not be covered and the Trust may not deliver its financial plan.	5	*10*

Norfolk and Norwich University Hospitals NHS Foundation Trust

5. Cash

Cash at 28th February is £99.8m reflecting the one month in advance payment arrangement. This will unwind in March 2021 with a forecast cash position using current 'run rates' of £21.2m which is above the required £1.0m minimum headroom. This is likely to improve with finalisation of national settlements around annual leave and other income. The twelve month forecast based on the underlying deficit of £114.4m means that, unmitigated, the Trust will require additional PDC support of £104.9m in the period to 1 April 2021 to 28 February 2022

Cash Financial Arrangements - financial envelope for months 7-12 2020/21 confirmed by NHSE/I on 15 September 2020.

This is system based, designed to fund achievement of Phase 3 goals and provide resource to meet additional costs of COVID-19 response and recovery - excluding testing costs. It is expected that the system will achieve financial balance within its allocated envelope. There will be no retrospective top up. The Trust's revised 'block' and top up is £53.9m per month. The allocation of COVID-19 funding within the envelope to the Trust is £18.8m, inclusive of £5.3m Independent Sector Capacity Support.

The Trust Phase 3 operational plan for the six months to 31 March 2021 shows a net deficit of £11.4m, excluding fines for elective performance. If no further funding is forthcoming this would mean that we will need cash support in Q4, forecast at c. £5.3m including £1m headroom. Our current forecast is set out below.

February Closing cash position

The closing balance at 28 February is £99.8m reflecting the one month in advance payment arrangements.

Cash Flow Forecast

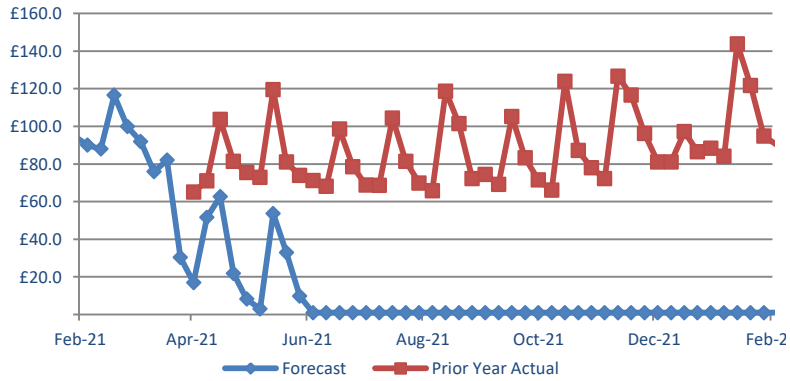
Operational - The Trust's cash flow forecast reflects the revised block and top-up cash amounts and assumes it continues to be received in advance, unwinding in March 2021. The cash position at 31st March using current 'run rates' is forecast to be £21.2m, above the minimum required headroom of £1.0m. However, this is under tight review due to the uncertain operational environment.

The rolling twelve month forecast to 28 February 2022, based on the underlying deficit position of £114.4m full year, shows a cash balance of the minimum allowed of £1m. This forecast assumes receipt of distressed funding for that additional ten month period of £104.9m.

Capital - The Trusts approved capital plan includes identified funding streams for all expenditure. The receipt of funding is subject to a national process which to date has been slow, in turn our expenditure plan has been delayed in order to prevent cash pressures and risk. Therefore the cash flow forecast for capital expenditure and associated funding is based on best understanding on the timing of approvals. Accordingly this may change, however it should not impact the cash flow overall as expenditure can be managed to align with funding.

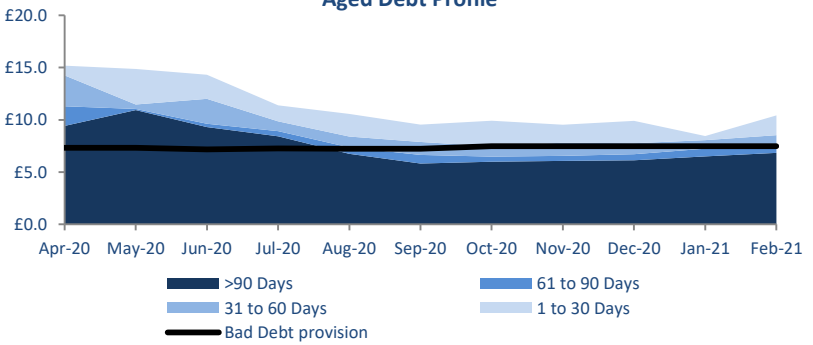
Aged Debt - Debtors at February 2021 are £10.4m, of which £6.8m is over 90 days. Of the NHS debt greater than 90 days, £1.3m is JPUH, up £0.2m from the prior month. Of the Non NHS debt greater than 90 days £2.1m relates to TPW, £0.5m relates to Big C and £0.9m relates to private/overseas patients. The trust continues to focus on resolving these debts.

Weekly Closing Cash (£m)



Debtors by Type	Total Debt			Debt > 90 days		
	Dec-20 £m	Jan-21 £m	Feb-21 £m	Nov-20 £m	Dec-20 £m	Feb-21 £m
NHS	4.09	2.55	4.18	1.56	1.75	1.97
Non NHS	5.81	5.90	6.24	4.57	4.75	4.88
Total	9.90	8.45	10.42	6.13	6.50	6.84

Aged Debt Profile



Norfolk and Norwich University Hospitals NHS Foundation Trust

6.1 Activity (Income PbR)

Provisional activity numbers for February continue to reflect the known pressures the hospital has faced as a result of Covid. Day Case & Elective Inpatient activity were only c.58% & c.29% respectively of 2019/20 levels, against the NHSE Compliance target of 90%. Outpatient activity was also reduced with restrictions on face to face activity, particularly outpatient procedure activity being only c.48% of 2019/20 levels. Outpatient attendances were also impacted, with activity for new appointments being c.67% of 2019/20 levels & c.80% for follow up appointments

In response to the COVID-19 pandemic, clinical income was set nationally. For the first four months of FY20/21 (April to July), a monthly block payment of £47.1m was provided to the Trust, with a further top-up payment of £6.4m also being made. This block payment was rolled forward into months 5 and 6 as a result of revised guidance. From October this block payment reduced to £46.3m, with a top-up payment of £7.6m. In addition at this time, some High Cost Drugs and Devices have returned to being reimbursed on a cost and volume basis.
Whilst block funding remains in place, activity expectations have been set by NHSE/I, from October these are 90% of Day Case/Elective and Outpatient Procedures, and 100% of Outpatient Attendances (without a procedure).

Guidance has however now been published to confirm that the Elective Incentive Scheme has been suspended and that no downside financial adjustments will be made.

Performance v 2020/21 Draft Annual Plan

Despite being block funded, full contract monitoring processing and reporting is still being completed so that true levels of activity, and income can be derived – i.e. had the Trust been paid on a Payment by Results (PbR) basis.

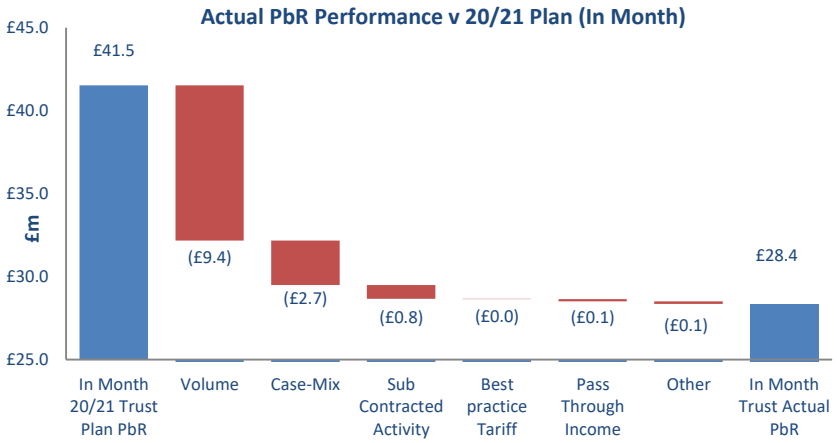
The charts to the right show February and Year to Date Income variances against 2020/21 draft annual plan (submitted February 2020) bridged by case mix and volume, as well as other areas of note. Both graphs show the significant effect the COVID pandemic has had on activity levels.

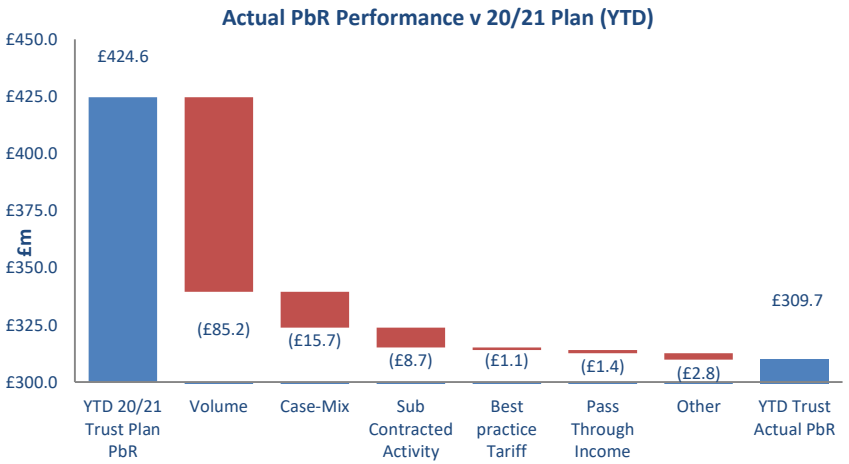
It should be made clear that the actual performance does not include activity that has been transferred to the independent sector as part of the national agreement between independent providers and NHSE, or activity that has been sub-contracted to the Independent Sector.

Elective Incentive Scheme (EIS)

Further guidance has now been published advising that in recognition of the significant pressures placed upon providers as a consequence of the COVID pandemic, the Elective Incentive Scheme is to be suspended.

No downside financial adjustments are to be made. Initial estimates were for the penalties to be c.£2m for the full period, September to March. Whilst this was reduced following rules on 10% tolerance / >15% Covid occupancy - this risk has now been removed.





Norfolk and Norwich University Hospitals NHS Foundation Trust

6.2 Activity - POD

Elective, Incl. Day Cases

Day Case and Elective inpatient activity has been severely impacted by the pressures brought on by the Covid pandemic, with Elective Inpatient numbers dropping to very low levels.
The impact was seen across all Specialties, with Surgical Division being particularly impacted.

The NHSE Phase III compliance target of 90% was not met by any Division. Specialties particularly impacted were Gastroenterology, Ophthalmology, Pain Management, Rheumatology and Cardiology, as well as Gynaecology where whilst numbers are lower the percentage of target achieved is low.

Non Elective

Non Elective activity has significantly reduced as a consequence of the Covid pandemic, and this continued to be the case in February – activity levels being c.90% of February 2020 activity.

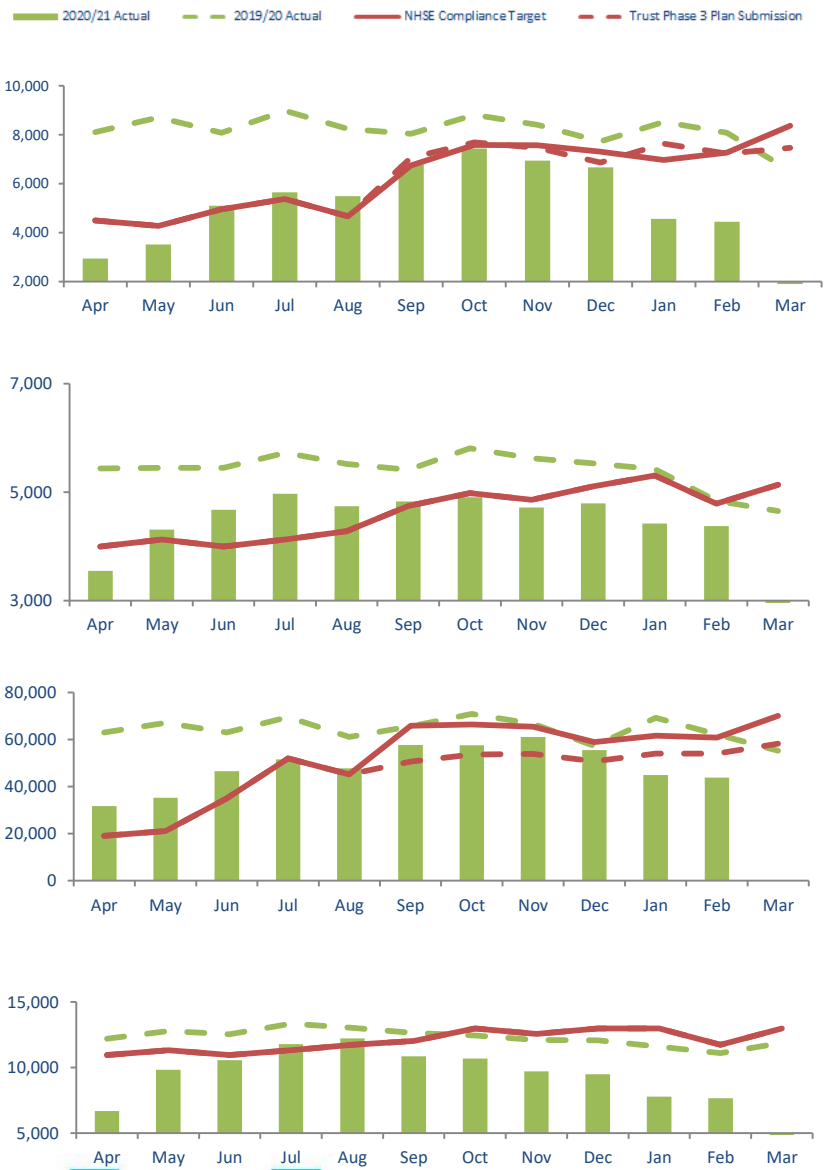
Whilst no formal expectations or requirements have been set by NHSE for Non Elective activity, the Trust did set out its own trajectory as part of the Phase 2 planning round, with activity being 411 spells less than planned for.
Medical and Women & Children Divisions are seeing non-elective activity at between c.90% to 95% of 2019/20 levels. Whereas Surgical Division activity in February 2021 was c.68% of February 2020 activity.

Outpatients

The NHSEI Phase III requirements are essentially for all outpatient activity to return to 100% of levels seen in 2019/20, the exception being activity where a procedure takes place where the expectation from October is 90%. Despite the procedure target being lower this is the target proving more difficult to achieve, and this continued to be impacted in February because of restrictions on face to face activity. Provisional figures for February 2021 indicate activity levels were only c.48% of February 2020.
Whilst some level of outpatient appointments have been able to be maintained whilst Covid impact has been in force through virtual (non face to face) appointments, provisional figures suggest activity levels are c.67% and c.80% of 2019/20 levels for new and follow up appointments respectively.

A&E Attendances

As with Non Elective activity no formal expectations or requirements have been set by NHSE as part of the Phase III planning, however the Trust did create a trajectory for the Phase II planning round.
Attendance levels in February have continued the downward trend seen since September, with February 2021 levels (only 7,641 attendances) being 68% of February 2020 (11,099 attendances). The number of attendances per day did increase from 250 per day in January to 273 per day in February.



Norfolk and Norwich University Hospitals NHS Foundation Trust

7. CIP

The Trust has delivered £6.62m of CIPs against a FIP board approved plan of £7.16m, an under-performance of £0.54m due to adverse performance of procurement schemes; a reduction in activity throughput impacting efficiency delivery and premium pay initiatives. The risk adjusted forecast outturn CIP delivery is currently £7.6m against a CIP target of £11.3m presenting a significant risk to achievement of the target.

