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

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

MEETING OF THE TRUST BOARD IN PUBLIC
WEDNESDAY 4 AUGUST 2021

A meeting of the Trust Board will take place at 9.30am on Wednesday 4 August 2021 in the Boardroom of the Norfolk and Norwich University Hospital

Due to the need for Covid-19 precautions, the number of places in the Boardroom is restricted. **Attendance at the meeting 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 - Chairman's Introduction - Feedback on visits	Chair	Information/ Discussion	
2	Experience of Care – Patient/Family Reflections (09.35 – 10.05 hrs) - *A visually impaired patient's experience of accessible information matters at NNUH*	NF	Information	**Video 2**
3	Minutes of the Board meeting held in public on 02.06.21	Chair	Approval	**5**
4	Matters arising and update on actions	Chair	Discussion	**13**
5	Freedom to Speak-Up Update (10.15 – 10.45hrs) • *Fran Dawson Lead FTSU Guardian to attend*	PJ	Information	**14**
6	Chief Executive's Report - inc CQC report on Urgent & Emergency Care	CEO	Discussion	**19**
7	**Reports for Information and Assurance:**		Information, Assurance and Approval as specified	
	(a) Quality and Safety Committee (27.07.21)* (b) IPR – Quality, Safety and Patient Experience data	GOS ED/NF		**35** **37**
	(c) Finance, Investments and Performance Committee (28.07.21) - inc RTT Access Policy – for approval* - 2x Digital FBC for approval* (d) i) IPR – Performance and Productivity data ii) Finance – Month 3 report iii) UOR Update	TS CC RC RC		**55** **57** **99** **120**
	(e) People & Culture Committee (26.07.21) (f) IPR – Workforce data	SD PJ		**135** **137**
8	Feedback from Council of Governors meeting 22.07.21	Chair	Information	**Verbal**
9	Questions from members of the public	Chair	Discussion	
10	Any other business	Chair	Discussion	

***** Documents uploaded to Diligent Resource Centre

Date and Time of next Board meeting in public
The next Board meeting in public will be at 9.30am on Wednesday 3 November 2021 – location/arrangements TBC

REPORT TO THE TRUST BOARD OF DIRECTORS	
Date	**04 August 2021**
Title	**Experience of Care Story – 'Information Matters'**
Author & Exec lead	**Dr Ruby Allen, Patient Engagement & Experience Facilitator; Sarah Higson, Associate Director for Patient Engagement & Experience** **Professor Nancy Fontaine, Chief Nurse**
Purpose	**For Information/Discussion and reflection**

1. Background/Context

1.1 An 'Experience of Care' 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 Experience of Care 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 Joy, a patient with visual impairment, presented by The Patient Engagement & Experience Team. It reflects on the experience of care for Joy, as a patient with information and communication support requirements, over three instances of her care at the NNUH. The Board will be able to reflect on these experiences with a view to understanding the information and communication support required by patients with accessible information needs at our hospital.

2. Key issues, risks and actions

2.1 Key learning:

- To ensure patients' information and communication support needs are identified and recorded in patient notes
- To improve staff awareness of how information and communication support needs can be met, to ensure the provision of accessible information and equality to patients with specific needs due to disability
- To improve Trust processes for identifying and meeting patients' information and communication support needs.

3. Conclusions/Outcome/Next steps

3.1 The experiences shared in this story provide valuable insight and learning which the organisation will use to drive forward improvement in the identification, recording and meeting of needs relating to the provision of accessible information and communication support. This improvement will be supported by the Trust's Accessible Information Standard Working Group.

3.2	The experiences relating to the Ophthalmology department in this story have been discussed within the relevant Clinical Governance meeting, and have been discussed for learning within the departmental teams. A key item of learning is that of the timing of information provision in an accessible format.
3.3	The short recording has been shared with the Trust's Accessible Information Standard working group to inform improvements and to raise staff awareness.
3.4	Joy will work as a partner to improve the processes followed at NNUH to ensure the provision of accessible information to meet patients' needs, via the Patient Engagement and Experience Team. Joy will be involved in the developments of the NNUH Accessible Information Standard Policy.

Recommendation:

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

Experience of Care – Patient Story – Board Meeting
Brief outline of the "story"
Joy is a patient at NNUH and has severe visual impairment. Joy shares three instances of care at the Trust where information was not provided in an accessible format to her in a timely way, resulting in Joy not being completely informed nor experiencing equality in relation to information provision. The instances described by Joy reference appointments within the Ophthalmology and Endoscopy departments, where she has encountered issues with obtaining information in an accessible format (*audio recording, or email accessible to assistive technology*) prior to treatments. Joy describes inconsistent knowledge across staff about how accessible formats for information can be sourced and provided. This has impacted the quantity, quality and timing of information that she has received regarding her care. Joy shares her appreciation that there is understanding of the needs of someone with visual impairment across the staff at NNUH, but highlights that the provision of information in an accessible format is both critical to providing equality of care, and adhering to the Accessible Information Standard. A lack of information in an accessible format has negatively impacted Joy's experience of care and resulted in higher levels of anxiety surrounding her treatment. Joy would like to see more knowledge and understanding across NNUH staff about how information can be obtained and provided in accessible formats for visually impaired patients, to ensure that patients' information and communication support requirements are met. Joy would also like to see that patients' own knowledge of their needs is considered, whilst they are supported to be partners in their care as part of a team.

What "point" it is trying to convey	
The story highlights the importance of correctly identifying and meeting the information and communication support needs of patients with disabilities – in particular, those with vision impairments. The provision of information in an accessible format to a patient can ensure that equality is maintained, and that patients are informed about their treatment and care within the Trust. Successfully meeting the needs of patients in this way can improve their experience of care, and ensure that the Trust is acting in accordance with the Equality Act and the Accessible Information Standard. This story provides an opportunity to reflect on the importance of providing information in an accessible format to ensure equality of care at NNUH. This example of an Experience of Care from the perspective of a patient with visual impairment highlights the need for the Trust to improve the processes followed for identifying and meeting the information and communication needs of all patients, and ensuring staff are informed and supported to consistently provide information in an accessible way.	
Who will be "speaking"	
Family member	Joy, via a short audio recording
Staff	Patient Engagement & Experience Team
Time allocation for each element	
Film	9 minutes
Staff	5 mins
Questions	5 mins
Any Other Pertinent Information	

MINUTES OF TRUST BOARD MEETING IN PUBLIC

HELD ON 2 JUNE 2021

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
	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 public and press by Teams	

21/023 **APOLOGIES, DECLARATIONS OF INTEREST, CHAIRMAN'S INTRODUCTION AND FEEDBACK ON VISITS**

Apologies were received from Mr Foster. No conflicts of Interest were declared in relation to matters for consideration by the Board.

Mr White explained that in line with Infection Prevention and Control guidance it is not yet possible to hold Board meetings with members of public present in person. The position will be kept under review as the pandemic restrictions are lifted.

Board members provided feedback from the Development & Assurance visits, which preceded the meeting and covered:

(a) Biorepository – Mr Lundrigan
(b) Quadram Institute Endoscopy - Mrs Hannam, Mr Cobb and Mr White
(c) Mulbarton Ward - Ms Dinneen, Mr Higginson and Mr Garside
(d) Clinical Coding Department - Mr Spink and Professor Denton
(e) Day Procedure Unit - Dr O'Sullivan, Mr Hackwell and Ms Prem
(f) Coltishall Ward – Children's Assessment Unit - Dr Chrispin and Mr Clarke

21/024 **EXPERIENCE OF CARE - PATIENT/FAMILY**

The Board received a report Ms Ruby Allen and Ms Sarah Higson (Patient Engagement and Experience Team) providing an update on the programme of work to review and learn from their experiences of care.

Ms Allen informed the Board that a structured approach has been established to ensure patients/families are listened to and that there is learning/improvement from their experiences. The Board has to date received accounts of the experiences of seven patients/families concerning a broad range of topics/areas:

- cancer services
- learning disabilities
- cardiology
- end of life
- dementia
- pain management and
- experience of carers.

A library of films encapsulating individual stories is being developed for wider sharing and learning.

At its meeting in April, the Board heard from James, a young carer for his mother and a number of steps have been taken to improve the experience of carers when attending the hospital:

- work with young carer networks to capture feedback/experiences of carers;
- provision of young carer awareness training;
- improving recording/identification of young carers within medical records;
- improving support for people in caring roles to self-identify to enable access to support;
- carer's audit planned from June to August to capture experiences of carers;
- carer's conference to be held during Carer's week in collaboration with the James Paget University Hospital and Queen Elizabeth Hospital Kings Lynn;
- our approach to sharing James' experience has been used as an exemplar by other trusts.

The Board welcomed the programme of engagement and learning from patient/family experience stories. It is evident that patients/family involvement is helping us to identify areas where we can improve the care we are providing.

Non-Executives asked whether the learning outcomes had been shared with James and Ms Allen confirmed that they have and he has been invited to provide further feedback on any future visits to the hospital.

Mr White thanked the Patient Engagement and Experience Team for their work to improve the experience of patients and families.

21/025 **MINUTES OF PREVIOUS MEETING HELD ON 7 APRI 2021**

The minutes of the meeting held on 7 April 2021 were agreed as a true record and signed by the Chairman.

21/026 **MATTERS ARISING**

The Board reviewed the Action Points arising from its meeting held on 7 April 2021 as follows:

(20/048(b) (Nov '20)) At 21/028(c), the Board was updated with respect to the improvement in performance regarding pressure ulcers. Action closed.

21/017(g) Workforce IPR narrative - Reviewed and subject to discussion/feedback at Board Committees. Action closed.

21/027 **CHIEF EXECUTIVE REPORT**

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

Mr Higginson expressed thanks to all the volunteers who support the Trust and who have been celebrated as part of National Volunteers Week.

The hospital remains in Local Covid State 1 with low numbers of positive patients in hospital and those patients who are positive, are being cared for on the Isolation Unit. There is a level of uncertainty in forecast modelling for future numbers of patients but we are continuing to prepare. All staff have been invited to participate in weekly LAMP testing and restrictions on visiting remain in place.

Work to restore services is progressing well and we are continuing to strive to achieve maximum productivity in our services. We are also looking to achieve optimal benefit from our resources, system-wide working/investment to create capacity in different ways. The waiting list of patients requiring surgery within 28 days has reduced but it remains a significant challenge.

The Board was alerted to some areas of particular clinical excellence in the Trust:

- The NNUH Thoracic Team are taking part in a national research trial (Second Primary Lung Cancer Cohort Study (SPORT)) which aims to detect early signs of secondary cancer in lung cancer patients 2-5 years after their treatment;
- The Diabetes Team have been awarded the Royal College of Physicians (RCP) 2021 Excellence in Patient Care Quality Improvement Award for their 18-month programme helping patients with diabetes.

Ms Prem reflected on the number of patients on the waiting list and asked about management of patients who did not attend their appointments. Mr Cobb explained that there are mandated actions within the national Access Policy for patients who do not attend. Mr White highlighted that some patients may have been anxious about coming into a clinical environment during the pandemic. Mr Higginson explained that if patients do not attend, this is a missed opportunity for other patients to receive their treatment and communication with patients is being increased to ensure that our resources are used in the best way possible.

21/028 **REPORTS FOR INFORMATION AND ASSURANCE**

(a) Audit Committee (26.05.21)

The Board received a report from Mr Foster in relation to the work of the Audit Committee – presented by Ms Dinneen in Mr Foster's absence.

Mr Lundrigan asked about the abbreviations in the Scheme of Delegation – it will be helpful to use CEO consistently through the document, rather than CE. With this revision and on recommendation of the Committee, the Board **approved** the updates to the Trust's Scheme of Delegation.

On recommendation of the Committee, the Board **approved** the updates to the Standing Financial Instructions.

The Committee's review of Annual Reports from each of the Board Assurance Committees had been useful in providing an overview of priorities, key risks and areas of focus across the Trust.

The Committee also reviewed a report concerning financial reporting and reimbursement costs incurred during Covid. A small number of issues were identified

but there were no control issues to be addressed demonstrating how well finances were managed during this challenging period.

The Board was informed that the Committee had re-approved the Code of Conduct for Directors and Governors without revision.

(b) Quality and Safety Committee (25.05.21)

The Board received a report from Dr O'Sullivan in relation to the work of the Quality & Safety Committee, highlighting key issues.

Dr O'Sullivan reported that the Committee had discussed the high rate of Caesarean Section deliveries. These surgical procedures carry risk for women the Committee requested further information to enable oversight. Professor Fontaine reported that the midwifery team will be promoting a reduction in Caesarean Sections through midwifery led conversations offering low risk women an opportunity to opt out. Ultimately however we wish to respect the choices made by women.

The Committee had heard that the risk rating relating to patients on the waiting list has reduced as a result of proactive and rigorous management. The ongoing risk concerning the Pharmacy Department was discussed and the Executives were asked to escalate the matter to the Management Board to identify a sustainable solution.

The Board was informed that the work of the Patient Experience Team in relation to the Equality Delivery System had been discussed and was considered to be a very positive initiative.

An update was received regarding the Use of the Virtual Ward, the scope of which is expected to expand and this is a welcome initiative in terms of efficiency and innovation, to the benefit of patients.

The Committee reviewed the draft 2020/21 Annual Quality Report and suggested that a summary for staff and the public would be a helpful addition. The Committee was also updated regarding plans under development to ensure compliance with the new national Strategy.

The Board was informed that the Committee had discussed Covid infection rates and the Board was provided with additional information by Professor Fontaine. Summary reports include deaths occurring as inpatients or within 30 days of discharge. Establishing association with Covid is complicated by the presence of long term underlying illness and time delays between transmission and development of symptoms. Work is continuing to establish thematic analysis and, with Dr Foster, to understand the implications for mortality rates.

Professor Denton updated the Board on the investigations that had been undertaken following complications sustained by a number of patients following gall bladder surgery in 2020. Reports commissioned by the Royal College of Surgeons, have been made available on the Trust's website.

(c) IPR – Quality, Safety and Patient Experience

Professor Fontaine informed the Board that the number of hospital acquired pressure ulcers has reduced to pre-covid levels. This is seen as evidence of the success of our Improvement Programme, targeting a 20% reduction in both pressure ulcers and falls.

Safe staffing fill rates have been on an upward trend since February with Registered Nurse fill rates at 87% and Unregistered Nurse fill rates at 90% in April. Hospital

acquired C Difficile, MRSA, Klebsiella, MSSA and Pseudomonas remain low compared to other organisations in the East of England.

Professor Denton reported that there has been an increase in the number of patients coming to hospital with eating disorders and mental health issues. We are working with mental health colleagues to try to ensure that these patients are treated appropriately but thereis an obvious need for additional resource to increase the number of mental health beds.

Professor Denton indicated that a raised mortality has been seen in some cancer groups and in cardiac/stroke patients and it is thought this may be due to people presenting to hospital later during the pandemic than would otherwise have been the case. This will however require careful review as matters develop.

(d) Finance, Investments and Performance Committee (26.05.21)

The Board received a report from Mr Spink in relation to the work of the Finance, Investments & Performance Committee.

Mr Spink informed the Board that the Committee had been updated on the favourable outturn variance compared to the Plan and a positive indication of strengthened governance and controls across the organisation.

There is obvious concern around the size of waiting lists and the Committee were encouraged to receive the Elective Recovery Plan. The Committee considered the Elective Recovery plan to be robust and that it met relevant elements of the Licence Undertakings.

CIP workforce opportunities were reviewed at the meeting and the Committee will be updated at its next meeting on the implementation plan for CIP workforce schemes.

Work is continuing with the PFI provider to reduce estates costs which were shown to be high in Model Hospital data. The Committee also considered the Strategic Outline Case for the Electronic Patient Record.

(f) IPR – Finance, Performance and Productivity

Mr Cobb informed the Board that work continues on planning for a projected increase in patients with Covid in July. The Trust will aim to manage patients within one level of the East Block in order to minimise disruption for the programme of elective surgery.

Elective surgery capacity is focussed on priority patients. Whilst the number of the longest waiting patients is reducing the position is dynamic due to the high level of referrals.

The Board was informed that Non-Elective activity has increased to pre-pandemic levels. The emergency pathway remains challenged by the level of demand and a number of projects are underway to improve performance.

Mr Clarke reported the financial position in April is a surplus of £1.5m being £700k favourable variance to plan. Supportive measures have been put in place to support the Medicine and Surgery Divisions to address overspends on pay and recovery plans are under development. The Capital Plan is underspent by £1.2m. CIP delivery is forecast at £14.4m and CIP plans for 2021/22 continue to be developed.

Non-Executives thanked the team for introducing trajectories into the reports, to provide visibility of what we are aiming for. Mr Higginson explained that there are a number of rate-limiting factors over surgical throughput, one element of which is the

availability of relevant specialist staff alongside Covid absences and annual leave. Purchasing additional capacity through the independent sector often involves Trust staff working on their days off and there are limits as to how long that can be sustained.

(g) People and Culture Committee (24.05.21)

The Board received a report from Professor Richardson in relation to the work of the People & Culture Committee.

The Board received a report from Mr Jones with respect to revision of the Trust's Misconduct Policy, in response to a national review following the suicide of an NHS employee in London during a disciplinary process. On recommendation of the Committee, the Board **approved** the updated Misconduct Policy.

The Committee reviewed the Gender Pay Gap report which indicated that there are no significant pay gaps in AfC bands 1-9 and that the pay gap in seven of twelve bands was actually in favour of female staff. The highest earning roles are however associated with medical roles in which there is a higher proportion of men. Attention is therefore focussed on this area, with a view to improve gender balance at that level.

Committee Annual Report:

The Board **received** the Annual Report of the People & Culture Committee. The work of the Committee has been affected by the pandemic but good progress was made in a number of areas, including freedom to speak up. It is recognised that improvements can take some time to embed. Key items for focus in the year ahead include implementation of actions arising from the National People Plan; development of the People and Culture Strategy; workforce planning and Trust Strategic Objectives.

The People and Culture Strategy is under development and is expected to be ready for the Board to review in October 2021.

Committee Terms of Reference:

The Committee reviewed its Terms of Reference and suggested increased emphasis on staff health and wellbeing in the Committee's Purpose. On recommendation of the Committee, the Board **approved** the updated Terms of Reference for the People & Culture Committee.

Wellbeing Guardian:

The committee discussed the role of the Wellbeing Guardian which was introduced by the National People Plan. The guidance indicates that this role should be undertaken by a Non-Executive Director and Professor Richardson has been nominated as Chair of the People & Culture Committee. Further national guidance however now suggests that the role is quite substantial and a Non-Executive fulfilling this role is likely to require significant support and time to do so.

It has been planned for the Wellbeing Guardian role to be undertaken by the Chair of the People & Culture Committee but the Committee has requested that further work should be undertaken to prioritise the key principles and to identify priorities and available support.

(h) IPR - Workforce

Mr Jones reported that mandatory training compliance has reached the 90% target.

Work is underway on preparing for further waves of the pandemic and we are looking a preventative steps in order to protect our staff. The NNUH sickness absence rate

was the best in the region during the pandemic at 4.48% compared to the national rate of 6.2% (6.3% East of England).

Staff turnover in April was 0.74% and the 12 month average is 10%. The Recruitment and Resourcing Group has been re-established and will be focusing on development of retention initiatives and looking at providing opportunities to progress careers here rather than leaving.

Non-Executives suggested that inclusion of targets and trajectories for key workforce metrics in the IPR would enable better oversight of the current position on performance and to identify those areas requiring further attention. **Action: Mr Jones**

21/029 **QUALITY PRIORITIES**

The Board received a report concerning implementation of the Quality Priorities for 2020/21 and plans for 2021/22.

The Board was informed that the pandemic had significantly disrupted work to achieve the Quality Priorities for 2020/21. 14 Quality Priorities were identified for 2020/21 and at the end of May 2021, two have been completed:

- Quality Domain - Experience – age appropriate patient and family feedback;
- Quality Domain - Safe – Cirrhosis and Fibrosis Tests for alcohol dependent patients;

The remaining 12 priorities from 2020/21 will be carried forward into 2021/22 and it is proposed that the following two new priorities should be added:

(i) Quality Domain – Experience – Improving patient centred transfers of care;
(ii) Quality Domain – Safe – All pregnant women will have a discussion regarding preferred place of birth and a risk assessment of their choice

This proposal has been reviewed by the Quality and Safety Committee and is recommended for agreement. Ongoing performance will be monitored through the Quality Programme Board.

Mr Higginson noted that our Licence Undertakings require submission of our Quality Improvement Plan to the regulator. Professor Fontaine confirmed that our submission has been reviewed by the Regional Team and is supported. Agreement and submission of the Priorities is understood to complete the requirements of the Undertakings.

The Board **agreed** the Quality Priorities for 2021/22.

21/030 **QUESTIONS FROM MEMBERS OF THE PUBLIC**

The Board was asked if bed capacity would be sufficient to treat elective patients alongside increased numbers of patients attending the Emergency Department. Mr Cobb explained that spikes in emergency activity usually occur at different times of the year – during the summer holiday season and in the winter between January and March. We will aim to ring fence elective capacity to ensure patients can continue to be treated for as long as possible.

The Board was asked if the Vaccination Centre will be closing and about the vaccination rate for staff. It was explained that 61,000 vaccines have been administered through the Vaccination Centre and the unit is expected to close on 6 June. The Centre may be required to reopen in the autumn if top-up vaccinations and

boosters are required. Approximately 98% of eligible NNUH staff have been vaccinated.

21/031 **ANY OTHER BUSINESS**
There was no other business.

21/032 **DATE AND TIME OF NEXT MEETING**
The next meeting of the Trust Board in public will be at 9.30am on Wednesday 4 August 2021 in the Boardroom of the Norfolk and Norwich University Hospital.

Signed by the Chairman: …… Date: ……
Confirmed and approved for signature by the Board on 04.08.21 [TBC}

Decisions Taken:

21/028 – Scheme of Delegation	On recommendation of the Audit Committee, the Board **approved** the updates to the Trust's Scheme of Delegation (uploaded to Trust Docs 14.06.21).
21/028 – Standing Financial instructions	On recommendation of the Audit Committee, the Board **approved** the updates to the Standing Financial Instructions (uploaded to Trust Docs 14.06.21).
21/028 – Misconduct Policy	On recommendation of the People & Culture Committee, the Board **approved** the updated Misconduct Policy (uploaded to Trust Docs 24.06.21).
21/028 – People & Culture Committee ToRs	On recommendation of the P&C Committee, the Board **approved** the updated Terms of Reference for the People & Culture Committee
21/029 – Quality Priorities	The Board **agreed** the Quality Priorities for 2021/22.

Action Points Arising:

	Action
21/028 – Workforce IPR targets & trajectories	Non-Executives suggested that inclusion of targets and trajectories for key workforce metrics in the IPR would enable better oversight of the current position on performance and to identify those areas requiring further attention. **Action: Mr Jones**

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

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NHS Foundation Trust

Action Points Arising from Trust Board meeting (public) – 02.06.21

Item	Action	Update – August
21/028 – Workforce IPR targets & trajectories	Non-Executives suggested that inclusion of targets and trajectories for key workforce metrics in the IPR would enable better oversight of the current position on performance and to identify those areas requiring further attention. **Action: Mr Jones**	Board to be updated at meeting

JPG 30.07.20

REPORT TO THE TRUST BOARD

Date	**04/08/21**
Title	**Freedom to Speak Up (FTSU) Guardian report**
Author & Exec lead	**Frances Dawson (Author) Lead Freedom to Speak Up Guardian - Paul Jones – Chief People Officer, Executive Lead.**
Purpose	**To provide the Board with a twice yearly summary and update, on Freedom To Speak Up activity, themes and progress in relation to the NNUH speak up culture.**

1.0 Introduction – FTSU

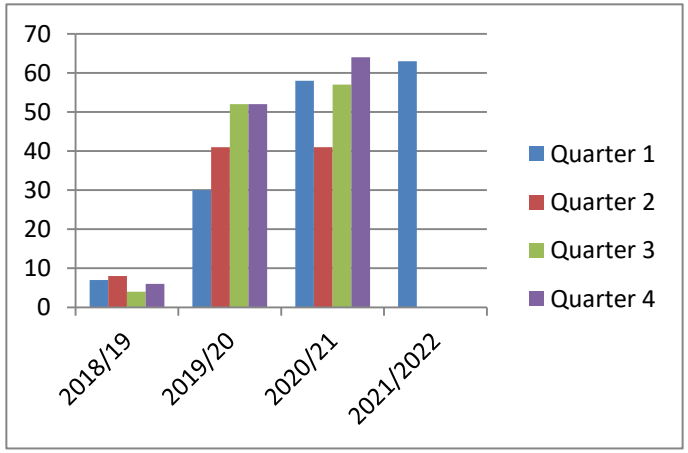
Speaking Up relates to anything that gets in the way of providing great care for patients or adversely impacts staff experience, it includes ideas for improvement. Nationally the ambition is that speaking us is considered *business as usual* in all teams, across the NHS (National Guardians Office NGO).
The NNUH can achieve this by ensuring; workers are supported in speaking up, barriers to speaking up are addressed, a positive culture of speaking up is fostered, and issues raised are used as opportunities for learning and improvement.

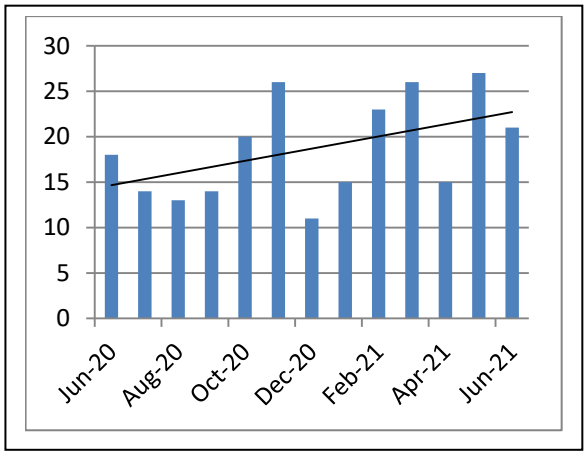
The FTSU service facilitates this and over recent years has developed and responded to staff needs, in a way that appears to have enabled the service to become trusted by staff and embedded as a service within the NNUH.

Yearly totals – NNUH

Staff using the FTSU Guardian service;

2017 - 2018	8
2018 - 2019	25 (+213%)
2019 – 2020	176 (+604%)
2020 - 2021	220 (+25%)





2.0 Embedding Speak Up Culture NNUH – Collaboration, role modelling from leaders and consistency of message are key factors that have been utilised to help embed the culture of speaking up at the NNUH. Progress requires a multifactorial, cumulative approach, maximising use of resources, linking with and learning from networks and groups both internal and external to the NNUH. It has both reactive and proactive elements. As our culture matures and we encourage staff to "own their own speak up culture" within their teams, we anticipate it will be possible for more collaborative, preventative type work to be undertaken. The FTSU Champion network will be able to support this work.

Below is a summary of some of the factors that have helped to underpin progress so far, the yellow outline indicates a particular current focus for the service;

Team of Guardians – Trained to support staff when raising concerns.
Approachable and flexible service.

FTSU Lead – Full Time dedicated post
Executive Lead Paul Jones CPO
NED Sandra Dineen

Open and transparent reporting – sharing learning to;
National Guardians Office,
Trust Board
Hospital Management Board
Workforce Education Sub Board
Patient Engagement and Experience Governance Sub-board
People and culture committee

EDI links –
Staff networks, EDGE and LEDGE meetings.
Improving FTSU data collection to enable active challenge of findings, with ambition to ensure FTSU is fully inclusive and represents our true diversity.

National Guardians Office (NGO) support.
Regional Network (East of England)
Acute Service Integration (ASI - Links with QEH, JPUH)

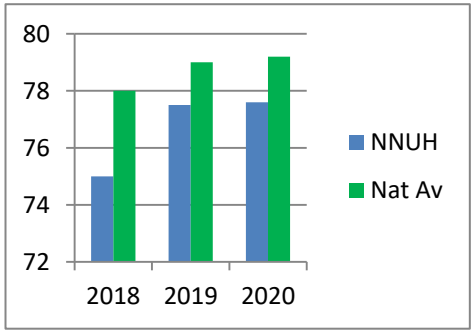
FTSU Champions – (Current focus for FTSU Service)
Trained staff who Champion healthy speak up culture.
Staff may be aware of perceived barriers and can encourage ownership at local levels.
Lateral cascade team for sharing learning from both National and local speak up activity.
Future Guardian resource – mitigating loss of skills in FTSU team.

Freedom To Speak Up: Raising concerns policy
Visibility – All Corporate inductions and bespoke presentations e.g. HCA's, International nursing staff FTSU presence.

Just culture – embedding lessons.
Training – Speak Up, Listen Up, Follow Up.

Work In Confidence.
Anonymous platform for staff to raise concerns giving direct access to Guardians and

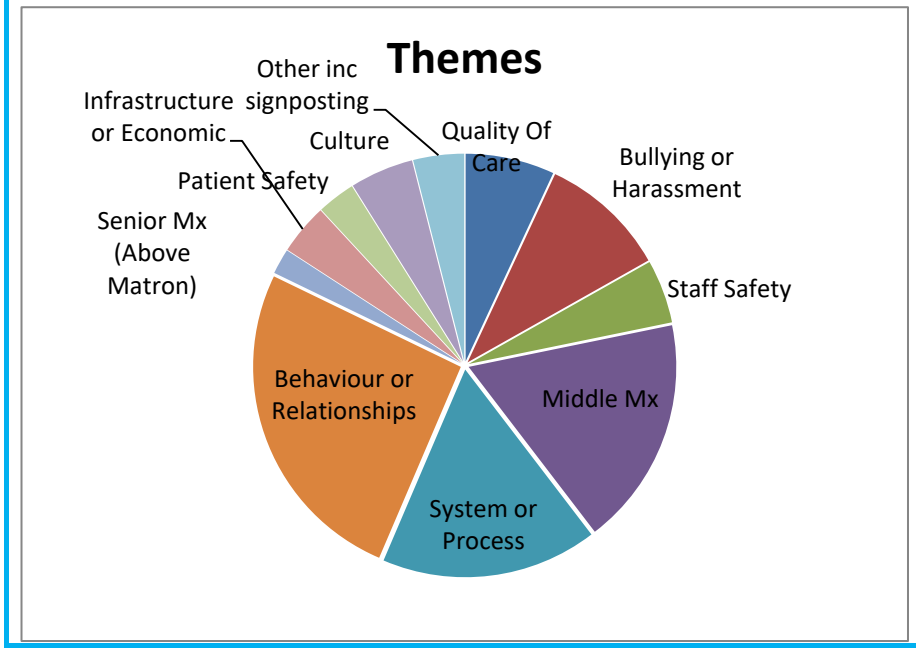
2.1 Freedom To Speak Up Index (FTSUI) – This is a measure of speak up culture taken from results from the NHS staff survey. It showed slowing of growth both nationally and locally but an ongoing upward trend.



A new question (18f) was included in the 2020 NHS Staff Survey. It asked if respondents felt safe to speak up about anything that concerns them in their organisation. 60.8 % of respondents felt safe to speak up about anything in the NNUHFT. The national average was 65.6%.

The FTSUI provides an opportunity to look at departments and staff groups across the NNUH. It highlights areas where speak up culture is thriving and scores above National average but also identifies areas where more needs to be done. Over the last 18 months, the changes in working practice due to Covid 19 and the pressure the staff and hospital came under, had a big impact by restricting this element of our work. We believe the next 18 months however will be different as the growing Champion network begins its positive influence.

3.0 Themes and learning; 141 cases reported between January 2021 and the end of June 2021, resulting in 169 categories. These have been grouped below; cases may have multiple themes (14 of these were raised anonymously).



A recent report by the NGO identified that communication between staff in view of the style of communication and differences in interpretation of messages, has been an issue for staff during the pandemic. Our data appears to reflect this also, especially at the middle management tier in the organisation.

Systems and processes related to delays that affected staff, procedures or guidance not being followed or interpretation of policies being questioned.

Bullying and/or harassment – a number of staff have spoken up about individuals they believe use bullying behaviours towards them or that they have witnessed it. When one person speaks up, others often find their voice. All cases were investigated further. HR and appropriate support from senior managers has been put in place.

Some changes in practice occurred from cases raised in relation to patient care. E.g. HCA staff not taking handover in the discharge suite as this was outside their role and therefore scope. The Associate Practitioner role was reviewed by the bank team. Skills of these staff can vary, not all skills are transferable to all specialist areas. Training is on offer to ensure staff and patients are not at risk.

4.0 FTSU Feedback – There is much to congratulate staff on, in view of the progress the NNUH has made with its speak up culture and it has been due to many staff who work outside of the FTSU service. The culture has improved both locally and nationally but we are clear more is required and believe this is achievable as we aim to build on what appears now to be a solid foundation.

All staff that use the FTSU service have an opportunity to provide anonymous feedback of their experience. 100% of those who responded said that they would recommend the service; they found the service helped them with their concern and they would speak up again. When asked about whether they suffered any detriment or demeaning treatment because of speaking up, 80% said no. The others report nervousness that it might happen in the future, not that it had happened - *"Hopefully not but it hard to know. What people say and then do aren't always the same"*

This is one of the real challenges for NHS Trusts. From this feedback we began a debate and discussion on detriment and fear, to consider how we further address these issues. This work is ongoing and will be published as part of a Comm's campaign for FTSU.

Other feedback is also gathered examples are below;

Look back over the NHS 30+ years ago and employ the right staff, bring back working values we had then, learn to care for the patient as we used to, make the actual nurses that are paid well BE nurses rather than hiding behind screens and laying all the pressure on one poor member of staff who was young and obviously stressed by too much on her plate. Let the admin staff do the paperwork let the Nurses nurse
7/9/2021 7:32 AM
View respondent's answers Add tags–

For the NNUH that the views they express at Trust level is not always reflected at Department or ward level. For the FTSU to keep up the valuable supportive work that they are doing. It makes a difference!
6/25/2021 8:57 AM
View respondent's answers Add tags–

I still feel there is a bit of an old school culture within the hospital. although the Trust has flexible working policies and home working policies in place, management are not open to this and use "service requirement" as a reason not to use these policies
5/7/2021 2:43 PM
View respondent's answers Add tags–

I think you do a great job
4/28/2021 3:21 PM
View respondent's answers Add tags–

5.0 Overview - Upcoming and ongoing work;

- Board to demonstrate ongoing commitment to the agenda by undertaking its National Guardian Office (NGO) speak up training.
- October speak up month – NNUH promotion
- Communication campaign to recruit and extend the FTSU Champion network.
- Improve our inclusivity and address representation, so all staff benefit with fewer barriers and easier access to find support.
- Continue to address barriers to speaking up – e.g. students (nominated person for NMC) other student groups, junior doctors and emergency care are key areas.
- Continue with debating detriment and fear – staff networks engaged with these discussions – share this knowledge more widely – regional and national debates.
- Utilise staff survey and pulse survey findings to be proactive in NNUH culture improvement.
- Liaising with risk, safety and patient experience teams to further triangulate themes and areas for improvement.
- Building stronger links with support networks e.g. WHWB team, volunteers and Chaplaincy as these groups have established networks across the NNUH.
- Ensure lessons from NGO case studies are embedded in our NNUH learning and activity.

Recommendation

The Board is asked to note the report and support the embedding of openness across the organisation by participating in the NGO Speak Up Training

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

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

NNUH Media Statement – 30 July 2021

Regarding CQC Inspection Report – Urgent & Emergency Care (overall rating 'Good')

The Care Quality Commission has published a report today about the Emergency Department at the Norfolk and Norwich University Hospital following an unannounced inspection in June 2021.

The Emergency Department has been rated as 'good', up from requires improvement, since the inspection in December 2020.

The service was also rated 'good' for being safe and well-led. It was rated as 'requires improvement' for being responsive to people's needs with more work needed by the Trust to reduce waiting times and address the mental health needs of patients.

Professor Erika Denton, Medical Director at the Norfolk and Norwich University Hospital, said:

"We are delighted that the team's service improvements have been recognised in providing safer care in this busy environment. This is thanks to the leadership team which has created a clear vision for the service with improvements in staffing levels, infection control and triage processes and the whole ED team who work exceptionally hard to support patients needing urgent and emergency care.

"Further improvements are being taken forward to reduce waiting times for patients through our Safer, Better, Faster programme. This is a whole hospital effort to transfer patients to the wards and discharge them again in a timely way."

Norfolk and Norwich University Hospitals NHS Foundation Trust

Norfolk and Norwich University Hospital

Inspection report

Colney Lane
Colney
Norwich
NR4 7UY
Tel: 01603286286
www.nnuh.nhs.uk

Date of inspection visit: 01 June 2021
Date of publication: 30/07/2021

Ratings

Overall rating for this service	Good
Are services safe?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Good**

Our findings

Overall summary of services at Norfolk and Norwich University Hospital

Good ↑

We carried out this unannounced focused inspection on the 1 June 2021 because at our last inspection on 8 December 2020, we identified a breach of the Health and Social Care Act (2008) Regulation 12, Safe Care and Treatment. Concerns were based on long waiting times for assessment, the uses or infection, prevention and control measures and staffing levels. We issued the provider with a warning notice served under Section 29A of the Health and Social Care Act 2008. Between January 2021 and 1 June 2021, the trust saw 22,870 children and 149,732 adults within its urgent and emergency care service.

At our inspection on 1 June 2021, we focused on the Care Quality Commission (CQC) domains of safe, responsive and well led. We rated the service as requires improvement for responsive and good for safe and well led. The overall rating has improved for urgent and emergency services from requires improvement to good.

We found:

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

The service had enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

Our findings

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

However:

People could not always access the service when they needed it or receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

Access to support for patients who required support with their mental health remained a challenge within the trust.

Urgent and emergency services

Good

Our overall rating for this service improved. We rated it as good.

Is the service safe?

Good

Our rating of safe improved. We rated it as good.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

All areas were clean and had suitable furnishings which were clean and well- maintained. This was an improvement from our previous inspection.

The service generally performed well for cleanliness. Data supplied by the trust following our inspection showed that compliance ranged between 97% and 100%. The service took actions where any service fell below the 100% standard.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly.

Staff followed infection control principles including the use of personal protective equipment (PPE). Clear signage reminded staff, patients and any relatives of restricted access to high risk areas. All ambulatory patients were met at the ED reception by a nurse navigator, who asked patients if they had any symptoms in relation to COVID-19, or any other infectious disease. They were then directed to the appropriate area.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff managed clinical waste well.

Patients could reach call bells and staff responded quickly when called. Staff ensured they were wearing the appropriate PPE for the environment they were entering and reassured patients whilst donning this.

The design of the environment followed national guidance. The trust had repurposed ED areas due to the impact of the COVID-19 pandemic and the need to maintain social distancing and the separation of patients with COVID-19 or symptoms of the infection. There had been repurposing of space to enhance the departments responsiveness to patient needs. However, the ED team had ensured during the COVID-19 pandemic that rooms used for patients who required mental health support had remained open and not changed to alternative use. This was an improvement on our last inspection.

Urgent and emergency services

Staff carried out daily safety checks of specialist equipment. This was an improvement from our previous inspection. However, identified that staff had not completed the ambulatory resus trolley checks on two occasions in May 2021, but all the equipment within the trolley was fit for purpose and we raised this with staff at the time of our inspection who escalated this to the nurse in charge.

The service had suitable facilities to meet the needs of patients' families. The leadership team had taken steps following our last inspection to manage the environment effectively including ensuring social distancing was in place, segregation of seating, clear signage and guidance for patients and relatives on waiting times.

The service had enough suitable equipment to help them to safely care for patients. We checked an additional ten items of equipment, for example monitors, probes and ultrasound equipment and found these all to be within service date, visibly clean and ready for use.

Staff disposed of clinical waste safely. Sharps bins we reviewed were labelled, closed and visibly clean.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The trust used the national early warning score system (NEWS2) for adults and the children's early warning score (CEWS) for children. An early warning score is a guide used by staff to quickly determine the degree of illness of a patient. Staff used a "Bay watch" system to give oversight of any patients who were likely to deteriorate or needed additional support. There were hospital wide outreach services to support deteriorating patients.