FY20/21 Year to date CIP Performance:

The Trust has delivered £6.62m of CIPs against a FIP board approved plan of £7.16m, an under-performance of £0.54m arising through adverse performance in procurement initiatives linked to national procurement improvement schemes; a reduction in activity throughput impacting efficiency delivery; and premium pay schemes as a result of staffing requirements in relation to the Trust's response to the ongoing COVID-19 pandemic.

The risk adjusted forecast outturn CIP delivery for FY20/21 is currently calculated as £7.6m based on the latest forecast financial performance of Gateway 2 schemes, progress against milestone delivery and performance against quality and performance indicators.

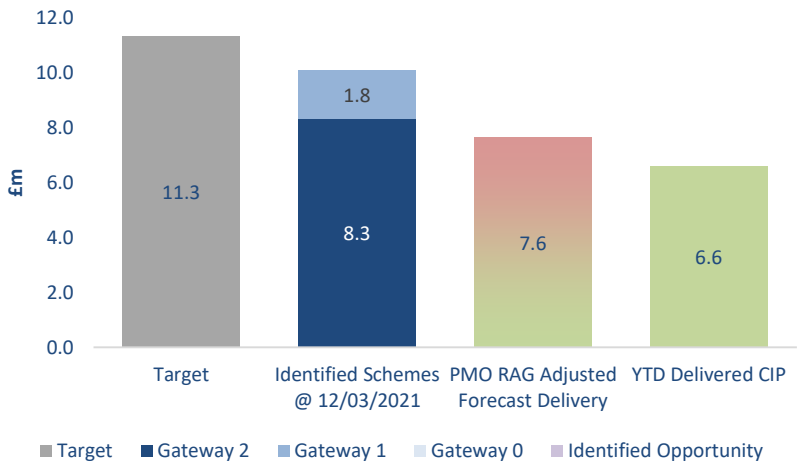
FY20/21 CIP Plan

Due to the significant risk surrounding the CIP Programme as the Trust continues to develop plans, alongside a lack of detailed approved schemes, a contingency of £10.9m has been offset against the programme within the Operational Plan.

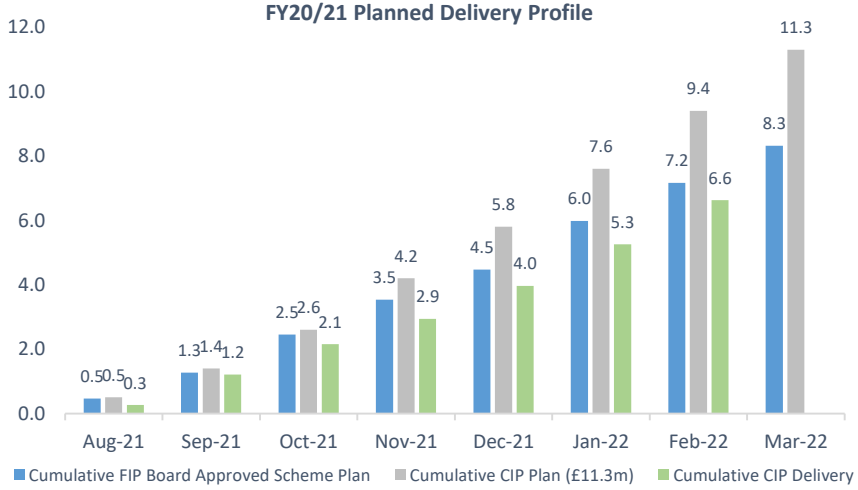
As at 12 March 2021, the programme consists of £8.3m of Gateway 2 approved schemes (of which £0.4m is contractually guaranteed) and £1.8m of Gateway 1 approved schemes.

Note: The plan submitted to the STP & NHSE/I comprises the £5.3m non-recurrent savings included within Intervention 2 of the Trust plan. The reported information does not include any impact of the £5.3m Intervention 2 savings.

FY20/21 CIP Identified Position



FY20/21 Planned Delivery Profile



FY20/21 CIP Plan - Divisional Breakdown	FY20/21 Indicative Target £m	FY20/21 FIP Board Approved £m	Gap £m	FY20/21 RAG Adj. Forecast Delivery £m	Gap £m
Medicine	3.1	3.1	(0.0)	2.6	(0.5)
Emergency & Urgent Care	0.2	0.2	0.0	0.2	0.0
Surgery	3.3	2.6	(0.7)	2.4	(0.9)
Women's & Children's	1.2	0.9	(0.2)	1.2	0.0
CSS	1.8	1.0	(0.8)	0.8	(0.9)
Corporate	1.8	0.5	(1.3)	0.4	(1.4)
Total	11.3	8.3	(3.0)	7.6	(3.7)

Norfolk and Norwich University Hospitals NHS Foundation Trust

8.1 Capital

Introduction and Background

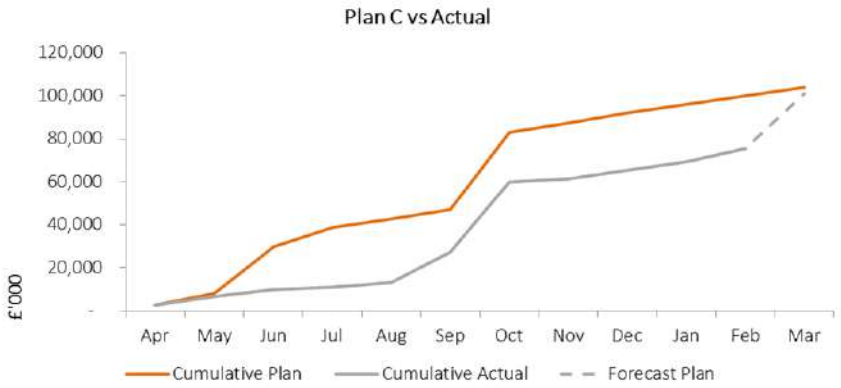
This report provides an update on the delivery of the Trust's capital plan (Plan C) as at 28 February 2021.

On 29th May 2020, the Trust submitted its 20/21 capital programme to NHSI which included the capitalisation of the ward block finance lease (£11.681m). This is Plan A.

Since this submission, the Trust has been awarded funds to purchase this contract outright of £14.5m which releases £11.681m of funding. This is Plan B.

On 18th November, the Trust was notified that it was awarded PDC funding excluding £3.312m of Digital schemes which are linked to the Digital Aspirant programme. This, in conjunction with other variations created a risk of breaching authorised expenditure limits. Accordingly a new plan C was produced highlighting how the risk could be managed. This was approved by the Board and delegated authority was given for the Executive to enact Plan C on confirmation of the ward block buy out.

M11 Plan £'000	M11 Actual £'000	M11 Variance £'000	YTD Plan £'000	YTD Actual £'000	YTD Variance £'000	FY Plan C £'000	FY FOT £'000	FY Variance £'000
8,022	9,972	1,950	99,818	75,436	(24,382)	103,791	100,759	(3,032)



The Trust received approval of the previously excluded Digital funding of £3.312m on the 4th December. The ward block buyout was completed in January. Therefore, this report monitors the Trust's performance against Plan C.

Year to date performance – 28th February 2021

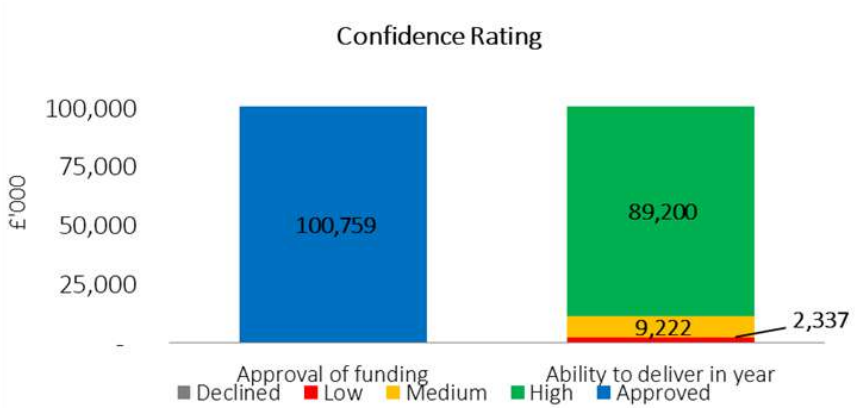
The Trust has underspent Plan by £24.4m YTD.
Key drivers of the YTD variance are the release of the new ward block lease of £9.7m (following buyout), IT of £10.3m, and Charitably funded Cromer MacMillan Centre of £2.6m. The remaining £6.2m underspend is spread over 58 projects.

Forecast Outturn:

Current forecast is to deliver to a revised Plan value of £100.8m. This forecast reflects £8.1m of additional PDC and £3.2m of additional internal funds since Plan C, less £1.6m for the New Ward Block buy out, £1.7m for underspend on donated assets, £1.4m reduction to Digital Aspirant, and £9.6m relating to delays and changes in the core programme, largely resulting from the impact of COVID– circa £1.6m of which has been requested by the STP.

Confidence rating for delivery of the Trust's Plan - the chart to the right provides detail of ratings by value across two domains:

- An assessment based on approval of funding
- An assessment based on the ability to deliver the projects.



Each scheme within the Plan has been reviewed and an assessment made. Overall, the Trust has high confidence of £89.2m (89%) of the forecast plan as being deliverable. This includes £31.8m (32% of Plan value) of spend related to PFI lifecycle capitalisation. Funding approvals have now been secured so the significant risk is the ability to deliver the plan in the remaining month of the year. Delays in funding approvals are a major factor in the deliverability risk identified.

Norfolk and Norwich University Hospitals NHS Foundation Trust

8.2 Capital

Key risks to delivery

The Table below identifies key risks to the delivery of the 2020/21 Capital Plan and planned actions and mitigations to against these risks.

Key Risks	Actions	Owner/Date	Link to Strategic Risk Register
2% (£2.3m) of the Plan is currently assessed at low confidence of delivery: This mainly relates to the ability to deliver the £1.1m Electronic Patient Record programme and the N&W Integrated Care Record of £0.5m. Failure to deliver the Trust's capital plan could result in significant risks not being appropriately mitigated, potential loss of funding, and introduces reputational risk of the Trust being able to deliver its Plans.	• All projects rated as low confidence of delivery to be subject to monthly review and appropriate actions identified to support delivery.	Director of Strategy Monthly	M - If capital funding applications are not approved in good time by NHSE/I **or the programme suffers operational slippage then the Trust will fail to deliver the capital programme in 20/21**. This would adversely impact operational capacity, Trust reputation and ultimately patient care.
Ability to spend contingency funding within financial year: £0.5m of unallocated contingency is held by the Trust.	• Formal communication started with NHSEI to begin process to re-provide funding for slipped projects into 21/22 and to release funding no longer required.	Chief Finance Officer Director of Strategy March	M - If capital funding applications are not approved in good time by NHSE/I **or the programme suffers operational slippage then the Trust will fail to deliver the capital programme in 20/21**. This would adversely impact operational capacity, Trust reputation and ultimately patient care.
9% (£9.2m) of the Plan is currently assessed at medium confidence of delivery: This mainly relates to Theatres Expansion of £4.1m and NNMC of £3.2m. Failure to deliver the Trust's capital plan could result in significant risks not being appropriately mitigated, potential loss of funding, and introduces reputational risk of the Trust being able to deliver its Plans.	• All projects rated as medium confidence of delivery to be subject to monthly review and appropriate actions identified to support delivery.	Director of Strategy Chief Information Officer Monthly	M - If capital funding applications are not approved in good time by NHSE/I **or the programme suffers operational slippage then the Trust will fail to deliver the capital programme in 20/21**. This would adversely impact operational capacity, Trust reputation and ultimately patient care.
Plan profile: £25.3m (25%) of the Capital Plan is forecast to be delivered in March 2021. This is 37% of the Plan excluding the £31.8m PFI lifecycle maintenance capitalisation. The profile of the Plan may result in lack of resource (people/equipment) to deliver projects and does not provide any contingency for unexpected delays.	• Resource requirements (people and equipment) have been identified as part of the business case development process and will be reviewed as funding is approved. • Monthly reviews of capital programme to identify issues with deliverability of projects and escalate as required.	Director of Strategy Monthly	M - If capital funding applications are not approved in good time by NHSE/I **or the programme suffers operational slippage then the Trust will fail to deliver the capital programme in 20/21**. This would adversely impact operational capacity, Trust reputation and ultimately patient care.
A surge in COVID-19 cases could impact on the Trust's ability to deliver its capital programme both in terms of resource availability and also access to areas of the Hospital under COVID restrictions.	• Monthly reviews of capital programme to identify issues with deliverability of projects and escalate as required.	Director of Strategy Monthly	M - If capital funding applications are not approved in good time by NHSE/I **or the programme suffers operational slippage then the Trust will fail to deliver the capital programme in 20/21**. This would adversely impact operational capacity, Trust reputation and ultimately patient care.

Norfolk and Norwich University Hospitals NHS Foundation Trust

9.1 Statement of Comprehensive Income

The reported period to date position on a control total basis for the period October to February is a surplus of £2.3m. This is a favourable position of £11.8m against plan of a £9.5m deficit. This consists of a £2.7m operating deficit before COVID, COVID costs of £6.9m offset by COVID income of £11.9m.

The Reported position on a control total basis for April to February was a surplus of £2.3m. This consists of a breakeven position for April-September and a £2.3m surplus for October-February. The headline deficit which includes donated income of £1.8m, donated asset depreciation of £1.2m, and impairments charges of £3.2m is £0.3m.

Month 11 (Feb-2021)	In Month Month 11 - February 2021			Apr 2020 - September 2020			October 2020 - March 2021 October 2020 - to Date			Year to Date			Forecast Outturn October 2020 - March 2021		
	Actual £m	Trust Plan £m	Variance £m	Actual £m	Trust Plan £m	Variance £m	Actual £m	Trust Plan £m	Variance £m	Actual £m	Trust Plan £m	Variance £m	FOT £m	Trust Plan £m	Variance £m
Clinical Income	46.7	46.6	0.1	282.4	282.7	(0.2)	233.1	232.9	0.229	515.5	515.5	(0.0)	279.4	279.4	0.0
NT Drugs Income	0.4	0.6	(0.2)	(0.4)	0.0	(0.4)	2.3	3.2	(0.9)	1.9	3.2	(1.3)	3.8	3.8	0.0
Total Clinical Income	**47.1**	**47.2**	**(0.1)**	**282.0**	**282.7**	**(0.6)**	**235.4**	**236.0**	**(0.7)**	**517.4**	**518.7**	**(1.3)**	**283.2**	**283.2**	**0.0**
Other Income Incl. Non NHS Clinical Income	14.9	14.4	0.5	74.4	75.3	(0.9)	74.6	71.6	3.0	149.0	146.9	2.1	91.1	86.0	5.1
Total Operating Income	**62.0**	**61.6**	**0.4**	**356.4**	**358.0**	**(1.6)**	**310.0**	**307.6**	**2.4**	**666.4**	**665.6**	**0.8**	**374.3**	**369.2**	**5.1**
Medical Staff	(11.1)	(10.9)	(0.1)	(64.4)	(64.9)	0.5	(55.6)	(54.7)	(0.9)	(120.0)	(119.6)	(0.5)	(65.6)	(65.6)	0.0
Nursing	(13.3)	(13.7)	0.3	(77.2)	(81.0)	3.8	(66.6)	(68.3)	1.7	(143.8)	(149.3)	5.5	(81.9)	(81.9)	0.0
A&C	(4.1)	(4.0)	(0.0)	(23.9)	(24.1)	0.2	(20.1)	(20.2)	0.1	(44.0)	(44.3)	0.3	(24.2)	(24.2)	0.0
Other Staffing Groups	(6.2)	(6.2)	0.0	(36.2)	(36.8)	0.6	(31.0)	(31.0)	(0.0)	(67.2)	(67.8)	0.5	(37.2)	(37.2)	0.0
Other Employee Expenses	0.1	(0.2)	0.3	(1.8)	0.3	(2.1)	(8.4)	(1.3)	(7.1)	(10.1)	(1.0)	(9.2)	(8.7)	(1.4)	(7.3)
Total Employee Expenses	**(34.5)**	**(35.0)**	**0.5**	**(203.4)**	**(206.4)**	**3.0**	**(181.7)**	**(175.4)**	**(6.3)**	**(385.1)**	**(381.8)**	**(3.3)**	**(217.7)**	**(210.4)**	**(7.3)**
Drugs Costs	(7.0)	(7.1)	0.1	(38.4)	(38.0)	(0.4)	(34.5)	(35.7)	1.2	(73.0)	(73.7)	0.7	(41.8)	(42.8)	1.0
Clinical Supplies	(4.9)	(6.9)	2.0	(29.3)	(35.3)	6.0	(28.9)	(34.5)	5.6	(58.2)	(69.8)	11.6	(35.1)	(41.4)	6.3
Non Clinical Supplies	(6.9)	(7.8)	1.0	(44.4)	(45.2)	0.9	(36.8)	(39.3)	2.6	(81.1)	(84.6)	3.4	(46.3)	(47.1)	0.8
PFI	(2.2)	(2.2)	0.1	(12.6)	(13.5)	0.9	(10.6)	(11.1)	0.5	(23.2)	(24.6)	1.4	(12.9)	(13.4)	0.5
Total Expenditure Excl. Employee Expenses	**(20.9)**	**(24.1)**	**3.2**	**(124.7)**	**(132.1)**	**7.3**	**(110.8)**	**(120.7)**	**9.9**	**(235.5)**	**(252.7)**	**17.2**	**(136.1)**	**(144.7)**	**8.6**
Total Operating Expenditure	**(55.5)**	**(59.1)**	**3.6**	**(328.2)**	**(338.5)**	**10.3**	**(292.5)**	**(296.1)**	**3.6**	**(620.7)**	**(634.5)**	**13.9**	**(353.8)**	**(355.1)**	**1.3**
Total Operating Surplus/(Deficit)	**6.6**	**2.5**	**4.1**	**28.3**	**19.5**	**8.8**	**17.5**	**11.6**	**5.9**	**45.8**	**31.1**	**14.7**	**20.5**	**14.1**	**6.4**
Total Non Operating Expenditure	(4.1)	(4.3)	0.3	(22.3)	(22.5)	0.2	(20.2)	(21.0)	0.8	(42.5)	(43.5)	1.0	(25.4)	(25.4)	0.0
Total Surplus/(Deficit)	**2.5**	**(1.8)**	**4.3**	**6.0**	**(3.0)**	**9.0**	**(2.7)**	**(9.5)**	**6.8**	**3.3**	**(12.5)**	**15.7**	**(5.0)**	**(11.4)**	**6.4**
COVID Expenditure	(1.9)	(4.5)	2.5	(15.8)	0.0	(15.8)	(6.9)	(18.2)	11.3	(22.7)	(18.2)	(4.5)	(9.3)	(31.3)	22.0
COVID Income	1.9	4.5	(2.5)	9.8	3.0	6.8	11.9	18.2	(6.3)	21.7	21.2	0.5	14.3	31.3	(17.0)
Total Surplus / (Deficit)	**2.5**	**(1.8)**	**4.3**	**0.0**	**(0.0)**	**0.0**	**2.3**	**(9.5)**	**11.8**	**2.3**	**(9.5)**	**11.8**	**0.0**	**(11.4)**	**11.4**
Control Total Adjustments															
Donated Income	0.4	0.7	(0.3)	0.1	0.1	0.0	1.7	4.3	(2.6)	1.8	4.3	(2.6)	5.0	5.0	0.0
Donated Assets Dep'n	(0.1)	(0.1)	(0.0)	(0.6)	(0.5)	(0.1)	(0.6)	(0.6)	0.0	(1.2)	(1.1)	(0.1)	(0.5)	(0.5)	0.0
Impairments	(3.2)	0.0	(3.2)	0.0	0.0	0.0	(3.2)	0.0	(3.2)	(3.2)	0.0	(3.2)	(3.2)	0.0	(3.2)
Headline Surplus / (Deficit) (Excl. COVID)	**(0.5)**	**(1.3)**	**0.8**	**(0.6)**	**(0.5)**	**(0.1)**	**0.2**	**(5.8)**	**6.0**	**(0.3)**	**(6.3)**	**5.9**	**1.3**	**(6.9)**	**8.2**

Norfolk and Norwich University Hospitals NHS Foundation Trust

9.2 Pay Expenditure

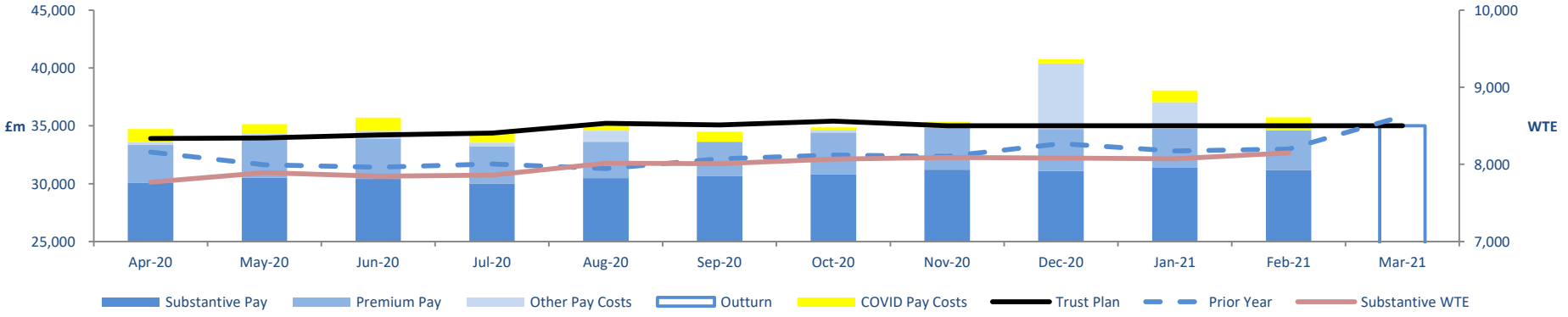
Year to date Pay expenditure is £385.1m, an adverse position to plan of £3.3m. This is made up of a favourable £3.0 from April to September and an adverse £6.3m for October to January. The YTD variance is due to the accrual for untaken annual leave (£7.3m) offset by; the delayed openings of the New Ward Block and IRU contributing c. £1.0m.

Pay Expenditure	Apr-20 £m	May-20 £m	Jun-20 £m	Jul-20 £m	Aug-20 £m	Sep-20 £m	Oct-20 £m	Nov-20 £m	Dec-20 £m	Jan-21 £m	Feb-21 £m	Mar-21 £m
Substantive staff	30.1	30.5	30.4	30.0	30.5	30.6	30.8	31.2	31.1	31.4	31.2	
Medical External Locum Staff	0.1	0.2	0.4	0.3	0.3	0.2	0.2	0.2	0.3	0.2	0.2	
Medical Internal Locum Staff	0.6	0.7	0.7	0.6	0.6	0.6	0.8	0.9	0.8	1.1	0.9	
Additional Medical Sessions	0.2	0.2	0.1	0.3	0.1	0.2	0.3	0.3	0.4	0.1	0.1	
Nursing Agency Staff	0.2	0.2	0.1	0.1	0.2	0.2	0.2	0.2	0.1	0.1	0.1	
Nursing Bank Staff	1.2	1.3	1.2	1.2	1.2	1.2	1.3	1.3	1.2	1.2	1.2	
Other Agency (AHPs/A&C)	0.2	0.2	0.4	0.3	0.3	0.3	0.3	0.3	0.3	0.2	0.2	
Other Bank (AHPs/A&C)	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	
Overtime	0.6	0.5	0.5	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.5	
Premium Pay	3.3	3.5	3.5	3.2	3.1	3.0	3.6	3.6	3.6	3.4	3.4	
Total Direct Pay Costs	33.4	34.1	33.9	33.2	33.6	33.6	34.4	34.8	34.7	34.8	34.6	
Redundancy	0.0	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Apprenticeship Levy	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	
Local CEA	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.1	(0.2)	
Central provision	0.0	0.0	0.4	0.0	0.7	(0.9)	0.0	0.0	5.3	2.1	0.0	
Total Other Pay Costs	0.2	0.2	0.6	0.3	1.0	(0.7)	0.2	0.2	5.7	2.3	(0.1)	
Total Pay Costs Excl COVID - Actual	33.6	34.3	34.6	33.6	34.6	33.0	34.7	35.1	40.4	37.1	34.5	
Total Pay Costs Excl COVID - Plan	33.9	34.0	34.2	34.4	35.2	35.1	35.4	35.0	35.0	35.0	35.0	
Favourable / (Adverse) v Plan	0.3	(0.4)	(0.3)	0.8	0.6	2.1	0.7	(0.1)	(5.4)	(2.1)	0.5	

Substantive WTE	Apr-20 WTE	May-20 WTE	Jun-20 WTE	Jul-20 WTE	Aug-20 WTE	Sep-20 WTE	Oct-20 WTE	Nov-20 WTE	Dec-20 WTE	Jan-21 WTE	Feb-21 WTE	Mar-21 WTE
A&C	1,574	1,577	1,583	1,578	1,578	1,598	1,565	1,570	1,598	1,572	1,566	
Medical	1,074	1,115	1,108	1,097	1,226	1,164	1,175	1,139	1,133	1,149	1,175	
Nursing	3,456	3,544	3,499	3,521	3,547	3,559	3,638	3,675	3,657	3,659	3,703	
Other	1,664	1,656	1,656	1,665	1,665	1,689	1,692	1,705	1,693	1,693	1,707	
Total	7,768	7,891	7,846	7,862	8,016	8,010	8,069	8,090	8,082	8,073	8,151	0

Premium Source (Excl COVID) Oct2020 to Date			Total Trust Total £m	Total Trust *Premium Cost* £m*
Medical	Source	Internal Locum	8.3	*1.7*
		External Locum	2.5	*1.3*
		WLI/NAG	2.5	*1.2*
		Total	**13.3**	***4.2***
Nursing	Source	Bank	13.5	*0.0*
		Overtime	2.9	*1.0*
		Agency	1.6	*0.4*
		Total	**17.9**	***1.3***
A&C & Other	Source	Bank	2.0	*0.0*
		Overtime	1.2	*0.4*
		Agency	2.9	*0.7*
		Total	**6.1**	***1.1***
Total	Source	Bank/Internal Locum	23.8	*1.7*
		Overtime	4.1	*1.4*
		Agency/External Locum	7.0	*2.3*
		WLI/NAG	2.5	*1.2*
		Total	**37.3**	***6.5***

** Incremental cost of premium staff over substantive staff*



Norfolk and Norwich University Hospitals NHS Foundation Trust

9.3 Statement of Financial Position

Property, plant and equipment
The key items are capital expenditure of £43.7m offset in part by depreciation of £15.0m and an impairment relating to the new ward block of £3.2m, together with a £31.8m transfer from trade and other receivables relating to the capitalisation of a lifecycle maintenance prepayment.

Trade and Other Receivables – non current
This balance is £25.3m lower than the opening balance, with the key item being a transfer of £31.8m to PPE for the capitalisation of a lifecycle maintenance prepayment.

Inventories
Inventories are £0.1m higher than the opening balance, mainly relating to an increase in implantable cardioverter defibrillator (ICD) stock.

Trade and Other Receivables - current
This balance is £6.0m lower than the opening balance. Debt being settled and not reinstated due to block contract.

Cash
Cash is £86.4m higher than the opening balance. The key reason is the payment of two months of clinical income & top-up income in April – this totals £53.4m. Following the release of guidance, it has been confirmed that this will reverse in March.

Trade and other payables
This is £16.3m higher than the opening balance. The opening balance was abnormally low because an extra payment run was made to suppliers at the end of 2019/20 due to COVID and the Octagon payment was made in advance, offset by high capital accruals. Since then the capital accruals have been largely settled and the Octagon payment has unwound and is accrued as normal at end February. A £7.3m holiday pay accrual has been made due to the inability of staff to be able to take their full allowance due to COVID. The closing balance reflects the above.

Borrowings
The £195.1m decrease in current borrowings relates to a debt to equity switch detailed in the PDC section below. The £3.0m decrease in non-current borrowings compared to the opening balance is the repayments relating to the PFI contract and Fuji PACS finance lease.

Deferred Income
This balance is £69.3m higher than the opening balance. The key item is the deferral of the receipt of March's clinical income & top-up income of £53.4m received in February.

Public Dividend Capital (PDC)
This balance is £224.6m higher than the opening balance. The key item is the receipt of £195.1m of funding to repay DHSC revenue and capital borrowings as part of a mandated debt to equity switch. It also includes in year PDC funding, for example £14.1m for the new ward block.

February 2021	Actual Mar-20 £m	Actual Feb-21 £m	Movement £m	Prior Month £m
Property, plant and equipment	268.1	325.5	57.4	320.9
Trade and other receivables	84.0	58.7	(25.3)	58.2
Total non-current assets	**352.1**	**384.2**	**32.1**	**379.1**
Inventories	11.9	12.0	0.1	12.2
Trade and other receivables	36.4	30.4	(6.0)	32.3
cash and cash equivalents	13.4	99.8	86.4	94.8
Total Current assets	**61.7**	**142.2**	**80.5**	**139.3**
Trade and other payables	(73.0)	(89.3)	(16.3)	(89.3)
Borrowing repayable within 1 year	(195.1)	0.0	195.1	0.0
Provisions	(0.3)	(0.3)	0.0	(0.8)
Deferred Income	(14.6)	(83.9)	(69.3)	(77.8)
Total current liabilities	**(283.0)**	**(173.5)**	**109.5**	**(167.9)**
Total assets less current liabilities	**130.8**	**352.9**	**222.1**	**350.5**
Borrowings - PFI & Finance Lease	(187.4)	(184.4)	3.0	(184.7)
Borrowings - Revenue Support	0.0	0.0	0.0	0.0
Borrowings - Capital Support	0.0	0.0	0.0	0.0
Provisions	(4.7)	(4.6)	0.1	(4.5)
Deferred Income	(3.5)	(4.4)	(0.9)	(4.5)
Total non-current liabilities	**(195.6)**	**(193.4)**	**2.2**	**(193.7)**
Total assets employed	**(64.8)**	**159.5**	**224.3**	**156.8**
Financed by				
Public dividend capital	38.5	263.1	224.6	263.1
Retained Earnings (Accumulated Losses)	(128.6)	(125.5)	3.1	(131.5)
Revaluation reserve	25.3	21.9	(3.4)	25.2
Total Taxpayers' and others' equity	**(64.8)**	**159.5**	**224.3**	**156.8**

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

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REPORT TO THE TRUST BOARD

Date	**7 April 2021**
Title	**Chair's Key Issues from People and Culture Committee Meeting on 29.03.21**
Lead	**Professor David Richardson (Committee Chair)**
Purpose	**For Information and assurance**

1 Background/Context

The People and Culture Committee held its latest meeting on 29 March 2021. Papers for the meeting were circulated to Board members for information in the usual way. The meeting was quorate and was held via MS Teams; it was attended by Carol Edwards (Public Governor) as observer. Due to the Covid-19 pandemic precautions, the meeting was not preceded by clinical/departmental visits.