Staff completed risk assessments for each patient on admission / arrival, using a recognised tool, and reviewed this regularly, including after any incident. This was an improvement on our last inspection. Data supplied by the trust following our inspection showed that the trust did not meet the 15-minute triage target consistently. The ED leadership team were focused on improving performance as part of their "Safer, Better, faster" project and consistently reviewed data to try and drive improvements. The ambulance crews would telephone the ED teams in advance if they were caring for patients who needed specialised support.

Staff knew about and dealt with any specific risk issues; these included the management of sepsis, neutropenic sepsis, stroke, falls and frailty. The trust monitored compliance with training around specific risk issues such as resuscitation, sepsis and NEWS/CEWS and had a plan to address where compliance was below the desired level.

The service had 24-hour access to mental health liaison and specialist mental health support who were located within the adult ED. Staff within the ChED could access mental health support for children by calling a dedicated mental health line to local mental health agencies for children, including an out of hours services. Staff at all levels with told us that mental health support for patients remained one of its biggest challenges but that they were working with other agencies and organisations to try and improve services.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. The service had a standard operating procedure for the management of mental health pathways within the ED. Risk assessments for the environment were in place and regularly reviewed by the trust's health and safety team.

Urgent and emergency services

Staff shared key information to keep patients safe when handing over their care to others. The team monitored performance against the internal standards for patients being seen within one-hour after referral to a specialism, for example the surgery or medical teams. The compliance with this target fluctuated with the capacity of the hospital however, this was monitored and reviewed.

Shift changes and handovers included all necessary key information to keep patients safe. We observed two safety huddles and observed staff pass on key information in relation to patients, performance and identifying patients who may need additional support.

Nurse staffing

The service had enough nursing staff and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants.

and healthcare assistants needed for each shift in accordance with national guidance. Where there were deficits to the planned numbers the nurse in charge took appropriate action, for example delegating staff from other areas or requesting additional support from the bank or agency to ensure all areas were safely staffed.

The department manager could adjust staffing levels daily according to the needs of patients. Managers used a safer staffing bundle to guide this process. The paediatric nurse staffing met the royal college of paediatric and child health's (RCPCH) national guidance as per recommendation 10: EDs treating children must be staffed by two registered children's nurses. During our inspection we found the safety nurse role was actively engaged in managing patient safety with an oversight on patient risk. This role was supernumerary, and one was allocated to each shift in advance on the staffing rota. The safety nurse shifts were planned, and staff told us that managers ensured this role remained focused on safety and risk. At times this role could be used to support other areas of the department dependent on demand.

Data supplied by the trust post inspection showed that as of April 2021, the ED had a 17% combined vacancy rate between adult and paediatric nursing. Sickness rates amongst nursing staff had reduced from 9.4% in January 2021 to 6.5% in April 21 and the turnover rate remained low at 0.4%. The use of bank and agency nurses had reduced during the same period from 41 shifts in January to 29 in April 2021. Senior staff we spoke with during our inspection told us that they had had recruited to all vacancies for band seven and six nurses and had recruitment plans to fill the remaining band five posts by the summer.

Nursing staff we spoke with told us they had access to a range of training and development opportunities and data provided by the trust showed 92% appraisal compliance for nurses as of May 2021.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix and gave locum staff a full induction.

Urgent and emergency services

The service had enough medical staff to keep patients safe. The service had successfully recruited with all medical vacancies within the ED. This was an improvement on our previous inspection. The service met the Royal College of Paediatric and Child Health's (RCPCH) national guidance to provide a PEM consultant as per recommendation *9: EDs treating children must be staffed with a PEM consultant with dedicated session time allocated to paediatrics.*

The service had reducing vacancy rates for medical staff. One consultant had a focus on recruitment and retention which had enhanced the rates in both areas.

The service had low turnover rates for medical staff. This was currently at 0% and had dropped from 7% in February 2021.

Sickness rates for medical staff were low and reducing. Sickness rate amongst the adult and paediatric medical team had reduced from 7.1% in January 2021 to 2.7% in April 2021.

The service had reducing rates of bank and locum staff. The trust used 50 bank shifts in January 2021, this had reduced to 19 in April 2021, with plans to reduce this further following the successful recruitment of additional medical staff.

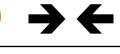
Managers could access locums when they needed additional medical staff. A significant portion of the locums did at least three shifts in ED each week and were established and used to working in the ED. All doctors who took up locum shifts had an inbuilt induction where they learnt how to use the trusts electronic systems within the ED.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Lead staff reviewed ChED's medical staffing twice weekly as part of their weekly staffing review to ensure appropriate staffing was in place. They were seeking to create an East of England paediatric emergency medicine training scheme in the future. Staff were encouraging medics to take up lead roles for ultrasound, mental health, teaching and trauma. The department had an established program of teaching and if a session was cancelled staff completed incident reports to highlight the cancellation.

The service always had a consultant on call during evenings and weekends. Medical staffing met with Royal College of Emergency Medicine (RCEM) recommendations of 16 hours of consultant presence per day.

Medical staff we spoke with told us they had access to a range of training and development opportunities and data provided by the trust showed 96% appraisal compliance for medical staff as of May 2021.

Is the service responsive?

Requires Improvement  

Our rating of responsive stayed the same. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Urgent and emergency services

Managers planned and organised services, so they met the needs of the local population. At the time of our inspection services had been reconfigured in response to pandemic and national guidelines and worked with system partners to facilitate care. The emergency department strategy 2020-2025 was developed with staff within the emergency department and external stakeholders.

The service relieved pressure on other departments when they could treat patients in a day. The same day emergency care (SDEC) pathways were in their early stages for ambulatory walk-in patients. The SDEC aims were to reduce the number of patients who would otherwise be admitted to the hospital or wait for extended periods in the ED. This was part of the trusts response to patient flow and aiming to reduce patient waiting times.

Access and flow

People could not always access the service when they needed it and or receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not always in line with national standards.

People could not always access the service when they needed it or receive the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were not in line with national standards. There were processes in place to ensure patients were monitored throughout their wait in the service.

Whilst the trust was not meeting the national target for the percentage of ambulances unloading within 15 minutes of arrival, we noted an improvement between February (52.6%) and May 2021 (56.8%). This showed an improvement from our last inspection.

The impact of the covid pandemic and high levels of demand within the department was seen in compliance with the target for patients waited 4 to 12 hours from decision to admit. This fluctuated between our inspections and was currently 33% in May 2021. However, this was an improvement on our last inspection in December 2020.

Managers monitored waiting times and made sure patients could access emergency services and received treatment. However, some patients were waiting long periods for decisions regarding their care and treatment, and decision to admit or discharge. We reviewed five patients who had been waiting beyond the four-hour target, in one case over 13 hours. The trust ensured that all patients who were waiting had actions were in place including prompt review and nursing checks. Unfortunately factors such as waiting for transport, waiting for additional clinical review, or mental health placement were key factors affecting the patients waiting times.

In January 2021, the median time from arrival to initial assessment (emergency ambulance cases only) was 28 minutes. Royal College of Emergency Medicine (RCEM) triage standard says that triage should be a face-to-face encounter that should occur within 15 minutes of arrival or registration and should normally require less than 5 minutes contact. The trust project “Safer, faster, better – emergency care improvement programme” was focused on improving performance and the data showed an improvement from our inspection in December 2020.

The Department of Health’s standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the ED. Data supplied by the trust following our inspection showed that the ED failed to achieve this target for the four months prior to our inspection. Compliance improved during February and March but dipped again in May 2021 to 53.7%. The ED team had actions in place to try and improve performance in this area including the trust project “Safer, faster, better – emergency care improvement programme” focused on improving performance.

Urgent and emergency services

In January 2021, the percentage of ambulance handovers that were longer than 60 minutes from arrival was 7.1%. This improved between February and 2.4% May 2021 (2.4%). This is an improvement on performance from the same period in 2020. Staff followed Royal College of Emergency Medicine (RCEM) standards and were not cohorting patients in corridors. Patients were however, being held on ambulances due to capacity issues within the wider hospital. The rapid assessment and treatment service (RAT's) area enabled staff to work with the local NHS ambulance trust to identify any patients likely to deteriorate whilst waiting to be seen and consultant cover enabled a clinician to review patients in a timely fashion.

Is the service well-led?

Good 

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff.

At our last inspection December 2020, we found leaders were not always aware of risks and issues. At our most recent inspection we found this had improved. Leaders were aware of the risks in relation to the emergency department (ED), there were clear lines of accountability and plans in place to monitor and improve performance and manage risk.

Urgent and emergency care services were led by a nurse director, associate medical director, and operations director. Operationally the service was led by a senior matron, service director and operations manager. We spoke with the nurse director who explained they had increased the leadership team operationally since our last inspection in December 2020 and appointed a nurse consultant to the team to increase leadership capacity and drive improvement.

Day-to-day oversight of the department was managed by the senior matron, service director and operations manager. Nursing and medical leads we spoke with had the relevant competencies, skills and experience for their roles and had led the emergency department throughout the COVID-19 pandemic providing hands-on support for the workforce.

Leaders had maintained a focus on recruitment and made changes within the workforce to ensure stability and sustainability. Staffing levels were now manageable and there were plans in place for additional recruitment to strengthen the staff team further.

We observed that leaders were visible and approachable in the service for patients and staff and staff clearly understood the leadership of the ED and who to contact to escalate concerns within the service.

Leaders implemented escalation plans and processes, ensuring that staff understood and followed them. We observed site operation staff working closely with the ED leadership team to manage any concerns regarding patient flow, identify additional resources and encourage patient movement to increase capacity.

Vision and strategy

Urgent and emergency services

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

ED leaders had an Emergency Department Strategy 2020-2025 and a vision to be "An outstanding emergency department that supports our staff to provide the best possible care to our patients." All staff we spoke with were aware of the ED strategy and vision, and involved in the local developments, for example the recent changes in the environment, the new building works and design of the emergency care pathway.

We observed staff safety huddles that focused on the key priorities within the strategy, for example ED performance, patient waiting times, safety and managing risk. Staff we spoke with had opportunities to develop their skills and competencies, the ED leadership team were focused on the future needs of the ED whilst balancing the day-to-day demands of the department, which had seen a surge in ambulatory patients due to relaxation of some of the national public COVID guidance.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service had an open culture where patients, their families and staff could raise concerns without fear.

The COVID-19 pandemic had been extremely challenging for the ED and wider hospital teams. Staff spoke about their experiences during the pandemic and the impact this had taken on their wellbeing and morale. During our inspection we observed a culture of positive patient and staff interaction. Staff were focused on meeting patient needs and ensuring their safety. Performance data was routinely discussed, and staff openly challenged each other regarding waiting times and treatment options.

Consultants we spoke with described a positive culture of working together and there was a focus on promoting the internal professional standards (IPS) to provide more support in the department from other specialties.

There was a positive working relationship and team approach between the ED staff team and the local NHS ambulance trust. ED and ambulance staff valued each other and identified any issues likely to impact on the ED, for example pre-alerting for complex arrivals. We routinely observed positive interactions between ambulance staff and the ED team and the hospital ambulance liaison officer (HALO) focused on ensuring ambulance staff worked alongside the ED team to achieve performance targets and promote safe care.

The safety nurse role promoted a culture of challenge and safety when routinely reviewing patients and ensuring their care plan was being monitored and patients at risk of deterioration were managed appropriately.

Data supplied by the trust following our inspection showed that in the 2020 NHS staff survey for emergency and urgent care 88% of staff always knew their work responsibilities and 69% of staff said they felt the team had shared objectives. Seventy percent of staff said they received respect from their colleagues and 85% said they got support from work colleagues.

Leaders operated effective governance processes.

Urgent and emergency services

Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The ED had robust governance processes in place, holding governance meetings monthly, urgent and emergency care risk management meetings monthly and a weekly ED action evidence meeting.

A range of additional ED meetings, for example the senior nurses meeting, band five, six and seven nurses meetings and the ED staff meetings provided staff with opportunities to feedback on concerns, complaints, incidents, friends and family feedback as well as sharing good practice to the wider governance structure teams.

These meetings fed into the monthly emergency and urgent care governance meeting, and the monthly emergency and urgent care board.

We reviewed the clinical governance meeting minutes from 25 March 2021, 22 April 2021 and 27 May 2021. Minutes demonstrated leaders discussed key risks and performance issues likely to affect patient safety, treatment times and well-being. The governance process was underpinned by local and national audits, the ED participated in a wide range of audits focused on improving quality and performance.

The ED had a dedicated quality improvement plan to deliver against any concerns raised in previous Care Quality Commission (CQC) inspections. The plan was RAG rated and had key lines of accountability for making improvements. Areas still needing development were ongoing staff recruitment, staff training and improving patient waiting times.

As part of the ED care governance structure, the ED team have developed a Wellbeing Group to oversee and provide a framework to protect and improve the health, safety and wellbeing of all ED staff.

We reviewed mortality and morbidity meeting minutes from 28 January 2021, 25 March 2021 and 27 May 2021. Minutes demonstrated that staff reviewed patient deaths to identify any concerns in relation to care or treatment, and discuss the lessons learned from incidents. We noted discussion on treatment pathways, the use of policy and escalation and reflective practice to determine if deaths could have been avoided or if changes were required to improve safety and manage risks.

Managing risks, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The ED leadership team had developed a project "Safer, faster, better – emergency care improvement programme". An example of the project work streams included initiatives within the rapid assessment and treatment service (RATs) to improve performance and patient safety. The project focused on standardising processes within RATS whilst keeping the processes safe and effective. ED leaders were aiming improve the ED's ability to meet the demands placed upon it from patients who arrived via ambulance. The ED were developing metrics to demonstrate prompt interventions and treatments had taken place and identify any gaps in performance.

ED leaders maintained a "Safer, faster, better action and risk log". This enabled them to identify additional risks within the service, assign these to individuals to ensure accountability for improvements in performance and RAG rate additional risks to show improvements had been made or where additional improvements were required.

Urgent and emergency services

The ED risk register had four main risks including: -

- A lack of physical capacity to perform initial nursing assessment on patients who do not arrive by ambulance in a timely fashion.
- Lack of adequate capacity of ED waiting rooms (mains and minors Norwich).
- The impact of delayed decision to admit within the ED.
- Delays in assessment/Treatment due to medical staffing shortage.

Leaders were aware of the risks within the ED and we observed mitigation in place to manage these, the risk register was reviewed on a monthly basis as part of the governance processes, however risks could be escalated and reviewed sooner by leaders if necessary. For example, the changes to the ambulatory assessment area to clearly identify patients at risk of deterioration, building works to create a new reception, assessment and navigation area to manage patient flow and demand. The ED had made significant improvements in medical and nursing staffing through its recruitment processes and were on target to have a full medical team by August 2021, to improve delays in patient treatment and assessment.

Managing information

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure.

The ED used electronic patient record systems to maintain security of patient details and use live data to manage treatment plans and escalate patients who were at risk of deterioration.

Performance data was shared at all safety huddles and during staff handovers. Staff had access to live performance data via secure electronic systems and electronic displays in order to review and improve performance, for example ambulance arrivals, priority patients and waiting times.

Audit data was available to staff via the trusts intranet and we observed performance and risk data displayed on notice boards in key areas throughout the ED.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The ED team developed the “Foundation Programme” following the introduction of the Emergency Care Assistant and Royal College of Nursing National Curriculum and Competency Framework – Emergency Nursing Level 1 to the Department. The ED team recognised that there were many staff competencies to achieve. The team created an 18 month programme, known as the “Foundation Programme” where newly qualified or new to speciality nursing team are separated into five groups, each group participated in a study around every two months to support them on ‘The Road to Becoming an Emergency Nurse’.

Urgent and emergency services

The ED education team ensured that bank and agency nursing staff were orientated and supported in the department including a supernumerary process, induction packs and checklists to complete. The education team worked with the nurse bank and were notified when there was a new agency nurse in the department to ensure timely orientation.

The education and governance team developed a department initiative called 'Governation - where Governance meets Education.' The teams met monthly to discuss a monthly focus, for example, falls February, medicines March and the Mental Capacity Act and Mental Health May.

The education team created a healthcare assistant competency pack including a programme that supported their professional development.

The ED action evidence group was created to ensure that serious Incident actions were being met and learning from incidents was shared throughout the ED.

At the time of our inspection the trust was engaged in a documentation quality improvement project to support more engaging ways of sharing the changes on the trusts electronic record system.

Areas for improvement

MUSTS

Urgent & Emergency Care

The trust must ensure they continue to do all that is reasonably practical to improve key national and trust performance targets such as the four-hour standard, triage within 15 minutes of patient's arrival, internal professional standards and time taken from decision to admit, ensuring risks to patients are effectively mitigated. (Regulation 12).

SHOULDS

Urgent & Emergency Care

The trust should ensure that European Paediatric Life Support should be completed by appropriate staff by January 2022.

The trust should ensure that staff complete checks on emergency medical equipment in line with trust policy.

Our inspection team

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

REPORT TO THE TRUST BOARD

Date	**4 August 2021**
Title	**Chair's key Issues from Quality and Safety Committee Meeting on 27.07.21**
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 27 July 2021. Papers for the meeting were made available to all Board members for information in the usual way via Diligent. The meeting was quorate and was held on site and by MS Teams. The meeting was attended by Mrs Ines Grote (Public Governor) as observer via MS Teams.

2 Key Issues/Risks/Actions

Key issues to highlight to the Board were identified as follows:		
1	Clinical Visits –	The meeting began with visits to the Maternity Unit and Physiotherapy/hydrotherapy department.
2	Quality Report (easy read version)	The Committee **approved** the Easy Read version of the Quality Report – uploaded to the Resource Centre
3	CQIA Update	The Committee received an update report and took positive assurance with respect to the Clinical Quality Impact Assessment process associated with our CIP programme. At a time of financial limitation and control, this is an important safeguard to quality and safety.
4	Update on E-obs implementation	The Committee received an update on implementation of the electronic-observations system. This is now in use on 9 wards, with further incremental roll-out planned. There will be ongoing evaluation of its benefits. The Committee recognised that the implementation is a major step forward in enhancing our digital maturity and in improving patient safety – especially in detecting and responding to deteriorating patients.
5	Follow-up of results on ICE	The Committee received an update on the follow-up of investigation results. The position is complex whilst we are operating parallel electronic and paper-based systems and this generates a risk, which requires management. The position will change with introduction of an EPR. In the meantime, the SOP for management of results will be reviewed and staff reminded to ensure that there is routine follow up of investigations and results are acted on appropriately.
6	Maternity Quarterly Update	The Committee received the latest quarterly update relating to our Maternity service. As previously reported, the initiative to introduce Continuity of Carer(CoC) has been impacted by staff turnover leading to a delay in its further rollout. However, there has been successful recruitment of midwives and further incremental introduction of CoC will be advanced from September.

7	Capital Plan Prioritisation	The Committee received a report concerning the process of prioritising capital expenditure in the Trust's Capital Programme. The Committee was assured that this had been conducted in a structured way involving clinical and divisional input in making decisions whilst balancing the priorities of quality and finance and informed by the Risk Register.

3 Conclusions/Outcome/Next steps

The next Committee meeting is scheduled for 28 September 2021.

Recommendation: The Board is recommended to:

- **note** the work of its Quality & Safety Committee.

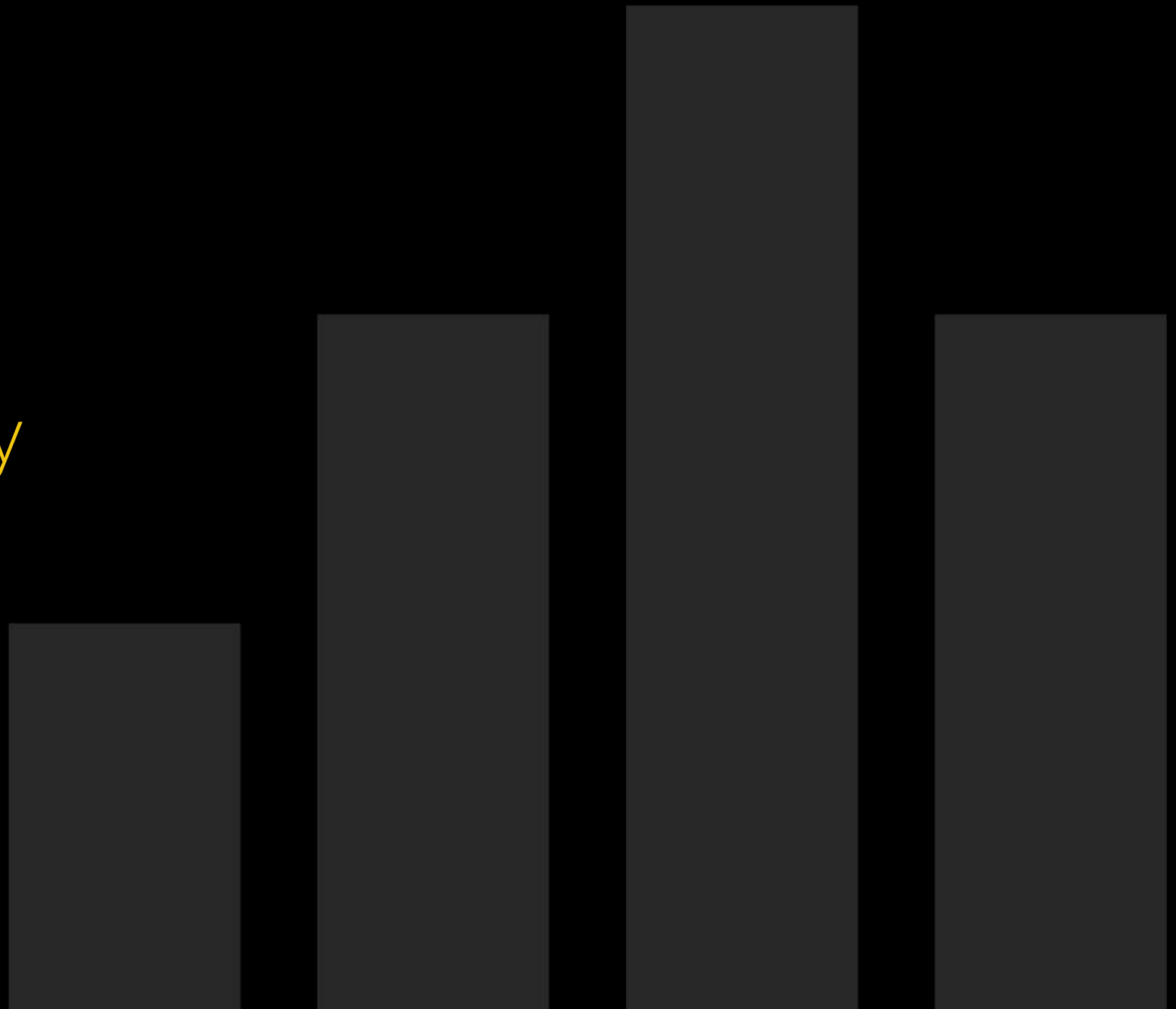
Microsoft | Power BI

Quality & Safety

View in Power BI

Last data refresh:
21/07/2021 07:30:27 UTC

Downloaded at:
21/07/2021 12:40:57 UTC



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
Complaints	Complaints - Acknowledgement	Jun 2021	100%	Improvement (High)	Unreliable
Maternity: Mothers	Caesarean Deliveries	Jun 2021	37.6%	Concern (High)	No Target
Patient Falls	Patient falls per 1,000 bed days (moderate harm or above)	Jun 2021	0.1	Improvement (Low)	Unreliable
Patient Safety	Duty of Candour Compliance	Jun 2021	100%	Improvement (High)	Unreliable
Patient Safety	Incidents	Jun 2021	2,939	Concern (High)	No Target

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

Jun 2021

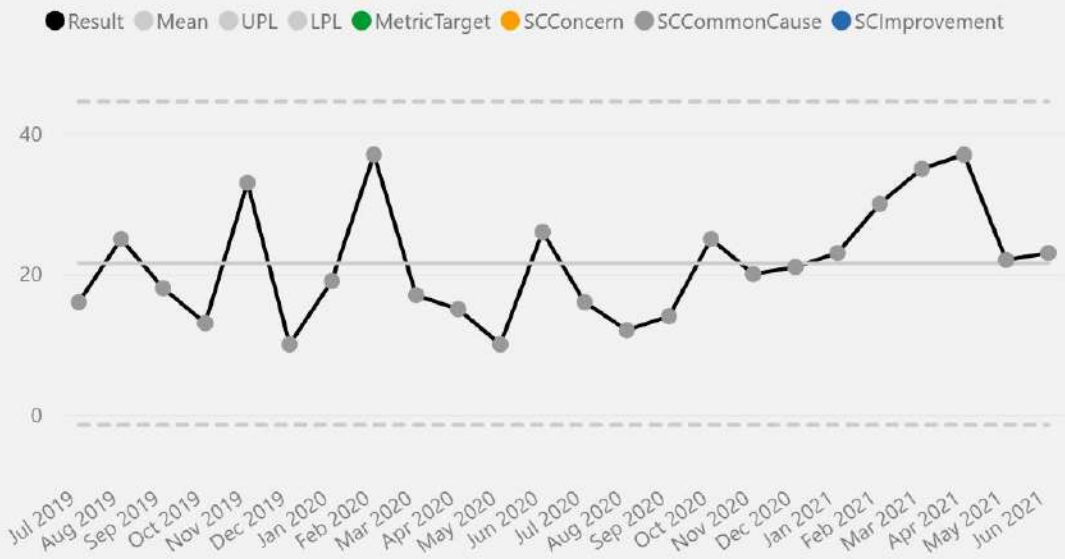
Variation | Assurance

23 Result
N/A Target
45 UPL
22 Mean
-1 LPL

Analytical Commentary

Variation is Common Cause

Serious Incidents



Assurance Commentary

The number of SIs reported (23) includes 10 commissioning incidents related to delays to admission to a mental health bed from the Emergency Department, and monthly ambulance handover delays. 12 safety incidents were reported; 4 treatment delay, 2 HCAI Covid clusters, 1 Maternity incident, 1 fall, 1 sub optimal care, 1 Self harm incident, 1 Information Governance Breach and a reportable radiation incident. 1 void agreed by CCG.
A high rate of incident reporting indicates a good safety reporting culture and is not cause for concern.

Improvement Actions

Staff are encouraged to report all patient safety incidents including those causing no, low harm and near misses. Learning and sharing of incidents takes place at divisional and specialty Governance meetings.
Incidents are discussed, learning is shared and informs QI work.
We continue to promote psychological safety and 'just' culture to encourage open, honest disclosure of incidents, using all incidents as learning opportunities.
Emerging risks are identified and added to risk register.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Duty of Candour Compliance	Jun 2021	100%		Improvement (High)		Unreliable
Incidents	Jun 2021	2,939		Concern (High)		No Target

Pressure Ulcers

NNUH Digital Health
business intelligence

Hospital Acquired Pressure Ulcers per 1,000 bed days

Jun 2021

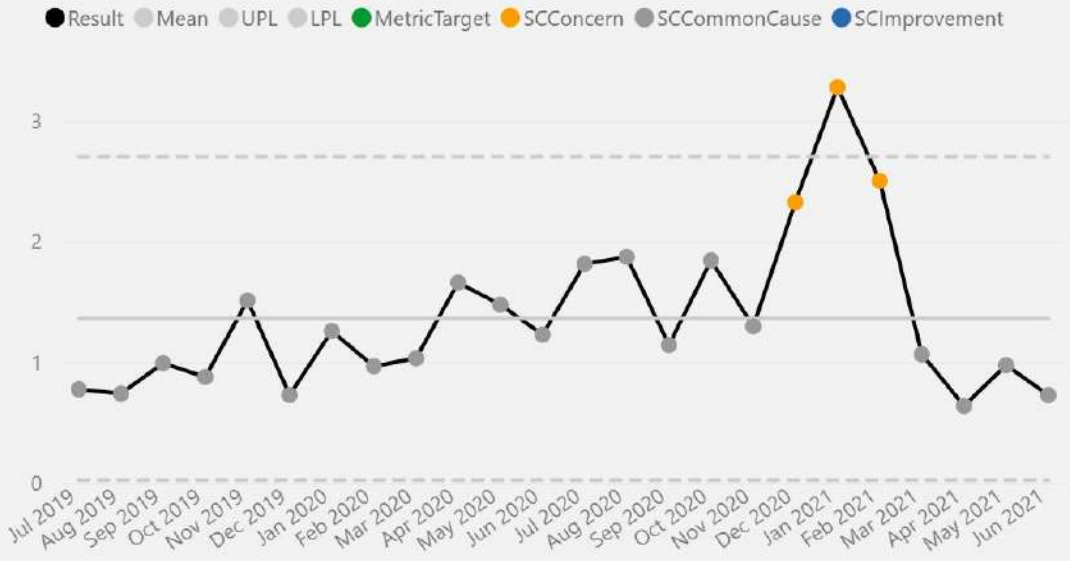
Variation | Assurance

0.7 Result	2.7 UPL
N/A Target	1.4 Mean
	0.0 LPL

Analytical Commentary

Variation is Common Cause

Hospital Acquired Pressure Ulcers per 1,000 bed days



Assurance Commentary

Hospital Acquired Pressure Ulcers are showing a reduction to pre pandemic levels, falling below the mean of 29 for the last four months.
We have achieved 105 Cat 3 pressure free days to the end of June.

Improvement Actions

The Pressure Ulcer Improvement Programme aims to achieve a 20% reduction in the number of hospital acquired pressure ulcers. Ward based QI projects are ongoing .
The Purpose T trial has started on Easton and AMU, further updates will be included in next month's report. The aim is to improve risk assessment and care planning for inpatients.
Medicine Division continue to work on their QI for pressure ulcer reduction with all wards reporting a reduction from the last quarter.

Patient Falls

NNUH Digital Health
business intelligence

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

Jun 2021

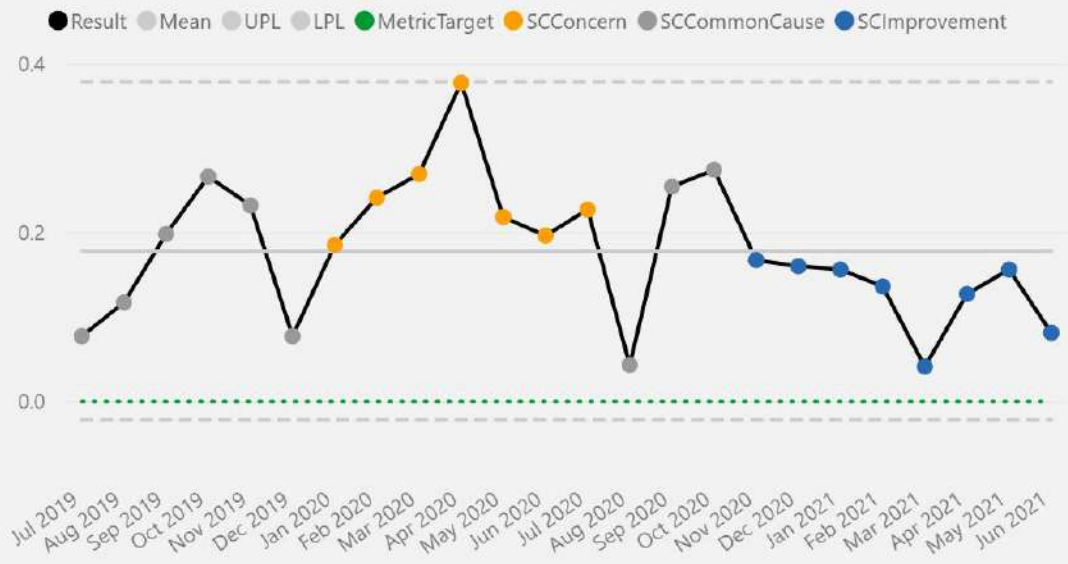
Variation	Assurance
L	?

0.1 Result	0.4 UPL
0.0 Target	0.2 Mean
	0.0 LPL

Analytical Commentary

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

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



Assurance Commentary

Patient falls continue to show common cause variation, the last 8 months the data has fallen below the mean, if this pattern continues it would indicate that we are seeing a reduction in the number of patient falls, 1 patient fall met SI criteria

Improvement Actions

Ward based improvement work is ongoing including relaunching 'Baywatch' which provides enhanced observations of patients identified as high risk of falling. Falls improvement work now extending to Kimberley & Langley, 5 ward areas are now working on the falls reduction programme.
The number of Adult Inpatient Metric (AIM) audits are increasing and are used as an educational tool as well as identifying areas for improvement.
Good use of Education Boards to share learning and success.
Staff engagement in QI projects is evident across all grades of staff, staff feedback is positive.

Patient Experience

NNUH Digital Health
business intelligence

Friends & Family Score

Mar 2021

Variation	Assurance

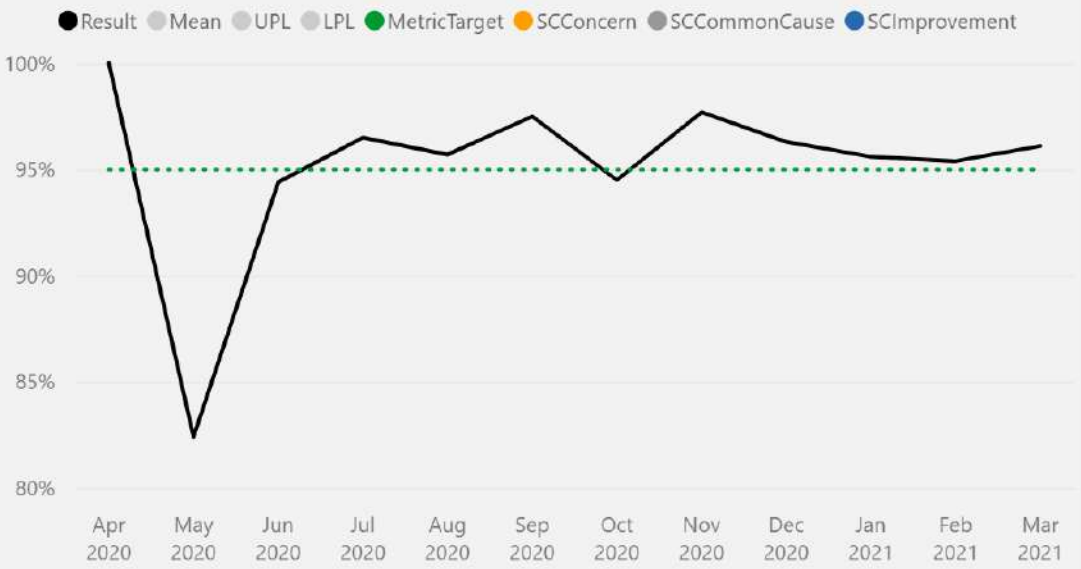
96.10% Result
95.00% Target

UPL
Mean
LPL

Analytical Commentary

Metric does not meet SPC criteria

Friends & Family Score



Assurance Commentary

The Friends and Family Test (FFT) data has been manually included due to the ongoing technical issues.

The overall FFT score for the Trust is 96% (1089 responses)
Maternity FFT score is 53% (17 responses)
Outpatients FFT score is 96% (851 responses)
Inpatients FFT score is 100% (1 response)
ED FFT score is 88% (42 responses)
Daycase FFT score is 99% (178 responses)

236 compliments were received in total.

Improvement Actions

To progress with actions to enable SMS for ED patients and to resolve FFT data transfer for reporting.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Compliments	Feb 2021	113		Common Cause		No Target

Patient Concerns

NNUH Digital Health
business intelligence

PALS % Closed within 48hours

Jun 2021

Variation | Assurance

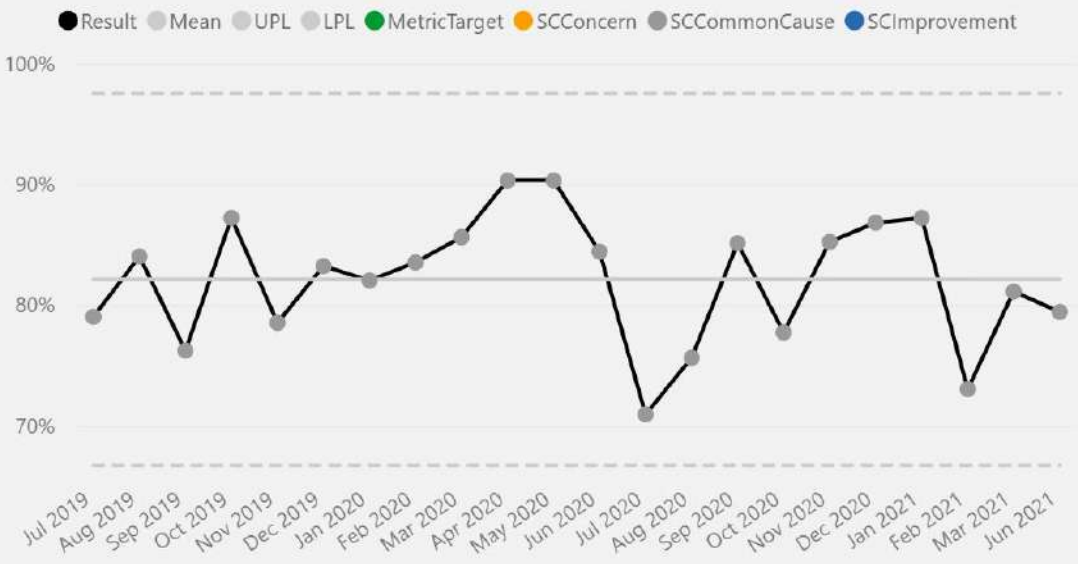
79.4% Result
N/A Target

97.5% UPL
82.1% Mean
66.7% LPL

Analytical Commentary

Variation is Common Cause

PALS % Closed within 48hours



Assurance Commentary

PALS data - Total PALS matters received 485

Concerns = 188
Enquiries = 158
Signposting = 120 (of which 50 are formal complaints)
Best Wishes =17
PALS compliment = 0
Suggestions = 2

Main Subjects (Top 3)

Appointment delays and cancellations
Communications
Waiting times

Improvement Actions

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
PALS Enquiries	Jun 2021	485		Common Cause		No Target

Complaints

NNUH Digital Health
business intelligence

Complaints - Trust

Jun 2021

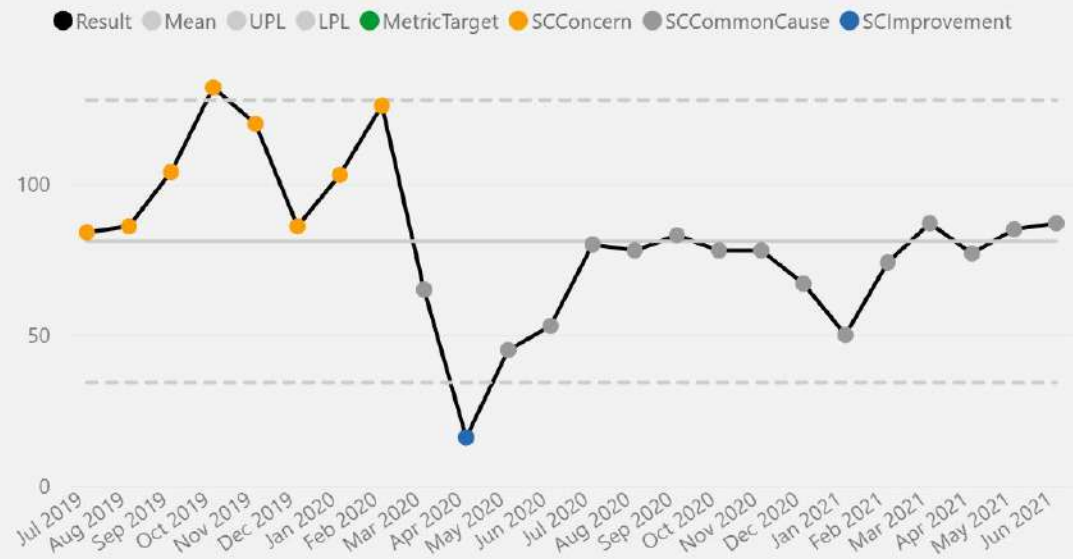
Variation | Assurance

87 Result
N/A Target
128 UPL
81 Mean
34 LPL

Analytical Commentary

Variation is Common Cause

Complaints - Trust



Assurance Commentary

All targets met.