2 Key Issues/Risks/Actions

The following items were identified to highlight to the Board:		
1	Workforce IPR	The Committee reviewed the Workforce IPR and key people metrics. There are obvious concerns about the impact of the pandemic on staff and risks around staff retention post-pandemic were highlighted. The Committee encouraged a proactive approach to identify particular staff groups in need of support and an update will be provided to the next meeting of the Committee regarding early retirement risks and mitigation actions.
2	Reports from Divisional Boards	The Committee received reports from each of the Divisional Triumvirates, with respect to People and Culture elements of their Divisions. There was a rich discussion, particularly noting the impact of the pandemic on teams. Issues such as redeployment, significant pressures in workload and changes in the way staff have been required to work, have all had an impact on staff morale. The Committee discussed the importance of staff empowerment. At times of financial or operational stress there can be a need for a more 'Command and Control' approach to ensure delivery of key actions and decisions. The discussion highlighted that it is important we move back towards a transformational leadership style to engage with staff and empower them to take responsibility and make decisions to progress service improvements.
3	National People Plan	The Committee reviewed an update to the Action Plan in response to the National People Plan. It was noted that a large number of the recommendations are led by other elements in the system, rather than by individual provider Trusts, but these will still require action on our part to optimise impact for staff. The Committee encouraged progress in priority areas, such as the Accelerated Leadership programme, which is due to be launched at the beginning of May 2021.

4	Staff survey results update	The Committee reviewed an update relating to the Staff Survey results and associated actions. The Committee supported a systematic approach over several years. A core element concerns 'Listening events' for staff to reflect on their experience of working in the Trust and what we can learn and identify as improvement actions. It was noted that this includes, but goes wider than, reflecting on the pandemic period. The Committee discussed the importance of clearly communicating the actions taken in response to these discussions – so that they are seen as meaningful and productive.

3 Conclusions/Outcome/Next steps

The Committee deferred a number of items on the agenda for discussion at its next meeting on 24 May 2021 in order to give due time for consideration.

Recommendation:

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

Microsoft | Power BI

Workforce

View in Power BI

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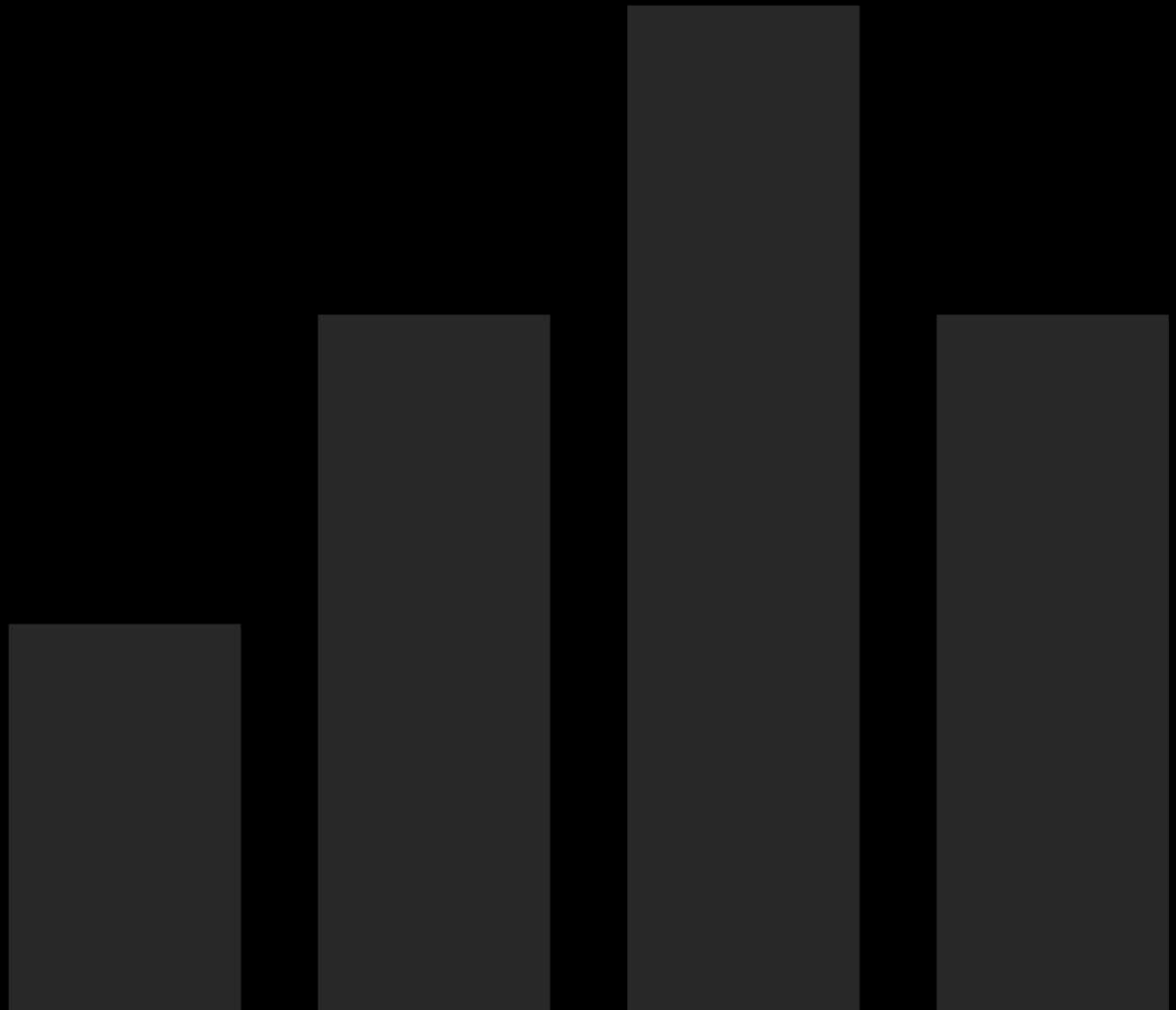
Downloaded at:
18/03/2021 11:15:56 GMT Standard Time



Workforce Summary

All metrics designated as Trust IPR Metrics, where the variation for the latest month of data was not common cause.

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business intelligence

Topic	Metric Name	Date	Result	Variation	Assurance
Recruitment (Non-Medical)	Time to Hire - Time with Manager	Feb 2021	13.7	Improvement (Low)	No Target
Recruitment (Non-Medical)	Time to Hire - Total	Feb 2021	51.9	Improvement (Low)	Unreliable
Staff in Post	Actual Substantive Headcount (WTE)	Feb 2021	8,184	Improvement (High)	No Target
Vacancies	Variance: Headcount (WTE)	Feb 2021	-546	Improvement (High)	Not capable
Non-Medical Appraisals	Non-Medical Appraisal	Feb 2021	76.6%	Concern (Low)	Not capable
Sickness Absence	Monthly Sickness Absence %	Feb 2021	5.1%	Concern (High)	Unreliable

SPC Variation Icons

Common Cause | Concern (High) | Concern (Low) | Improvement (High) | Improvement (Low)

SPC Assurance Icons

Capable | Not capable | Unreliable

Mandatory Training

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business intelligence

Mandatory Training

Feb 2021

Variation	Assurance
	

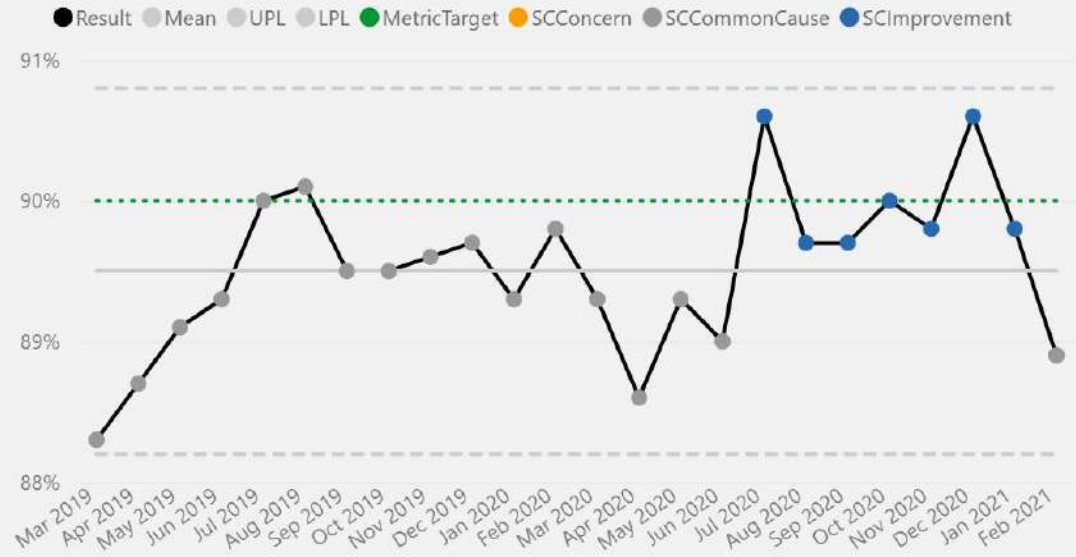
88.9% Result
90.0% Target

90.8% UPL
89.5% Mean
88.2% LPL

Analytical Commentary

Variation is Common Cause

Mandatory Training



Assurance Commentary

As at the end of February, the compliance rate was 88.9%. There is confidence that as the pressures of the pandemic ease, the compliance rate will again exceed 90%.

Improvement Actions

A series of improvements and interventions have been in place to support mandatory training compliance. More training topics are being made available by eLearning and targeted messages are being sent to non-compliant staff to advise them to complete this learning on-line.

Non-Medical Appraisals

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business intelligence

Non-Medical Appraisal

Feb 2021

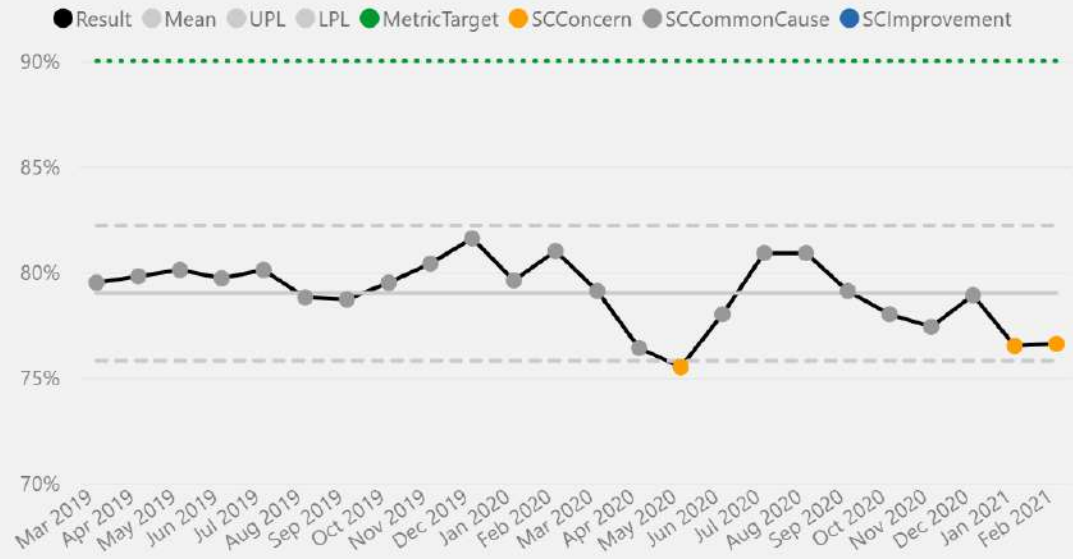
Variation	Assurance
L	F

76.6% Result	82.2% UPL
90.0% Target	79.0% Mean
	75.8% LPL

Analytical Commentary

2 out of 3 data points have been close to the process limits, and therefore the variation is Special Cause Variation - Concern (Low)

Non-Medical Appraisal



Assurance Commentary

For appraisals, the Operating Plan for 2020/21 reflects an aspiration for 90% compliance but accepting that consistently exceeding 85% compliance would represent excellent progress.

76.6% of eligible staff (Non-Medical appraisals) had an appraisal during the last 12 months.

The new 'appraisal' process, Check In Check Out (CICO), was launched on 21st September. This replaces the appraisal process and simplifies the approach from both a manager and staff perspective.

Efforts to deliver improvements will resurrect as the pressures of the pandemic begin to ease.

Improvement Actions

21/09/2020 – A replacement to appraisal introduced – Check In Check Out.

Sickness Absence

NNUH Digital Health
business intelligence

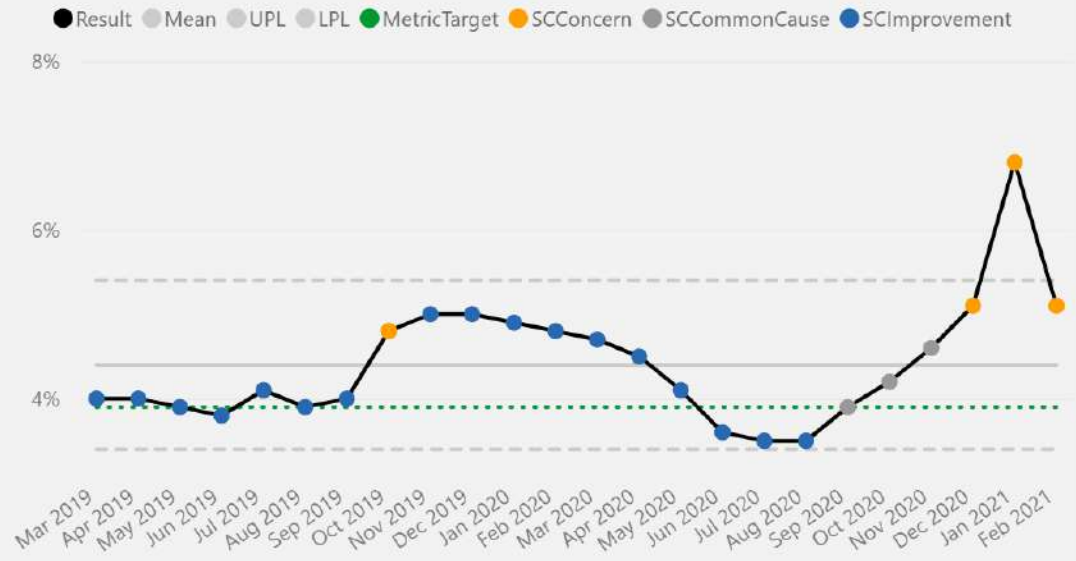
Monthly Sickness Absence %

Feb 2021

Variation	Assurance
H	?

5.1% Result	5.4% UPL
3.9% Target	4.4% Mean
	3.4% LPL

Monthly Sickness Absence %



Improvement Actions

Jan-2020 – Sickness Absence – a focus at Performance Committees
Mar-2020 – Covid impact on sickness absence
Jul-2020 - HMB Paper highlighting interventions focused on minimising and preventing long term sickness absences
Oct-2020 – A refresh of the attendance policy and toolkits were approved at PACS on 15/10/2020
Nov-2020 – Further spike in Covid sickness absence

Analytical Commentary

2 out of 3 data points have been close to the process limits, and therefore the variation is Special Cause Variation - Concern (High)

Assurance Commentary

The Operating Plan for 2020/21 has set a challenging 12 month rolling average target of 3.9% for sickness. As at 28 February 2021, that rate is 4.45%. The monthly absence figure for February is 5.09%.