Improvement Actions

Responsibility for administration of formal complaints has now been passed to the PALS and Complaints Team, with transitional arrangements and close liaison in place during handover.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Complaints - Acknowledgement	Jun 2021	100%		Improvement (High)		Unreliable
Complaints - Response Times - Trust	Jun 2021	100%		Not Applicable		Not Applicable
Post-investigation enquiries	Jun 2021	4		Common Cause		Capable

Mortality Rate

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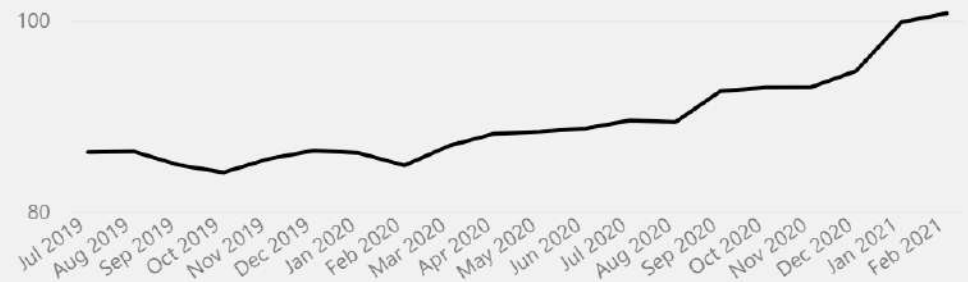
business intelligence

MetricName	Date	Result
HSMR	Feb 2021	100.73
SHMI	Feb 2021	120

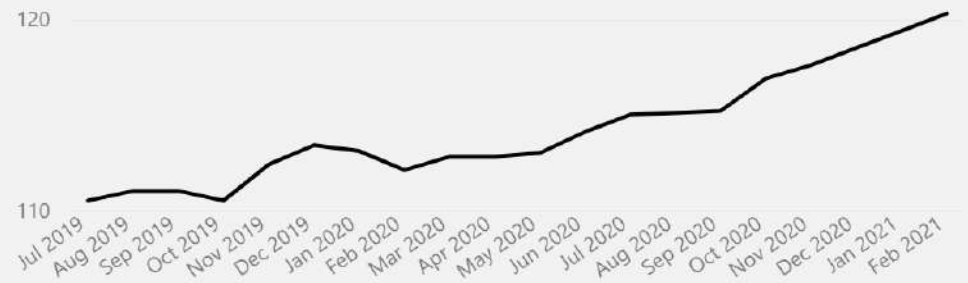
Assurance Commentary

The overview of the March 2020 – Feb 2021 period shows the HSMR metric (101.1) is in the 'as expected' range. NNUH is 1 of 2 Trusts (within the East of England peer group of 12) with an HSMR as within the 'as expected' range.

HSMR



SHMI



Improvement Actions

Actions plans remain in progress for NNUH SHMI and SJR back log.
Work continues to complete the SJR cohort review of SHMI 30 day deaths and the SJR cohort review of Covid Deaths for the second wave.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Crude Mortality Rate	May 2021	4.00%		Common Cause		No Target

Safer Staffing

NNUH Digital Health
business intelligence

Safe Staffing Fill Rates

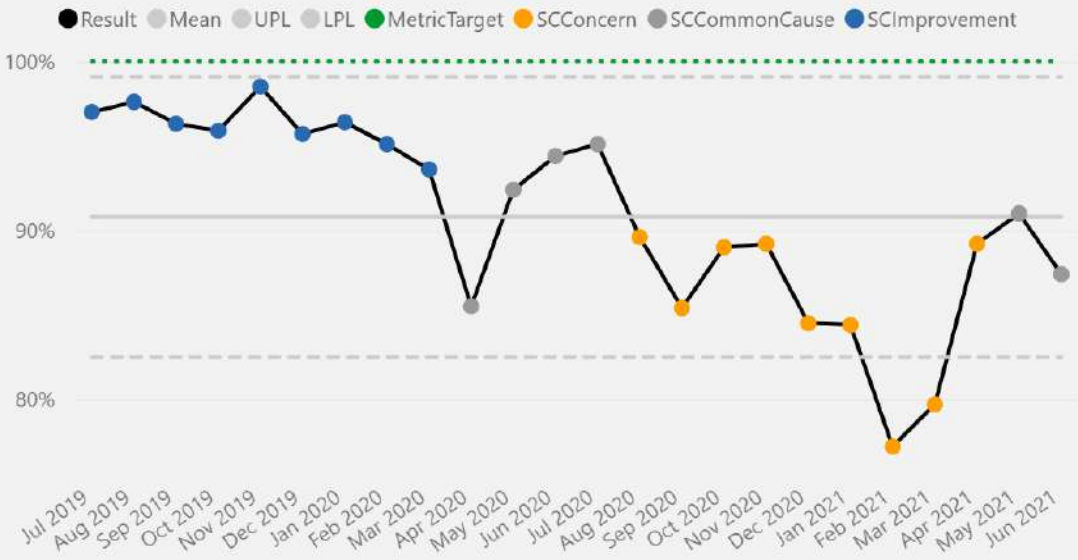
Jun 2021

Variation	Assurance		
	F	87.40% Result	99.10% UPL
		100.00% Target	90.80% Mean
			82.50% LPL

Analytical Commentary

Variation is Common Cause

Safe Staffing Fill Rates



Assurance Commentary

In June, the overall RN/M and HCA fill rate was 90.2%. The RN fill rate fell below 90% on 25 occasions and below 90% on 24 occasions for HCAs. CHPPD has remained relatively static, in June at 8.1 which is a 0.2 decrease from May. In June, 1504 red flags were raised with 635 remaining open and 800 mitigated across the divisions. 4 red flags remained opened on nights for less than 2 RNS on shift. However, this does not match what the roster suggests. Nursing redeployment remained stable in June at 826 with 54% of these for RN shifts. The highest deployment was FROM Brundall and highest deployment TO Escalation.

Improvement Actions

Daily staffing report sent to DNDs & Matrons senior teams highlighting safer staffing compliance, staff redeployment, red flag mitigations & use of temporary staffing.
Business case in development for internationally recruited nurses to maximise opportunities to reduce costs through direct recruitment. Establishment reviews for inpatient wards completed. Speciality areas commence 6 Sept. Safer staffing board assurance framework in development. Roster Scrutiny panel to be instigated.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Safe Staffing CHPPD	Jun 2021	7.7		Common Cause		No Target

Infection Prevention & Control

NNUH Digital Health
business intelligence

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

Assurance Commentary

Edgefield Supportive measures were concluded on 18/06/21 with no further cases of C.difficile. Following 2 cases of C.difficile on Docking ward within 28 days Supportive measures were commenced on 24/06/21. These cases were both ribotype 005. There have been no further cases.

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

Improvement Actions

Actions from NHSE/I visit:
A review of ED cubicles and risk assessment for time patients remain in the ED cubicles when COVID-19 positive.
Further communication sent around the number of available socially distanced seats in rest rooms to match poster on door.
Trust wide walk around of rest rooms undertaken and any extra chairs taken out of use.
Communication offering patient facemasks after meal times.

NNUH Staff COVID-19 Testing

Latest COVID test results from ICE for NNUH Staff Members, where possible staff mapped to data provided by HR.

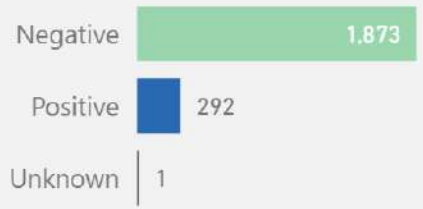
NNUH Digital Health
business intelligence

NNUH Staff Tested	Results Recieved	COVID-19 Confirmed	Avg. Hrs Test to Result
2,178	2,166	292	62.3

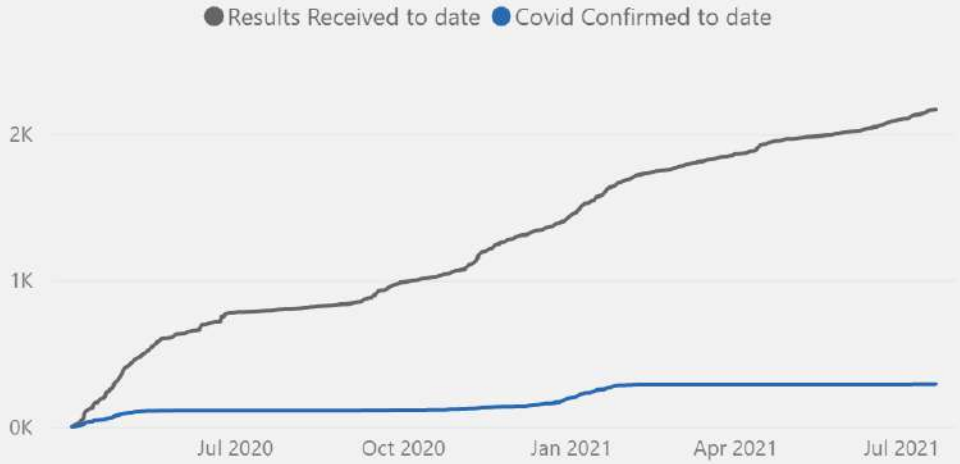
Unmapped Staff *

642

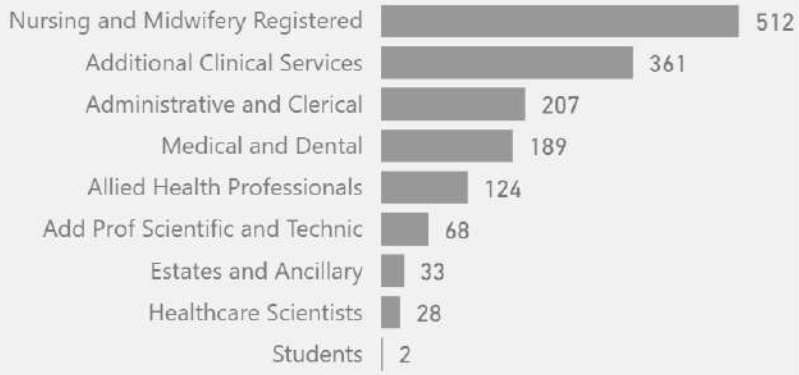
COVID-19 Status



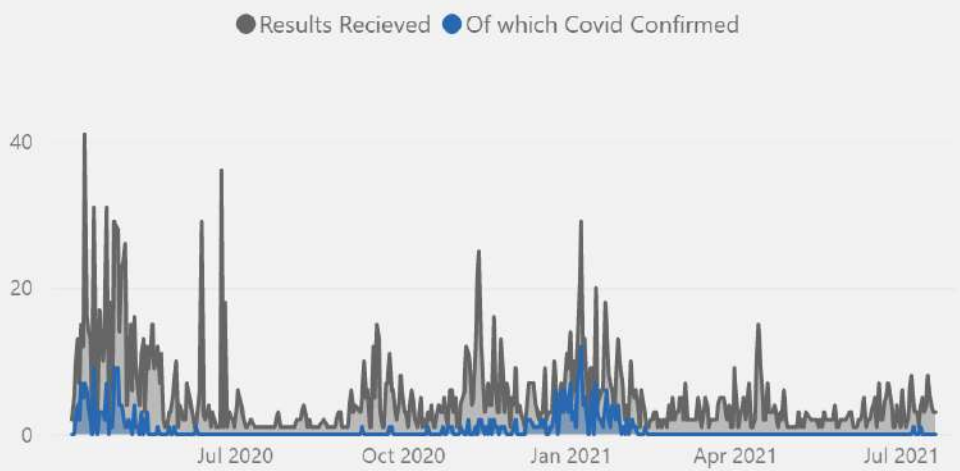
Cumulative NNUH Staff Testing to Date



Results Received by Staff Group



NNUH Staff Results by date of Result



Results Received by Organisation (10+ results)

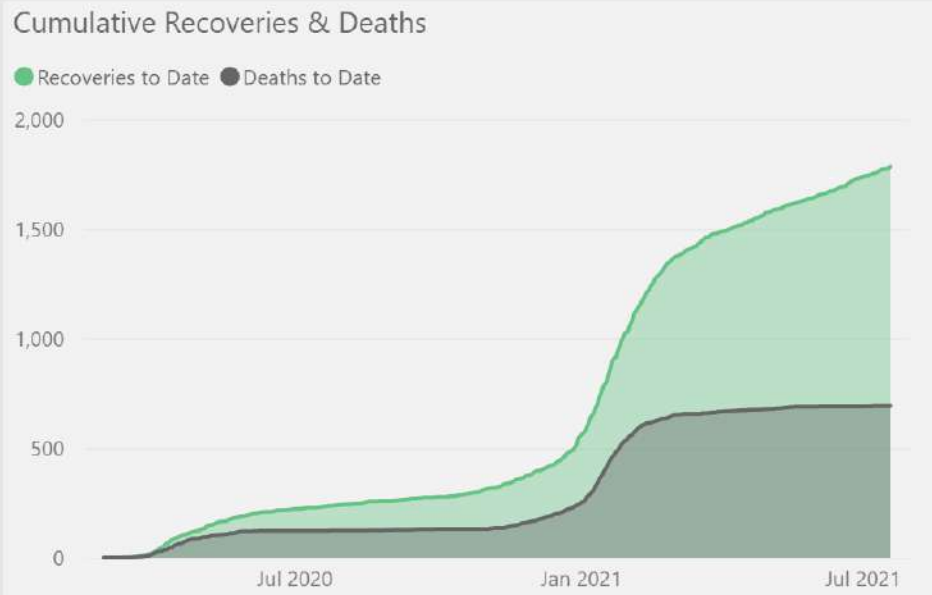
* Of COVID-19 tests recorded on ICE as NNUH staff, a number of records were unable to be mapped back to HR data.

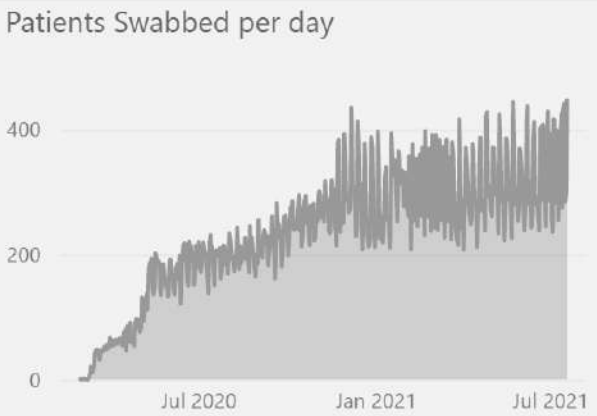
COVID-19 Report - Timeseries

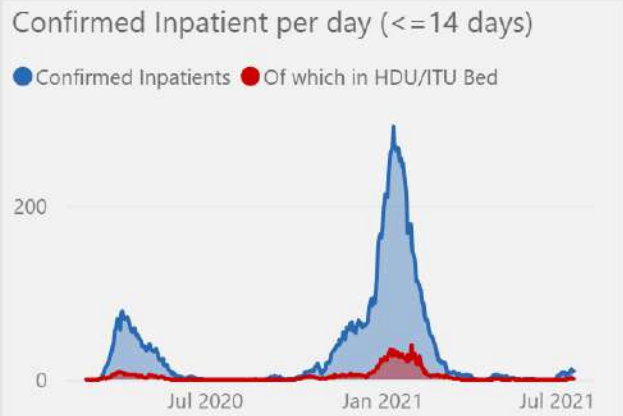
To date record of swabs taken, confirmed cases, discharges and deaths

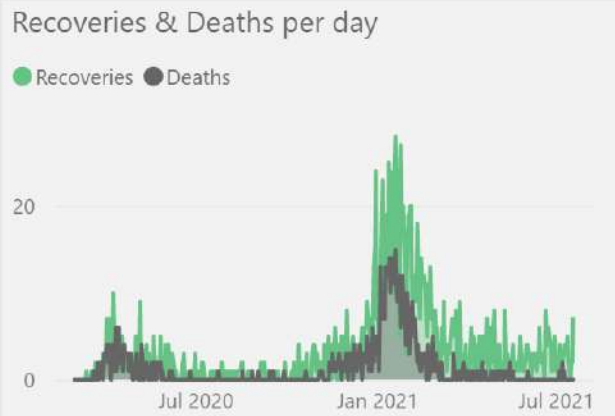
NNUH Digital Health
business intelligence

Cumulative	Total Swabs Taken	Patients Swabbed	Confirmed Cases	Recoveries	Deaths
01/03/20 - 19/07/21	122,314	44,897	2,514	1,784	693









Maternity: Mothers

NNUH Digital Health
business intelligence

Caesarean Deliveries

Jun 2021

Variation	Assurance
H	

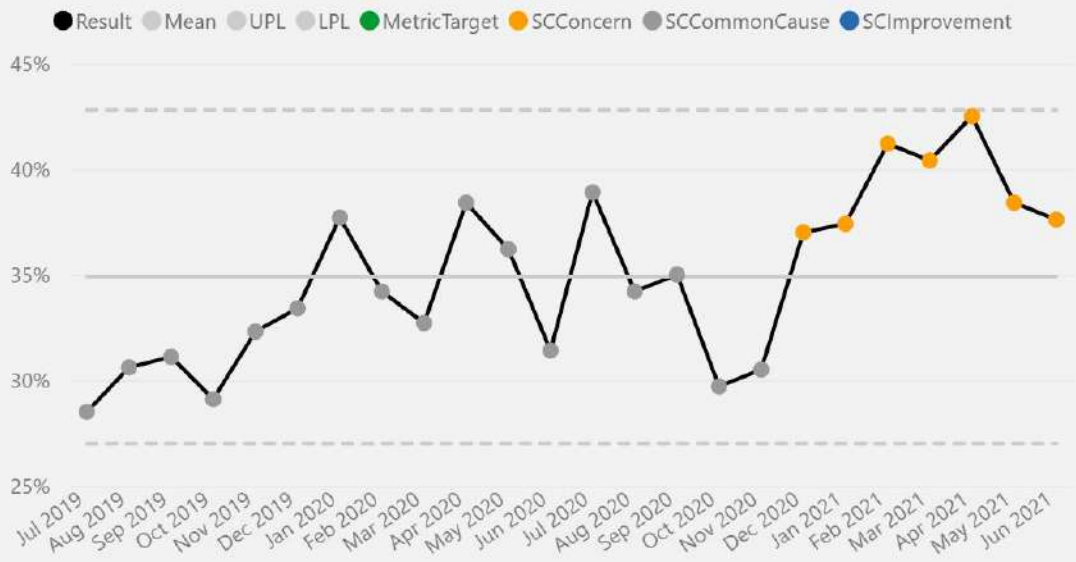
37.6% Result
N/A Target

42.8% UPL
34.9% Mean
27.0% LPL

Analytical Commentary

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

Caesarean Deliveries



Assurance Commentary

In June there were 458 babies born to 450 mothers.
LSCS accounted for 37.6%, this was a reduction from 38.4% in May.

1:1 care in labour was 98.3%. This was due to the co-ordinating midwife having to provide clinical care (therefore not remaining as supernumerary) during a period of high acuity and short staffing.

Of the 450 mothers delivered 3.6% sustained a 3rd or 4th degree tear, which is below the national average of <4%.

There were 5 BBA's in June.

Improvement Actions

Continue to share Learning with the teams.
Documentation around the circumstances of BBA's needs to be improved.
Continue to monitor Caesareans clinical appropriateness via weekly CTG meetings chaired by Intrapartum Lead Consultant.
Awaiting outcome of funding bid for fetal monitoring lead clinician.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
1:1 Care in Labour	Jun 2021	98.3%		Common Cause		No Target
3rd & 4th Degree Tears	Jun 2021	3.6%		Common Cause		Unreliable
Births Before Arrival	Jun 2021	5		Common Cause		No Target
Post Partum Haemorrhage ≥1500mls	Jun 2021	1.6%		Common Cause		No Target

Mothers Delivered
450
Babies Delivered
458

Maternity: Babies

NNUH Digital Health
business intelligence

Unplanned NICU ≥37 week Admissions (E3)

Jun 2021

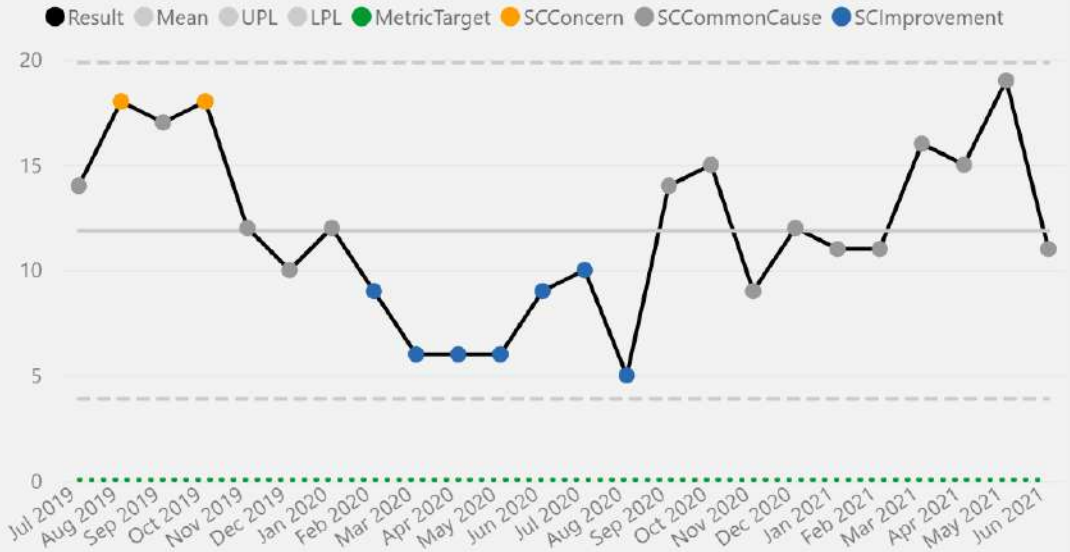
Variation	Assurance
	

11 Result	20 UPL
0 Target	12 Mean
	4 LPL

Analytical Commentary

Variation is Common Cause

Unplanned NICU ≥37 week Admissions (E3)



Assurance Commentary

In June there were 11 unanticipated admissions to NICU. 8 of these were primigravid women and 3 were multigravid, 10 of these cases were >38/40. A twin delivery at 34 weeks resulted in one twin being admitted to NICU with cord gasses of 6.9, however care in this case was appropriate.
4 were admitted following the mother being induced.
8 babies were admitted with RDS (1 case of meconium aspiration). 1 baby was diagnosed with renal abnormalities following NIPE. 2 babies were admitted with low cord gases but did not require theraputic cooling.

Improvement Actions

In 8 of the cases care was viewed as appropriate. 1 case is awaiting a baby Kardex to be completed. 1 case is awaiting review by the fetal surveillance midwife.
In 1 case, care was not appropriate, the CTG was misinterpreted and not correctly acted upon. The case was presented at SIG and an investigation will be conducted. Learning and lessons learned from the case has been shared widely with the team.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Adjusted Still Births	Jun 2021	2		Not Applicable		No Target
Apgar score <7 @5, ≥37 weeks	Jun 2021	3		Common Cause		No Target
Early Neonatal Death	Jun 2021	0		Not Applicable		No Target
Mothers Transferred Out of Unit	Jun 2021	6		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	Jun 2021	11.1%		Common Cause		Unreliable
Fetal Growth Restriction	Less Than 3rd centile born > 37+6 weeks	Jun 2021	1%		Common Cause		Unreliable
Fetal Growth Restriction	SGA detected Antenatally	Jun 2021	52%		Common Cause		No Target
Reducing Preterm Birth	Singleton Births Preterm	Jun 2021	8%		Common Cause		Unreliable
Reducing Preterm Birth	Singleton live births < 34 wks (AN corticosteroids within 7 days PN)	Jun 2021	55%		Common Cause		Unreliable
Effective Fetal Monitoring	CTG Training and Human factors situational awareness compliance	Jun 2021	88%		Common Cause		Unreliable

Assurance Commentary

Improvement Actions

Reminder to all midwifery staff involved with booking/36 weeks to recommence Carbon Monoxide monitoring.
New fetal monitoring lead midwife has action plan to improve GAP training compliance.
Review data pull for <30week deliveries to confirm correct details are being pulled across.

Adult Safeguarding

NNUH Digital Health
business intelligence

Safeguarding Adults

Jun 2021

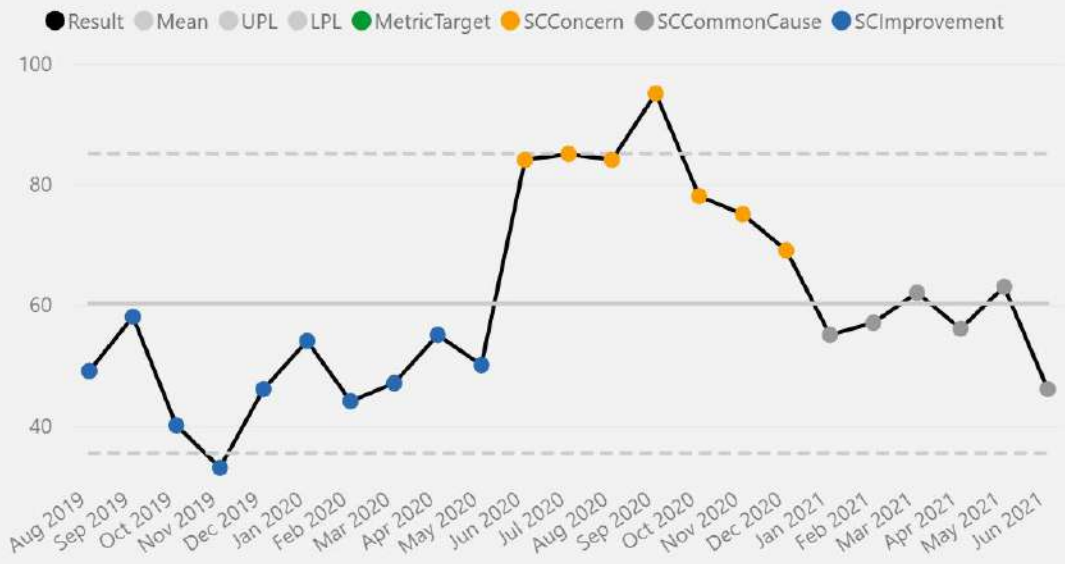
Variation | Assurance

46 Result
N/A Target
85 UPL
60 Mean
35 LPL

Analytical Commentary

Variation is Common Cause

Safeguarding Adults



Assurance Commentary

Safeguarding Adult concerns continue to be recognised and reported by Trust staff. The NNUH Safeguarding Team are continuing to liaise with NCC on a daily basis and have requested that reports of themes, incidents upheld and any actions are provided as a monthly report by NCC in order to provide further assurance via the NNUH Safeguarding Assurance meeting.

Improvement Actions

Face to face Safeguarding Training has recommenced from April 2021.
The Local Authority and Designated Safeguarding Adult Team (DSAT) from CCGs have been invited to the Safeguarding Assurance Meeting in order to provide feedback/actions on historical safeguarding concerns raised against NNUH.

Funding has been approved by the CCG for an Mental Health Emergency Responder role and the planning phase has commenced, with an anticipated service delivery date of September 2021.

Children & Midwifery Safeguarding

NNUH Digital Health
business intelligence

Safeguarding Children and Midwife...

Jun 2021

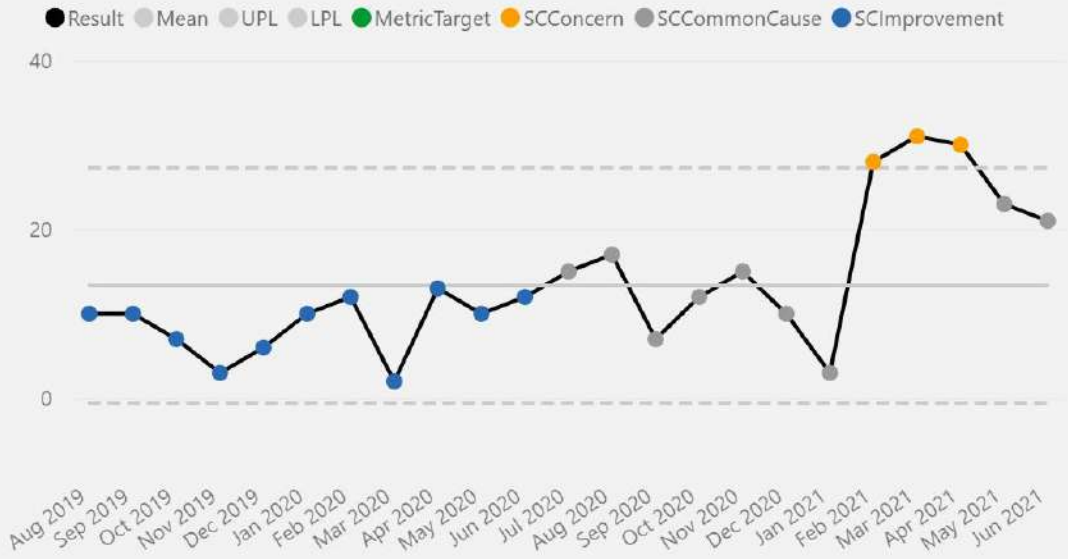
Variation	Assurance
	

21 Result	27 UPL
N/A Target	13 Mean
	-1 LPL

Analytical Commentary

Variation is Common Cause

Safeguarding Children and Midwifery



Assurance Commentary

Safeguarding concerns continue to be recognised and reported across all areas of paediatrics and maternity services. There continue to be high levels of mental health presentations in paediatrics and a system-wide response and support plan is being developed. The intention is to provide a regular weekly update to all CEOs to provide additional assurance and to articulate the current risks being managed by the system.

Improvement Actions

Face to face safeguarding training has recommenced from April 2021. Staff will continue to be reminded of the need to complete a Datix for each safeguarding referral made to the Local Authority.

4 beds of the Jenny Lind refurbishment project have been ring fenced for Complex Mental Health Patients. Service delivery modelling includes input/in-reach from the Children's intensive support team
Discussion are in progress to develop the service specifications and pathways

Supplementary Metrics

Metric Name	Date	Result	Variation	Assurance
Safeguarding Children	Jun 2021	16	Common Cause	No Target
Safeguarding Midwifery	Jun 2021	5	Not Applicable	No Target

REPORT TO THE TRUST BOARD	
Date	**4 August 2021**
Title	**Chair's Key Actions from Finance, Investments and Performance Committee meeting on 28 July 2021**
Lead	**Tom Spink – Non-Executive Director (Committee Chair)**
Purpose	**For Information, assurance and approval as specified**

1 Background/Context

The Finance, Investments and Performance Committee met on 28 July 2021. The meeting was quorate and was attended by Mrs Jackie Hammond (Public Governor) as observer. Papers for the meetings were circulated to Board members for information in the usual way via Diligent.

The Committee considered the usual suite of information regarding operational and financial performance and actions to improve the Use of Resources position. The items below were identified by the Committee for highlighting to the Board:

2 Key Issues

The following issues were identified to highlight and escalate to the Board		
1	Performance & Productivity (IPR)	• The Committee was updated on the operational challenges facing the Trust and: - was assured that elective capacity is focussed on treating patients of the greatest priority but the waiting position is very dynamic as the number of incoming referrals remains high; - there is significant pressure relating to non-elective demand in the context of increasing Covid-related admissions and staff absences as a result of isolation. The hospital's escalation processes had reached the level of Critical Incident 4 times in the preceding 7 days. - Despite the pressures, the Trust remains compliant with the agreed national plan • The Committee enquired whether there are any actions that would assist in the coming months. Maintaining a collective position on protecting the elective programme was highlighted. • Recognising the operational pressures and their impact on teams and individual members of staff, the Committee advocated reviewing commitments and whether non-essential items can be scaled-back. The Committee questioned whether the number of Committee meetings should be scaled-back again over the next 6 months.
2	Elective Care Strategy	• The Committee reviewed updates to the Trust's Elective Access Policy, which has been revised together with neighbouring trusts – so that there is a common policy across N&W acute providers. This updated Policy has been **uploaded to the Resource Centre** and is **recommended to the Board for approval**. All three Trust Boards are being asked to approve this common policy.

3	Financial Performance YTD	The Committee was pleased to note that the Trust remains ahead of our financial plan being £3.8m favourable YTD and that CIP delivery is £1.1m ahead of plan.
4	Digital Health Business Cases	• The Committee reviewed two business cases relating to development of the Trust's Digital Maturity. These cases relate to : i) the Digital Aspirant Programme (2021/22) (collectively with the other two acute Trusts); and ii) the Trust's Digital Capital Programme (2021/22) which forms part of the Trust's agreed overall Capital Programme. These cases have been uploaded to the **Resource Centre** and the Committee **recommends both cases to the Board for approval.**
5	Major Projects – Post Implementation Review	The Committee received a report concerning the major projects scheduled for post implementation review, and the associated timetable. The Committee supported the approach but suggested that the timetable be reviewed, so that it will be less challenging in deliver in the next 6 months, given the operational priorities that are anticipated.

3 Conclusions/Outcome/Next steps

The next Committee meeting is scheduled for 29 September 2021.

Recommendation:

The Board is recommended to:

- **note** the work of its Finance, Investments and Performance Committee
- **approve** the updated RTT Elective Access Policy (in common with JPUH and QEKL)
- **approve** the two Digital Business cases as specified

COVID-19 Update

June 2021

Current position: Local Covid State 2 – Low prevalence of Covid-19 within the Hospital

Executive Summary – June 2021

COVID-19

There was a slight increase in COVID-19 bed occupancy in June. All admissions were managed through the Hoveton Unit as the daily number did not exceed 9 inpatients at any time. The hospital remained in Local COVID State 1 throughout the month escalating to Local COVID State 2 on 2nd July. Daily IMT meetings remain in place.

Non-Elective Care

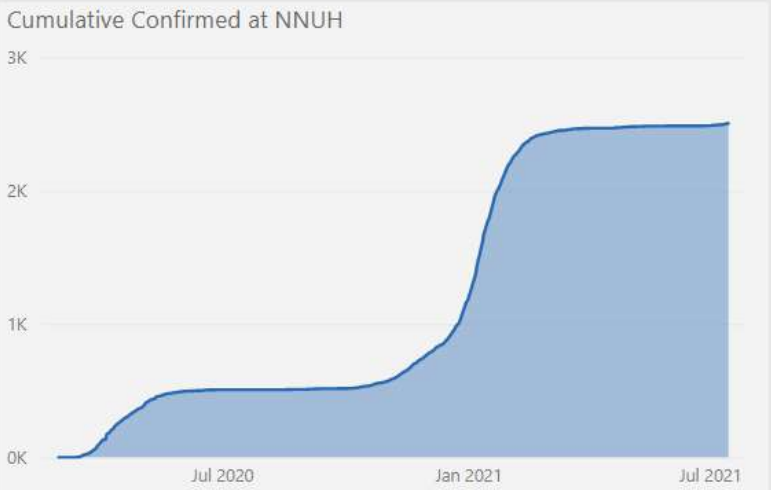
The Trust saw a deterioration in performance against most key metrics in June. The primary drivers for under-performance were increased attendances, batching of presentations in ED, reduced flow and increased numbers of delayed discharges. The Safer, Better, Faster work streams have been re-formatted to focus on the revised volume and pattern of attendances. System working in discharge and Mental Health pathways is ongoing. CEO deep dive into discharge planned for July 2021.

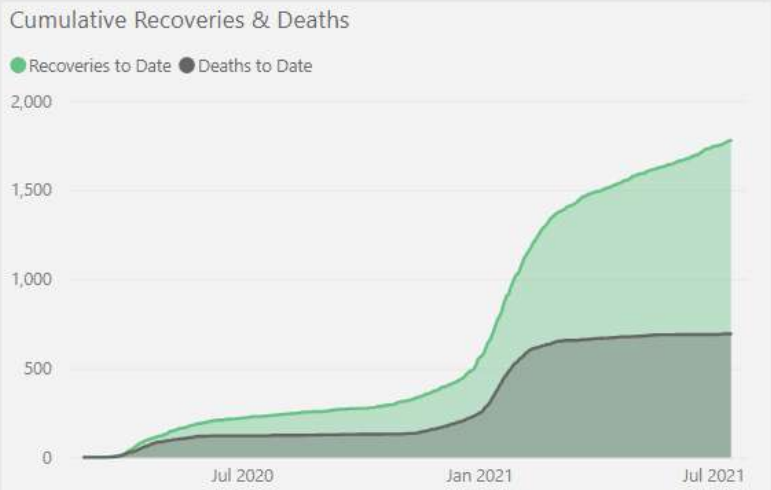
Elective Care

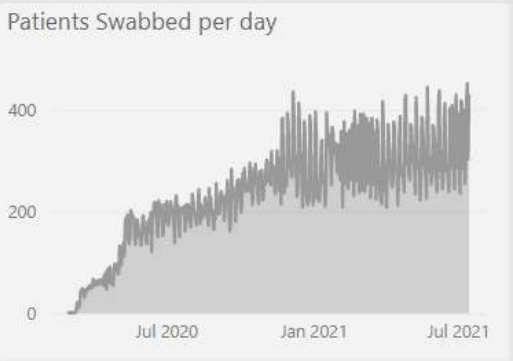
The Trust over-performed against the NHSE Activity targets in June. This saw the NNUH generate a £6.3M favourable variance for the system ERF at M3. Continued delivery of the P2 backlog removal plan negatively impacted performance % against the key metrics as large volumes of patients who have already breached the standards were treated in Theatres. Extraordinary demand on 2WW cancer pathways, particularly Breast Cancer have impacted on 2WW, 62 day and Faster Diagnosis performance in June. There was also very little take up of WLI/weekend working until 26/06 resulting in a reduction in speed of progress against waiting list reductions. However, the total number of patients waiting over 52 weeks has reduced in month.

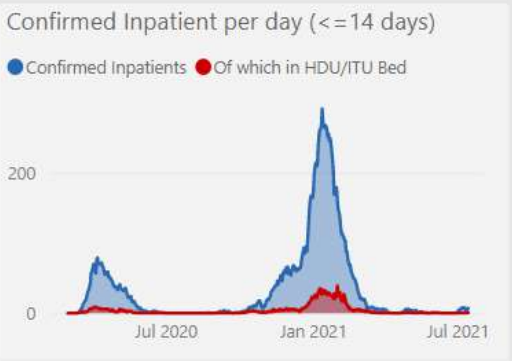
COVID-19 Report: Time Series

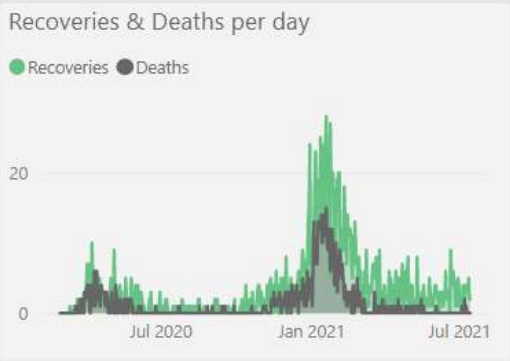
Cumulative	Total Swabs Taken	Patients Swabbed	Confirmed Cases	Recoveries	Deaths
01/03/20 - 15/07/21	120,904	44,516	2,502	1,778	693











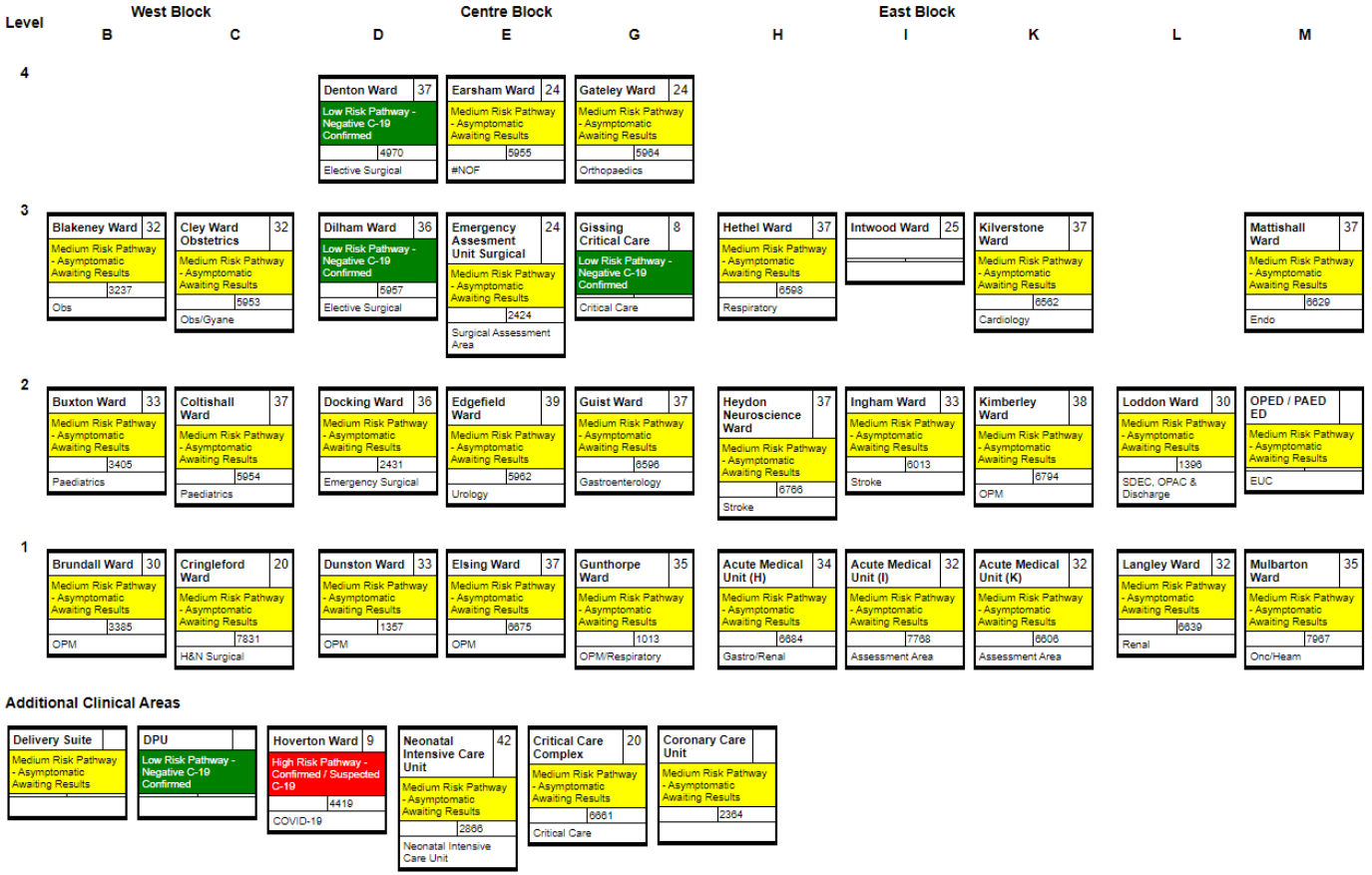
Commentary

There was a slight increase in COVID-19 bed occupancy in June. All admissions were managed through the Hoveton Unit as the daily number did not exceed 9 inpatients at any time.

The hospital remained in Local COVID State 1 throughout the month escalating to Local COVID State 2 on 2nd July.

Daily IMT remains in place.

COVID-19 Report: Current Local Covid State



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

Commentary

The Trust remains on Local Covid State 2 with capacity for 9 patients on Hoveton Isolation Unit. There are currently 9 patients in the hospital (8 on Hoveton and 1 in critical care) and 2 on the virtual ward. One patient is being tested (information as of 16th July 21). Brundall is designated as a red area if the number of positive cases continues to grow. All side rooms on Brundall have been vacated in preparation.

COVID-19 Report: Incident Management Team – Command & Control

Incident Management Team – Daily COO Office Recovery Plan Oversight Schedule

Monday	Tuesday	Wednesday	Thursday	Friday
IMT Meeting: Weekend review of elective and non-elective performance Set expectations for week ahead and prioritise capacity/ focus	Divisions to follow up cancer and RTT PTL/Check and challenge sessions. Non-elective LLOS Reviews and breach analysis meetings SET/SBF progression of actions (can be any day for project group meetings) Alternate weekly open conversation sessions	IMT Meeting: Obstacles to delivery and current format meeting Operational delivery group meetings for SBF	Weekend planning – both elective and non-elective Divisional reviews finance and quality actions/plans Leadership forum sessions after connected	IMT Meeting: Review and approve SET & SBF flash reports – address and agree remedial actions for any slippage and firm up plans for following week delivery Sign off the weekend plan and IMT Highlight report

Monthly Elective & Non-elective Recovery Plan Governance and Assurance Meeting Schedule

Week 1	Week 2	Week 3	Week 4
IMT 3x meetings a week	→	→	→
Operational Delivery Group weekly (for both programmes)	→	→	→
	SET Programme Board Monthly		
		SBF Programme Board Monthly	
HMB weekly	→	→	→

NNUH – "Safer, Better, Faster" Emergency and Urgent Care Improvement Programme: Progress Report

Norfolk and Norwich University Hospitals NHS Foundation Trust

Programme	Non-Elective Improvement Programme	Prog SRO & Prog Lead	Paul Walker	Week	
Workstream	Optimising Patient Flow Through ED	Workstream Lead	Rachael Cocker	RAG	

Project Progress

Activities completed this week	Comments	Lead	Planned Comp	Actual Comp	Activity RAG

Activities planned for next week and objectives	Comments	Lead	Planned Comp	Actual Comp	Activity RAG

Project Risks	Mitigation	Lead	Priority	RAG

Project Decisions Required	Outcome	Who	Where	When	RAG

Commentary

To support the Trust's recovery plans for elective and non-elective care, a revised meeting and governance framework to the current Incident Management Team meetings will be implemented with effect from 26th July. The rationale is that the programmes have been aligned to and are the main conduit for delivering the Trust Recovery Plan for addressing both planning guidance and undertakings. The aim is to have weekly oversight to support timely change and early intervention if actions have fallen behind or barriers to delivery emerge. The guiding principles are that these programmes are an organisational priority and require strong leadership, clear accountability and responsibility for implementation and commitment to delivering in line with specified timeframes as set out in the recovery plan.

Integrated Performance Report:

Performance & Activity Domains

June 2021

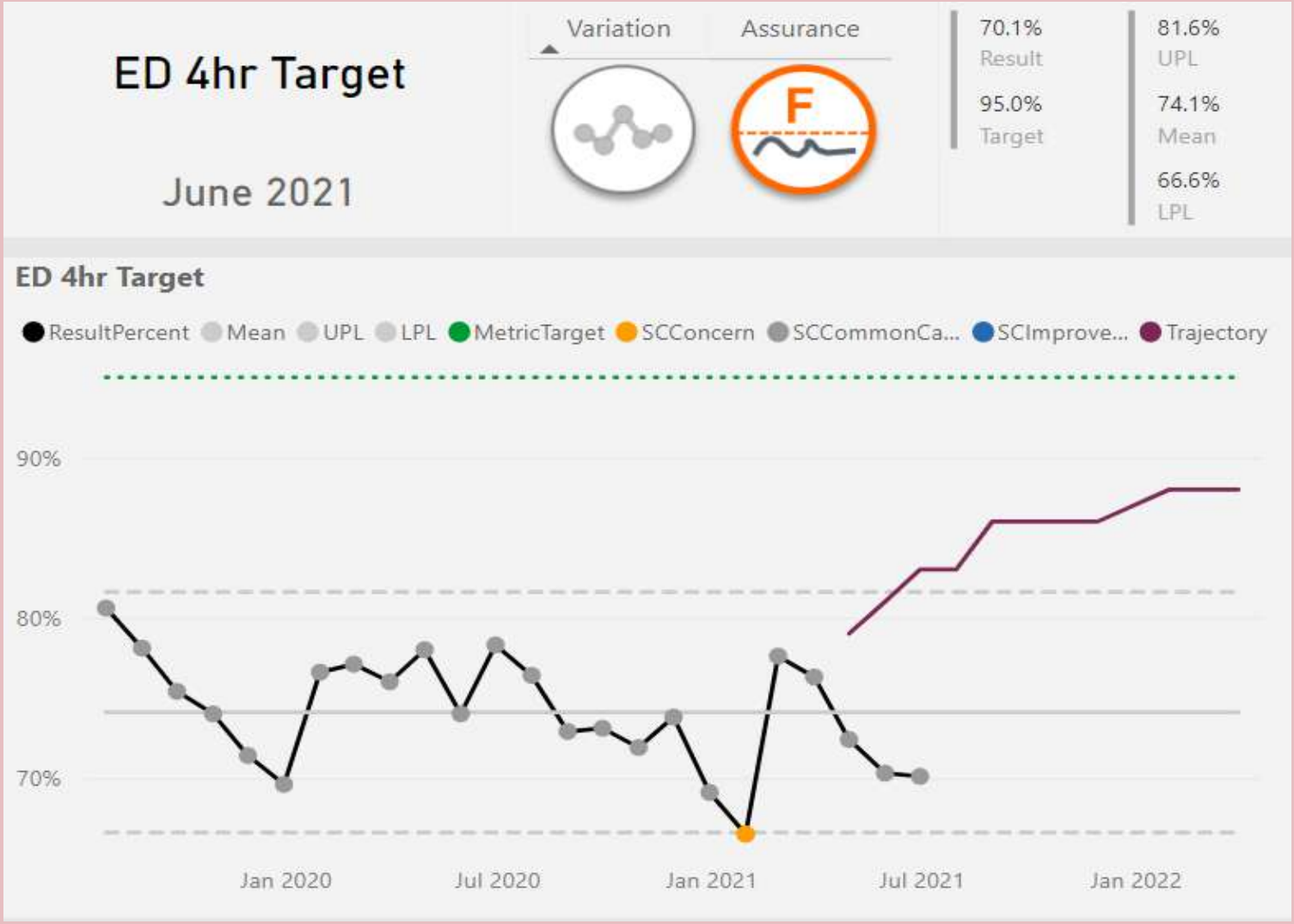
Non-Elective Care Standards

The Trust saw a deterioration in performance against most key metrics in June. The primary drivers for under-performance were increased attendances, batching of presentations in ED, reduced flow and increased numbers of delayed discharges. The Safer, Better, Faster work streams have been re-formatted to focus on the revised volume and pattern of attendances. System working in discharge and Mental Health pathways is ongoing. CEO deep dive into discharge planned for July 2021.

Safer, Better, Faster (SBF) Performance Dashboard

KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
4hr Standard	95% (N)	Actual	72.60%	70.30%	70.10%									
		Trajectory	79.43%	80.67%	82.87%	83.45%	85.78%	85.99%	86.02%	86.45%	87.35%	87.69%	87.92%	88.04%
Initial Assessment <15 mins (ED)	85% (N)	Actual	61.20%	57.70%	53.10%									
		Trajectory	54.06%	56.89%	58.02%	60.90%	64.80%	69.43%	71.04%	75.88%	79.98%	82.67%	84.98%	85.01%
Avg Time in ED (Non-Admitted)	<220 (N) <180 (L)	Actual	229.00	230.70	234.10									
		Trajectory	181	180	178	175	175	175	175	175	175	175	175	175
Avg Time in ED (Admitted)	<220 (N) <200 (L)	Actual	372.00	411.00	415.80									
		Trajectory	311	308	298	285	278	268	260	251	240	238	228	220
Admitted within 1 hour of clinically ready to proceed*	100% (N)	Actual	17.9%*	34.70%	36.50%									
		Trajectory	30.00%	45.00%	50.00%	55.00%	60.00%	65.00%	70.00%	75.00%	80.00%	85.00%	85.00%	85.00%
Total Time in ED <12 hours	100% (N)	Actual	97.00%	96.50%	96.90%									
		Trajectory	97.90%	98.01%	98.90%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%
Ambulance Handovers <=15mins	90% (N)	Actual	63.50%	56.90%	49.13%									
		Trajectory	57.00%	58.76%	59.05%	61.24%	65.98%	70.65%	78.65%	80.77%	88.72%	89.79%	90.24%	90.88%
>21 Days LLoS Patients	86 (N) 80 (L)	Actual	93.6	81.7	92.80									
		Trajectory	88	86	85	82	81	80	79	78	79	80	81	82
14-20 Days LLoS Patients	TBC (N) 49 (L)	Actual	61.60	69.00	67.40									
		Trajectory	87	82	75	70	65	60	53	48	46	49	50	48
SDEC as % of Emergency Attendances*	>30% (N)	Actual	47.35%	43.82%	44.3%									
		Trajectory	23.85%	24.00%	24.86%	25.78%	26.85%	27.83%	28.79%	29.61%	29.97%	30.00%	30.42%	30.89%
Triage	<60 mins (L)	Actual	95.10%	94.70%	91.80%									
		Trajectory	98.90%	99.00%	99.00%	99.00%	99.10%	99.42%	99.58%	99.75%	99.89%	99.92%	99.96%	100.00%
GP Streaming	TBC (N)	Actual	17%	17%	20%									
		Trajectory	17%	17%	20%	20%	20%	22%	24%	28%	28%	28%	28%	28%

Performance – ED 4 Hour Standard



KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
4hr Standard	95% (N)	Actual	72.60%	70.30%	70.10%									
		Trajectory	79.43%	80.67%	82.87%	83.45%	85.78%	85.99%	86.02%	86.45%	87.35%	87.69%	87.92%	88.04%

Commentary

June 2021 Performance

ED Attendances continued to increase from 12,289 in May to 12,500 in June.

4h standard performance was below trajectory during June. This is mostly a symptom of increased attendances, slow flow out of ED due to a rise in delayed discharges on pathways 1 – 3 combined with significant delays in waits to be seen. Minors performance has been very challenged and attendances continue to be well above pre-COVID levels. The Trust exceeded 500 attendances a day in June for the first time. This is well above the predicted activity levels.

Improvement Actions

1. New role - Senior Clinician at the front door to reduce both time to first clinician and divert inappropriate attendances.

2. Bookable appointments: ambition is to move as quickly as possible to bookable only attendances for minors. Requested support from regional NHSEI EUC Lead via CSORT; STP UEC Programme Manager to support too. To be implemented in Q4 at the latest.

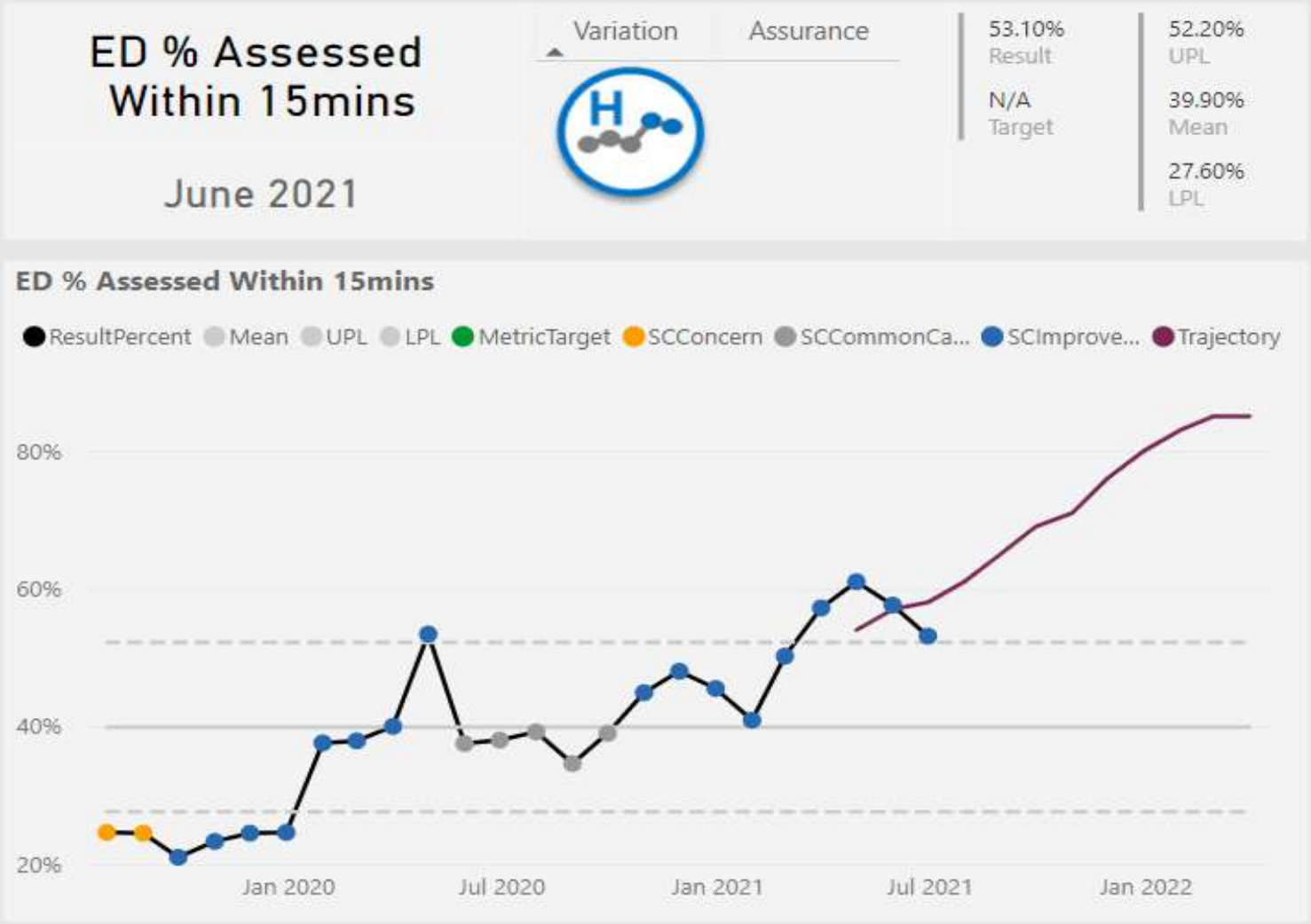
3. System support has been required to expedite plans for ED navigator to stream patients directly to GP Front Door service.

4. MADEs planned to support decongesting, but unlikely to recover against trajectory until the end of September due to the need to address external and upstream issues along with workforce and digital enablers coming on line.

Risk To Delivery

RED

Performance – ED Assessed Within 15 Mins %



KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Initial Assessment <15 mins (ED)	85% (N)	Actual	61.20%	57.70%	53.10%									
		Trajectory	54.06%	56.89%	58.02%	60.90%	64.80%	69.43%	71.04%	75.88%	79.98%	82.67%	84.98%	85.01%

Commentary

June 2021 Performance

Performance remains above the mean aside from a dip in June in line with the wider pressures.

Focus remains on ensuring safe and effective front door assessment in-line with patients arrival time and source.

The main risk to delivery of this trajectory remains the physical capacity to place staff and patients in the appropriate area.

Improvement Actions

1. Improved monitoring process of performance on a live basis to enable real time decision making and actions driven by dashboard.

2. The proposed reconfiguration of ED Phase II will address some of the physical space issues; creating 2 additional assessment spaces to be utilised at peak times.

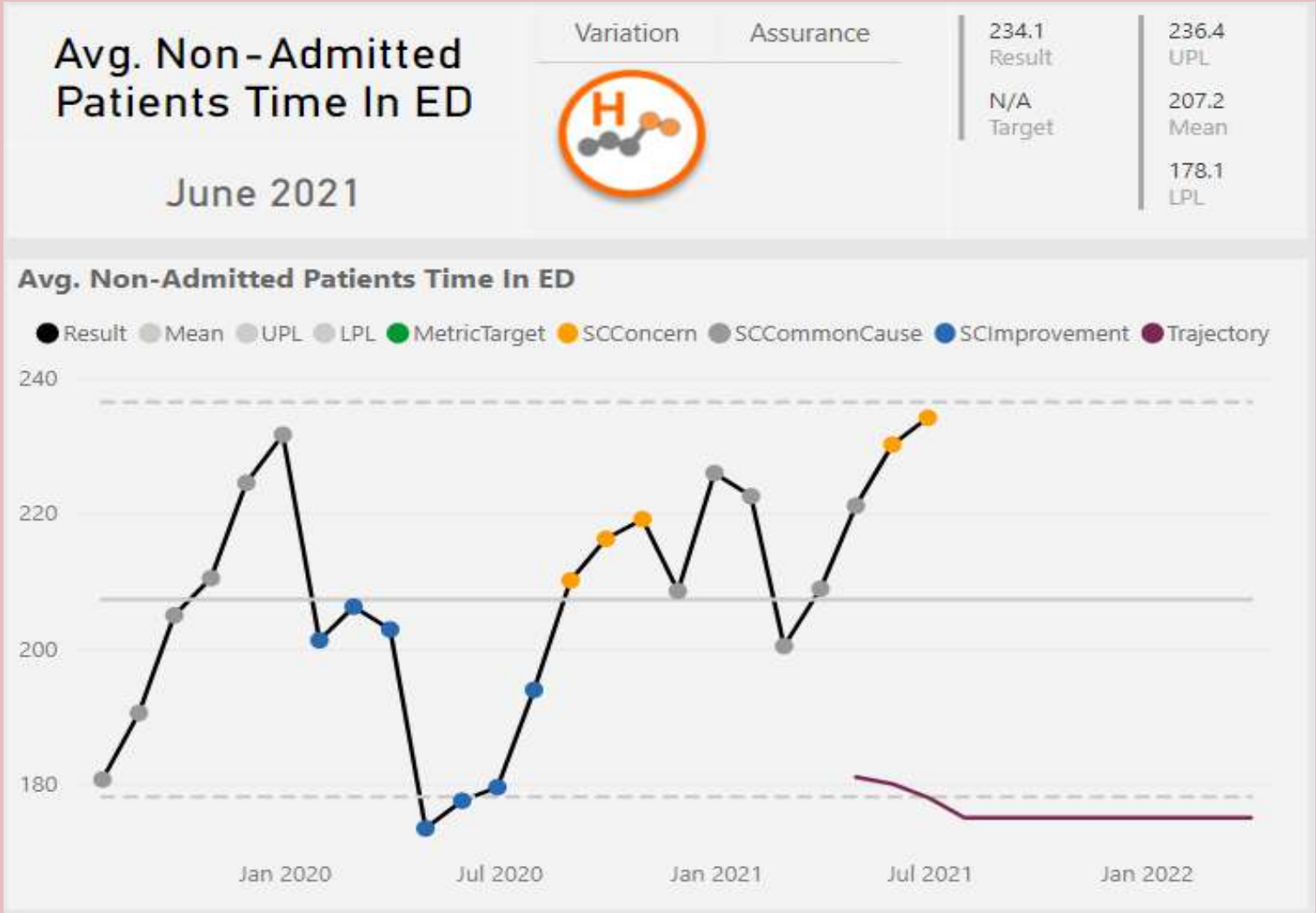
3. Enhanced escalation of this standard to ED matron and Operational Manager to explore mitigations in real time.

4. Place a Senior Clinician at the front door to reduce both time to first clinician and divert inappropriate attendances.

Risk To Delivery

AMBER

Performance – Average non admitted patient time in ED



KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Avg Time in ED (Non-Admitted)	<220 (N) <180 (L)	Actual	229.00	230.70	234.10									
		Trajectory	181	180	178	175	175	175	175	175	175	175	175	175

Commentary

June 2021 Performance

The non-admitted time in ED has increased in line with record numbers of walk-in attendances. Physical capacity in order to see and treat patients continues to be challenging with numbers in the department reaching 155 which is well above the predicted levels.

This KPI remains a high cause for concern and is directly related to the poor 4 hour position; supportive measures are being enacted with a step up to weekly performance monitoring and Executive oversight. Workforce challenges are a contributory factor. However, this reflects the need to progress to bookable appointments.

Recruitment is underway to facilitate addition ENPs to release medics to do minors and run the service like Cromer MIU

Improvement Actions

1. Action plan to re-evaluate space and improve turnover of Ambulatory patients once they have been assessed to allow for more rapid and effective utilisation of space.

2. Improved use of GP Streaming – revised contact under discussion

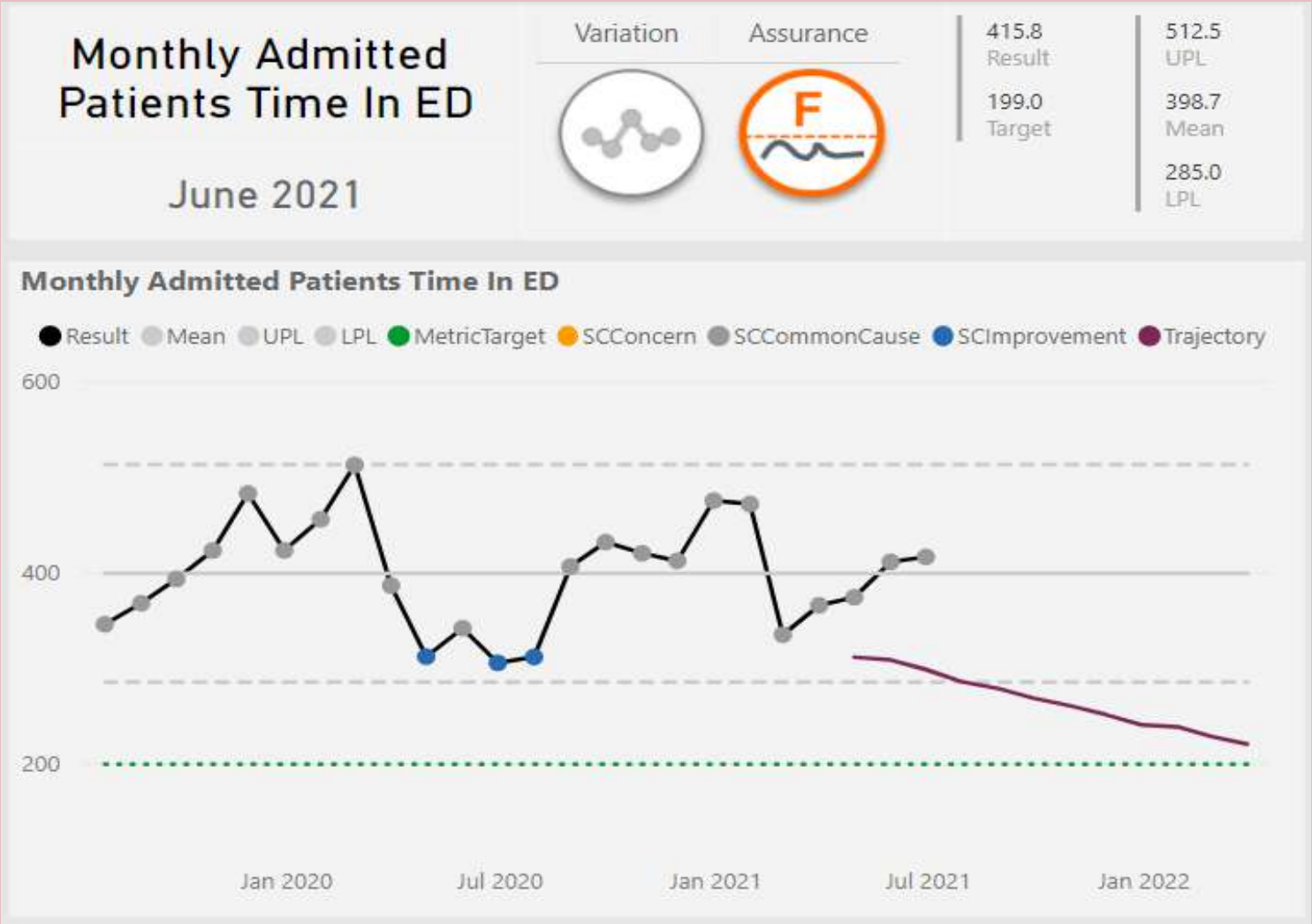
3.SDEC to be reinforced with additional clinicians from July 2021.

4. Recruit ENPs.

Risk To Delivery

RED

Performance – Average admitted patient time in ED



KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Avg Time in ED (Admitted)	<220 (N) <200 (L)	Actual	372.00	411.00	415.80									
		Trajectory	311	308	298	285	278	268	260	251	240	238	228	220

Commentary

June 2021 Performance

Exit block is the main contributory factor to the admitted time within ED. The Trust is progressing Clinically Ready to Proceed into business as usual.

Improvement Actions

1. Convert the test of change process and learning to BAU over the next 4 weeks – monitor live via the updated dashboard and via the IMT meetings

2. Re-design of the medical SDEC and AMU model during July/August to support improved pull out of ED

3. Prepare for national reporting of this metric from October 2021.

Risk To Delivery

RED

Performance – Admitted within 1 hour of Clinically Ready to Proceed

KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Admitted within 1 hour of clinically ready to proceed*	100% (N)	Actual	17.9%*	34.70%	36.50%									
		Trajectory	30.00%	45.00%	50.00%	55.00%	60.00%	65.00%	70.00%	75.00%	80.00%	85.00%	85.00%	85.00%

Commentary

June 2021 Performance

Work is ongoing to embed this new standard and the associated processes; recording compliance is being monitored daily and the divisions are revising the original DTA trajectories. National reporting is expected to commence in October 2021.

Days of higher performance (75-90%) were reflective of the tests of change. These are aggregated during the month with low performance days which are typically days when we started with large numbers of patients with a DTA in ED and poor flow out.

The Trust level trajectory will be developed and refreshed as we establish the baseline and embed recording of CRTP. From the learning so far a number of process changes are being made and evaluation will continue.

Improvement Actions

1. Convert the test of change process and learning to BAU over the next 4 weeks – monitor live via the updated dashboard and via the IMT meetings

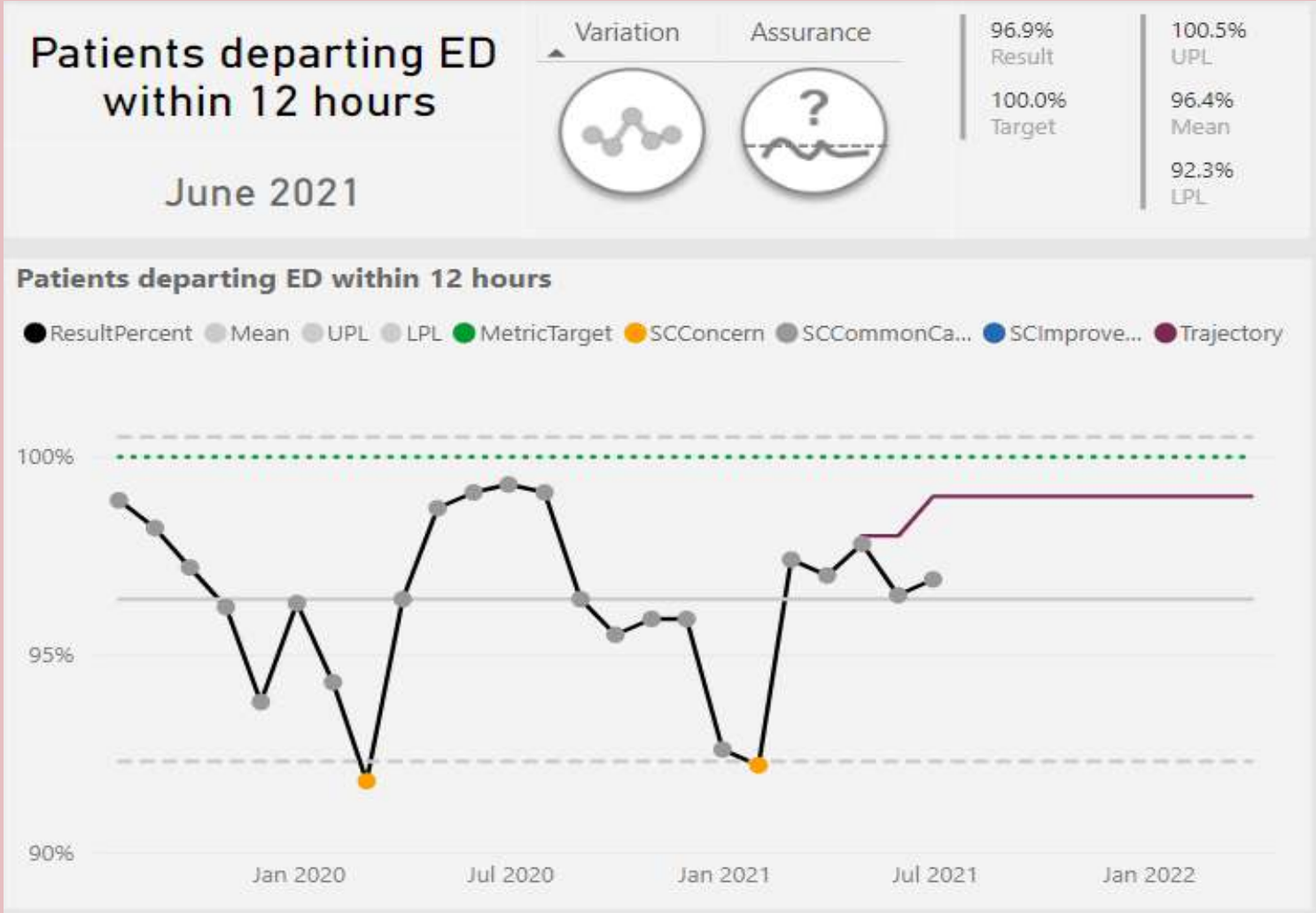
2. Re-design of the medical SDEC and AMU model during July/August to support improved pull out of ED

3. Prepare for national reporting of this metric from November 2021.

Risk To Delivery

AMBER

Performance – Patients Departing ED within 12 hours



KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Total Time in ED <12 hours	100% (N)	Actual	97.00%	96.50%	96.90%									
		Trajectory	97.90%	98.01%	98.90%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%	99.00%

Commentary

June 2021 Performance

There is no system resolution to enable ED to achieve 100% due to the continued capacity issues for mental health patients. 7 12 hour DTA breaches in ED occurred within June 2021, all attributed to mental health capacity issues.

2 system wide workshops have been held and a new Crisis Care Concordat starting to address this specific challenge.

Daily monitoring of numbers of patients with an ED episode of 12 hrs or more via the daily IMT meeting – the daily challenge is to ensure this is a single figure number with a view to improve this as work develops.

Improvement Actions

1. Ongoing liaison and engagement with Norfolk & Suffolk Foundation Trust, Norfolk County Council, NHS England and other partner organisations involved with the delivery of Mental Health services.

2. CEO Commissioned crisis care concordat being established. Workshops scheduled with recovery plan to follow.

Risk To Delivery

RED

Performance – Ambulance Handovers <15 mins

KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Ambulance Handovers <=15mins	90% (N)	Actual	63.50%	56.90%	49.13%									
		Trajectory	57.00%	58.76%	59.05%	61.24%	65.98%	70.65%	78.65%	80.77%	88.72%	89.79%	90.24%	90.88%

Commentary

June 2021 Performance

June saw a deterioration across EoE. The performance at the NNUH dipped as a result of frequently saturated department. EEAST have also been unable to support cohorting due to workforce pressures adding to offload delays.

The targeted improvement work to transfer out of ED within 1 hour and also the new SBF work stream for time to first clinician will facilitate improved performance as when there is physical space to offload the process is now effective.

Work is continuing as a system with the community response programme to target falls and catheter pathways to reduce conveyances; need to expedite the direct conveyance to alternative location; work being coordinated at system level to further reduce volumes into ED.

Handovers

Improvement Actions

1. Continued work with the region, EEAST and ICS on resilience planning and daily/weekly escalation calls.

2. Working across the ICS to standardise expectations and role of the HALOs

3. Implement SHREWD.

Risk To Delivery

AMBER

Performance – 15 Minute Handover % Trends EoE

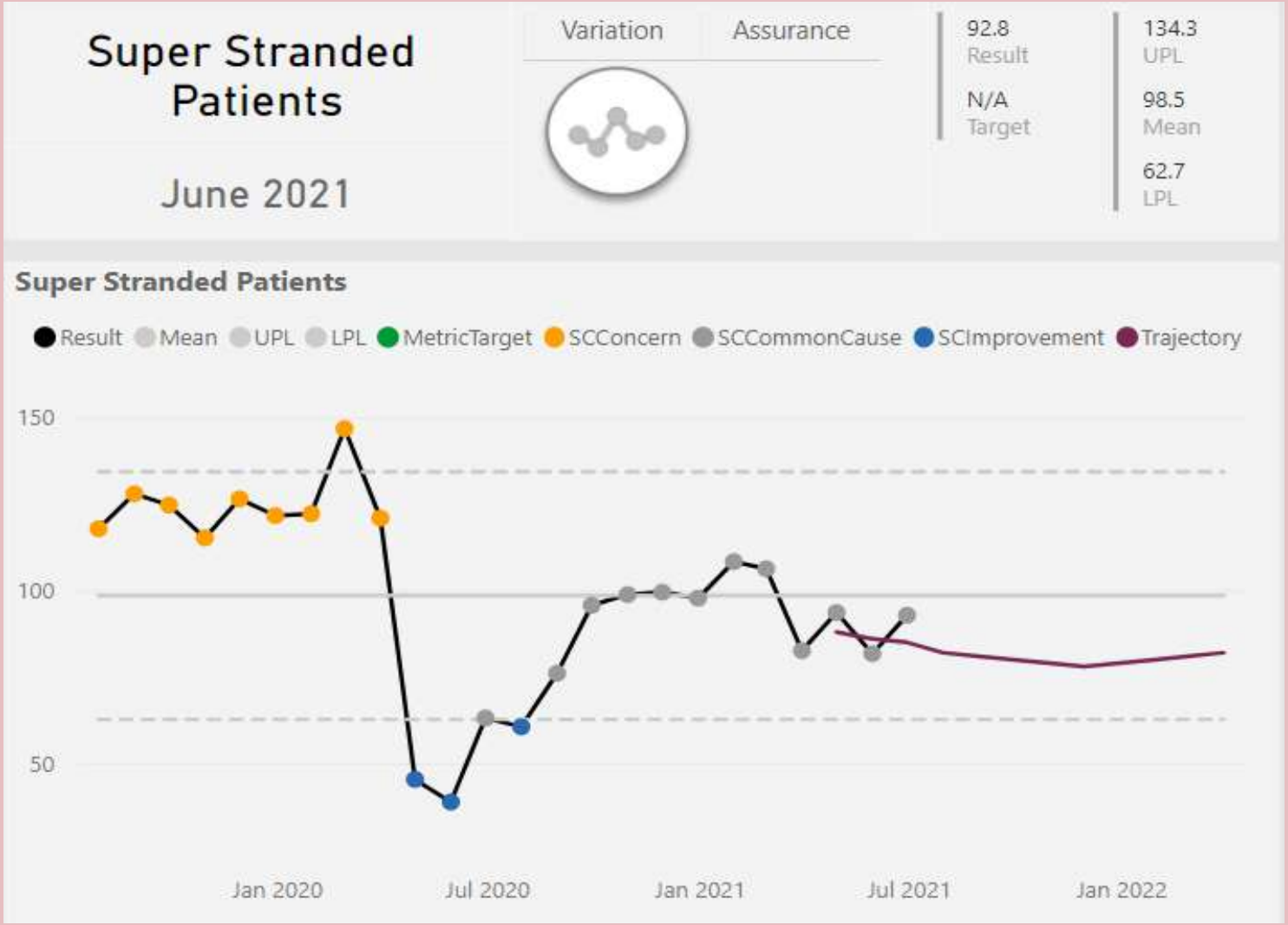
NNUH Digital Health
business intelligence

Hospital Name	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Total	Total June Handovers
Addenbrookes Hospital	45.68%	46.78%	43.82%	41.20%	41.42%	41.97%	36.58%	37.31%	37.28%	42.67%	42.13%	38.95%	32.18%	40.67%	2860
Basildon & Thurrock Hospital	57.37%	59.51%	62.74%	63.40%	58.31%	55.66%	41.42%	52.59%	67.97%	69.22%	68.44%	66.29%	55.48%	59.83%	2466
Bedford Hospital South Wing	51.40%	50.14%	44.36%	44.21%	41.02%	40.66%	37.85%	33.11%	48.91%	60.26%	57.65%	65.66%	60.42%	48.99%	1543
Broomfield Hospital	31.33%	32.80%	37.75%	37.88%	40.10%	40.98%	31.03%	33.23%	44.31%	50.06%	44.24%	42.54%	67.24%	40.99%	2429
Colchester General Hospital	31.24%	32.58%	28.51%	28.61%	31.98%	30.93%	24.96%	21.65%	29.73%	35.56%	33.22%	30.25%	31.05%	30.03%	3061
Hinchingbrooke Hospital	33.33%	34.31%	29.94%	26.70%	30.48%	34.05%	31.96%	27.55%	28.06%	27.79%	23.37%	22.77%	20.94%	28.29%	1380
Ipswich Hospital	41.78%	44.47%	37.19%	41.29%	38.80%	40.17%	31.59%	29.23%	41.16%	44.14%	39.89%	41.09%	35.90%	39.04%	2338
James Paget Hospital	53.97%	66.80%	50.72%	51.53%	43.97%	27.74%	21.39%	19.43%	33.45%	48.38%	44.76%	36.36%	30.82%	40.98%	2038
Lister Hospital	32.48%	33.27%	31.16%	27.33%	26.54%	23.51%	20.09%	21.57%	26.61%	25.70%	21.96%	19.20%	13.90%	24.86%	2478
Luton And Dunstable Hospital	42.52%	49.58%	47.59%	42.36%	47.22%	50.70%	41.45%	41.13%	48.15%	47.54%	47.93%	47.89%	47.55%	46.32%	2608
Norfolk & Norwich University Hospital	37.91%	56.52%	51.10%	56.31%	62.25%	62.97%	51.17%	34.45%	52.68%	60.31%	63.51%	57.12%	49.13%	53.67%	4093
Peterborough City Hospital	26.36%	49.54%	33.93%	27.09%	20.39%	17.15%	12.31%	10.95%	20.50%	18.05%	18.93%	16.26%	9.99%	22.03%	2031
Princess Alexandra Hospital	41.84%	40.56%	33.37%	30.50%	32.20%	28.97%	22.19%	9.32%	11.74%	17.14%	30.11%	25.43%	23.45%	26.94%	1728
Queen Elizabeth Hospital	56.74%	50.13%	41.05%	33.59%	39.38%	37.17%	33.57%	45.24%	55.17%	59.19%	58.86%	52.50%	50.26%	47.21%	1856
Southend University Hospital	22.70%	28.18%	28.00%	27.29%	23.99%	22.01%	17.83%	21.98%	23.15%	21.40%	21.04%	22.16%	21.66%	23.21%	2400
Watford General Hospital	37.90%	35.05%	35.22%	35.60%	32.98%	33.39%	15.33%	15.19%	30.76%	31.06%	40.66%	34.81%	30.34%	31.65%	2651
West Suffolk Hospital	42.99%	48.40%	51.81%	47.11%	39.01%	43.36%	39.61%	38.49%	50.70%	50.63%	52.47%	47.88%	45.60%	46.04%	1920
Total	40.50%	45.08%	40.99%	40.07%	39.61%	38.71%	31.29%	29.93%	39.59%	42.90%	42.88%	40.20%	37.73%	39.25%	**39880**
NNUH Rank	11	3	3	2	1	1	1	6	3	2	2	3	5	2	

Comments

The Trust managed a total of 4,093 ambulances in June 2021, over 1,000 more than the next busiest hospital. 49.13% of the ambulance handovers were completed within 15 minutes of arrival (down from 56.52% in May). NNUH was ranked 5th best in the region for performance in June, a drop of 2 places since May.