All figures since March 2019 include Covid related sickness absence. Had Covid been excluded the rates from March would have been significantly lower – March (4.08%) April (3.19%) May (3.27%) June (3.27%), and July (3.30%), August (3.29%), September (3.65%), October (3.93%), November (3.95%), December (3.94%), January (4.06%) and February (3.88%).

The 12-month rolling average is 4.45% but if Covid sickness is excluded, the rate is 3.65%.

Staff Turnover

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business intelligence

Monthly Turnover

Feb 2021

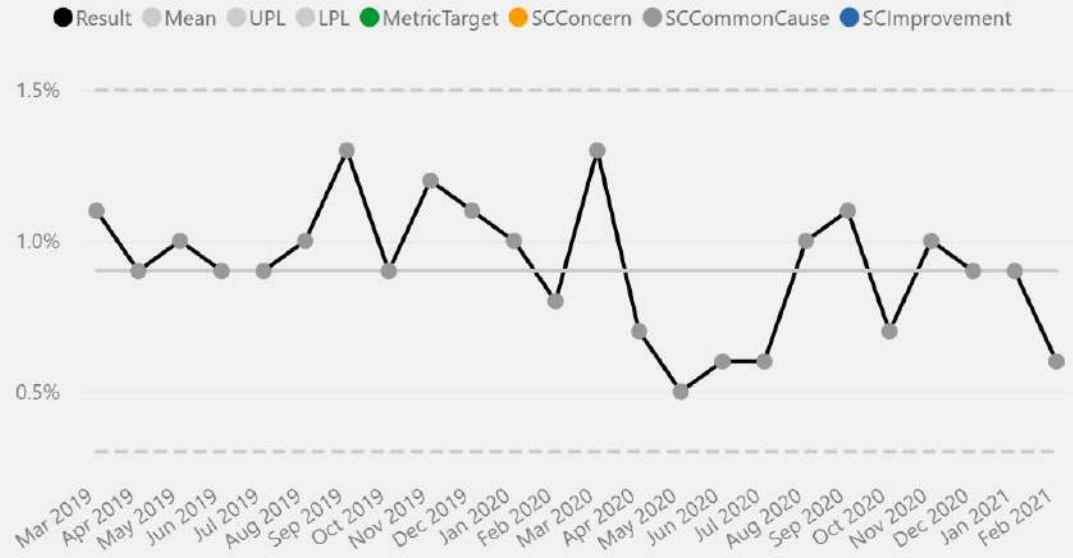
Variation | Assurance

0.6% Result	1.5% UPL
N/A Target	0.9% Mean
	0.3% LPL

Analytical Commentary

Variation is Common Cause

Monthly Turnover



Assurance Commentary

The monthly turnover rate for February 2021 is 0.62% - a decrease from January. It is noted that the numbers of leavers for February (44.0 WTE) is actually fewer than for February 2020 (52.2 WTE).

The 12-month average for turnover is 10.0%, the 11th consecutive monthly reduction, from the peak of 12.4% (March 2020).

Improvement Actions

Staff in Post

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business intelligence

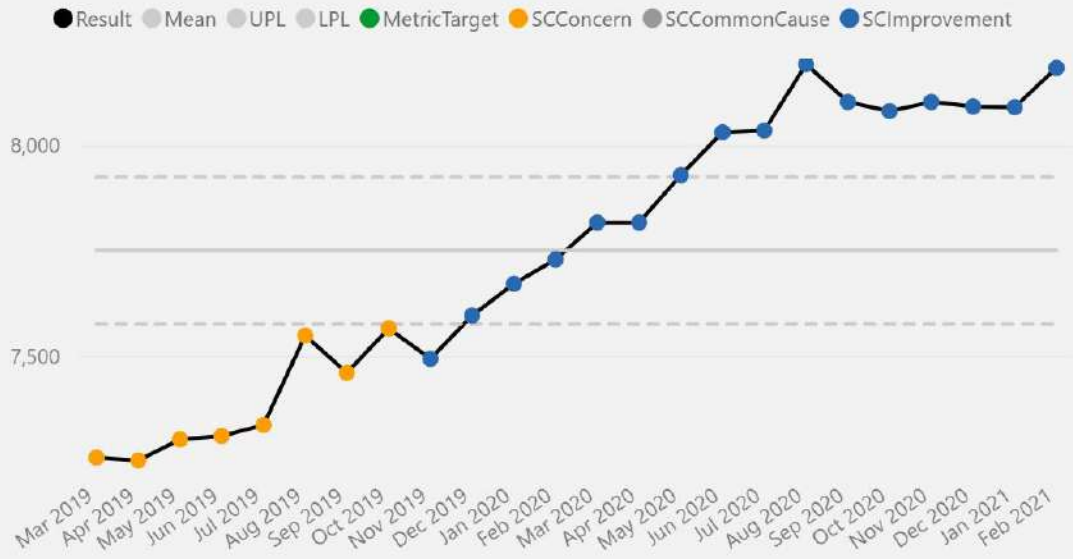
Actual Substantive Headcount (WTE)

Feb 2021

Variation	Assurance
	

8,184 Result	7,924 UPL
N/A Target	7,750 Mean
	7,575 LPL

Actual Substantive Headcount (WTE)



Improvement Actions

Sept/ Oct 2020 - end of fixed term contracts, including for temporary Covid support workers – leading to staffing reduction.

Analytical Commentary

Data point fell outside of process limits, Data is consistently above mean, and therefore the variation is Special Cause Variation - Improvement (High)

Assurance Commentary

Since April 2020 there has been an increase of 4.9%, 377.7 WTE (7,730.2 staff in post 31-Mar-20)

Since April 2019 there has been an increase of 13.0%, 930.4 WTE (7,177.5 staff in post 31-Mar-19)

Since April 2018 there has been an increase of 19.5%, 1,320.8 WTE (6,787.1 staff in post 31-Mar-18)

Since April 2017 there has been an increase of 25.8%, 1,660.3 WTE (6,447.6 staff in post 31-Mar-17)

Taking RNM, from April 2015 to February 2021, the staff in post has increased to 2,390.6, a growth of 26.1% (494.6 WTE). Similarly, over the same period for Nursing support workers, the staff in post has increased to 1,100, a growth of 87.3% (513 WTE).

Vacancies

NNUH Digital Health
business intelligence

Variance: Headcount (WTE)

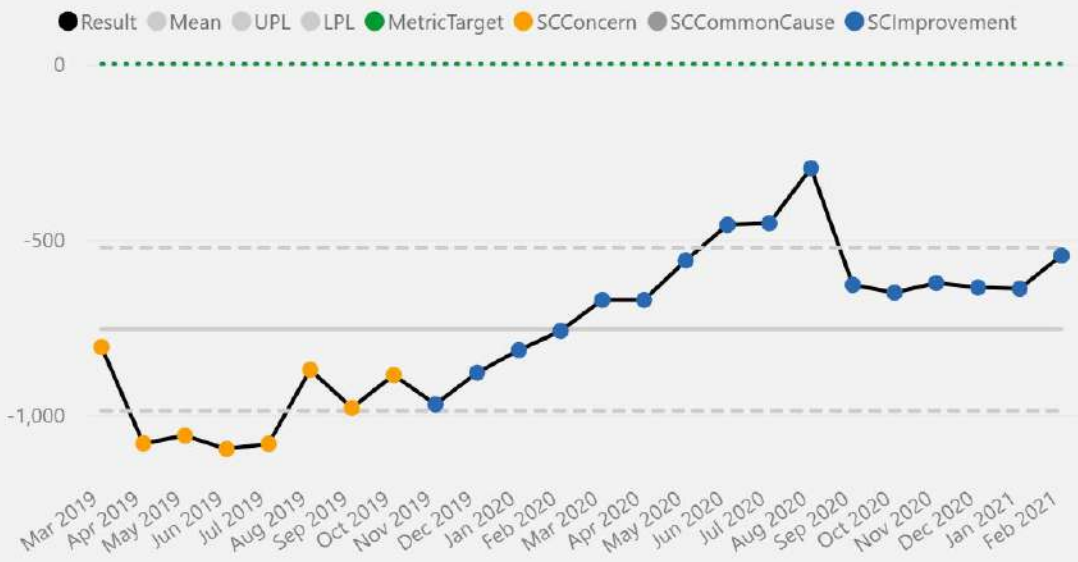
Feb 2021

Variation	Assurance
H	F

-546 Result
0 Target

-523 UPL
-755 Mean
-988 LPL

Variance: Headcount (WTE)



Analytical Commentary

Data is consistently above mean, and therefore the variation is Special Cause Variation - Improvement (High)

Assurance Commentary

Since April 2020 there has been an increase of 4.9%, 377.7 WTE (7,730.2 staff in post 31-Mar-20)

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Improvement Actions

Sept/ Oct 2020 - Finance establishment for September has been revised to 8,732.1, an increase of 243.2 (which includes 111 posts for the new ward block).

Sept/ Oct 2020 - End of fixed term contracts, including for temporary Covid support workers – leading to staffing reduction and vacancy increase.

Recruitment (Non-Medical)

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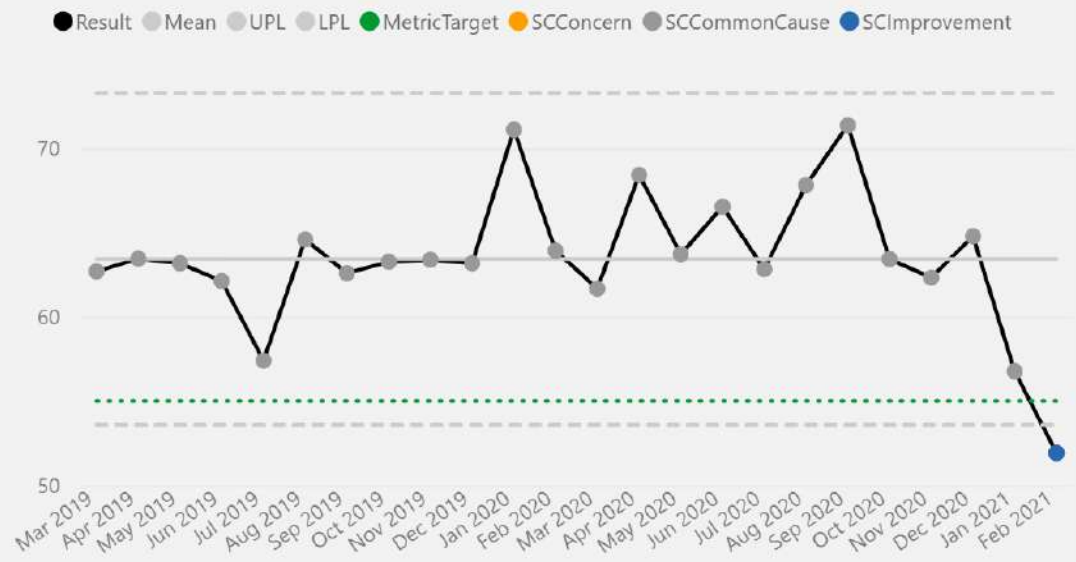
Time to Hire - Total

Feb 2021

Variation	Assurance
L	?

51.9 Result	73.3 UPL
55.0 Target	63.4 Mean
	53.6 LPL

Time to Hire - Total



Analytical Commentary

Data point fell outside of process limits, and therefore the variation is Special Cause Variation - Improvement (Low)

Assurance Commentary

There is an ambitious time to hire target of 55 days with time with manager set at 15 days. The performance committees include a focus on time to hire and supportive measures to enable improvements. The Recruitment and Resourcing Improvement Group will recommence meeting to continue to assist with improvements to the time to hire.

For February the time to hire figure is 51.9 days

Improvement Actions

Oct-2018 – Additional resources approved for the Recruitment team in HR.

Aug-2020 – Resourcing pressures on WHWB due to Covid has led to delays in completing OH checks

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Time to Hire - Time with Manager	Feb 2021	13.7		Improvement (Low)		No Target

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REPORT TO THE TRUST BOARD OF DIRECTORS	
Date	7 April 2021
Title	CQC Quality Improvement Plan – Must Do and Should Do Recommendations for Urgent and Emergency Care
Authors: **Executive leads:**	Dr Caroline Kavanagh (Associate Medical Director for Urgent and Emergency Care), Jess Woodhouse (Improvement Manager), Vicky Thompson (Associate Director of Quality Improvement - Governance and Assurance) and Urgent and Emergency Care Senior Management Team Professor Nancy Fontaine (Chief Nurse) and Professor Erika Denton (Medical Director)
Purpose	For Information

1. Executive Summary

This paper provides an overview of the 'Must Do' and 'Should Do' recommendations for Urgent and Emergency Care services published by the CQC in February 2021. The CQC Quality Improvement Plan (QIP) (Appendix 1) details the actions the Trust will take to address the 'Must Do' and 'Should Do' recommendations identified in the report.

This report has previously been reviewed and noted at Quality Programme Board (QPB) and Quality and Safety Committee.

To ensure delivery of the improvements to meet the recommendations, this improvement plan cannot been seen or reviewed in isolation to the wider improvement work being undertaken across the trust in relation to other CQC recommendations but also other improvement work on discharge planning and Discharge to Assess, Red too Green (R2G) and The NNUH Safer Better Faster (SBF) Improvement Programme which focuses on improving emergency and urgent care (EUC) across the organisation; the primary aim is reducing delays so flow is maintained in through and out of the hospital.

The SBF programme brings together a number of key aspects of the national Emergency Access Standards including 7 day services and ambulance handovers.

The combination of these improvements and the work being undertaken to support the trusts journey to outstanding will support the delivery of these recommendations throughout the organisation and wider integrated care system.

2. Background/Context

On 8th December 2020, the CQC carried out an unannounced inspection of Urgent and Emergency Care services. The CQC issued a Section 29A warning notice and published the full report on 16th February 2021.

Urgent and Emergency Care services were rated overall as 'requires improvement'.

3. CQC 'Must Do' and 'Should Do' Recommendations

The CQC inspection report makes 4 'Must Do' and 5 'Should Do' recommendations for the services inspected. These 9 recommendations are summarised in Table 1 below.

Table 1 CQC 'Must Do' and 'Should Do' Recommendations for Core Services

Area	Level	Recommendation
CORE SERVICES		
Urgent and Emergency Care	**Must Do**	The trust must ensure ED staff embed an effective form of triage prioritisation to better respond to patients at greater risk of deterioration.
		The trust must ensure they continue to do all that is reasonably practical to mitigate the risks of failing to meet key national and trust performance targets such as the four-hour standard, triage within an hour of patient's arrival and monthly decision to admit (DTA) patient numbers.
		The trust must ensure ED nursing staff pressures do not cause delays in triage and the allocated safety nurse can fulfil their role properly.
		The trust must also ensure fewer of their junior medical staff are locums, and medical staff shortages do not limit their ability to set up SDEC pathways.
	Should Do	The trust should ensure all ED staff adhere to the latest PPE guidance for COVID-19 and hand hygiene policy when treating patients.
		The trust should ensure ED staff in all area's complete daily checklists on all emergency equipment and medicine boxes.

		The trust should ensure all ED areas offer patients a suitable environment with clear signposting to help them socially distance.
		The trust should ensure that patients waiting areas are organised in a manner to prevent cross contamination or risk in line with social distancing.
		The trust should ensure that there are sufficient numbers of consultants within the Children's ED (ChEd) in line with guidance.

4. CQC Quality Improvement Plan (QIP)

The Trust has developed the CQC Quality Improvement Action Plan (QIP) (Appendix 1) in line with the 28-day timeline advised by the CQC. The action plan provides an overview of the Trust's response to the 9 'Must Do' and 'Should Do' recommendations and forms an immediate programme of improvement work. 2 of the 'Should Do' recommendations have been combined in the QIP.