Performance – Long Length of Stay >21 Day Patients



KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
>21 Days LLoS Patients	86 (N) 80 (L)	Actual	93.6	81.7	92.80									
		Trajectory	88	86	85	82	81	80	79	78	79	80	81	82

Commentary

June 2021 Performance

There was an average of 92.8 patients with a Length of Stay >21 days during June. This increase on May's position reflects issues with exit block with D2A1-3 pathways to community care.

Improved recording to Long Length of Stay Actions has been implemented digitally and recorded for each patient with specific action owners and timescales. This helps with the capture, review and completion of actions across multi disciplinary clinical and non-clinical teams. This has been implemented in conjunction with digital recording of patients criteria to reside status.

Improvement Actions

1. Focus on patients with no criteria to reside.

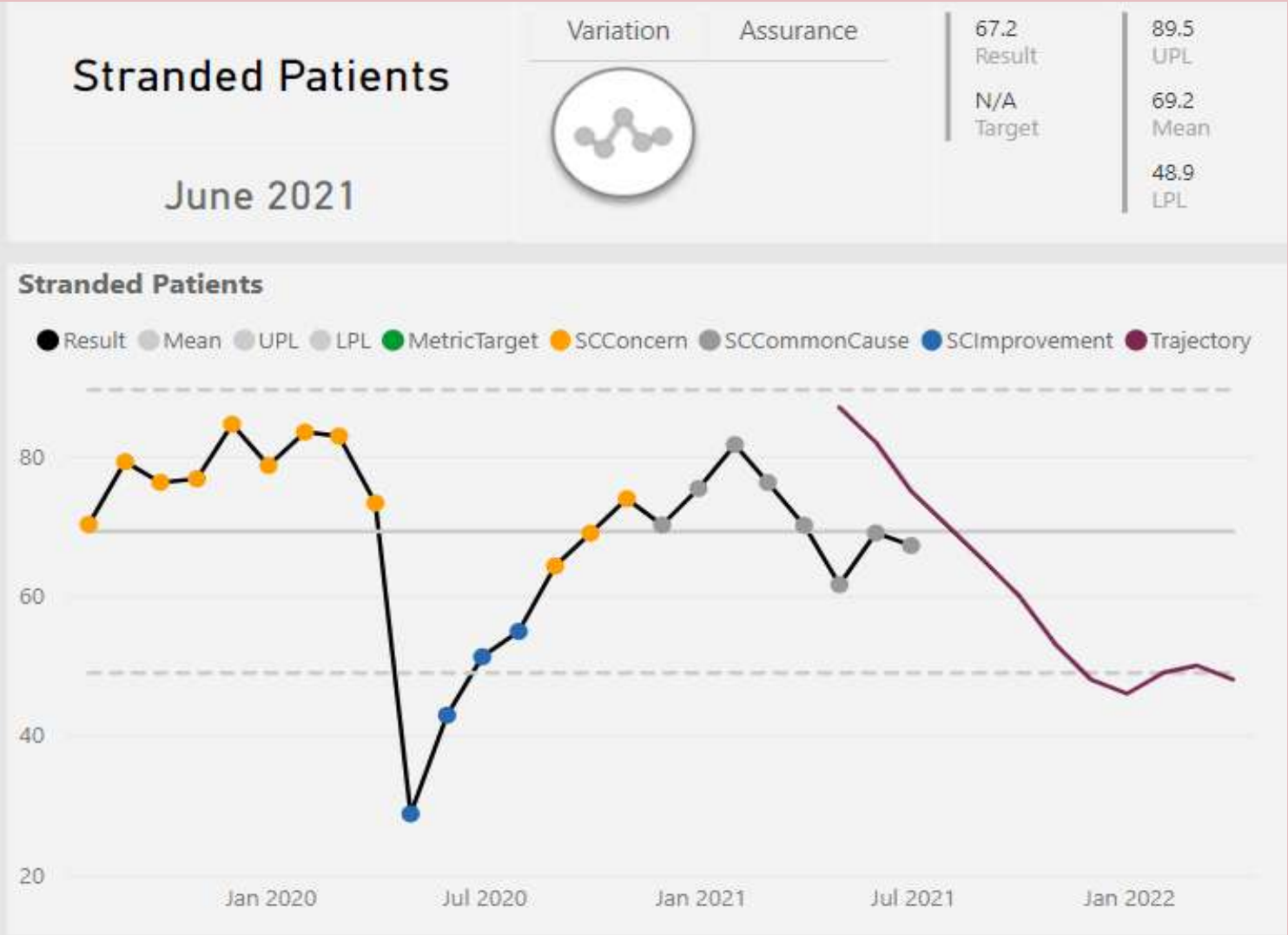
2. Escalations to community teams are ongoing with the system capacity cell .

3. Daily expand use of Virtual Ward – standard operating procedures for patients that can automatically meet the criteria for virtual ward due to be produced.

Risk To Delivery

AMBER

Performance – Long Length of Stay 14-20 Day Patients



KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
14-20 Days LLoS Patients	TBC (N) 49 (L)	Actual	61.60	69.00	67.40									
		Trajectory	87	82	75	70	65	60	53	48	46	49	50	48

Commentary

June 2021 Performance

There was an average of 67.2 patients with a Length of Stay 14-20 days during June, a slight reduction on May's position and below the mean. This remains ahead of internal trajectory.

A national target is yet to be set, however, the Trust is undertaking benchmarking at both a regional and national level to explore other Trusts best-practice for managing this cohort of patients.

Improvement Actions

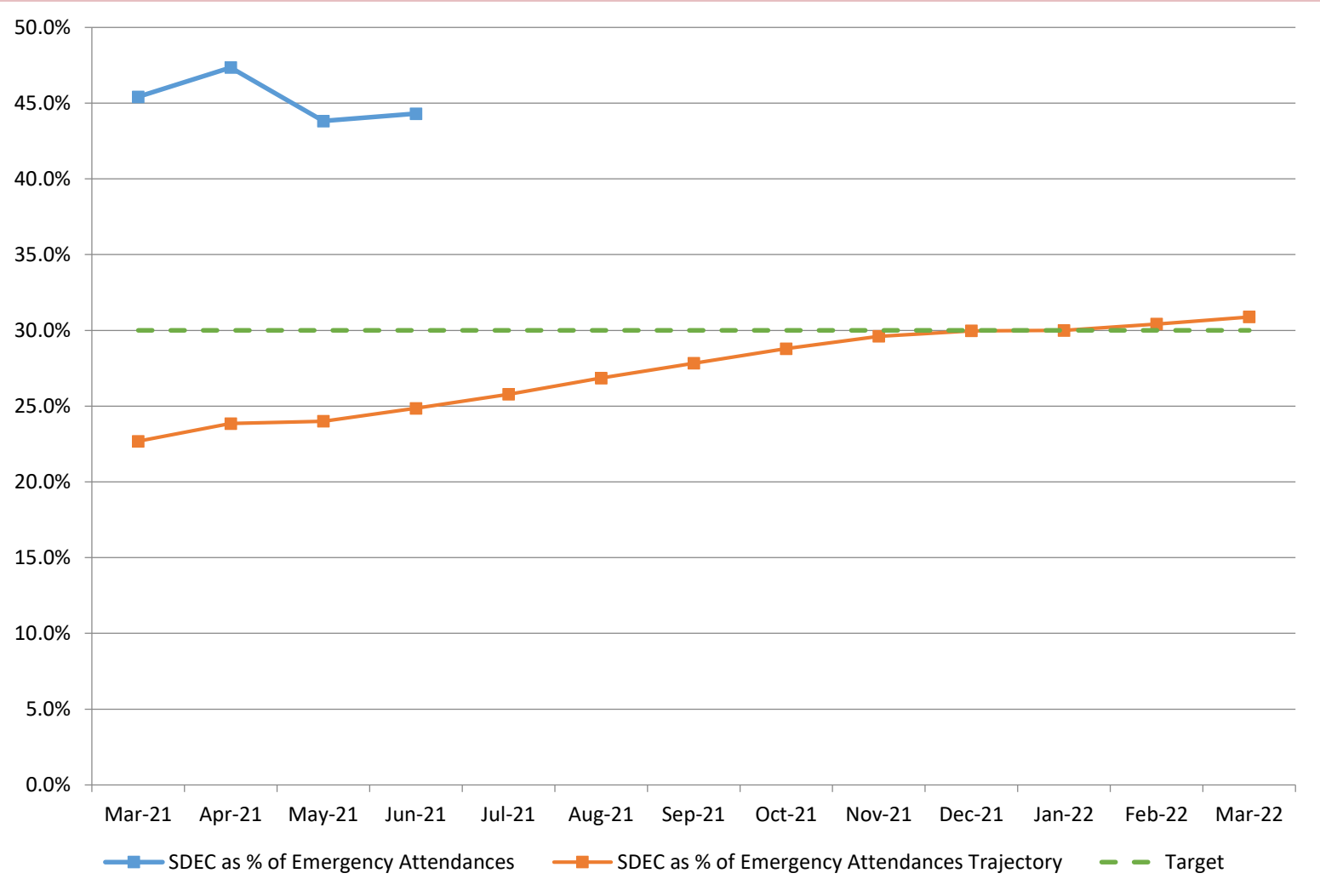
1. Focus on patients with no criteria to reside and rationale

2. Expand use of Virtual Ward – standard operating procedures for patients that can automatically meet the criteria for virtual ward due to be produced.

Risk To Delivery

GREEN

Performance – SDEC as % of Emergency Attendances



KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
SDEC as % of Emergency Attendances*	>30% (N)	Actual	47.35%	43.82%	44.3%									
		Trajectory	23.85%	24.00%	24.86%	25.78%	26.85%	27.83%	28.79%	29.61%	29.97%	30.00%	30.42%	30.89%

Commentary

June 2021 Performance

SDEC has been embedded in a number of pathways. However, there is much more scope to expand the current service provision to more clinical pathways and generate increased access to 111.
Work is continuing to develop plans in both of these areas.

Improvement Actions

1. Improved data quality and recording; group established and exercises to validate data

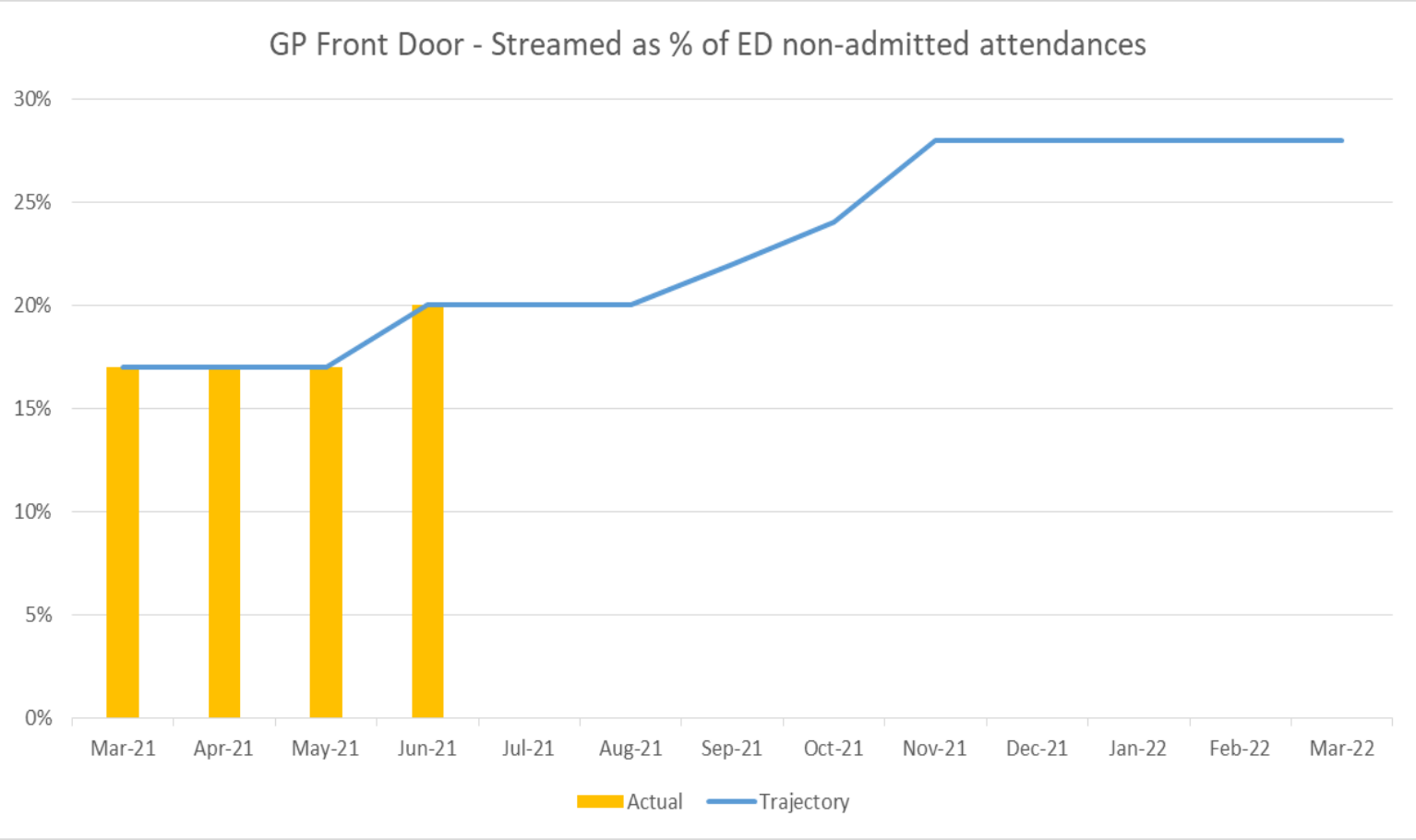
2. Expanded consultant presence and revised model to be implemented from July 2021.

3. Implementation of enhanced pathways with support of ECIST and national best practice examples

Risk To Delivery

GREEN

Performance – GP Streaming



KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
GP Streaming	TBC (N)	Actual	17%	17%	20%									
		Trajectory	17%	17%	20%	20%	20%	22%	24%	28%	28%	28%	28%	28%

Commentary

June 2021 Performance

This service will convert to the UTC model longer term supporting the cessation in walk-in models to ED; arrivals will be booked, redirected or ambulance only.

Improvement Actions

1. Convert to navigators streaming to the GPs and not dual-assessing to release GPs

2. Move towards non-medical model where appropriate

3. Work with CSORT and Pre-hospital group toon establishing redirect people to SDEC/admission avoidance/herald service

4. Space reconfiguration in ED

5. UTC Development plans

6. Develop ED APP to manage attendances

Risk To Delivery

AMBER

Elective Care Standards

The Trust over-performed against the NHSE Activity targets in June. This saw the NNUH generate a £6.3M favourable variance for the system ERF at M3. Continued delivery of the P2 backlog removal plan negatively impacted performance % against the key metrics as large volumes of patients who have already breached the standards were treated in Theatres. Extraordinary demand on 2WW cancer pathways, particularly Breast Cancer have impacted on 2WW, 62 day and Faster Diagnosis performance in June. There was also very little take up of WLI/weekend working until 26/06 resulting in a reduction in speed of progress against waiting list reductions. However, the total number of patients waiting over 52 weeks has reduced in month. Plans remain mainly on track.

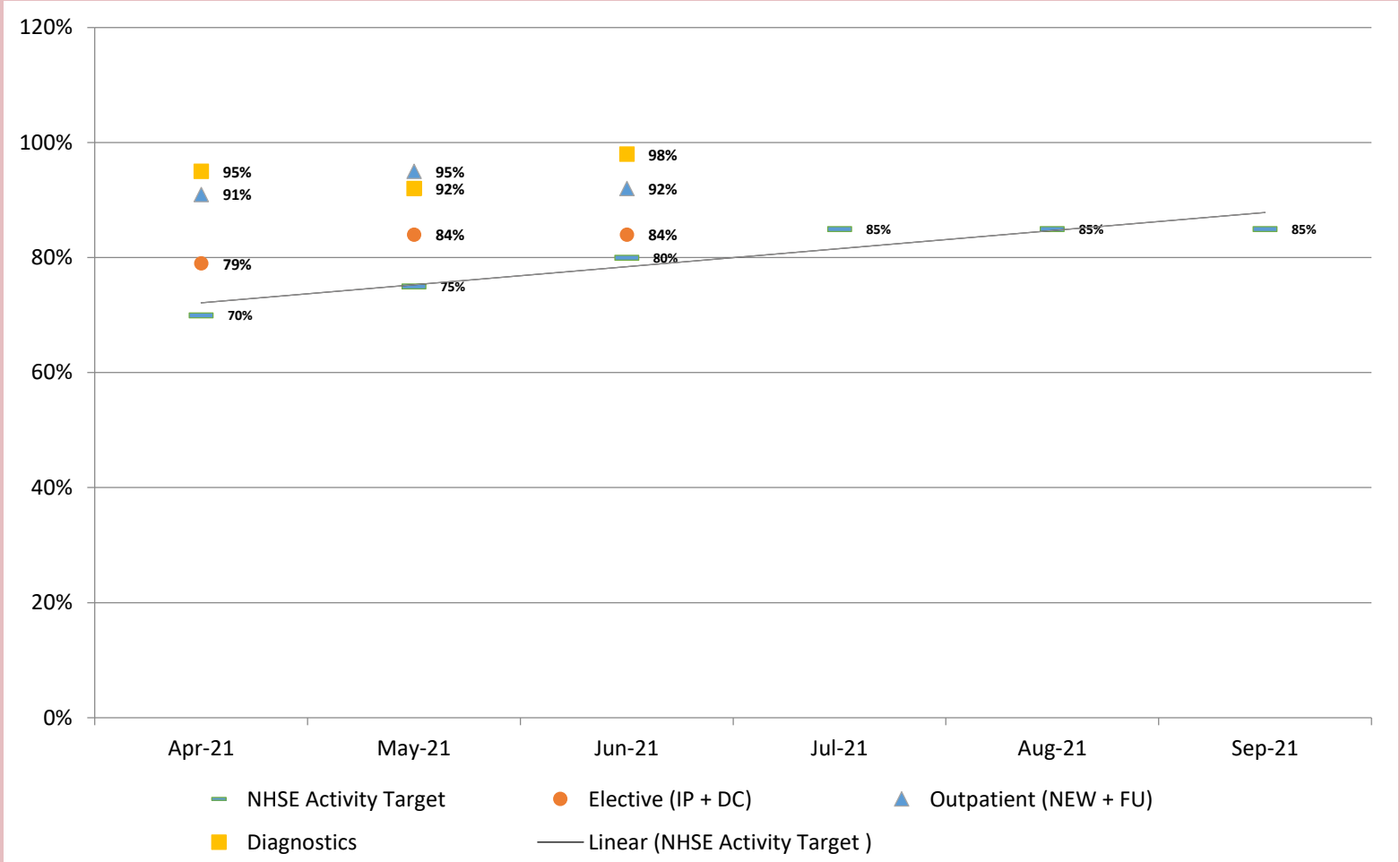
Safer, Efficient, Productive (SET) Performance Dashboard

KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Cancer 2WW Performance	93% (N)	Actual	59.5%	58.6%	49.0%									
		Trajectory	76.4%	75.3%	82.0%	85.0%	86.0%	90.0%	92.6%	93.3%	93.0%	89.3%	93.0%	92.8%
Cancer 2WW Backlog	38 (Feb 20)	Actual	264	448	731									
		Trajectory	264	353	225	131	93	77	48	23	27	76	41	22
Cancer 62 Day Performance	74% National Avg (Feb 20)	Actual	63.0%	59.6%	55.9%									
		Trajectory	64.3%	67.0%	64.5%	66.3%	70.2%	74.3%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%
Cancer 62 Day Backlog	184 (Feb 20)	Actual	223	237	279									
		Trajectory	223	222	219	217	196	205	174	146	145	181	159	143
Cancer 62 Day Waits >104 Days	0	Actual	73	41	55									
		Trajectory	73	60	34	29	21	28	26	16	12	27	19	9
Cancer Faster Diagnosis Standard	75% (N)	Actual	79.7%	74.0%	64.4%									
		Trajectory	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%
RTT 52 Week Breaches		Actual	10764	10235	10127									
		Trajectory	0	0	0									
RTT 98 Week Breaches	0	Actual	297	563	756									
		Forecast												
P2 Patients Waiting >28 Days for Theatre	0	Actual	776	574	381									
		Trajectory	841	630	372	106	0	0	0	0	0	0	0	0
Waiting List - Health Inequality Indicators	Variation	Ethnicity	No	No	No									
		IMD	No	No	No									
Activity Targets	70% (A) 75% (M) 80% (J) 85% J-S)	OP	91%	95%	92%									
		Electives	79%	84%	84%									
		Diagnostics	95%	92%	98%									
		Trajectory	70%	75%	80%	85%	85%	85%	95%					

Safer, Efficient, Productive (SET) Performance Dashboard

KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Virtual Outpatients	25% (N)	Actual	38.7%	37.4%	35.4%									
		Trajectory	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%
PIFU	Implement in 3 specialties	Actual	28	31	30									
		Trajectory	3	3	3	3	3	3	3	3	3	3	3	3
Advice and Guidance	1000	Actual	834	1003	1020									
		Trajectory	800	800	800	800	800	800	800	800	800	800	800	800
Achieve Upper Decile: Orthopaedics	Touchtime 85% (N) Cases 1.9 (N)	Touchtime	59.00	73.00										
		Cases Per Session	1.30	1.40										
Achieve Upper Decile: Ophthalmology	Touchtime 85% (N) Cases 3.8 (N)	Touchtime	64.00	71.00										
		Cases Per Session	3.40	4.4										
Theatre Utilisation	Touchtime (Elective) 89%	Actual												
		Trajectory				74.0%	75.0%	78.0%	80.0%	82.0%	84.0%	86.0%	88.0%	89.0%
	Touchtime (Day Case) 89%	Actual												
		Trajectory				74.0%	75.0%	78.0%	80.0%	82.0%	84.0%	86.0%	88.0%	89.0%
Theatre Cancellations	On Day Cancellations (15)	Actual												
		Trajectory				22	22	22	20	20	18	18	15	15
Theatre Sessions	Late Starts (30%)	Actual												
		Trajectory				65.0%	60.0%	58.0%	55.0%	50.0%	45.0%	40.0%	35.0%	30.0%
	Early Finishes (25%)	Actual												
		Trajectory				40.0%	38.0%	36.0%	34.0%	30.0%	28.0%	28.0%	25.0%	25.0%
	Av. Cases per List (2)	Actual												
		Trajectory				1.98	1.98	1.98	1.99	1.99	1.99	2.00	2.00	2.00

Performance – H1 Activity Requirements



KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Activity Targets	70% (A) 75% (M) 80% (J) 85% J-S)	OP	91%	95%	92%									
		Electives	79%	84%	84%									
		Diagnostics	95%	92%	98%									
		Trajectory	70%	75%	80%	85%	85%	85%						

Commentary

June 2021 Performance

The activity threshold level is set against a baseline value of all elective activity delivered in 2019/20:
April 70%
May 75%
June 80%
July – September 85%

In June 2021, the Trust over-delivered against June 19/20 levels:
84% Elective Admitted Care (Inpatient and Day case)
92% Outpatient Appointments (New and Follow Up)
98% Diagnostic Activity (DM01 Definitions)

Improvement Actions

1. Implement Model Hospital efficiency measures to increase productivity June -September.

2. Increased use of out-of-hours and weekends wef 26 June.

3. Maximise use of IS.

4. Engage with system on transformation of key pathways.

Risk To Delivery

GREEN

Performance – H1 Activity Requirements: ERF

ERF Estimate - Month 3

System Level	Adjusted Baseline £000s	Activity Value £000s	ERF System Level £000s	Plan ERF £000s	Variance (Adv)/Fav £000s
DC	25,864	21,665	2,256		
EL	20,656	15,685	139		
OPPROC	9,586	7,514	310		
OPA	31,625	29,159	5,847		
Total	**87,731**	**74,023**	**8,247**	**4,554**	**3,693**

Org Level	Adjusted Baseline £000s	Activity Value £000s	ERF System Level £000s	Plan ERF £000s	Variance (Adv)/Fav £000s
JPUH	14,415	14,505	4,120	4,554	(434)
NNUH	54,382	46,809	6,386	0	6,386
QEH	17,137	11,317	(1,549)	0	(1,549)
NCH&C	251	181	(1)	0	(1)
IS	1,548	1,211	71	0	71
Total	**87,733**	**74,023**	**8,247**	**4,554**	**3,693**

Note: Only adjustments applied are ASI between Providers and BMI Sandringham switch to QEH

Commentary

M3 Performance

Elective Recovery Fund (ERF) estimates for June 2021 (M3) present a favourable variance for NNUH of £6,386,000 against plan contributing to a system favourable variance of £3,693,000.

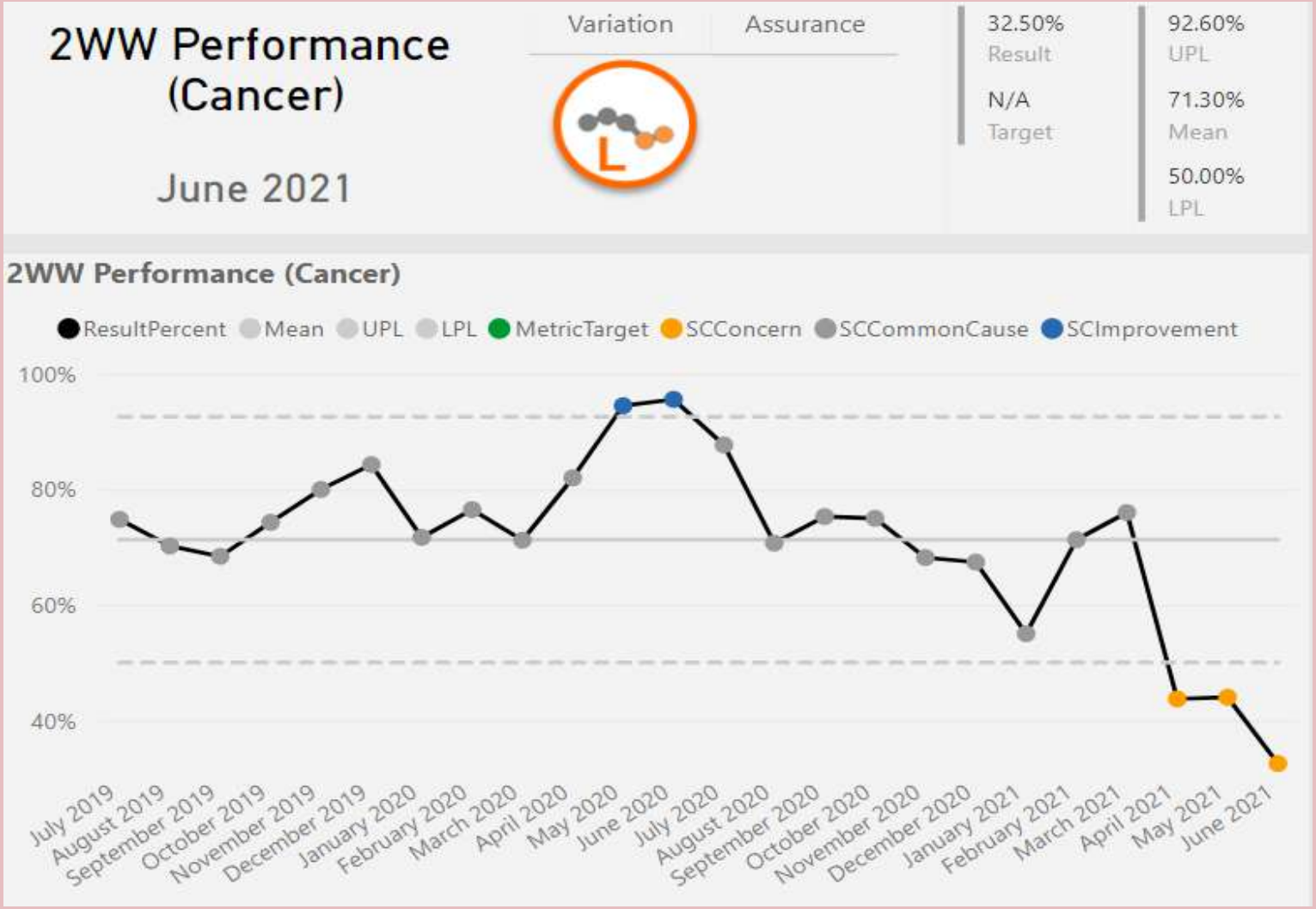
Elective Recovery Funding & Reform Letter

On 9th July NHSE issued a letter outlining that the thresholds for earning ERF are being adjusted to 95% of 2019/20 of activity levels from 1st July 2021.

"ERF will be paid at 100% of tariff above the 95% threshold, and at 120% of tariff above 100% of 2019/20 activity. The ERF will continue to be earned on a system basis to encourage systems to continue to use their capacity and resources as flexibly as possible across organisations to maximise recovery activity. Use of the Independent Sector to help achieve this remains an integral part of the arrangements".

The NNUH has not based our plan on delivery of ERF funding and the N&W system do not expect to attract additional ERF in future months.

Performance – Cancer 2WW Performance



KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Cancer 2WW Performance	93% (N)	Actual	59.5%	58.6%	49.0%									
		Trajectory	76.4%	75.3%	82.0%	85.0%	86.0%	90.0%	92.6%	93.3%	93.0%	89.3%	93.0%	92.8%

Commentary

June 2021 Performance

2WW referrals reached unmanageable levels in June, mainly in Skin, Lower GI and Breast.
Breast Referrals in particular exceeded pre-pandemic levels by 200 per month , this led to a significant backlog which has significantly impacted on the overall 2ww performance and subsequent cancer performance statistics.

Improvement Actions

1. Continue to provide additional weekend Breast clinics to both reduce backlog and ensure catch up to book within 14 days.

2. Contract agreed with IS provider for 700 one-stop breast clinic slots to commence at weekends in August.

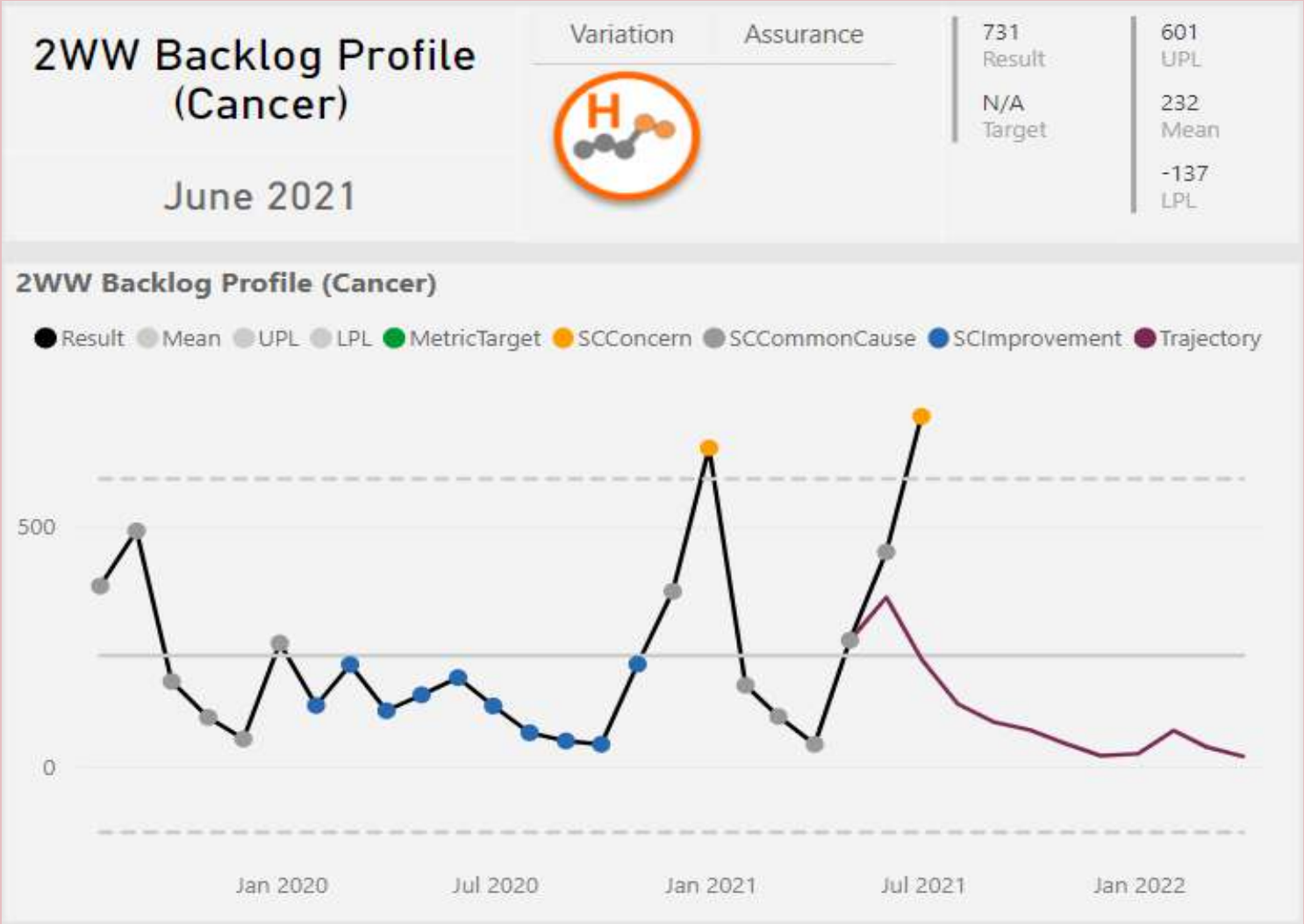
3. Frequent reviews of 2WW protected slots with body site teams ensuring capacity is flexed to meet expected demand.

4. Reviews of referral pathways with STP and Cancer Alliance to ensure appropriate referrals seen and received.

5. Review of Straight to Test criteria in Lower GI to ensure equity of access to Endoscopy, Radiology and Outpatients.

RED

Performance – Cancer 2WW Backlog



KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Cancer 2WW Backlog	38 (Feb 20)	Actual	264	448	731									
		Trajectory	264	353	225	131	93	77	48	23	27	76	41	22

Commentary

June 2021 Performance

2WW referrals continue to exceed all previous levels, mainly in Skin, Lower GI and Breast.
Increase in Breast referrals has been significantly growing since December 2020. Unprecedented levels well above the normal expectations in June have created a significant backlog that needs external support to rectify.

Improvement Actions

1. Continue to provide additional weekend Breast clinics to both reduce backlog and ensure catch up to book within 14 days.

2. Contract agreed with IS provider for 700 one-stop breast clinic slots to commence at weekends in August.

3. Frequent reviews of 2WW protected slots with body site teams ensuring capacity is flexed to meet expected demand.

4. Reviews of referral pathways with STP and Cancer Alliance to ensure appropriate referrals seen and received.

5. Review of Straight to Test criteria in Lower GI to ensure equity of access to Endoscopy, Radiology and Outpatients.

Risk To Delivery

RED

Performance – Cancer 62 Day Performance

KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Cancer 62 Day Performance	74% National Avg (Feb 20)	Actual	63.0%	59.6%	55.9%									
		Trajectory	64.3%	67.0%	64.5%	66.3%	70.2%	74.3%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%

Commentary

June 2021 Performance

Urgent Cancer referral levels have continued to exceed all previous levels. As such, the cancer waiting list size has grown to just under 4000 patients. Waiting List size pre-COVID was around 2900. This has caused additional pressure across all cancer pathways requiring additional Outpatient, Diagnostic and Treatment capacity to keep up with demand. Unfortunately, this has meant a higher number of patients have rolled over the 62-day point. Clinicians are continuing to operate on the tail of the waiting list as well as the sickest patients, therefore there is a significant deterioration impact on the performance %.

Improvement Actions

1. The full focus on P2 patients in order to reduce numbers waiting >28 days for surgery and maintain this turnover will encompass many patients on a cancer 62-day pathway.