The QIP provides an overview of the Trust's response to each recommendation and is aligned with the format and content of the CQC reporting domains. The QIP contains an action plan for each recommendation, provides clearly stated desired outcome statements (what Good looks like) and is supported by defined actions and timescales for delivery. Each recommendation has an assigned Senior Responsible Officer and Operational Delivery Lead.

In addition, each recommendation has been added to the schedule for discussion at Evidence Group and has an evidence sheet for assurance. These evidence sheets describe the concerns raised by the CQC in their inspection report. They define what Good and Outstanding look like, as set out in the CQC core services (Urgent and Emergency Services) framework and key lines of enquiry. The actions required to achieve Good and Outstanding are set out and progress against each recommendation and the agreed action plan will be reviewed through Evidence Group and reported to the Trust's Quality Programme Board (QPB).

5. Update on QIP as of 31/3/21

- New triage processes involve monitoring triage times and priority chairs highlighting patients who are at higher risk of deterioration
- New Emergency access standards adopted to ensure ED attendance avoidance where appropriate (e.g. SDEC) and the IMT

meeting focus on the Divisions in regards to flow trajectories for admitted patients

- Appropriate ED nursing staffing levels and enablement of the ED safety nurse function ensured
- Overseas programme of middle grade doctor recruitment now live and other new middle grade appointments ongoing
- IP&C improvements involving team challenge and enhanced perfect ward monitoring underway
- Ongoing software instalment to improve medicine access safety
- ED waiting areas with socially distanced chairs and signage improved
- 3 WTE CHED Consultants appointed joining from March-August 2021

6. Next Steps

The CQC QIP was submitted to the CQC on 12th March 2021. The CQC will be attending the next QPB on the 13th April to hear about progress and improvements that have been made since their inspection.

All recommendations have been added to the Trust's Power BI dashboard, which monitors and tracks progress, and have been approved at the 9th March 2021 meeting of QPB. All recommendations will be added to the schedule for discussion at upcoming Evidence Groups.

Further, the recent internal audit recommendations agreed on the 18/3/21 are now integrated into the overarching ED / Urgent and Emergence Care Improvement plan, and all evidence against the recommendations will be scrutinised through the Evidence Group, chaired by the Chief Nurse/ Medical Director and will continue to be presented at QPB.

To ensure we have continued patient engagement and experience reflected across all our improvement plans we will do further work to ensure that the patient voice is represented in the 'what good looks like' sections of the QIP, we also envisage restarting the Quality Assurance Audits (QAA) with Patient Panel involvement once visiting recommences on 12th April.

To enable sustainable improvements in all aspects of Emergency and Urgent care and specifically to support us to improve the Emergency Department pathways we need to ensure all patient pathways, patient flow and capacity building improvement activity is connected and appropriate links and co-production is in place with all stakeholders. This will be achieved through the cross fertilisation of both clinical experts and improvement colleagues supporting improvements and change to take place.

Appendix 1 – CQC Improvement Plan February 2021

Adobe Acrobat Document

Action the trust MUST take to improve

Urgent and Emergency Care

Ref	Recommendation	Regulation	Desired Outcome ('What does good look like?)	Recommendation Completion Date	Executive SRO	Operational Lead
EUC40.1	**The trust must ensure ED staff implement some form of triage prioritisation to better respond to patients at greater risk of deterioration.**	Regulation 12	• There are processes in place to ensure appropriate prioritisation of patients. • The Triage nurse role card includes observation of patients in the waiting room. • A process is in place for identifying and escalating deteriorating patients on Symphony. • A SOP and training is in place to include Navigation and Streaming. • An audit is taking place with regular results to evidence compliance with SOPs and processes. • HealthRoster competencies for Streaming and a set shift for streaming are in place to ensure staff have the correct competencies. • A dedicated space is identified to run triage from. • At times of need for increased triage an escalation space is available. • An escalation process & SOP is in place if triage times are above the target time of 15 minutes. • Prompt prioritisation of sick patients to RATS and Resus can be demonstrated through Symphony audits	31/05/2021	Associate Medical Director for Emergency and Urgent Care	ED Senior Matron
Current position	• SOP being written for discussion at Emergency Department Clinical Governance on March 25th, process already in place but this will ensure robust education and audit around the process, change of role names (e.g. Streaming and Navigating). • Competencies are already being added to Health Roster and the rostering team will be creating a new roster template from May 31st roster. • The role cards already explicitly state that the Triage nurse has observation of the waiting room. • Escalation processes are already outlined in the role cards but will be included in the SOP. • Risk to be written. • Estates work ongoing. • Information services now providing data of time to triage broken down by first location to allow for further analysis. • The average time from arrival to initial assessment (triage) in February 2021 was 15 minutes for non-admitted patients and 17 minutes for admitted patients. • Currently 7.09 vacancies out of a 147.76 WTE nursing establishment (4.8%) - see further detail under EUC42.1 below					
Local actions to achieve desired outcome						
EUC40.1.1	Implement process for appropriate prioritisation of patients					
EUC40.1.2	Implement ongoing audits of the process for identifying and escalating deteriorating patients on Symphony					
EUC40.1.3	Implement SOP and training to include Navigation and Streaming.					

EUC40.1.4	Implement audit of navigation, streaming, prioritisation and escalation processes.
EUC40.1.5	Implement HealthRoster competencies for Streaming and a set shift for streaming.
EUC40.1.6	Ensure the role card for the Triage nurse includes observation of patients in the waiting room.
EUC40.1.7	Identify a dedicated space to run triage from and escalation space for times of need for increased triage.
EUC40.1.8	Implement escalation process & SOP for when triage times are outside target of 15 minutes.
EUC40.1.9	Add risk to risk register regarding inability to triage 100% of patients within 15 minutes.
EUC40.1.10	Conduct analysis of time from arrival to RATS (cubicles 5-19) or resus (since 15th Feb) to demonstrate prompt prioritisation of sick patients

CQC Improvement Plan - February 2021

Ref	Recommendation	Regulation	Desired Outcome ('What does good look like?)	Recommendation Completion Date	Executive SRO	Operational Lead
EUC41.1	**The trust must ensure they continue to do all that is reasonably practical to mitigate the risks of failing to meet key national and trust performance targets such as the four-hour standard, triage within an hour of patient's arrival and monthly decision to admit (DTA) patient numbers.**	Regulation 12	• Immediate breach analysis is in place for all patients that breach the 4 hour performance standard • Performance against the 4 hour standard is no lower than 75% • Divisional scrutiny of relevant performance metrics in the Internal Professional Standards is in place • Weekly monitoring of all key performance metrics with the EUC Triumvirate is in place and reported to ED monthly Directorate meeting with specific and targeted plans for improvement • Sustained improvement is seen in the key metrics identified: o 12 hour breaches (NNUH and Mental Health) o 4 hour breaches / 4 hour performance o Time to triage o Time to first clinician o Ambulance handovers within 15 minutes o Median time in department o More than 12 hours from DTA o More than 4 hours from DTA o Median time from DTA to admission • Monitoring is in place for all of the new performance metrics currently being consulted on	30/09/2021	Associate Medical Director for Emergency and Urgent Care	Operational Manager - Emergency Department
Current position	• Immediate breach analysis is done on an ad hoc basis via the 3 hourly ED Safety Huddle and this process will be formalised. • Trajectory for the 4 hour performance standard has been for March to June 2021. • The performance matrix is discussed at the Emergency Department's monthly Directorate Meeting. • Weekly monitoring of the performance matrix is conducted at the Patient Flow through ED work stream meeting. • The agreed new performance matrix will be incorporated into the monitoring forums mentioned above. • The percentage of ambulances handed over within 15 minutes was 52.6% in February 2021. • 4 hour breach performance for February 2021 was 80.4%.					
Local actions to achieve desired outcome						
EUC41.1.1	Implement immediate breach analysis for all patients that breach the 4 hour performance standard by Lead Nurse, Operational Manager and Flow Coordinator – during daytime hours					
EUC41.1.2	To set a trajectory for NNUH performance against the 4 hour standard to achieve no lower than 75% by 30 June 2021					
EUC41.1.3	Implement Divisional scrutiny of relevant performance metrics in the Internal Professional Standards including time from DTA to admission and time from referral to seen by specialty					
EUC41.1.4	Establish weekly monitoring of all key performance metrics with the EUC Triumvirate and reported to ED monthly Directorate meeting with specific and targeted plans for improvement.					
EUC41.1.5	Monitoring is in place for all of the new performance metrics currently being consulted on.					

CQC Improvement Plan - February 2021

Ref	Recommendation	Regulation	Desired Outcome ('What does good look like?)	Recommendation Completion Date	Executive SRO	Operational Lead
EUC42.1	**The trust must ensure ED nursing staff pressures do not cause delays in triage and the allocated safety nurse can fulfil their role properly.**	Regulation 18	• Relates to EUC40.1 • The Safety Nurse role is prioritised and competencies are clearly demonstrated on Health Roster. • The funded establishment meets the demand of the service • A recruitment trajectory is agreed for full establishment of nurses • There is a robust process for sickness management –Alice and admin team, B6/B7 competency training pack includes management of sickness • A skill gap analysis has been completed by PDN and all skills are uploaded • An appropriate proportion of staff meet level 1 and level 2 Nursing Workforce standards • A plan is in place to mitigate risks of staffing mix and education profile • Role cards are in place for key roles including escalation. Role cards identify which level of competency is required for each role.	31/05/2021	Associate Medical Director for Emergency and Urgent Care	ED Senior Matron
Current position	• Competencies are already being added to Health Roster and the rostering team will be creating a new roster template from May 31st roster. • Annual establishment review has been undertaken – awaiting finance approval • BEST audit being planned • Recruitment trajectory to be supplied • SOP for Emergency Department sickness management • Practice Development Nurse currently undertaking skills gap analysis • Roster will evidence Level 1 and Level 2 nurse availability • Staffing escalation plan to be written • Role cards already written and contain competencies to be expanded to contain RCN levels • The average time from arrival to initial assessment (triage) in February 2021 was 15 minutes for non-admitted patients and 17 minutes for admitted patients. • Currently 7.09 vacancies out of a 147.76 WTE nursing establishment (4.8%): - Band 4: Budget 5.9 WTE, in post 8.0 WTE - Band 5: Budget 91.8 WTE, in post 91.61 WTE - Band 6: Budget 28.9 WTE, in post 21.72 WTE * - Band 7: Budget 21.16 WTE, in post 19.34 WTE * The 7.18 WTE Band 6 vacancies have been appointed to; these will convert to Band 5 vacancies as all appointments were internal promotions					
Local actions to achieve desired outcome						
EUC42.1.1	To ensure the Safety Nurse role is prioritised and competencies are clearly demonstrated on Health Roster.					
EUC42.1.2	To ensure the funded establishment meets the demand of the service					
EUC42.1.3	To agree a recruitment trajectory for full establishment of nurses					
EUC42.1.4	Implement a robust process for sickness management					

EUC42.1.5	PDN to complete skill gap analysis and ensure all skills are uploaded.
EUC42.1.6	Ensure an appropriate proportion of staff meet level 1 and level 2 Nursing Workforce standards.
EUC42.1.7	Ensure a plan is in place to mitigate risks of staffing mix and education profile.
EUC42.1.8	Ensure role cards are in place for key roles including escalation. Ensure role cards identify which level of competency is required for each role.

CQC Improvement Plan - February 2021

Ref	Recommendation	Regulation	Desired Outcome ('What does good look like?)	Recommendation Completion Date	Executive SRO	Operational Lead
EUC43.1	**The trust must also ensure fewer of their junior medical staff are locums, and medical staff shortages do not limit their ability to set up SDEC pathways.**	Regulation 18	• 8 new substantive Consultant positions that have been recruited commence (between March and August 2021) • ACP recruitment and credentialing plans are in place • All regular locums are included in distribution lists for safety notices/clinical governance • Additional Paediatric Emergency Medicine (PEM) trainees have been requested from Health Education England • Additional 13 x Senior Decision Makers have been recruited through ECIST recommended agency • An enhanced business case for further Emergency Department medical staffing has been written. • The Trust's first ED Nurse Consultant is in post with plans for ongoing recruitment. • An SDEC service has been established, with ongoing multi-disciplinary team pathway development (NB - SDEC is run by Medicine Division)	30/09/2021	Associate Medical Director for Emergency and Urgent Care	Service Director
Current position	• Designated consultant with allocated SpA time for recruitment and retention proving successful. • 8 new WTE substantive (5 Adult, 2PEM and 2 Paeds) Consultant positions have been interviewed and offered posts to commence (between March and September 2021). • ACP recruitment and credentialing plans are in place. • Funding has recently been approved and released to recruit an additional 13 x Senior Decision Makers (Senior Clinical Fellow posts) through ECIST recommended agency. Service Director and Recruitment and Retention Lead Consultant are leading on this. • An enhanced business case for further Emergency Department medical staffing has been partially written by Recruitment and Retention Lead Consultant. • Interviewing applicants for ED Nurse Consultant on 30th March 2021 • Interviewed and offered posts to 2 Junior Clinical Fellows and 1 Senior Clinical Fellow commencing summer 2021 - dependent on the impact of Covid on foreign travel and recruitment outside the UK. • Advertised for and interviewing for a Specialty Doctor post in April 2021. • All regular locums are included in distribution lists for safety notices/clinical governance.					
Local actions to achieve desired outcome						
EUC43.1.1	Ensure 8 new substantive Consultant positions that have been recruited commence (between March and August 2021)					
EUC43.1.2	Ensure ACP recruitment and credentialing plans are in place					
EUC43.1.3	Ensure all regular locums are included in distribution lists for safety notices/clinical governance					
EUC43.1.4	Request additional Paediatric Emergency Medicine (PEM) trainees from Health Education England					
EUC43.1.5	Recruit additional 13 x Senior Decision Makers through ECIST recommended agency					
EUC43.1.6	Write an enhanced business case for further Emergency Department medical staffing					

EUC43.1.7	Recruit the Trust's first ED Nurse Consultant post and put in place plans for ongoing recruitment
EUC43.1.8	Establish an SDEC service, with ongoing multi-disciplinary team pathway development (NB - SDEC is run by Medicine Division)

Action the trust SHOULD take to improve

Ref	Recommendation	Regulation	Desired Outcome ('What does good look like?)	Recommendation Completion Date	Executive SRO	Operational Lead
EUC44.1	**The trust should ensure all ED staff adhere to the latest PPE guidance for COVID-19 and hand hygiene policy when treating patients.**	Regulation 12	• We have an IP&C action plan that includes regular and robust audits that demonstrate we are compliant with local policy. • Over 90% mandatory training compliance	31/05/2021	Associate Medical Director for Emergency and Urgent Care	ED Senior Matron
Current position	• The IP&C working group has been re-established. The Terms of Reference are currently being updated and an Action Plan is to be written and agreed within the team. • IP&C mandatory training is currently at 90.7% for ED nursing staff					
Local actions to achieve desired outcome						
EUC44.1.1	Implement an IP&C action plan that includes regular and robust audits that demonstrate we are compliant with local policy.					
EUC44.1.2	Ensure over 90% mandatory training compliance.					