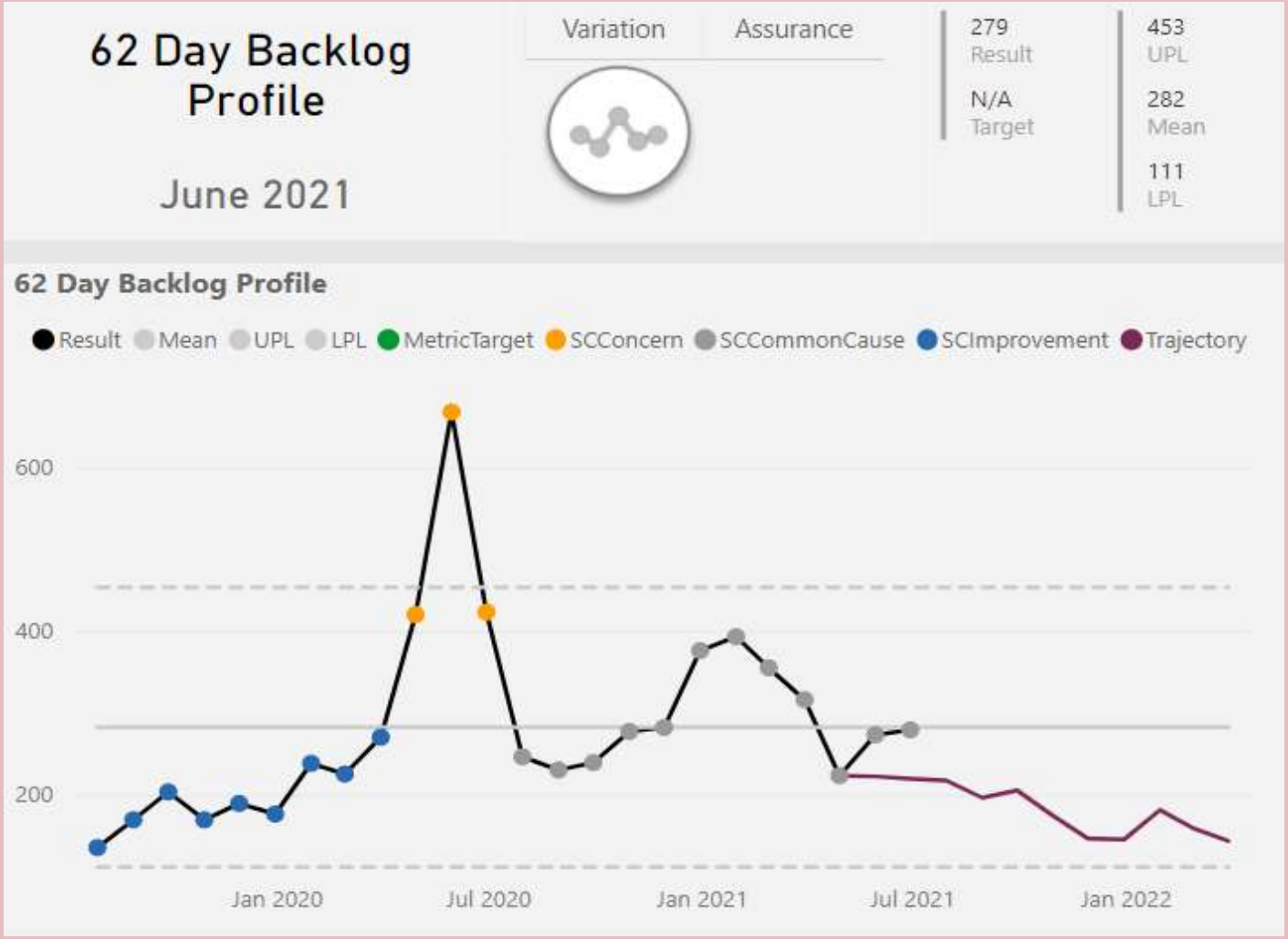
2. Renewed focus on Cancer Red to Green process to improve engagement with senior teams.

3. Focus on additional Urology activity in H1.

4. Review of existing 104 day trajectory, with clear plans for an increased reduction through to 31/08/21.

RED

Performance – Cancer 62 Day Backlog Profile



KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Cancer 62 Day Backlog	184 (Feb 20)	Actual	223	237	279									
		Trajectory	223	222	219	217	196	205	174	146	145	181	159	143

Commentary

June 2021 Performance

Urgent Cancer referral levels have continued to exceed all previous levels. As such, the cancer waiting list size has grown to just under 4000 patients. The waiting list size pre-COVID was around 2900. This has caused additional pressure across all cancer pathways requiring additional outpatient, diagnostic and treatment capacity to keep up with demand. Urology and colorectal have the highest backlogs.

Improvement Actions

1. A further focus on theatre allocations over the summer to direct theatre time to the most urgent cases.

2. Additional HDU capacity bid to improve bed numbers by 6 under consideration.

3. Renewed focus on Cancer Red to Green process to improve engagement with senior teams.

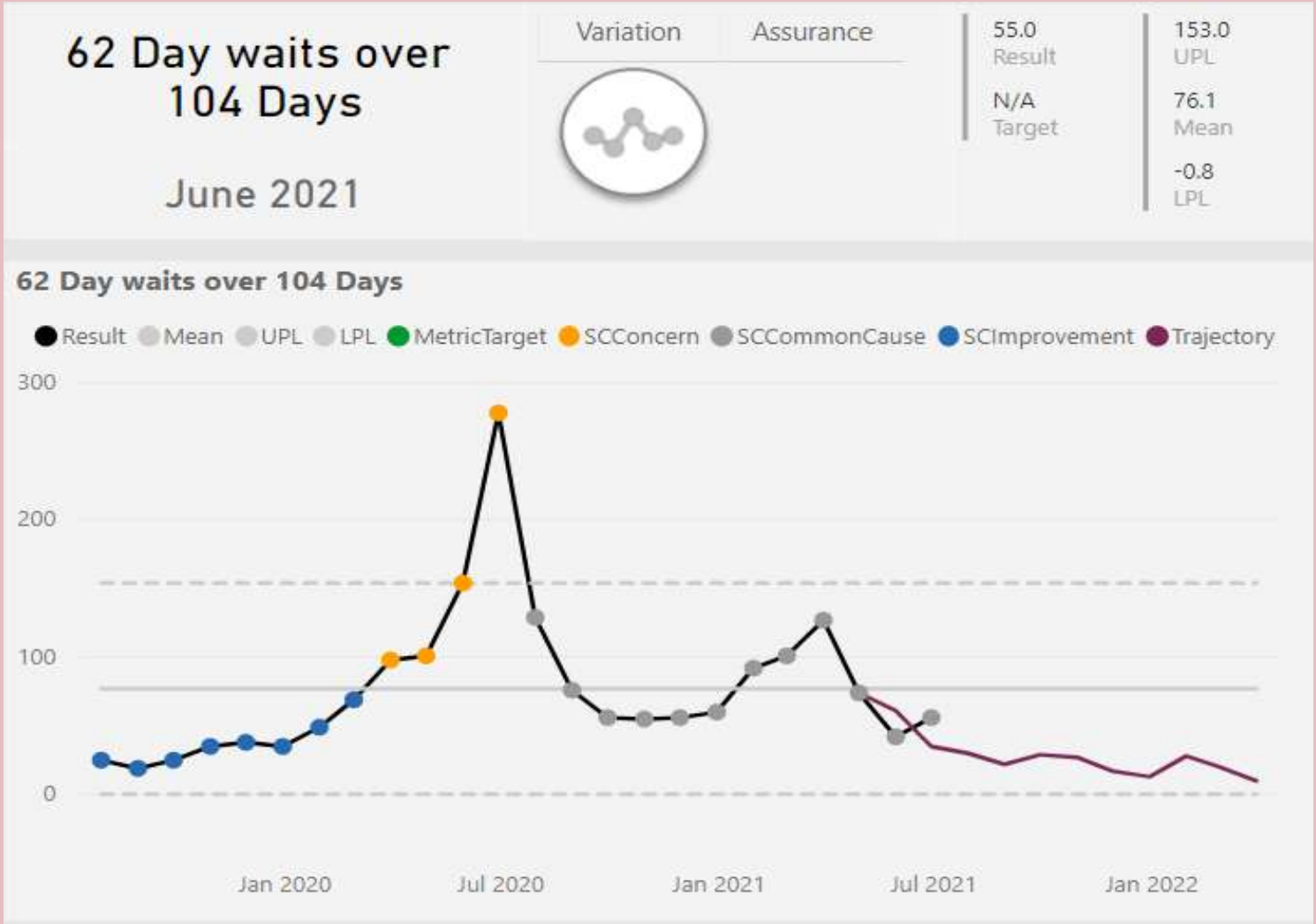
4. Focus on additional Urology activity in H1 including additional theatre lists out of hours and use of insourcing during August and September.

5. Review of existing 104 day trajectory, with clear plans for an increased reduction through to 31/08/21.

Risk To Delivery

AMBER

Performance – Cancer 62 Day Waits over 104 Days



KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Cancer 62 Day Waits >104 Days	0	Actual	73	41	55									
		Trajectory	73	60	34	29	21	28	26	16	12	27	19	9

Commentary

June 2021 Performance

Urgent Cancer referral levels have continued to exceed all previous levels. As such, the cancer waiting list size has grown to just under 4000 patients. Waiting List size pre-COVID was around 2900. This has caused additional pressure across all cancer pathways requiring additional Outpatient, Diagnostic and Treatment capacity to keep up with demand. Unfortunately, this has meant a higher number of patients have rolled over the 62-day point and the reduction of patients over 104 days has slowed.

Improvement Actions

1. The full focus on P2 patients in order to reduce numbers waiting >28 days for surgery and maintain this turnover will encompass many patients on a cancer 62-day pathway.

2. Renewed focus on Cancer Red to Green process to improve engagement with senior teams.

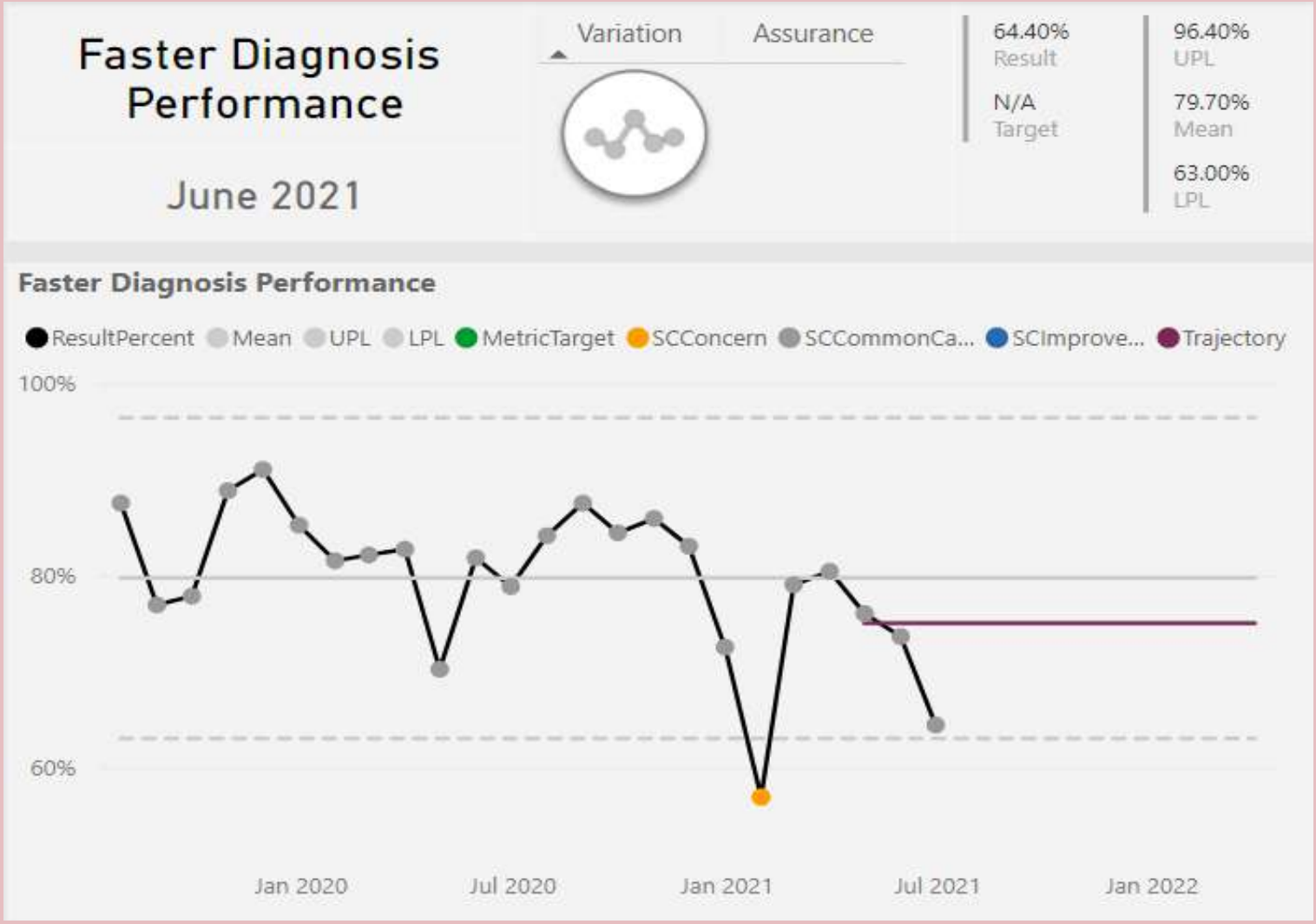
3Additional theatre lists at weekends to support Urology and other P2 priority cases

4. Review of existing 104 day trajectory, with clear plans for an increased reduction through to 31/08/21.

Risk To Delivery

AMBER

Performance – Faster Diagnosis Standard



KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Cancer Faster Diagnosis Standard	75% (N)	Actual	79.7%	74.0%	64.4%									
		Trajectory	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%

Commentary

June 2021 Performance

Faster Diagnosis performance continues to decline as we are seeing Breast patients in excess of 28 days for their one-stop appointment and diagnostic delays within Lower GI.

Improvement Actions

1. Continue to provision additional weekend Breast clinics to both reduce backlog and ensure catch up to book within 14 days by the end of September.

2. Contract agreed with an insourcing company to clear the backlog during August and September which will support this standard being delivered .

3. Plan for additional CTC capacity in August to tackle current backlog (Booking in excess of 28 days).

Risk To Delivery

AMBER

Performance – RTT 52 Week Breaches

KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
RTT 52 Week Breaches		Actual	10764	10235	10127									
		Trajectory	0	0	0									

Commentary

June 2021 Performance

The continued slow reduction in over 52 week waiters is linked to a steady increase in over 52 week activity.
Priority continues to be to treat the sickest patients first; those on a cancer or urgent pathway and clearing the P2 backlog. Some progress has been made on reducing the outpatient waiting times in some specialities, however, a large backlog still remains.

Improvement Actions

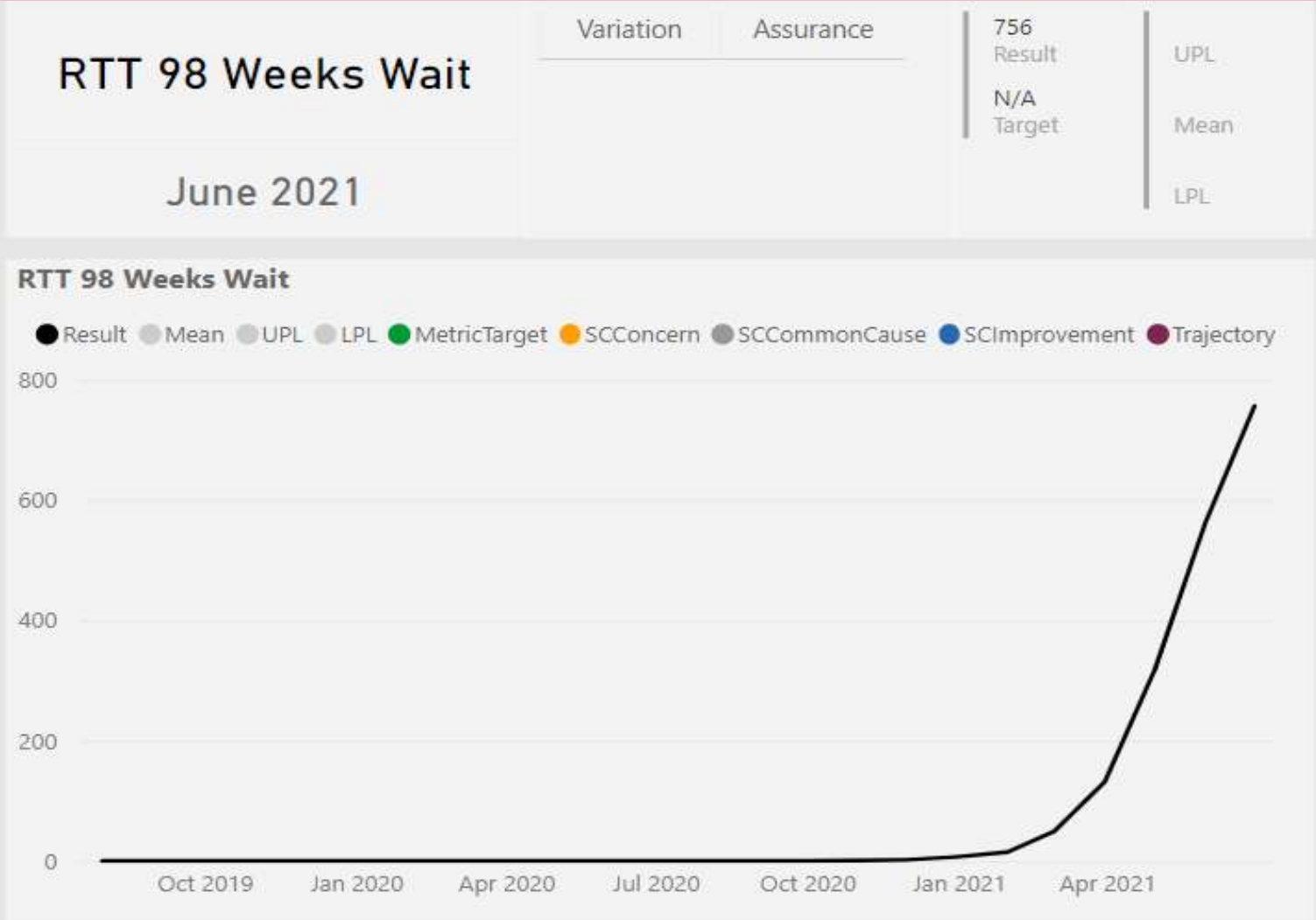
1. Continued focus on creating additional capacity (WLI at weekends) to treat most urgent patients to then focus on longer waiting patients.

2. Insourcing and independent sector solutions being explored.

Risk To Delivery

AMBER

Performance – RTT 98 Week Breaches



KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
RTT 98 Week Breaches	0	Actual	297	563	756									
		Forecast												

Commentary

June 2021 Performance

Orthopaedics cannot currently deliver a 98 week wait within the available capacity. Plans are in development to create additional theatre capacity. GIRFT will visit to the Trust in late July to provide support to the system on orthopaedic recovery.

Improvement Actions

1. Complete removal of P2 backlog.
2. Move to upper quartile performance in Theatres.
3. Create additional theatre capacity through agreed interventions.
4. Improve use of Independent Sector and out of hours.

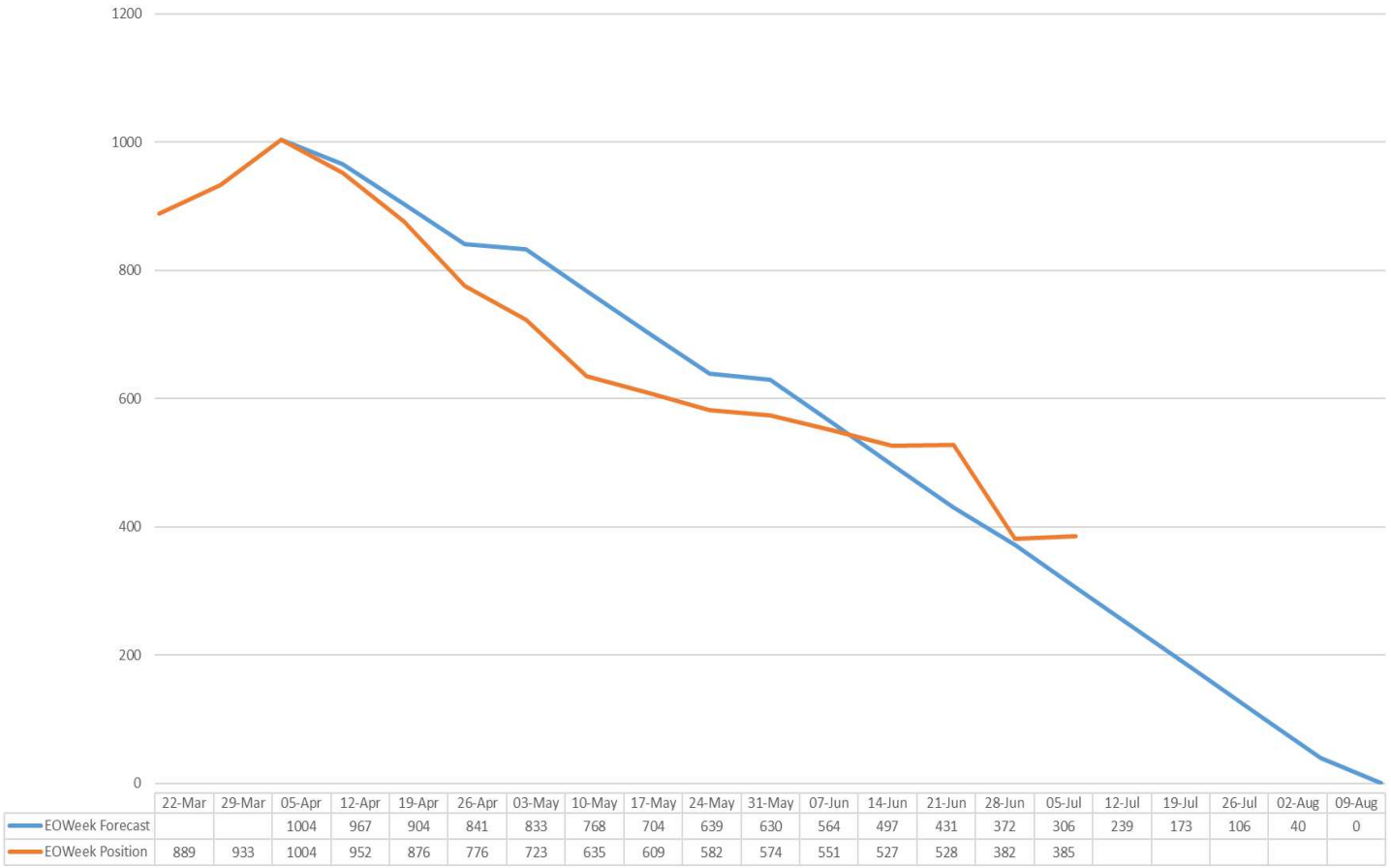
Risk To Delivery

RED

Performance – P2 Patients Waiting > 28 Days for Theatre

NNUH Digital Health business intelligence

Figure 1. - P2 >28 Day Trajectory (Theatre Procedures)



	22-Mar	29-Mar	05-Apr	12-Apr	19-Apr	26-Apr	03-May	10-May	17-May	24-May	31-May	07-Jun	14-Jun	21-Jun	28-Jun	05-Jul	12-Jul	19-Jul	26-Jul	02-Aug	09-Aug
EOWeek Forecast			1004	967	904	841	833	768	704	639	630	564	497	431	372	306	239	173	106	40	0
EOWeek Position	889	933	1004	952	876	776	723	635	609	582	574	551	527	528	382	385					

KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
P2 Patients Waiting >28 Days for Theatre	0	Actual	776	574	381									
		Trajectory	841	630	372	106	0	0	0	0	0	0	0	0

Commentary

June 2021 Performance

COVID-19 created a backlog of 1200 P2 patients waiting for treatment through theatres.

In accordance with the planning guidance, the Trust has dedicated almost all available theatre time to P2 patients from April 2021. Daily monitoring of the position has seen a significant reduction in the backlog to 385 patients at the end of June.

Removal of the backlog is key to re-opening theatres to long-waiting P3 patients in August 2021. Delivery against trajectory slipped from trajectory during June due to annual leave, low uptake of WLI and weekend sessions, theatre staffing vacancies. To compensate for this, additional lists at weekends have been planned during August and September for Urology via an insourcing company.
The clinical staff will be working additional hours at weekends between July and September and the independent sector will be utilised, where available.

Improvement Actions

1. 90% of theatres allocated to P2 April – August 31.

2. Daily monitoring at IMT.

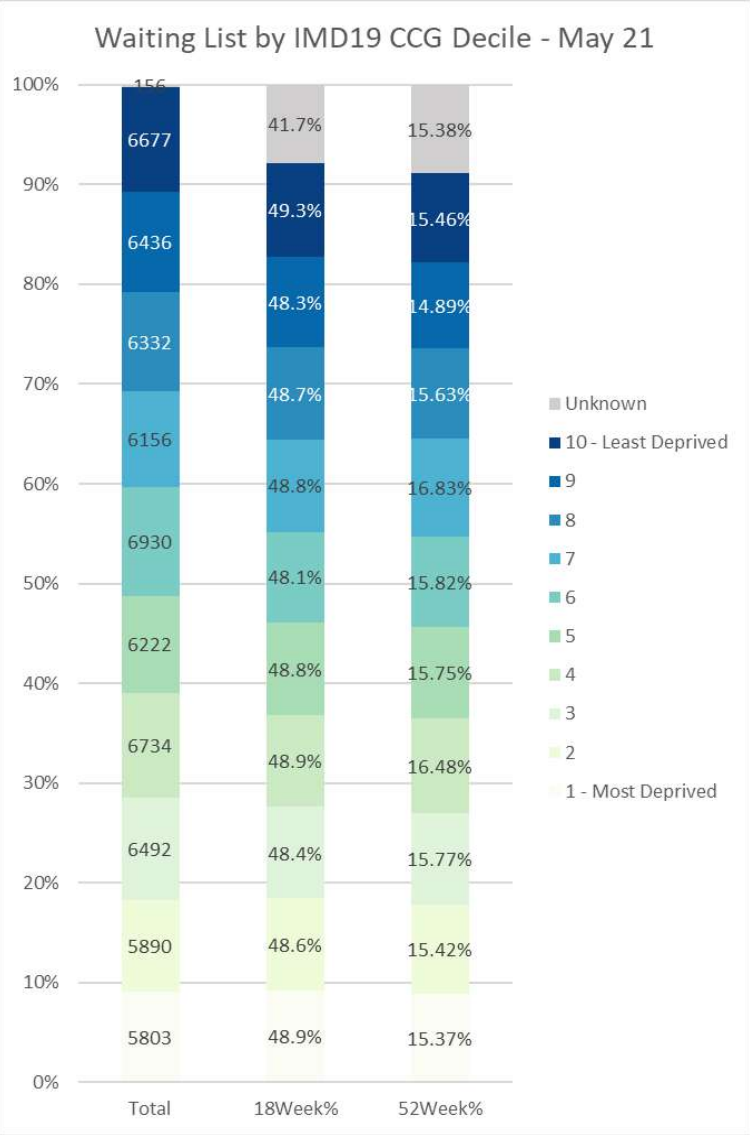
3. Additional lists at weekends and out-of-hours.

4. Maximise use of IS.

Risk To Delivery

AMBER

Performance – Waiting List Health Inequalities

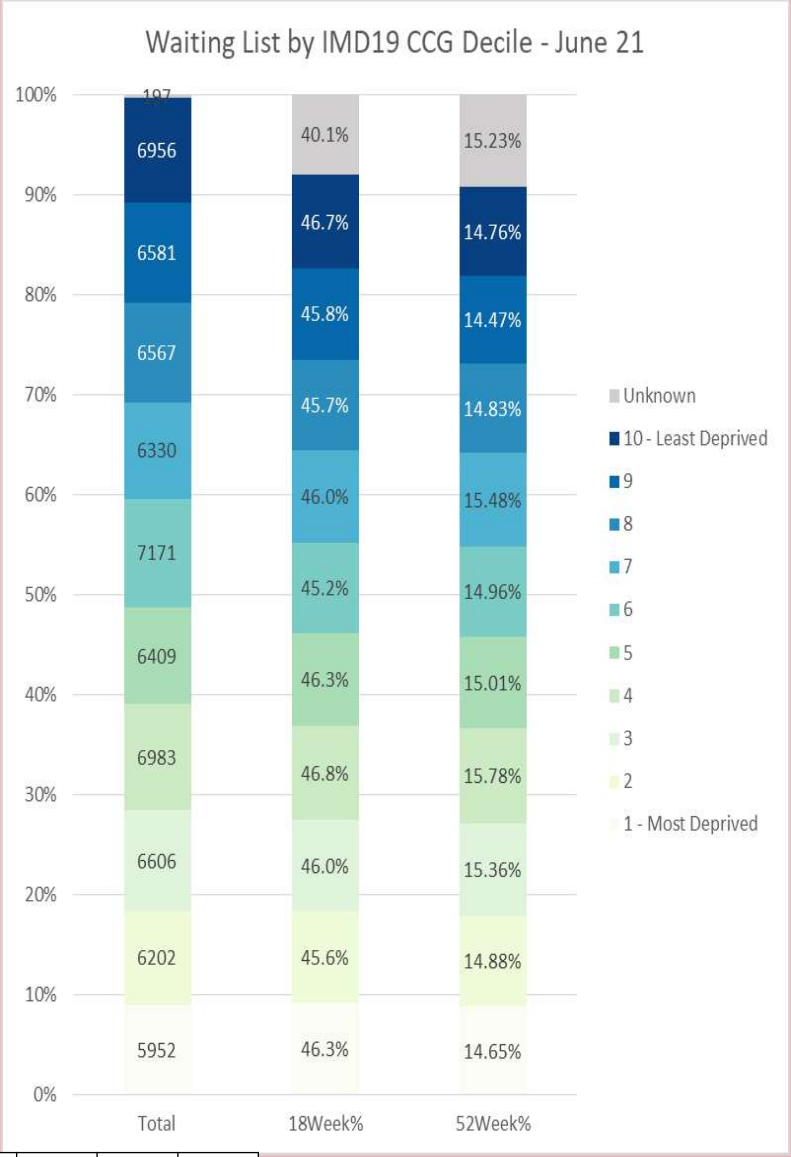


Commentary

Trust Waiting List: Deprivation
As part of the monitoring of health inequalities, the Trusts waiting list is monitored for variation in demographics.
The table below summarises any change in the Trusts waiting list profile by Ethnicity from May to June 2021.

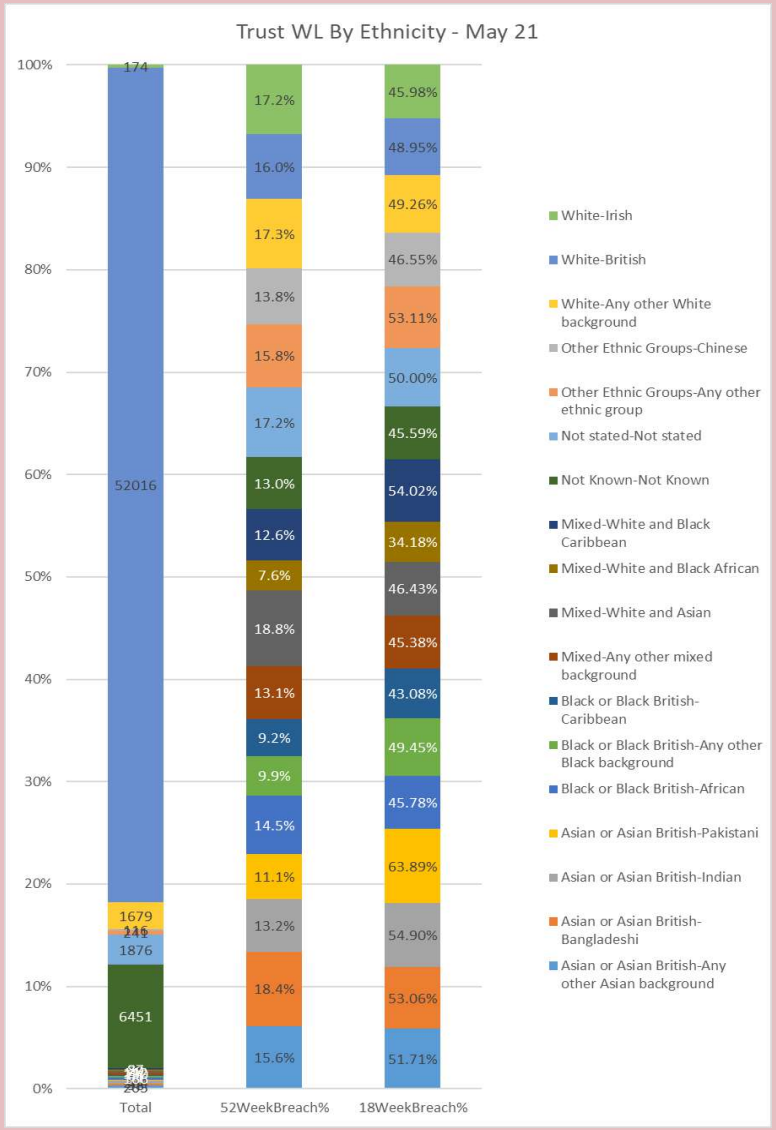
The Index of Multiple Deprivation (IMD)
The indices rank 32,844 small areas (neighbourhoods) across England. The indices comprise 39 indicators organised across 7 domains which are combined and weighted to calculate the overall Index of Multiple Deprivation. Outputs displayed in deciles (10 equal groups) of deprivation (1-10) and quintiles (5 equal groups of 20%).

There was no significant variation or concern in June 2021.



KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Waiting List - Health Inequality Indicators	Variation	Ethnicity	No	No	No									
		IMD	No	No	No									

Performance – Waiting List Health Inequalities

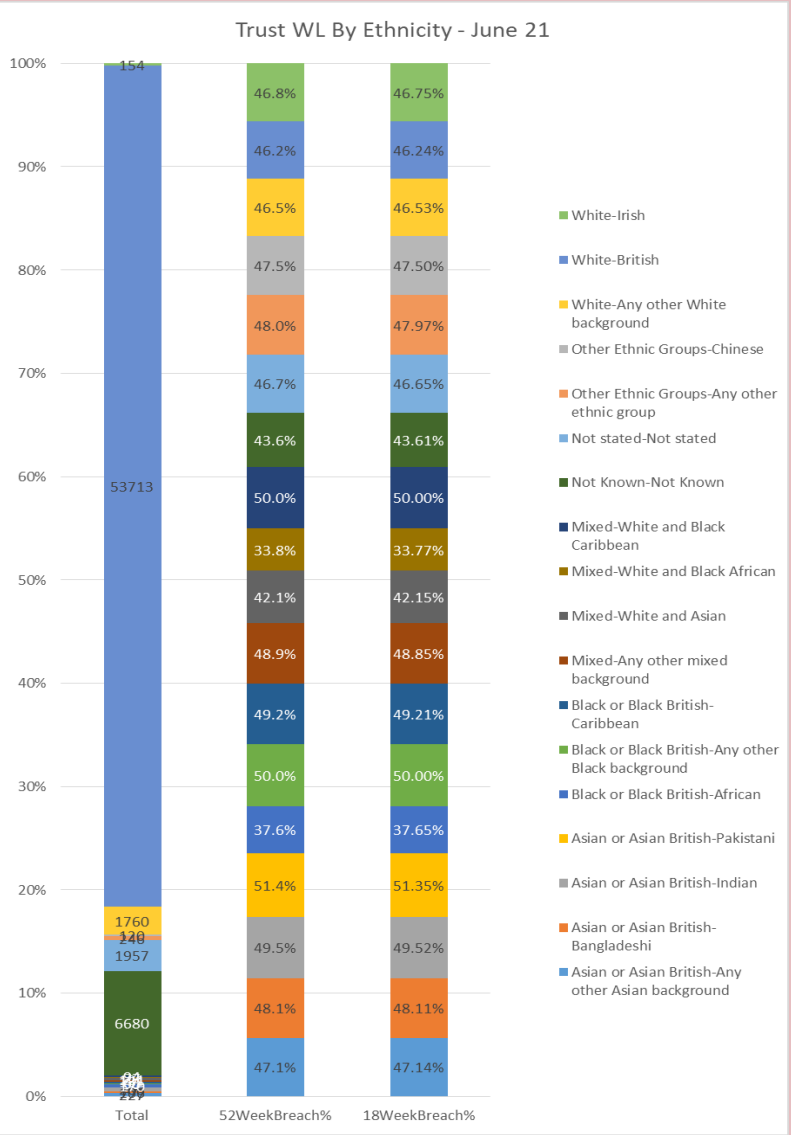


Commentary

Trust Waiting List: Ethnicity

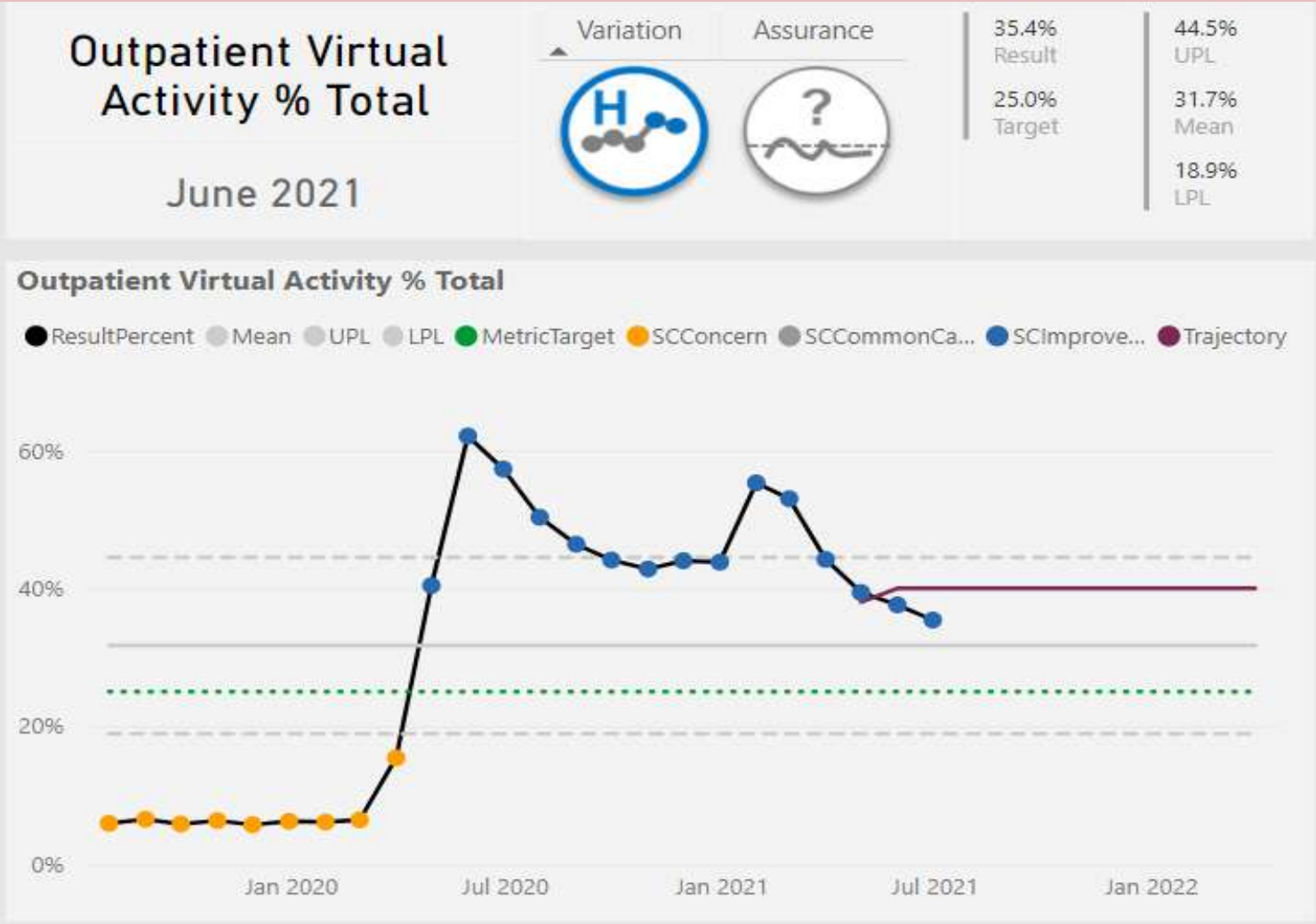
As part of the monitoring of health inequalities, the Trusts waiting list is monitored for variation in demographics. The table below summarises any change in the Trusts waiting list profile by Ethnicity from May to June 2021.

There was no significant variation or concern in June 2021.



KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Waiting List - Health Inequality Indicators	Variation	Ethnicity	No	No	No									
		IMD	No	No	No									

Performance – Remote Outpatients



KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Virtual Outpatients	25% (N)	Actual	38.7%	37.4%	35.4%									
		Trajectory	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%	25.0%

Commentary

June 2021 Performance

The Trust delivered 35.4% of outpatient appointments remotely during June, ahead of the 25% national target but adrift of internal trajectory.