CQC Improvement Plan - February 2021

Ref	Recommendation	Regulation	Desired Outcome ('What does good look like?)	Recommendation Completion Date	Executive SRO	Operational Lead
EUC45.1	**The trust should ensure ED staff in all area's complete daily checklists on all emergency equipment and medicine boxes.**	Regulation 17	• We have regular and robust audits that demonstrate we are compliant with local policy. • Over 90% mandatory training compliance • The Lead Nurse role is recording and documenting safety check compliance on daily shift sheet and using the tannoy	31/05/2021	Associate Medical Director for Emergency and Urgent Care	ED Senior Matron
Current position	• The Lead Nurse now completes a checklist every shift of checklist completion ensuring all areas are safe. Accountability sits with the Lead Nurse of that shift.					
Local actions to achieve desired outcome						
EUC45.1.1	Implement regular and robust audits that demonstrate we are compliant with local policy					
EUC45.1.2	Ensure over 90% mandatory training compliance					
EUC45.1.3	Ensure the Lead Nurse role is recording and documenting safety check compliance on daily shift sheet and using the tannoy					
EUC45.1.4	Feed into the Resus team to review the design of Resus trolley and Hypobox check sheets. Enquire into audit process from Resus Officers.					

CQC Improvement Plan - February 2021

Ref	Recommendation	Regulation	Desired Outcome ('What does good look like?)	Recommendation Completion Date	Executive SRO	Operational Lead
EUC46.1 & EUC47.1	**The trust should ensure all ED areas offer patients a suitable environment with clear signposting to help them socially distance.** **The trust should ensure that patients waiting areas are organised in a manner to prevent cross contamination or risk in line with social distancing.**	Regulation 12 Regulation 15	• The waiting rooms areas are routinely assessed for prevention of cross contamination or risk in line with social distancing. • Identified improvements have been implemented to ensure required standards of cleanliness, hygiene and prevention and control of infections. • All waiting room areas are utilised effectively to minimize the risk of healthcare-associated infections.	30/04/2021	Associate Medical Director for Emergency and Urgent Care	ED Matron
Current position	• Chairs removed and additional posters placed 09/12/2021 • Area part of overall estates review • Hourly social distancing audit underway • Chairs taped off to maintain social distancing					
Local actions to achieve desired outcome						
EUC46/47.1.1	Conduct environmental review of the Emergency Department waiting room areas					
EUC46/47.1.2	Implement actions as identified in the environmental review					
EUC46/47.1.3	Implement regular environmental audits in relation to social distancing					

CQC Improvement Plan - February 2021

Ref	Recommendation	Regulation	Desired Outcome ('What does good look like?)	Recommendation Completion Date	Executive SRO	Operational Lead
EUC48.1	**The trust should ensure that there are sufficient numbers of consultants within the Children's ED (ChEd) in line with guidance.**	Regulation 18	• The department meets the RCPCH standard of a dedicated PEM consultant with session time allocated to Paediatrics.	31/03/2021	Associate Medical Director for Emergency and Urgent Care	Service Director
Current position	• Full time Paediatric Emergency Medicine Consultant in post for over 10 years. All clinical shifts are in ChED except when on call. • Successfully interviewed and offered posts to two paediatric trained consultants who will have split posts between Children's Assessment Unit and ChED. • Also successfully interviewed and offered posts to two full time PEM consultants. • By late summer 2021 it is anticipated there will be a total of 4 WTE consultants in post within ChED.					
Local actions to achieve desired outcome						
EUC48.1.1	Demonstrate compliance with the RCPCH standard of a dedicated PEM consultant with session time allocated to Paediatrics.					

REPORT TO THE TRUST BOARD OF DIRECTORS

Date	**7 April 2021**
Title	**Dementia Strategy 2021 - 2026**
Author & Exec lead	**Author: Elizabeth Yaxley, Dementia Services Manager** **Professor Nancy Fontaine, Chief Nurse**
Purpose	**For approval**

1. Background/Context

A new NNUH Dementia Strategy has been written which sets out the background and goals required to achieve excellence in dementia care across NNUHs. A detailed operational delivery plan will be developed to sit alongside this to enable monitoring and reporting of progress.

The document was approved by Mental Health Board on 30/09/2020 and Hospital Management Board on 03/11/2020. Quality and Safety Committee reviewed the document in February 2021 and suggestions were made for improvement. Quality and Safety Committee approved the document on 30/03/2021.

2. Key issues, risks and actions

At any one time there are on average of 134 in-patients in NNUH with a diagnosis of dementia. Quality of care and patient safety is dependent on all elements of this strategy being realised.

3. Conclusions/Outcome/Next steps

Trust Board is asked to scrutinise this document and offer feedback with the aim of approval. Amendments will be made in line with any feedback received. Should Trust Board approve the NNUH Dementia Strategy, The Dementia Strategy Group will commence creation of an operational delivery plan. The strategy will also be shared with the STP Dementia Programme Board, NNUH colleagues and the wider local community.

Recommendation:

The Board is recommended to:

- Approve the NNUH Dementia Strategy 2021-2026

NHS
Norfolk and Norwich
University Hospitals
NHS Foundation Trust

Dementia Strategy 2021 - 2026

Towards excellence in dementia care

Contents

Foreword

Our aspiration is to provide the best possible care and support for people living with dementia and those who care for them.

Our 5-year strategy challenges us to go further for people, by anticipating their core needs, from early diagnosis with regular assessment, planning care with patients, carers and families.

It is critical that we continue to improve the experience and support of patients with dementia through the care journey, including a focus on palliative care.

Our eight goals have been constructed in partnership with our dementia champions, dementia specialist practitioners, dementia support team and our families who are experts by experience. The goals aim to develop a blended workforce that has specialist skills to enable delivery of an enhanced personalised experience for patients in hospital and then onward transfer to a community setting or home. We aim to expand a cadre of specifically trained volunteers to work alongside staff and carers, to ensure timely and connected support.

Finally, by investing in research, we can utilise our results to influence the future and the Norfolk and Waveney Strategic intent for improving dementia care in our county.

Professor Nancy Fontaine

Chief Nurse
Norfolk and Norwich University Hospitals

Introduction

The Norfolk & Norwich University Hospital NHS Foundation Trust (NNUH) is one of the country's largest teaching hospitals and carries out almost one million outpatient appointments, day cases procedures and inpatient admissions each year.

In recent years the NNUH has seen an increase in the number of patients requiring physical health treatment who also have a diagnosis of dementia. This document sets out the Dementia Strategy at Norfolk and Norwich University Hospitals for 2021 – 2026. It has been designed and developed for all patients, staff and stakeholders that provide care and services for people with dementia and their families/carers in order to provide integrated healthcare, designed to care for each person as a whole. A full list of stakeholders is provided at the end of this document.

The strategy describes the goals necessary to achieve our vision of excellence in dementia care. It builds on our current service provision to date and draws on both local and national guidance and policies, as well as what local people tell us is important to them (Norfolk and Waveney STP 2018).

Optimising health and wellbeing outcomes for people with dementia and their carers across Norfolk and Waveney cannot be done alone. We will continue to collaborate with our health, social care, voluntary sector, public service and university partners towards an overarching dementia strategy and unified operational plans which put people with dementia and their carers at the centre.

NNUH's Vision for Excellence in Dementia Care

We will provide dignified, compassionate, clinically effective and safe person-centred care for our patients living with dementia, delivered by staff who are appropriately trained and who work in partnership with families and carers. This care will be provided in environments which promote safety, well-being and independence.

We aim to provide comprehensive and specialist assessments and services at the level required for each individual. We will work with our multi-agency partners to keep the length of in-patient stay as short as possible and enable safe and supported discharge.

Our care and services will demonstrate best practice principles by promotion of research and development in the fields of Ageing and Dementia studies and through co-production with people with dementia, their families and carers.

National Context

In England around 460,000 people are diagnosed with dementia with an additional 200,000 people estimated to be undiagnosed. (NICE 2019). The estimated number of carers of people with dementia in England is 540,000 (NHS England).

Hospital admission can trigger distress, confusion and delirium for people with dementia. This can contribute to a decline in function, a longer length of stay and reduced ability to return home to independent living (NICE 2019).

A key aspiration of **Challenge on Dementia 2020 (DoH 2015)** is to create dementia-friendly hospitals. The **National Dementia Action Alliance** and **Dementia Friendly Hospital Charter (NDAA 2019)** contribute to improving the experience and outcomes for people with dementia in hospital care.

NICE guidance on **dementia** supports these initiatives by setting out expectations, including appropriate admission to hospital, comprehensive assessments, personal history-taking, co-ordinated discharge, referral and diagnosis, advanced care planning and reducing the use of antipsychotic medication (NICE 2019).

The Dementia Statements (NDAA 2017) are endorsed by the Dementia Programme Board, which monitors and supports the implementation of the current Dementia Challenge across the NHS, social care, the research sector and wider society. They reflect the elements that people with dementia and carers say are essential to their quality of life. The Statements recognise that people with dementia should not be treated differently because of their diagnosis. The standards set out in the Dementia Statements are enshrined within the Equality Act 2010, the Mental Capacity Act 2005, health and social care legislation and human rights legislation. They are central to NNUH's Dementia Strategy 2021-26:

Dementia Statements

Identity We have the right to be recognised as who we are, to make choices about our lives including taking risks, and to contribute to society. Our diagnosis should not define us, nor should we be ashamed of it.

Community We have the right to continue with day-to-day and family life, without discrimination or unfair cost, to be accepted and included in our communities and not live in isolation or loneliness.

Carers We have the right to be respected, and recognised as partners in care, provided with education, support, services, and training which enables us to plan and make decisions about the future.

Care We have the right to an early and accurate diagnosis, and to receive evidence-based, appropriate, compassionate and properly funded care and treatment, from trained people who understand us and how dementia affects us. This must meet our needs, wherever we live.

Research We have the right to know about and decide if we want to be involved in research that looks at cause, cure and care for dementia and be supported to take part.

Dementia Care at Norfolk and Norwich University Hospitals

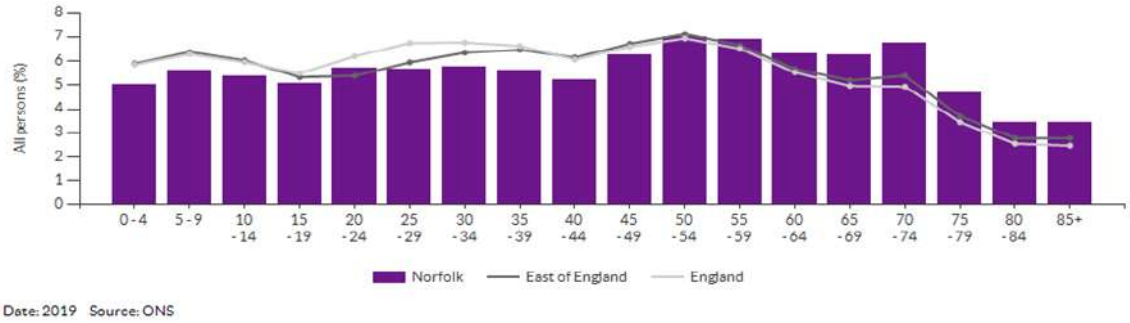
The population of Norfolk is older than the East of England and England averages, with 25% of people being aged 65 or over compared to 20% and 18% respectively (see figure 1). The population increase in Norfolk over the last five years has been predominately in the 65 and over age range. This trend is predicted to continue with Norfolk population increasing by 50,700 by 2030, mainly within the older age groups.

By 2041, the population aged 85+ is predicted to double in size. This will mean there will be approximately 61,000 people in Norfolk aged 85 and over. The area of Norfolk with the highest numbers of older people is North Norfolk. (Norfolk Insight 2020).

Figure 1: Age of residents (Norfolk Insight 2020)

	Norfolk		East of England		England	
	Count	%	Count	%	Count	%
Persons aged 0 - 15	154,108	17	1,212,041	19.4	10,816,679	19.2
Persons aged 16 - 64	530,986	58.5	3,785,525	60.7	35,116,566	62.4
Persons aged 65+	222,666	24.5	1,238,506	19.9	10,353,716	18.4

Figure 2: Percentage of residents within each age range (ONS, 2019)



There were 10,545 recorded cases of dementia in Norfolk and Waveney in January 2020, with the estimated number of actual cases at 16,652 (NHS Digital). In Norfolk the recorded dementia prevalence equates to 4.21% of the population of people aged 65 and over and 4.01 per 10,000 people aged under 65 (PHE 2020)

It is estimated that by 2025 the number of people living with dementia in Norfolk alone will exceed 18,900 (Norfolk JSNA 2016).

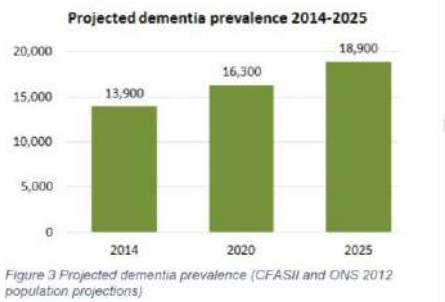
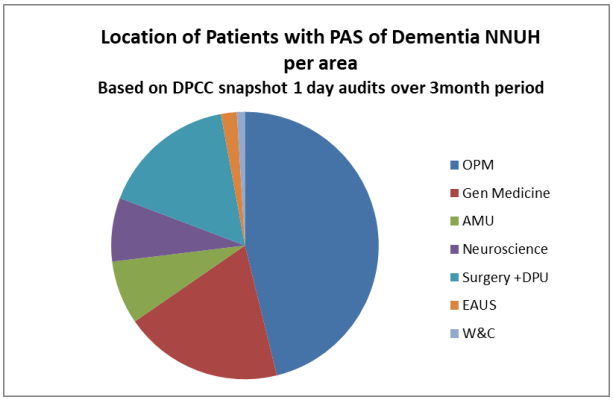


Figure 3 Projected dementia prevalence (CFASII and ONS 2012 population projections)

In-Patient Care

5260 patients were admitted to NNUH with a diagnosis of dementia in 2018/19, with 14.41 people admitted on average daily. The daily average number of in-patients with dementia is 134 throughout specialities across NNUH (NNUH IS), which means that approximately 10-11% of NNUH inpatients at any one time have a dementia diagnosis. Approximately half of the in-patients with dementia in NNUH are located in Older People's Medicine (OPM) wards.



It is likely that these figures are an underestimate due to the fact that not all cases of dementia are diagnosed.

Out-patient Care

Currently we do not collate the numbers of people living with dementia who access out-patient services across specialities. Going forward our vision is to be able to identify all patients with dementia at the point of referral so that preparations and reasonable adjustments can be offered to maximise best quality care and patient experience.

Towards Excellence

The challenges for people with dementia in acute hospitals are well documented (NICE 2019, Alzheimer's Society 2016). Not only are people away from their usual environments, they will also be faced with different carers, new information to understand and decisions to make, whilst being physically unwell and undergoing treatment. Across our services at NNUH we see people at different stages along their journey with dementia; from those who live independently with mild cognitive changes, to those receiving end of life care. Some will be diagnosed with dementia; some we suspect may have dementia and require investigations. Some may be well supported at home; some not.

NNUH has made great strides in laying the building blocks for excellence, including the provision of the Older People's Emergency Department, embedding the NNUH's dementia identification scheme and the use of 'This is Me' booklets, as well as establishing 140 Dementia Links across in-patient and out-patient services. Through the generous support of charitable partners, we have further grown the Dementia Support Team and created an innovative post of dementia palliative care specialist

nurse. The dementia perioperative pathway has been established and the NNUH's Carers Passport acknowledges and supports the importance of shared care. We have also built strong working relationships and pathways with community support services including the Alzheimer's Society and Admiral Nurses across Norfolk and Waveney.

The NNUH Dementia Strategy 2021-26 sets out how we build on these foundations to ensure excellence in dementia care and embrace the opportunities which digital technology offers both in terms of patient care, accessing appointments and in the ongoing task of educating our workforce.