The number of outpatient appointments delivered during June was 67,872 an increase of 5,000 from 62,554 in May. The number of virtual outpatients delivered also increased from 23,662 in May to 24,348 in June. The number of mandatory face-to-face outpatient attendances continues to increase due to clinical reasons and 'catching up' with patients of concern who have previously had a number of virtual appointments during COVID.

The Trust remains in the upper decile nationally for numbers and % of outpatient appointments delivered virtually during June 2021.

Improvement Actions

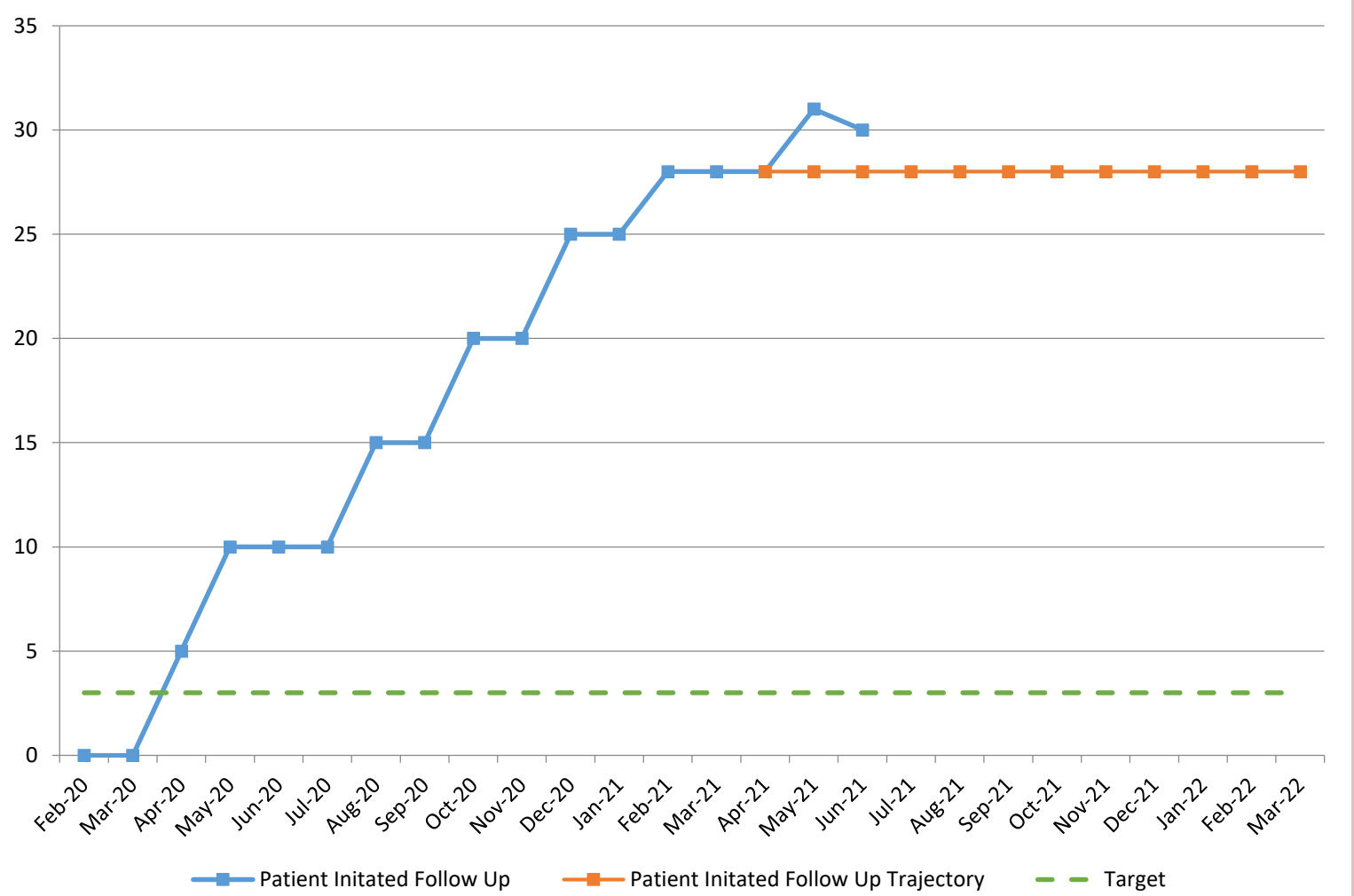
1.Ongoing transformation initiatives to review National best practice models for delivering remote care in each speciality.

2. Dedicated programme and project manager now in place

Risk To Delivery

GREEN

Performance – Patient Initiated Follow Up (PIFU)



KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
PIFU	Implement in 3 specialties	Actual	28	31	30									
		Trajectory	3	3	3	3	3	3	3	3	3	3	3	3

Commentary

June 2021 Performance

The Trust is delivering PIFU within 30 specialities as of June 2021, ahead of target and internal trajectory.

The Trust's Outpatient Transformation Programme has supported all specialties to identify pathways/patients that would benefit from being placed upon a PIFU list. These patients are selected clinically. Triggers, timelines and access back to the service are agreed between patient and clinician.

Additional analysis is due to be undertaken by the transformation team to ensure the most appropriate cohorts of patients are being offered PIFU.

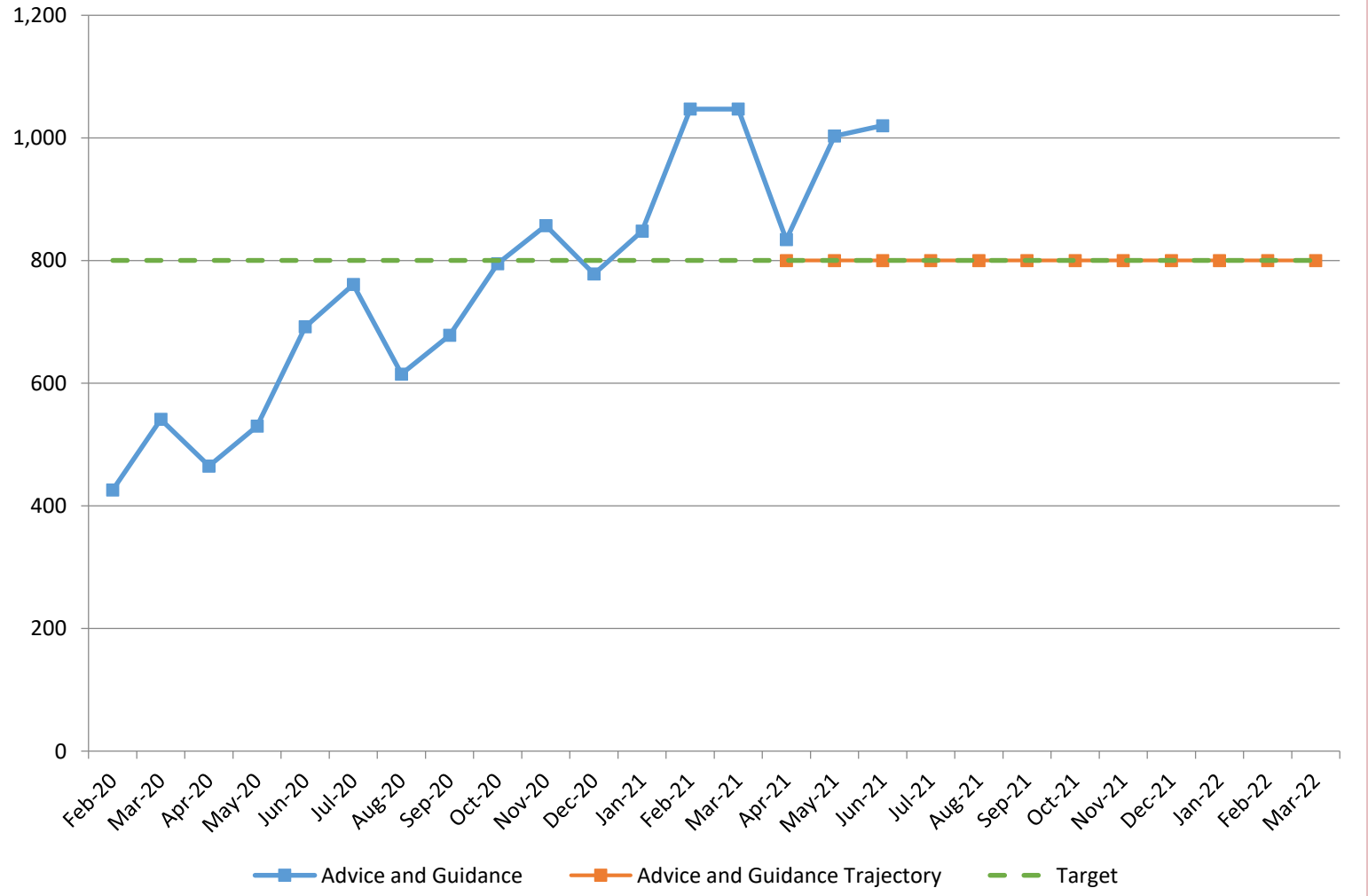
Improvement Actions

1. Work ongoing to refine and align SOPs, standards and processes for PIFU across specialties.
2. Working with the regional community of practice group on development of a wider data set around PIFU, including number of patients that return.
3. Working with our Patient Engagement team to better understand how patients are experiencing PIFU and their level of satisfaction.

Risk To Delivery

GREEN

Performance – Advice & Guidance



KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Advice and Guidance	1000	Actual	834	1003	1020									
		Trajectory	800	800	800	800	800	800	800	800	800	800	800	800

Commentary

June 2021 Performance

Advice and Guidance requests responded to increased further in June 2021 to 1,020. This is primarily due to the higher volume of referral rates and numbers of outpatients appointments being re-instated.

Improvement Actions

1. Continued monitoring by speciality and division
2. Exploring best practice and use of A&G across N&W System with Primary Care
3. Task and finish group established as part of transformation programme to re-launch A&G

Risk To Delivery

GREEN

Performance – Theatre Dashboard: Utilisation

NNUH Digital Health business intelligence

StartOfWeek: All

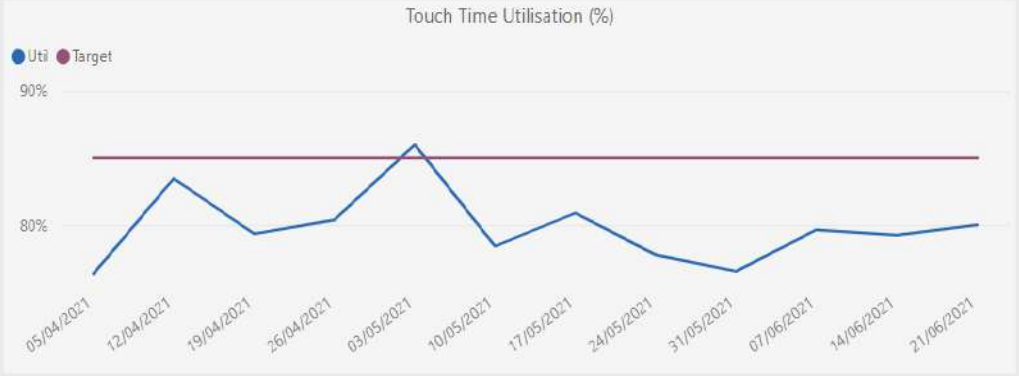
Specialty: All

Theatre: All

Session Owner: All

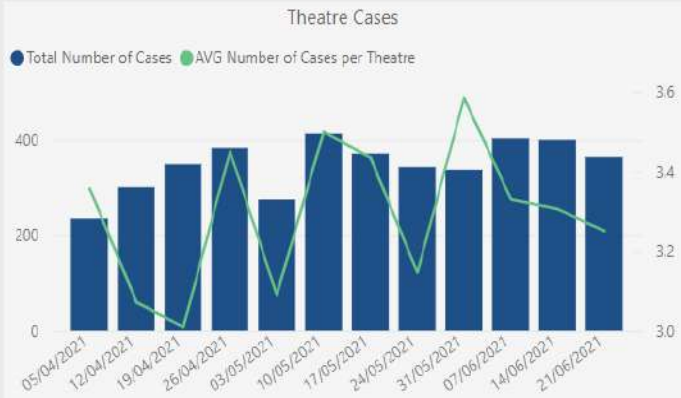
Specialty	Util
Clinical Oncology	129.62%
Paediatric	99.75%
Trauma and Orthopaedic	85.47%
General Surgery	84.02%
Plastic Surgery	82.94%
Gynaecology	80.52%
Thoracic Surgery	79.67%
Oral Surgery	79.35%
Urology	79.23%
Vascular Surgery	78.22%
Ear Nose and Throat	76.00%
Ophthalmology	65.59%
Pain Management	52.31%

Cromer | Level 2 | Level 3 | Ophthal | Robots | Vanguard



Week Starting 21/06/21

Number of Theatres Running	AVG Number of Cases per Session
23	1.98
Total Number of Sessions	**AVG Operating Hours per Case**
184	02 hrs 32 min



Commentary

June 2021 Performance

- Touchtime delivery improvement and maintained at circa 80% throughout June.
- Plans to improve to 89% target in place and being actioned – expected continued increase being worked through.
- Case mix of complex elective (rather than high throughput cases) will support improvement.

Improvement Actions

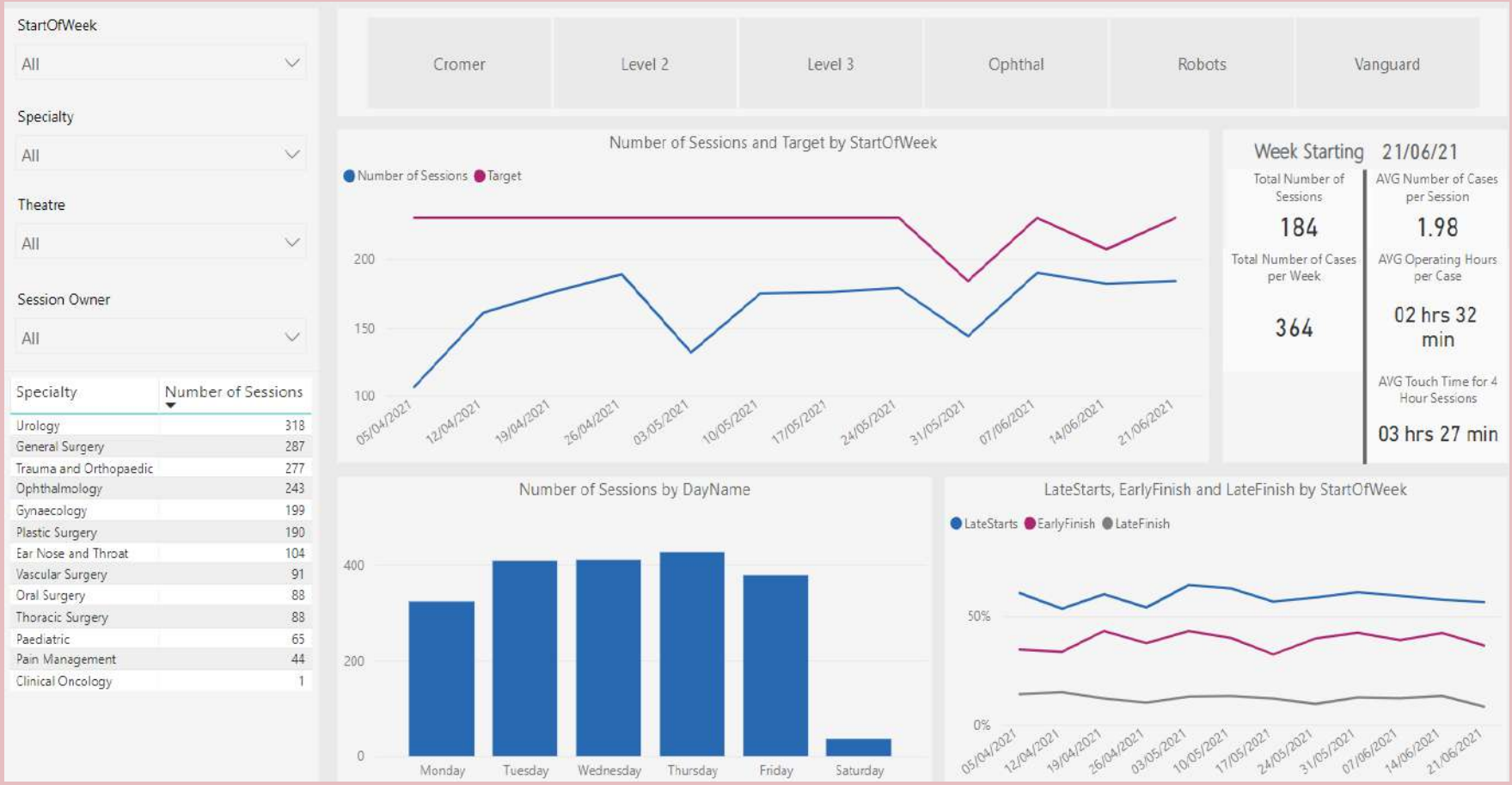
- Analysis of booking opportunity and efficiency opportunity undertaken by Theatre Triumvirate – being modelled into improvement plan.
- Areas of highest opportunity outlined and more detailed focus with Model Health Opportunities to be developed.
- Focus on reflective review and proactive push for improved booking levels reinstated.

Risk To Delivery

AMBER

KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Theatre Sessions	Late Starts (30%)	Actual												
		Trajectory				65.0%	60.0%	58.0%	55.0%	50.0%	45.0%	40.0%	35.0%	30.0%
	Early Finishes (25%)	Actual												
		Trajectory				40.0%	38.0%	36.0%	34.0%	30.0%	28.0%	28.0%	25.0%	25.0%
	Av. Cases per List (2)	Actual												
		Trajectory				1.98	1.98	1.98	1.99	1.99	1.99	2.00	2.00	2.00

Performance – Theatre Dashboard: Sessions



Specialty	Number of Sessions
Urology	318
General Surgery	287
Trauma and Orthopaedic	277
Ophthalmology	243
Gynaecology	199
Plastic Surgery	190
Ear Nose and Throat	104
Vascular Surgery	91
Oral Surgery	88
Thoracic Surgery	88
Paediatric	65
Pain Management	44
Clinical Oncology	1

KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Theatre Utilisation	Touchtime (Elective) 89%	Actual												
		Trajectory				74.0%	75.0%	78.0%	80.0%	82.0%	84.0%	86.0%	88.0%	89.0%
	Touchtime (Day Case) 89%	Actual												
		Trajectory				74.0%	75.0%	78.0%	80.0%	82.0%	84.0%	86.0%	88.0%	89.0%

Commentary

June 2021 Performance

- Challenge process commenced in month – incremental improvement seen.
- Staff availability impacting running at full capacity – robust recruitment process now in place and enhancements being worked through to improve delivery.
- Weekly monitoring by Matrons of late starts and early finishes has demonstrated improvement in early July.

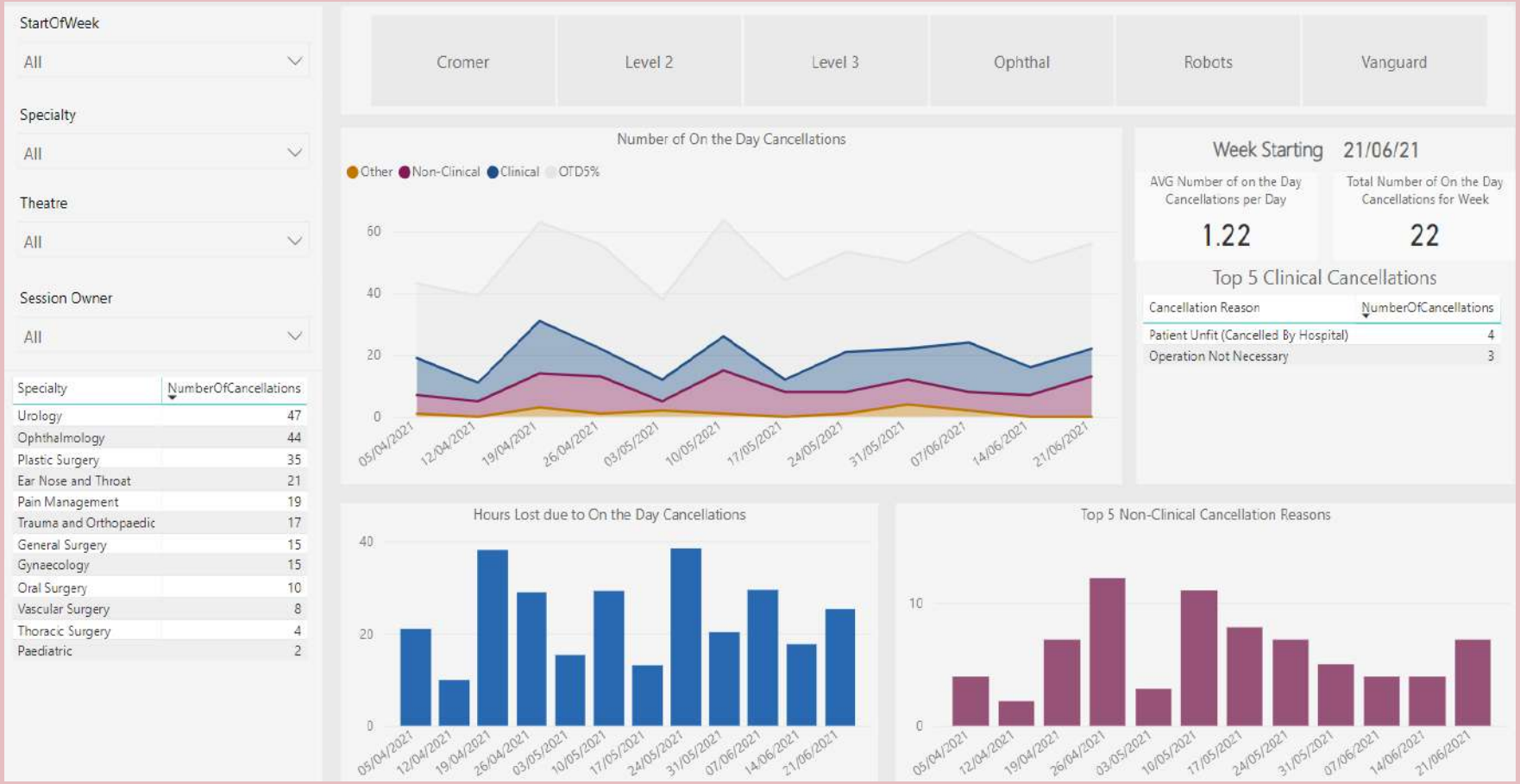
Improvement Actions

- Theatre productivity group working on significant improvements to late starts and early finishes – improvement already seen in July.
- Focus on decreasing turnaround in-between cases also driving improvement in list utilisation.
- Elective review meetings to refocus on review of prior week and list challenge to ensure maximised productivity.
- Plan being developed to monitor incremental improvement to delivery of identified opportunity (5% each month from August 2021).
- Processes of booking and patient review to be scrutinised to reduce on the day cancellations.

Risk To Delivery

AMBER

Performance – Theatre Dashboard: Cancellations



Specialty	NumberOfCancellations
Urology	47
Ophthalmology	44
Plastic Surgery	35
Ear Nose and Throat	21
Pain Management	19
Trauma and Orthopaedic	17
General Surgery	15
Gynaecology	15
Oral Surgery	10
Vascular Surgery	8
Thoracic Surgery	4
Paediatric	2

KPI	Target		Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Theatre Cancellations	On Day Cancellations (15)	Actual												
		Trajectory				22	22	22	20	20	18	18	15	15

Commentary

June 2021 Performance

- Cancellation rate throughout June low.
- Expectation that this may increase due to push for list fill – not to be considered a failure metric.

Improvement Actions

- Escalation process for 'zero tolerance' on cancellations being revised and will be relaunched – to minimise cancellations on the day.
- Further data analysis of cancellation reasons to be audited – pre-op and booking pathways to be scrutinised.
- As productivity is being driven – a higher chance of cancellation is introduced through fully booked theatre lists (no room for complexity on day).
- Specific cancellation reasons to be developed – lack of Critical Care Bed, for example, to evidence specific shortfalls.

Risk To Delivery

AMBER

Performance – Theatre Dashboard: Emergency Theatres

NNUH Digital Health business intelligence

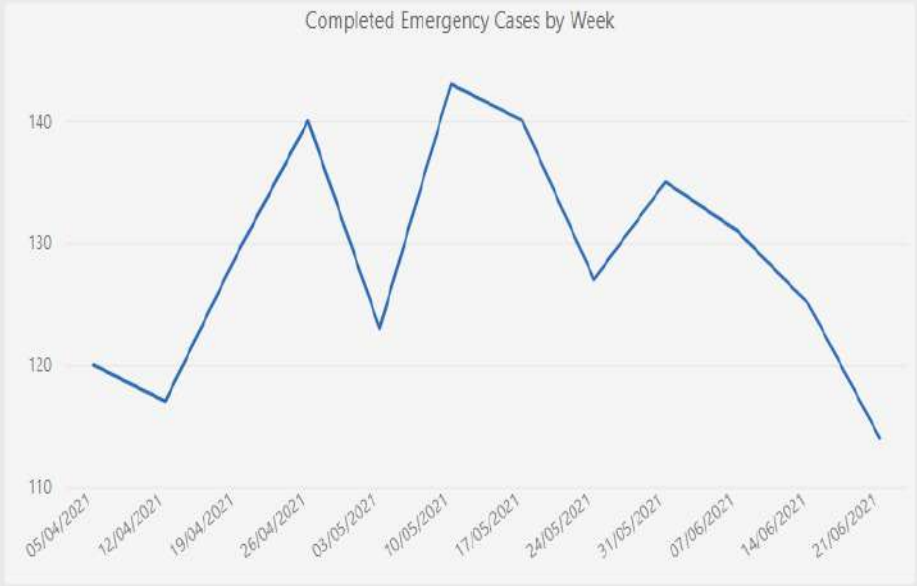
StartOfWeek: All

Specialty: All

Theatre: All

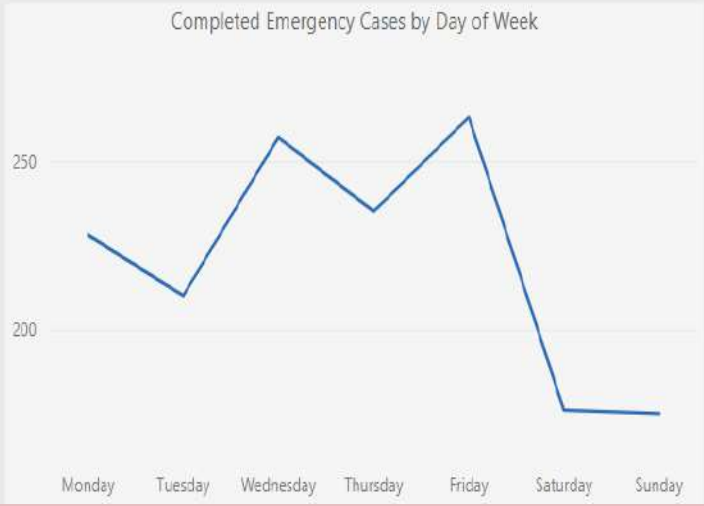
Time of Day: All

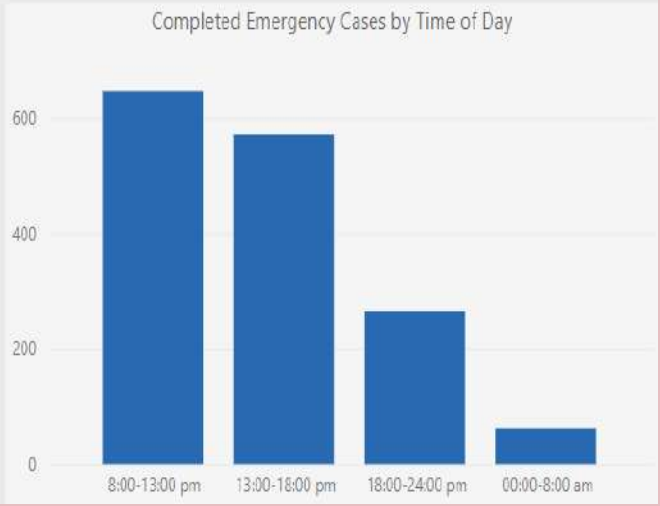
Specialty	NumberOfCases
Trauma and Orthopaedic	544
General Surgery	340
Plastic Surgery	135
Vascular Surgery	112
Urology	84
Paediatric	81
Gynaecology	76
Oral Surgery	56
Ear Nose and Throat	31
Ophthalmology	23
Anaesthetic	18
Obstetrics	14
Thoracic Surgery	12
Clinical Oncology	10
Cardiology	5
Pain Management	3



Week Starting 21/06/21

Total Number of Emergency Cases per Week	AVG Number of Emergency Cases completed per Day
114	16
AVG Total Touch Time per day	**AVG Operating Hours per Case**
38 hrs 35 min	02 hrs 22 min





Commentary

June 2021 Performance

- Activity delivered in line with demand (P1a and b cases).
- Utilisation work to commence to ensure suitable allocation of resource to emergency vs elective.

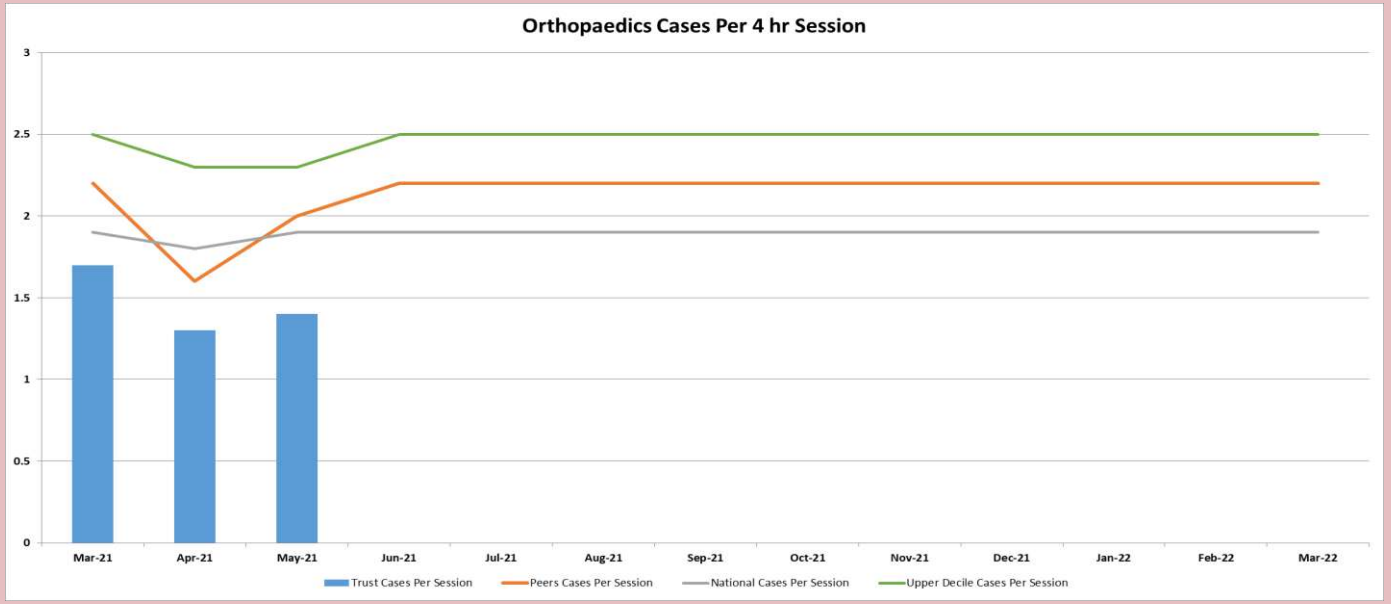
Improvement Actions

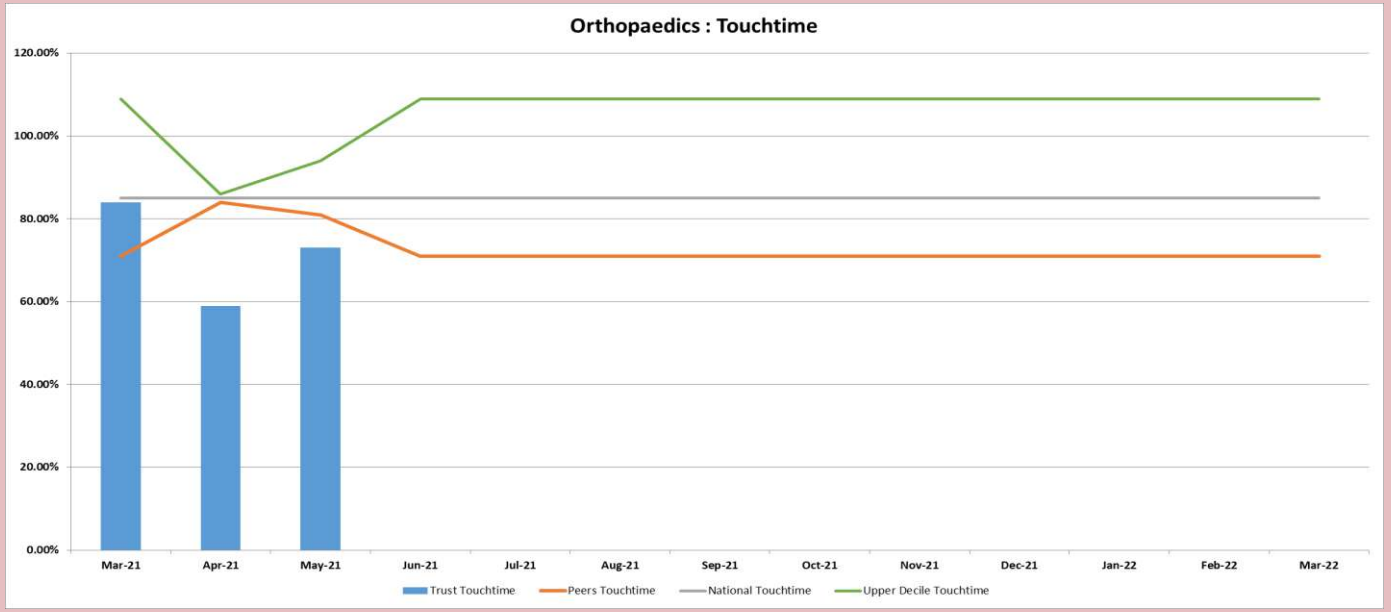
- Plan to review start times (gold case arrival in anaesthetic room) – ensuring identification the night before is taking place (Ortho and Emergency).
- Specific focus on improvement in turnaround time between cases to be developed.
- Work stream to focus on elective and emergency Obstetric theatres and opportunity for improvements.
- Review of theatre allocation and demands – increased trauma capacity has impacted on elective provision; modelling to be undertaken to understand continued value of this offer.

Risk To Delivery

AMBER

Performance – Model Hospital Orthopaedics





Commentary

June 2021 Performance

The Trust continued to focus on P2 recovery throughout May. This impacted the numbers of patients on Orthopaedic lists. Furthermore, the number of long cases waiting over 98 weeks treated further reduced the volume of patients treated.

The Trust will use Model Hospital data to increase efficiency in 2 key areas:

1) Theatre touch time
2) Cases per list

using upper decile levels of efficiency in April 2021.

There was capacity to treat an additional 18 patients (using touch time indicators) and the average number of cases per 4-hour session gave an opportunity for the Trust to increase from 1.4 to 2.0 (peer's median).

Support will be provided by the National GIRFT lead for Orthopaedics.

The Orthopaedics GIRFT follow up visit is due to be held in July 2021 to examine GIRFT clinical quality metrics and additional opportunities for efficiency and process improvement across N&W.

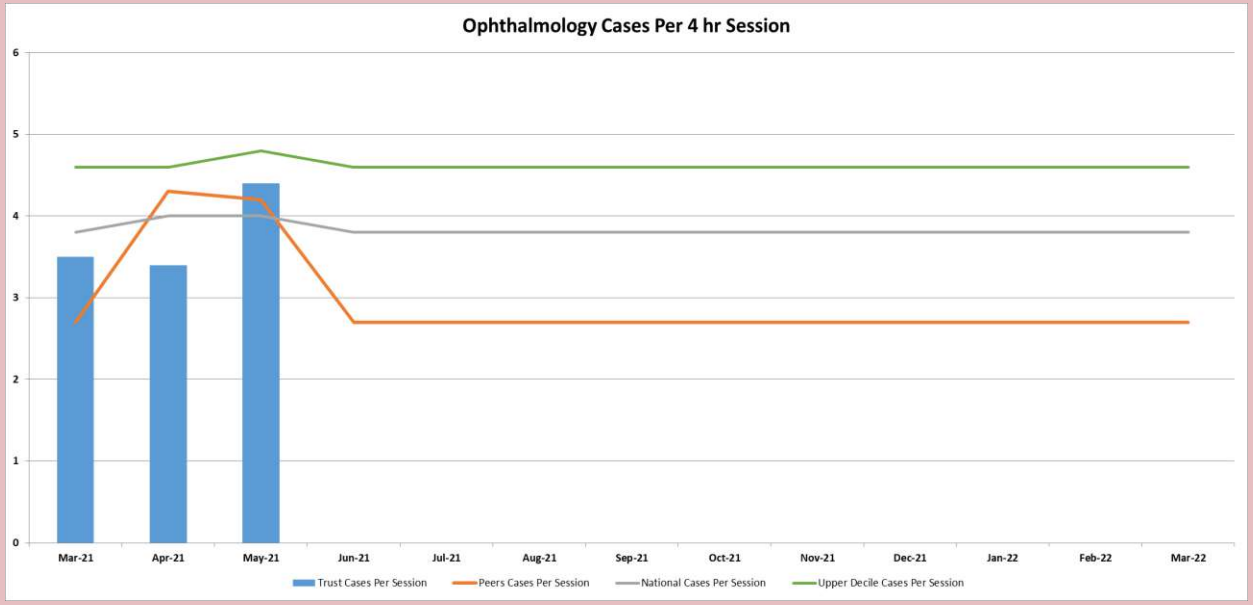
Improvement Actions

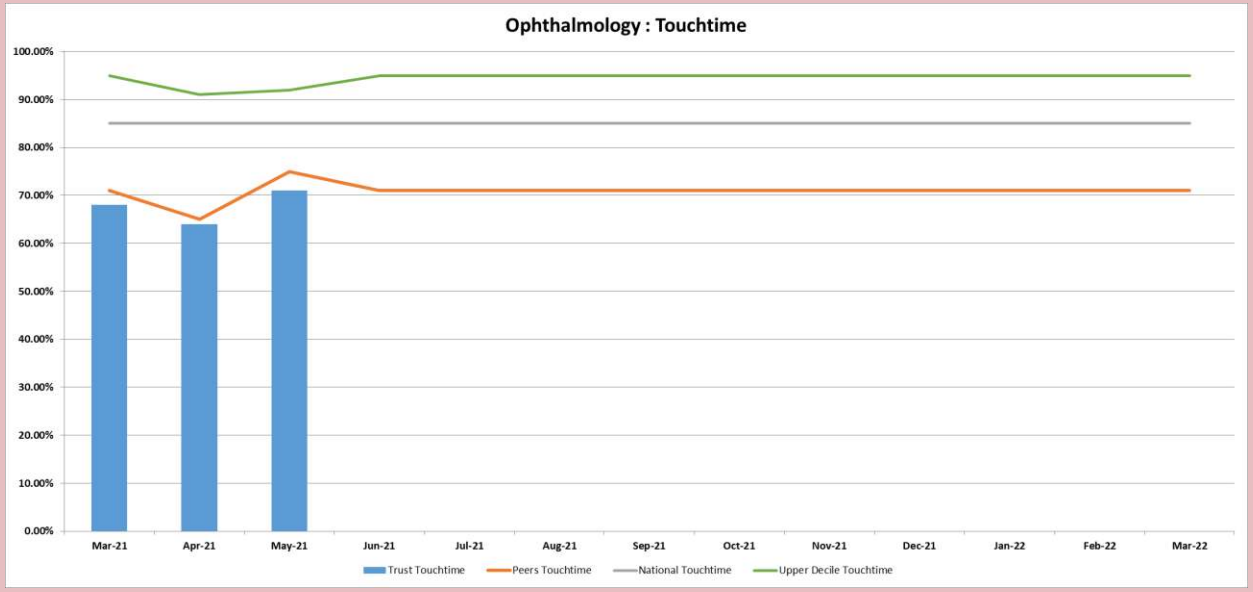
1. Plans to work closely with the Orthopaedics Service Director and senior clinicians to implement the recommended interventions and practices to increase activity.
2. Use the new theatres dashboard and data to inform and drive efficiency improvement.
3. Potential to increase capacity via a cold-elective site.