Goals of the NNUH Dementia Strategy in Summary:

This is what the Norfolk and Norwich University Hospitals aim to provide if you are living with dementia. The word 'carers' relates your family or people you describe as being your carer.

Skilled Workforce

- We will ensure that staff are trained and skilled in dementia care
- We will provide specialist services which support you and your carers

Working Together

- We will treat you and your carers as partners in care
- We will work alongside your GP and community services
- We will promote dementia awareness and develop our services with our local community

Assessments

- We will ensure that you and your carers have a comprehensive assessment of your needs
- We will refer you for an assessment if we think you may have dementia
- We will support your decisions through use of the Mental Capacity Act

Person Centred Care

- We will ensure our staff are aware that you are living with dementia
- We will ensure your care is person-centred and meets your individual needs
- We will enable smooth transition between our services and as you are discharged home

Volunteer Support

- We will ensure trained volunteers are available who can offer additional support for activities and pastoral care

Environments

- We will provide your care in environments which are comfortable and supportive and promote your safety, well-being and independence
- We will enable you to find your way around the hospital sites

Research

- We will build on existing and develop new regional, national and international research collaborations so that you have the opportunity to participate in world-class research

Governance

- We will strive for continuous improvement in the quality of our care
- We will ensure that our governance structures and resources support staff to deliver care which is dementia–friendly

NNUH Dementia Strategy Goals in Detail

Goal 1

Skilled Workforce

We recognise that our staff are from many professional groups, with a wide variety of training and experience. We want to provide staff with training which will enable them to provide the best person-centred care in order to improve safety, patient and carer experience and outcomes.

To achieve this, we will ensure that:

Staff will participate in dementia training relevant to their role

- Training will be in line with the Dementia Training Standards Framework (Skills for Health, Health Education England and Skills for Care 2018) and in partnership with health and social care providers across Norfolk and Waveney.
- Training will be accessible, experiential and relate to acute hospital care.

Care will be provided by staff that are appropriately trained and skilled in dementia care.

- Dementia care competency framework will be developed and adopted.
- Preceptorship programmes and appraisal processes will identify staff that require competency development and link them to experienced or specialist services for practice development.

Specialist services are available and adequately staffed to support patients, families/carers and staff

- Mental Health Liaison Team, Dementia Support Team and the dementia palliative care specialist nurse will provide additional assessment and support where needed.
- The role of dementia links in wards and departments across NNUH will continue to be developed.
- Referrals to partner agencies for specialist mental health support will be made for those requiring it following discharge from hospital.

Goal 2

Working Together

We will continue to work alongside our health, social care and third sector partners to ensure the ongoing health and wellbeing of people with dementia and their carers.
We will promote the principles of 'Triangle of Care' (NHS England 2017) which recognises the benefits of collaboration between the person with dementia, with staff and their carer, in promoting safety, supporting communication and sustaining wellbeing.

To achieve this, we will ensure that:

People with dementia and their families/carers are partners in care

- Carers will be identified at point of admission or on consultation.
- We will keep carers involved and informed throughout assessment, treatment and discharge planning and give them the opportunity to be with the person they care for.
- Carers will be involved in assessments and best interest decisions as required under the Mental Capacity Act 2005.
- Carers will be offered Carers Passports and the opportunity to share care and flexible visiting.
- The perioperative pathway will enable carers to be by the side of the person up to the point of surgery and as they recover.
- Carers will feel supported by staff and be offered specialist services where required.
- Staff will refer people with dementia and their carers for ongoing support and advice.
- NNUH's Carers Forum will include representatives from the dementia leadership team to coordinate identified improvement plans.

Development of services in Norfolk and Waveney is influenced through participation in regional strategic dementia groups

- Representatives of NNUH will promote a unified approach to dementia care, services and training across Norfolk and Waveney.

Dementia awareness is promoted in our local community
NNUH will work in partnership with local health, social care and third sector providers to:

- Host, advertise and participate in public awareness and educational events.
- Promote awareness of health and wellbeing initiatives in NNUHs and the community.

Goal 3

Assessments

We want to ensure that people with dementia and their carers have access to accurate assessment of their needs and that their care is delivered accordingly.

To achieve this, we will ensure that:

Assessments are comprehensive and person-centred:

- All patients aged 80 and over will undergo frailty screening and multi-disciplinary assessment as indicated.
- All patients aged 75 and over will undergo cognitive screening on admission and further investigation as indicated.
- Risks to health are identified and risk reduction strategies put in place.
- Person-centred care needs are identified as part of routine care assessments.
- Tertiary referral clinics are provided for atypical and young onset dementia diagnostics and treatment via NNUH Neuroscience Centre.

People with suspected dementia are referred for investigation:

- Diagnostic pathways, including post-diagnostic support, will be in place for patients assessed at the NNUH and for those who are referred for investigation in the community. Follow up assessments will be arranged where investigations are inconclusive if clinically indicated.

Principles of the Mental Capacity Act 2005 are applied when asking people with dementia to make specific decisions:

- Staff will understand their responsibilities in relation to the Mental Capacity Act and will record and share outcomes with all relevant stakeholders. Patients and carers will be involved in assessments and best interest meetings.

Goal 4

Person-Centred Care

Providing the best possible care requires us to know which patients are living with dementia and to understand their individual needs, preferences and wishes. Care plans need to be adjusted accordingly and pathways in place to facilitate seamless transitions of care.

To achieve this, we will ensure that:

Staff will be aware of who is living with dementia and of their carers

- Patients living with dementia will be identified and a PAS alert and bedside /personal identification scheme applied from point of admission or contact. Carer's details will be entered in healthcare records.

Care is person-centred and meets individuals' needs

- 'This is Me' personal profiles are completed and stored at the bedside to help all staff and volunteers get to know the person and what is important to them.
- Care and treatment planning is person-centred with patients fully involved in the decision-making process where possible.
- Reasonable adjustments are implemented to enable person centred care.
- Support is provided for people to retain independence, mobility and involvement in activities that support their health and wellbeing.
- Advice and support is provided on reducing risk, including health promotion strategies.
- Service provision for all patients and their carers is equitable, in a way which respects their age, sexual orientation, gender identities, race, ethnicity, religion and beliefs.
- Specialist palliative care will be provided for those reaching end of life.
- Preference for future care and end of life care are based on patients' personal wishes.

Care pathways are seamless through inter-agency collaboration:

- Care pathways are established and information is shared between GPs and community providers to facilitate admission and discharge.
- Transfers of care are supported both within the hospital environment and at point of discharge.

Goal 5

Volunteer Support

Volunteers contribute to positive patient experience by providing additional support for activities and pastoral care which compliment those of paid staff. We want volunteers to have the appropriate training and support structures to help patients and carers across our hospital environments.

To achieve this, we will ensure that:

Structures are in place to support volunteers:

- There is a policy in place on the role of volunteers in supporting patients with dementia and their carers.
- Volunteer roles are clearly defined and understood by the volunteers, person living with dementia, their carers and staff.
- Volunteers are regularly supervised and supported in their role.
- Ward staff and the Dementia Support Team will support volunteers to enable wellbeing activities.
- Voluntary services will have a dedicated Dementia Link.

Volunteers participate in training relevant to their role:

- All volunteers will be Dementia Friends.
- Volunteers will be invited to participate in NNUH dementia awareness training.

Services are developed for volunteers to offer their support across NNUH:

- Voluntary Services Manager will further develop services across NNUH with the support of the Dementia Strategy Group.

Goal 6

Environment

Adjusting to new surroundings can be particularly challenging for people living with dementia. We want our care environments to be comfortable and supportive and promote patient safety, well-being and independence.

To achieve this we will ensure that:

Structures are in place to support dementia-friendly principles:

- NNUH Estates Strategy incorporates dementia-friendly design principles for new build and refurbishment programmes
- PLACE audits (patient led assessments of the care environment) are used to meet the required standards.
- Policies are in place to minimise moves within the hospital which are audited.

People with dementia are enabled to find their way around Hospital sites:

- Signage and orientation cues support navigation throughout buildings and grounds.

Ward and departments adopt dementia friendly design principles:

- Noise, distraction and visual clutter are minimised.
- Environments promote safety, encourage independence, activity and social interactions.

Goal 7

Research

Research helps us to understand the causes of dementia, develop effective treatments and improve care. NNUH wishes to build on existing research and develop new, regional and international research collaborations so that our patients and carers have the opportunity to participate in world class research.

To achieve this, we will ensure that:

- Improved access to research is enabled for patients and carers.
- Tertiary cognitive clinics are further developed.
- NNUHs' Neuroscience Centre will develop the use of CSF biomarkers in clinical practice.
- Research is developed in collaboration with UEA partners.
- Research ideas generated by staff and students of all disciplines are encouraged and supported.
- Staff are aware of latest published dementia research.

Goal 8

Governance

It is essential that systems are in place to enable continuous improvement in the quality of care for people with dementia and their carers, including resources and governance structures that support staff to deliver care that is dementia-friendly.
To achieve this, we will ensure that:

Governance structures are in place

- The Chief Nurse has executive responsibility for dementia care.
- The dementia lead consultant and service manager guide and monitor delivery of the dementia strategy.
- Regular updates on dementia care and strategy are provided through the trust reporting structure at both divisional and executive level.
- The Dementia Strategy Group includes key clinical staff, voluntary services manager, community service providers and lay members that monitors delivery of care and includes perspectives of people with dementia and their carers.
- NNUH is signed up to the Dementia-Friendly Hospital Charter and the Dementia Statements are used to inform approaches to care.
- The Dementia Strategy Group will share learning from serious incidents relating to dementia care and formulate action plans.
- Dementia specialist leads have access to dementia links to support the delivery of care.
- Processes are in place for sharing best practice across NNUH, Norfolk and Waveney STP and the wider community.

Staff affected by dementia are supported

- Support will be provided for staff who require leave to care for a person with dementia.
- Policies and procedures will be in place to help combat stigma towards employees affected by dementia.
- Reasonable adjustments are made enabling people affected by dementia to continue working wherever possible.

Patients, carers and staff are engaged

- Meaningful feedback is regularly gathered on how people with dementia and their carers experience the hospital and its services and is scrutinised by the Dementia Strategy Group to identify areas for service improvement.
- Patient and carer voices are embedded into service improvements from the initial planning stages.
- Information from patients and carers on what is important to them will be shared with staff.
- Staff have opportunities to contribute thoughts on dementia care and ideas for service improvement.

Measuring our Success

Excellence in caring for people affected by dementia requires us to strive for continual improvement in all aspects of this strategy.
A detailed operational delivery plan will be agreed, prioritised and monitored by the Dementia Strategy Group.
There will be regular reporting of progress to both the NNUH Patient Experience and Engagement Governance Sub-board and the Mental Health Board. Importantly, the voice of our patients and carers will be heard both in helping to evaluate progress and by participation in audit and quality improvement initiatives.

Produced in consultation with members of:

- Norfolk and Waveney STP Dementia Working Group
- Norfolk and Waveney Dementia Partnership (includes representatives from Norfolk Older People's Strategic Partnership, Alzheimer's Society, Admiral Nurse Service, Norfolk and Suffolk Foundation Trust, Norfolk Community Health and Care, University of East Anglia, Norfolk Constabulary, Norfolk County Council)
- NNUH Dementia Strategy Group
- NNUH Patient Panel
- NNUH Patient Engagement and Experience Team

Thank you to the people living with dementia and their carers who voiced their needs and wishes at national level (leading to the development of the NDAA Hospitals Charter 2019) and at local level (over 150 participants attended Norfolk and Waveney STP Dementia Review Public Consultation events in 2018) on which this strategy is based.

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Appendix

1. Stakeholder map

Stakeholders
Supporting People affected by Dementia

NHS Providers	Other Public Providers	Community Service Providers	Community Groups
• James Paget University Hospital • Queen Elizabeth Hospital • Norfolk Community Health and Care • Norfolk and Suffolk Foundation Trust • NNUH staff and volunteers • NNUH Patient Engagement & Experience • NNUH Dementia links	• Norfolk Constabulary • Norfolk & Waveney STP Dementia Review Group • Norfolk County Council • UEA	• Age UK Norfolk • Age UK Norwich • Admiral Nurses • Alzheimer's Society • Carers Matter Norfolk	• Pricilla Bacon Lodge Support Group • Norfolk Older People's Strategic Partnership • Norfolk & Waveney Dementia Partnership • Healthwatch • Charitable Partners

Equality Impact Assessment Initial Screening Form

Name of the Policy or Function/Service: NNUH Dementia Strategy 2021-2026 - Implementation	
Type of function or policy	Existing ☐ Proposed ☒

Division	Trustwide	**Department**	Corporate, Complex Health Hub
Name of person completing form	Liz Yaxley	**Date**	March 2021

Equality Area	Potential Negative Impact	Impact Positive Impact	Which groups are affected	Full Impact Assessment Required YES/NO
Race	None	Yes	N/A	No
Pregnancy & Maternity	None	Yes	N/A	No
Disability	None	Yes	N/A	No
Religion and beliefs	None	Yes	N/A	No
Sex	None	Yes	N/A	No
Gender reassignment	None	Yes	N/A	No
Sexual Orientation	None	Yes	N/A	No
Age	None	Yes	N/A	No
Marriage & Civil Partnership	None	Yes	N/A	No
EDS2 – How does this change impact the Equality and Diversity Strategic plan (contact HR or see EDS2 plan)?	Positive impact upon Better Health Outcomes 1.1 – 1.4, as the vision of the Dementia Strategy is to provide integrated healthcare, designed to care for each person as a whole. This will be achieved via the goals of working together, assessments and person centred care. Positive impact upon Improved Patient Access and Experience 2.1 – 2.4, particularly though achievement of goals on environment, person-centred care, assessments and working together. Patients and their carers will be actively encouraged to share their views of their experiences to help develop care and services. Positive impact upon A Representative and Supported Workforce, particularly objective 3.3 through achievement of the goal of 'skilled workforce' by developing dementia education and competency frameworks.			

- **A full assessment will only be required if: The impact is potentially discriminatory under the general equality duty**
- **Any groups of patients/staff/visitors or communities could be potentially disadvantaged by the policy or function/service**
- **The policy or function/service is assessed to be of high significance**

IF IN DOUBT A FULL IMPACT ASSESSMENT FORM IS REQUIRED

NOTES: (Please use to record and describe any decisions made or discussions had regarding the EIA)

The Norfolk & Norwich University Hospital NHS Foundation Trust (NNUH) is one of the country's largest teaching hospitals and carries out almost one million outpatient appointments, day cases procedures and inpatient admissions each year.

In recent years the NNUH has seen an increase in the number of patients requiring physical health treatment who also have a diagnosis of dementia. This document sets out the Dementia Strategy at Norfolk and Norwich University Hospitals for 2021 – 2026. It has been designed and developed for all patients, staff and stakeholders that provide care and services for people with dementia and their families/carers in order to provide integrated healthcare, designed to care for each person as a whole.

The strategy describes the goals necessary to achieve our vision of excellence in dementia care. It builds on our current service provision to date and draws on both local and national guidance and policies, as well as what local people tell us is important to them (Norfolk and Waveney STP 2018).

Optimising health and wellbeing outcomes for people with dementia and their carers across Norfolk and Waveney cannot be done alone. We will continue to collaborate with our health, social care, voluntary sector, public service and university partners towards an overarching dementia strategy and unified operational plans which put people with dementia and their carers at the centre.

This form should be 1. attached to any policy submitted to the relevant ratifying group; 2. Sent to the Equality and Diversity steering committee secretary (details on the intranet); 3. Retain a copy for audit purposes. 4. Head of Compliance Governance for Document Repository.