Risk To Delivery

RED

Performance – Model Hospital Ophthalmology





Commentary

June 2021 Performance

The Trust will use Model Hospital data to increase efficiency in 2 key areas:

1) Theatre touch time
2) Cases per list

using upper decile levels of efficiency in April 2021.

There was capacity to treat an additional 40 patients (using touch time indicators) and the average number of cases per 4-hour session gave an opportunity for the Trust to increase from 4.4 to 4.8 (upper decile performance).

Improvement Actions

1. Plans to work closely with the Ophthalmology Service Director and senior clinicians to implement the recommended interventions and practices to increase activity.
2. Use the new theatres dashboard and data to inform and drive efficiency improvement.
3. CQIA/Risk Assessments on clinic space.
4. NHSE/GIRFT efficiency workshop/visit 5 July

Risk To Delivery

AMBER

Norfolk and Norwich University Hospitals NHS Foundation Trust

Finance Report
June 2021

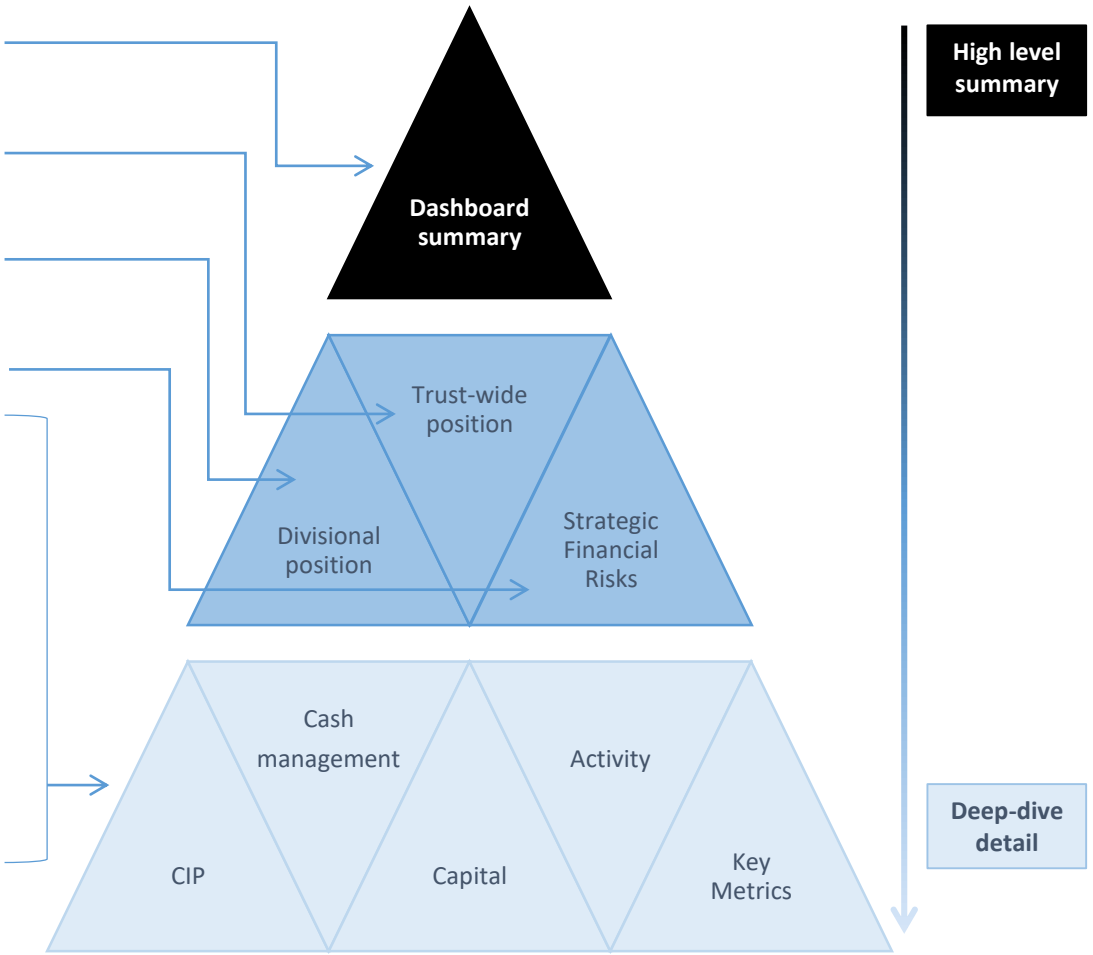
Roy Clarke, Chief Finance Officer

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

On the 25th March 2021, the FY21/22 Priorities and Operational Planning Guidance was released, which outlined the key national priorities and deadlines for the plan submission for the first six months of 2021/22 - (H1) FY21/22. These were reported within Cycle 4 of the financial plan.

The Trust operational plan position at Cycle 4 is:

- A 2021/22 deficit of £55.2m, comprising a breakeven position for H1 and a £55.0m interim forecast deficit for H2.

The year to date position on a control total basis as at Jun 2021 is a surplus of £4.9m. This is a £3.8m favourable variance to the planned £1.1m surplus. The favourable variance of £3.8m comprises of an underspend in Pay of £1.7m, clinical & non clinical supplies of £1.4m and income of £0.9m. The position excludes any Elective Recovery Funding that may have been earned subject to validation.

Forecast Outturn (H1):

Forecast outturn remains on plan at breakeven with an Upside Forecast Outturn of a £13.7m surplus, based on current run rates and committed expenditure. However, assuming expenditure increases in line with the operational plan for the remaining months, to fully spend the H1 budget, the risk adjusted forecast outturn would be a breakeven position. This would be in line with the operational plan.

Management action is required to deliver the planned H1 breakeven position by increasing non recurrent expenditure in key recovery areas.

Reduction of the underlying planned deficit requires continued focus through further CIP identification and completion of cycle 4 outstanding actions.

Activity:

The Trust continues to be measured against the activity targets set by NHSE for 2021/22 H1. The target for June 2021 being 80% of 2019/20 activity levels. Provisional figures for the first quarter (Apr to Jun) indicate that the Trust has exceeded the targets overall, although not across every point of delivery – Elective Inpatient particularly still representing a challenge. Early estimates have also been calculated for the Elective Recovery fund (ERF) and these also reflect that targets have been exceeded, this presents the possibility of the Trust receiving some additional funding, although still subject to overall system performance and NHSE/I sign-off. With effect from 1st July the threshold for earning ERF is being increased to 95% of 19/20 activity levels. Overall elective activity levels are ahead of plan at Month 3.

Cash held at 30 June 2021 is £51.3m. The closing balance is £4.5m above plan for the following main reasons: cumulative operational underspends in 2021/22, exceptional capital creditors, accruals and levels of general debt. This forecast to continue through H1, thus the cash position at 30 September is forecast to be £44.2m, £3.5m higher than plan.

Capital: As at 30th June the Trust has underspent its plan by £0.2m YTD. The key driver of the YTD variance is an underspend of £0.1m on the CT and MR replacement programme.

Capital: The Capital Plan funding has a new £3.3m risk as the plan assumed PDC support and the application for this has been deferred due to the cash balances held, with no guarantee of future approval. Hospital Management Board have agreed to continue to progress the capital programme as this remains within the CDEL envelope.

	YTD			April21 - September21			
	Actual £m	Plan £m	Variance £m	FOT £m	Plan £m	Variance £m	RAG
Clinical Income	142.6	141.1	1.5	282.3	282.3	0.0	
Other Income	51.5	52.1	(0.6)	108.3	108.3	0.0	
Pay	(106.9)	(108.5)	1.7	(217.3)	(217.3)	0.0	
Non Pay	(50.3)	(51.7)	1.4	(108.1)	(108.1)	0.0	
Net Drugs Cost	(18.1)	(18.0)	(0.1)	(36.0)	(36.0)	0.0	
Non Opex	(14.0)	(14.0)	(0.0)	(29.2)	(29.2)	0.0	
Surplus / (Deficit)	4.9	1.1	3.8	0.0	0.0	0.0	
COVID (Out of System) Expenditure	1.6	0.0	1.6	1.6	0.0	1.6	
COVID (Out of System) Income	(1.6)	0.0	(1.6)	(1.6)	0.0	(1.6)	
Reported Surplus / (Deficit)	4.9	1.1	3.8	0.0	0.0	0.0	
Headline Surplus / (Deficit)*	5.5	3.2	2.3	2.2	2.2	(0.0)	
Cash at Bank (before support funding)	51.3	46.8	4.5	44.1	40.7	3.4	
Capital Programme	21.7	21.9	(0.2)	52.4	52.4	(0.0)	
CIP	2.5	1.4	1.1	3.5	3.5	0.0	
Inpatients** (000's)	37.8	33.3	4.5	70.4	70.4	0.0	
Outpatients** (000's)	179.7	165.1	14.6	345.3	345.3	0.0	
A&E** (000's)	36.4	36.1	0.3	82.0	82.0	0.0	

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

*** Activity for Apr-Sep: Plan is Trust Activity plan*

Norfolk and Norwich University Hospitals NHS Foundation Trust

1.2 Executive Dashboard

Risks

The Trust's overall risk profile remains stable, with no changes in risk scoring in month.

Divisional Performance

The Medicine division is overspent YTD as a result of increased drug expenditure although this is offset by additional income centrally managed in the 'other' division. EUC is also overspent as a result of locum expenditure covering vacant ED shifts. The CSS division is underspent mostly as a result of vacancies. All other divisions are on plan or <£0.1m favourable to plan.

The Medicine division is showing an adverse position to plan of £1.6m, this is as a result of increased expenditure on high cost drugs in April and June. The NHSEI commissioned drugs are offset by additional income centrally managed in the 'other' division. The CSS Division is showing a favourable position of £1.7m, mostly relating to vacancies against their establishment. EUC are overspent as a result of locum expenditure covering vacant ED shifts. Surgery, Women's & Children's and Corporate are all c. on plan year to date

As 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' includes Clinical Income block and Top up funding along with R&D and the Trust Reserves. The net favourable variance of £3.6m is driven by £1.2m from additional income relating to cost & volume drugs income (recognised based on usage), £0.9m FYE of 2020/21 CIP and £1.0m relating to additional clinical income for devices based on usage.

Cost Improvement Programme

YTD the Trust has delivered £2.5m of CIPs against a budgeted plan of £1.4m, a favourable variance of £1.1m.

The favourable variance of £1.1m is comprised of a performance variance of £1.1m. This has arisen through £1.3m of accelerated CIP delivery above budgeted plan; £0.2m of additional delivery through schemes developed since finalising the plan; offset by £0.4m of adverse performance against budgeted schemes across pay and discretionary spend initiatives.

The risk adjusted forecast outturn CIP delivery for FY21/22 is currently calculated as £13.1m based on the latest forecast financial performance of Gateway 2 schemes, progress against milestone delivery and performance against quality and performance indicators.

FY21/22 CIP Plan Development

As at 12 July 2021, the programme consists of £10.9m of Gateway 2 approved schemes; £5.2m of FYE of FY20/21 schemes; £2.9m of Gateway 1 approved schemes, which are being reviewed and developed to be progressed or removed from the programme; and £0.9m of schemes within the CIP development pipeline (Gateway 0).

Strategic Financial Risks	Extreme (15-25)	High (8-14)	Moderate (4-6)	Low (1-3)
Total This Month	7	6	0	0
Total Last Month	7	6	0	0
Overall Trend	↔	↔	↔	↔

YTD Divisional Performance Excl. COVID	Medicine		Emergency & Urgent Care		Surgery		Women's & Children's		CSS		Corporate Incl. COVID		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
YTD Surplus / (Deficit)	(56.1)	(1.6)	(7.2)	(0.3)	(36.8)	0.3	(13.7)	0.1	(23.0)	1.7	(28.7)	0.0	170.4	3.6	4.9	3.8
Apr-Sep FOT	(108.3)	0.0	(13.9)	0.0	(75.1)	0.0	(27.6)	0.0	(49.4)	0.0	(61.3)	0.0	335.6	0.0	0.0	0.0
Inpatients*	22.4	2.0	0.0	0.0	9.2	0.5	6.1	2.0	0.0	0.0	-	-	-	-	37.8	4.5
Outpatients*	69.7	6.9	0.1	0.1	81.5	3.9	17.9	3.5	10.4	0.2	-	-	-	-	179.7	14.6
A&E*	0.0	0.0	36.4	0.3	0.0	0.0	0.0	0.0	0.0	0.0	-	-	-	-	36.4	0.3
CIP RAG																
FINANCE RAG**																
PAF RAG**																

Activity variance against H1 Draft Activity plans (000's)

** Prior Quarter PAF Rating*

FY21/22 CIP Plan - Divisional Breakdown	FY21/22 Indicative Target £m	FY21/22 FIP Board Approved £m	FYE FY20/21 £m	Gap £m	FY21/22 RAG Adj. Forecast Delivery £m	Gap £m
Medicine	7.2	6.0	2.4	1.2	7.0	(0.2)
Emergency & Urgent Care	1.1	0.8	0.3	0.0	0.9	(0.2)
Surgery	7.8	2.5	1.5	(3.8)	3.0	(4.8)
Women's & Children's	2.7	0.7	0.2	(1.8)	0.6	(2.1)
CSS	4.1	0.6	0.5	(3.0)	1.1	(3.0)
Corporate	3.5	0.3	0.2	(3.0)	0.5	(3.0)
Total	26.4	10.9	5.1	(10.4)	13.1	(13.3)

Norfolk and Norwich University Hospitals NHS Foundation Trust

2.1 Financial Performance – June 2021

For the month of June 2021, the position on a control total basis is a surplus of £1.2m. This is a £1.0m favourable variance to the planned £0.2m surplus for the month. The favourable variance of £1.0m is made up of additional income of £0.4m, an underspend in Pay of £0.7m and clinical & non clinical supplies of £0.2m offset by £0.2m overspend on net drugs costs.

Clinical Income:
Clinical Income is reporting a favourable variance of £0.9m in June 2021 due to increased High Cost Devices recharged based on usage and is offset by additional clinical supplies expenditure.

Other Income:
There is a £0.6m adverse variance to plan for Jun 2021. This predominantly relates to independent sector capacity support income of £0.5m being matched to the plan submitted to the regulator.

Pay:
There is a £0.7m favourable position against plan for June 2021. This is predominantly as a result of net vacancies against establishment mainly in CSS & Corporate. In June there were c. 920 vacancies across the Trust with c. 725 premium WTE thus c. net 195 WTE vacancy.

Net Drugs Cost:
There is a £0.2m adverse variance in June 2021. This is increased costs of £0.8m predominantly across neurosciences and respiratory, offset by additional income of £0.6m for those drugs classed as cost and volume.

Non Pay:
There is a small £0.2m favourable variance in June 2021.

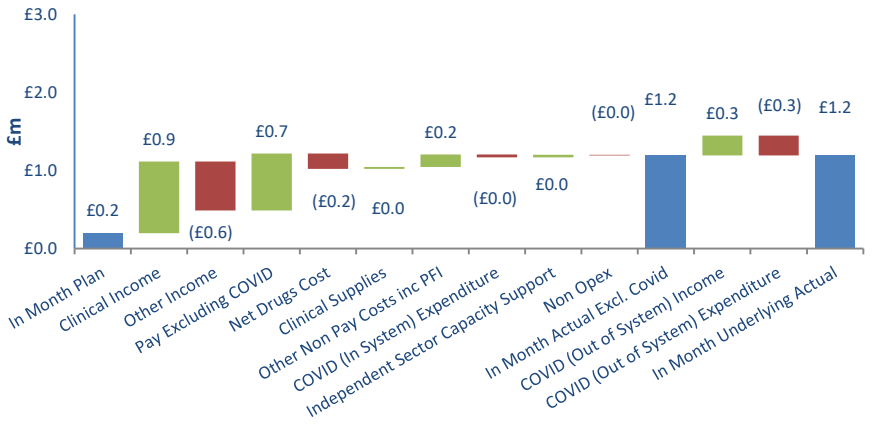
In System COVID 19 Expenditure:
There is a small adverse variance of <£0.1m for June 2021.

Independent Sector Capacity Support:
Independent Sector Capacity Support is on plan for June 2021.

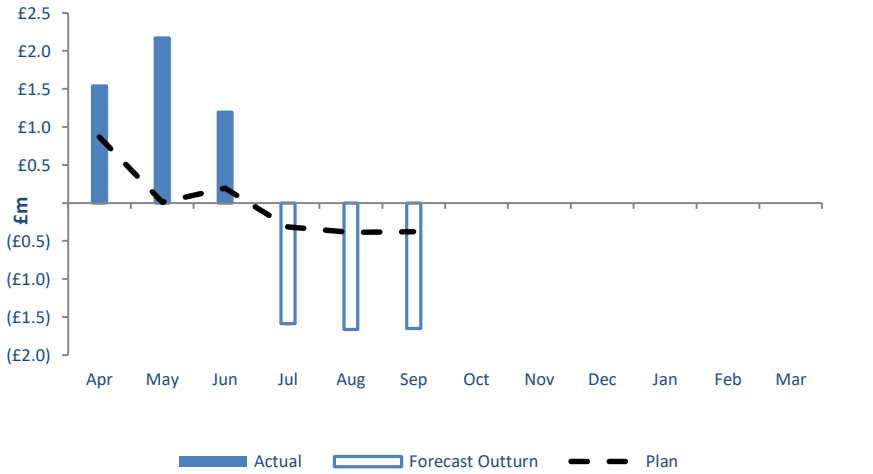
Non Operating Expenditure:
Non operating expenditure is on plan for June 2021.

Out of System COVID 19 Expenditure:
The COVID-19 expenditure in month is £0.3m, with offsetting income of £0.3m and therefore an in month breakeven position. The main area of expenditure remains and testing.

In Month Variance



Monthly Reported Surplus/(Deficit)



Norfolk and Norwich University Hospitals NHS Foundation Trust

2.2 Financial Performance – YTD

The year to date position on a control total basis as at June 2021 is a surplus of £4.9m. This is a £3.8m favourable variance to the planned £1.1m surplus. The favourable variance of £3.8m is made up of an underspend in Pay of £1.7m, clinical & non clinical supplies of £1.4m and clinical income of £1.5m, offset by reduced other income of £0.6m

Clinical Income:
Clinical Income is reporting a favourable variance of £1.5m year to date due to increased High Cost Devices recharged based on usage and is offset by additional clinical supplies expenditure.

Other Income:
There is a £0.6m adverse variance to plan year to date. This relates to a number of small adverse variances including reduced Education & Training and ASI both matched by reduced expenditure.

Pay:
Including COVID, there is a £1.7m favourable position against plan year to date. This comprises of a £0.4m adverse variance for In System COVID and IS capacity support, and an operational variance of £2.1m favourable relating to net vacancies against establishment mainly in CSS & Corporate. In June there were c. 920 vacancies across the Trust with c. 725 premium WTE thus net 195 WTE vacancy.

Net Drugs Cost:
There is a small £0.1m favourable variance year to date This is increased costs of £1.7m predominantly across neurosciences and respiratory, offset by additional income of £1.6m for those drugs classed as cost and volume.

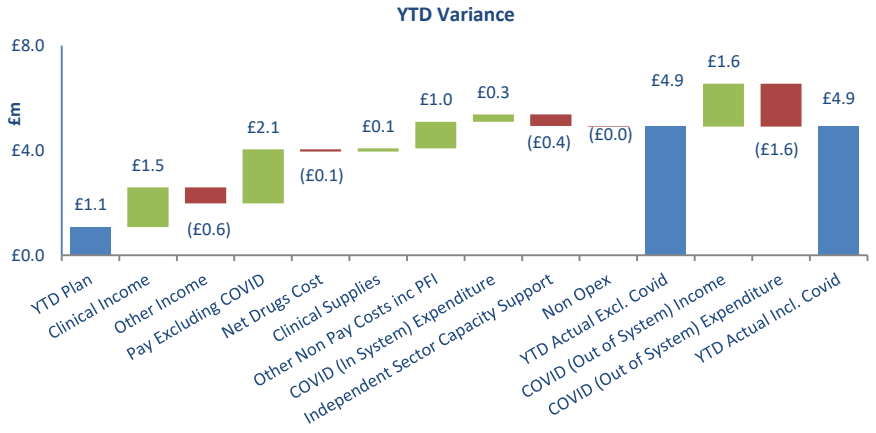
Non Pay:
Including COVID, there is a £1.4m favourable position against plan year to date. This comprises of a £0.4m adverse variance for IS capacity support, and an operational variance of £1.0m favourable of which the majority relates the full year effect of 20/21 CIP.

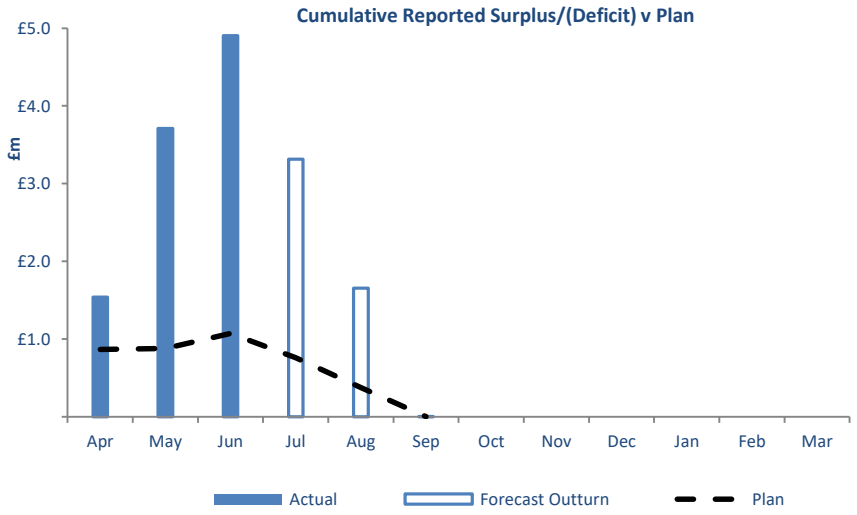
In System COVID 19 Expenditure:
In System COVID expenditure is on plan year to date.

Independent Sector Capacity Support:
Year to date there is an overspend of £0.4m. This is as a result of activity being delivered more quickly than was originally planned. The IS forecast outturn remains on plan for the period Apr-Sep with delivery being monitored weekly.

Non Operating Expenditure:
Non operating expenditure is on plan year to date

Out of System COVID 19 Expenditure:
The COVID-19 expenditure year to date is £1.6m, with offsetting income of £1.6m and therefore breakeven. Of this £0.7m has been spent in the vaccination programme and £0.8m on Testing





Norfolk and Norwich University Hospitals NHS Foundation Trust

2.3 Forecast Outturn H1

Forecast outturn remains on plan at breakeven. This has been risk assessed as an Upside Forecast Outturn of a £13.7m surplus, based on current run rates and committed expenditure. This is £13.7m favourable to the breakeven plan. However, assuming expenditure increases for the remaining months to fully spend the H1 budget, the risk adjusted forecast outturn would be a breakeven position. This would be in line with the operational plan.

1 **CIP Delivery/Operational Expenditure:** Additional Delivery of CIP/Operational Underspends - £6.1m

2 **Cost Pressure Budget:** Uncommitted Cost Pressure budget remains unused - £0.1m

3 **Restoration Reserve budget:** Underspend of Restoration Reserve budget - £2.0m

This results in a risk adjusted upside forecast outturn before ERF of a £8.2m surplus, £8.2m favourable to the operational plan of breakeven

4 **Elective Recovery Funds (ERF):** Potential £5.5m of additional income from Elective Recovery Funds based on prior year case mix assumptions and year to date activity delivered

This results in a risk adjusted upside forecast outturn including ERF of a £13.7m surplus, £13.7m favourable to the operational plan of breakeven

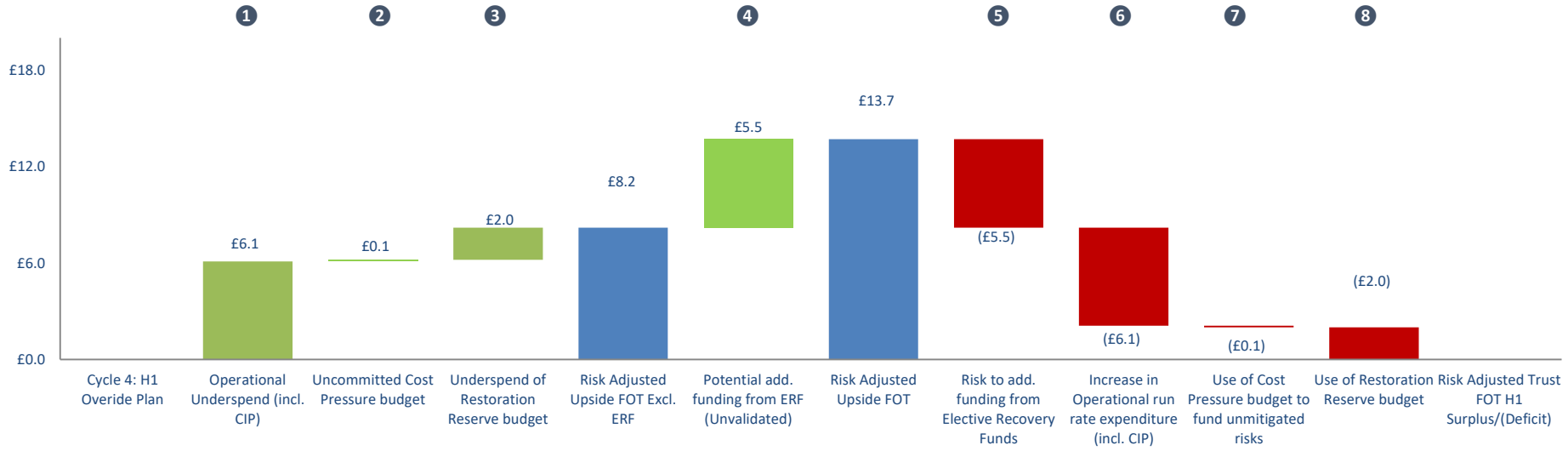
5 **Elective Recovery Funds:** Recognition of ERF is high risk due to 1) high level of uncertainty over case mix and work complete under ERF at this stage, 2) confidence in whole system performance and 3) system distribution of planned ERF not yet agreed

6 **Operational Expenditure/CIP Delivery:** Operational Expenditure run rate risk in line with accelerated restoration activity – (£6.1m)

7 **Cost Pressure Budget:** Use of cost pressure reserve to support unmitigated cost pressures – (£0.1m)

8 **Restoration Reserve budget:** Identification of additional restoration activities through divisional restoration clinics - £2.0m

This results in a forecast outturn of breakeven, in line with plan.



Norfolk and Norwich University Hospitals NHS Foundation Trust

2.4 Underlying Plan Analysis

The recent planning guidance confirms that Business Rules for H1 FY21/22 are the same as H2 FY20/21, with block top up funding arrangements to continue for six months. This guidance resulted in an updated plan - Cycle 4, being a break even position for the first six months of 2021/22, moving to a deficit of £55.0m for H2 as the plan reverts to normal business rules. This is based on an underlying planned deficit of £110.1m for 2021/22. Analysis below bridges the H1 plan to the underlying deficit.

1 **Cycle 4 H1 Plan:** Breakeven

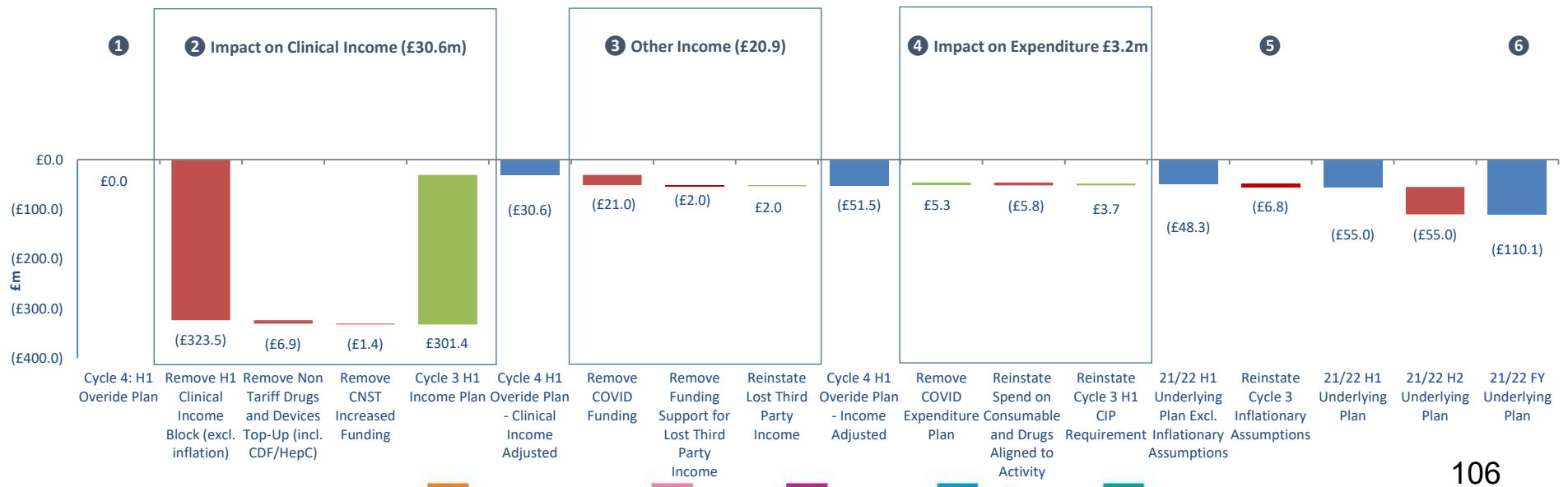
2 **Impact on Clinical Income** – The underlying plan included £301.3m of clinical income across commissioning contracts, including non tariff drugs. This has been replaced by £331.9m of system allocated block funding. **Reverting back to the underlying plan is a £30.6m adverse movement.**

3 **Other Income -** The system financial allocation includes £21.0m for In-system COVID, £2.0m of funding support for income loss, which is matched by a forecast reduction of £1.0m for private patient income and £1.0m for car parking, clinical excellence awards and small elements of provider to provider charges. **Reverting back to the underlying plan is a £20.9m adverse movement.**

4 **Impact on Expenditure** – H1 plan included £5.3m of in-system COVID expenditure offset by reduction in cost of £5.8m. This was calculated through a review of the variable non-pay expenditure included within H1 Cycle 3, in line with the activity trajectories outlined within the planning guidance from 70% of FY19/20 activity in April 2021 to 85% in July-September 2021. H1 efficiency requirement was a reduction of £3.7m against Cycle 3. **Reverting to back the underlying plan is a £3.2m favourable movement.**

5 **Inflationary Impact** – The planning guidance assumptions surrounding inflation resulted in a £6.8m positive impact. This was as a result of the removal of cycle 3 pay inflation of 2.8% (£6.1m) offset by £1.9m of inflation at 0.86%, and additional tariff of £2.5m at 0.86% blended tariff. **Reverting to back the underlying plan is a £6.8m adverse movement.**

6 **Annualised Underlying Deficit of £110.1m**



Norfolk and Norwich University Hospitals NHS Foundation Trust

3.1 Divisional Performance - Summary

The Medicine division is overspent YTD as a result of increased drug expenditure although this is offset by additional income centrally managed in the 'other' division. EUC is also overspent as a result of locum expenditure covering vacant ED shifts. The CSS division is underspent mostly as a result of vacancies. All other divisions are on plan or <£0.1m favourable to plan.

The below commentary is against the year to date position:

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

Medicine:

Net expenditure of £56.1m, £1.6m adverse against plan. Pay is underspent by £0.1m. Non Pay has an adverse variance of £1.8m, predominantly as a result of an increase in expenditure on specialised commissioned high cost drugs, which is offset by an increase in drugs income.

Emergency:

Net expenditure of £7.1m, £0.3m adverse against plan. This is driven by £0.2m of CIP underachievement and £0.2m of pay overspends, which is made up of £0.5m of ED medical overspend, driven by locums, offset by vacancy savings in other areas of the Division, notably, the Ops Centre and Integrated Discharge Team.

Surgery:

Net expenditure of £36.8m, £0.3m favourable against plan. Despite achieving the internal activity plan in the current & previous month, the Division continues to report a favourable variance against Non-Pay of £0.2m. Within Pay, the Division is reporting a £0.2m favourable Year to Date position following the transfer of additional session (WLI) costs to the COVID budget. CIP remains a challenge, the Division reporting £0.7m of savings achieved against the £7.8m annual target.

Women's & Children's:

Net expenditure of £13.7m, £0.1m favourable against plan. Pay is favourable against plan by £0.2m driven by the continuation of underspends still showing within Paediatric nursing due to vacancies. Small overspend in drugs of £0.1m.

Clinical Support:

Net expenditure of £23.0m, £1.7m favourable against plan. £1.4m of this is within Pay due to the number of vacancies across the division notably within Therapies Imaging, and Cellular Pathology, and £0.5m underspends in clinical supplies, due to reduced activity across both pathologies.

Corporate Incl. COVID:

Net expenditure of £28.7m, on plan year to date.

Other:

Other includes Clinical Income block and Top up funding along with R&D and the Trust Reserves. Net favourable variance of £3.6m mostly being £1.6m from additional income relating to cost & volume drugs income recognised based on usage, £0.9m FYE of 2020/21 CIP and £1.5m relating to additional clinical income for devices based on usage.

YTD Divisional Performance Excl. COVID	Medicine		Emergency & Urgent Care		Surgery		Women's & Children's		CSS		Corporate Incl. COVID		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	142.6	1.5	142.6	1.5
Other Income	0.7	0.1	0.0	0.0	1.4	(0.1)	0.2	0.1	3.4	0.2	2.0	(0.3)	43.7	(0.6)	51.5	(0.6)
Pay	(29.8)	0.1	(6.5)	(0.2)	(29.6)	0.2	(11.9)	0.2	(17.4)	1.4	(10.1)	(0.2)	(1.5)	0.2	(106.9)	1.7
Non Pay	(8.6)	0.0	(0.7)	(0.1)	(6.4)	(0.0)	(0.8)	(0.0)	(8.5)	0.1	(20.5)	0.5	(4.8)	0.9	(50.3)	1.4
Net Drugs Cost	(18.4)	(1.8)	(0.1)	(0.0)	(2.3)	0.2	(1.2)	(0.1)	(0.5)	(0.0)	(0.1)	(0.0)	4.4	1.6	(18.1)	(0.1)
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	(14.0)	(0.0)	(14.0)	(0.0)
YTD Surplus / (Deficit)	(56.1)	(1.6)	(7.2)	(0.3)	(36.8)	0.3	(13.7)	0.1	(23.0)	1.7	(28.7)	0.0	170.4	3.6	4.9	3.8
Actual (M1-6)	(56.1)	(1.6)	(7.2)	(0.3)	(36.8)	0.3	(13.7)	0.1	(23.0)	1.7	(28.7)	0.0	170.4	3.6	4.9	3.8
Apr-Sep FOT	(108.3)	0.0	(13.9)	0.0	(75.1)	0.0	(27.6)	0.0	(49.4)	0.0	(61.3)	0.0	335.6	0.0	0.0	0.0
CIP*	0.0	(0.6)	0.1	(0.2)	0.6	0.1	0.4	0.3	0.1	0.0	0.1	0.1	1.2	1.4	2.5	1.1
Inpatients*	22.4	2.0	0.0	0.0	9.2	0.5	6.1	2.0	0.0	0.0	-	-	-	-	37.8	4.5
Outpatients*	69.7	6.9	0.1	0.1	81.5	3.9	17.9	3.5	10.4	0.2	-	-	-	-	179.7	14.6
A&E*	0.0	0.0	36.4	0.3	0.0	0.0	0.0	0.0	0.0	0.0	-	-	-	-	36.4	0.3
CIP RAG																
FINANCE RAG**																
PAF RAG**																

*Variance against H1 plan submitted to regulator

**Activity variance against H1 Draft Activity plans (000's)

*** Prior Quarter PAF Rating

Norfolk and Norwich University Hospitals NHS Foundation Trust

3.2 Divisional Performance - Service Line Reporting 2020/21

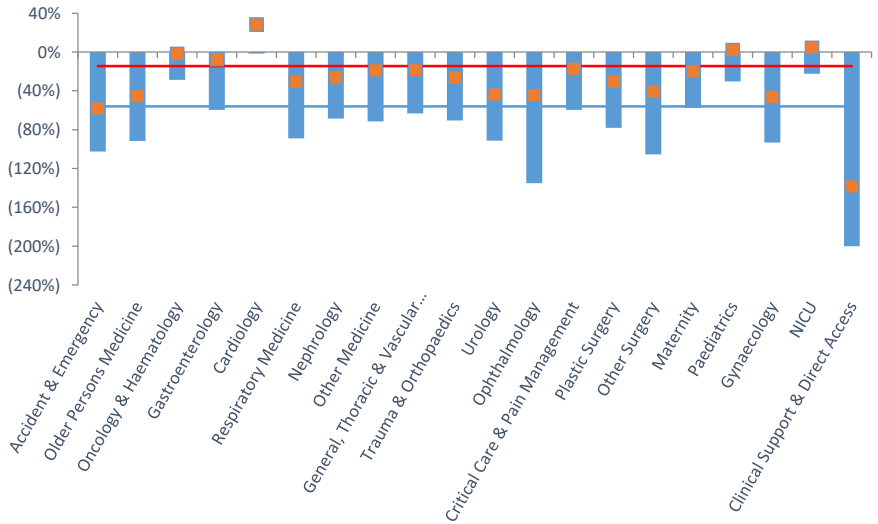
SLR data for the period April-March 2020/21 reflects the impact of COVID. All Divisions reported a deficit for contribution (Income less controllable costs) due to reduced activity levels within the same cost base.

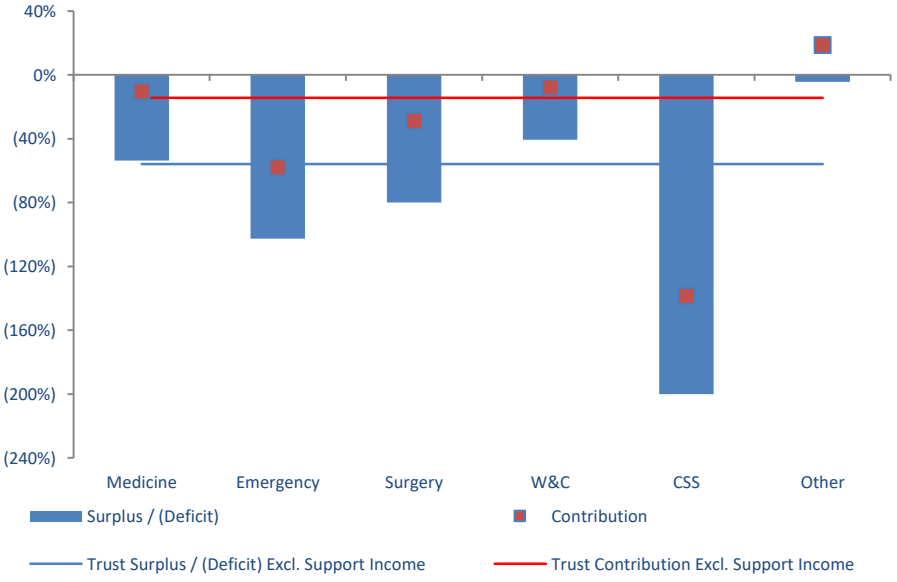
The impact of Covid in the New Year was a fall in activity and PBR-based income of 10-15% in Q4 compared to Q3, with Surgery most affected. This level of activity and income was 20% below 2019/20 levels, whilst costs increased, resulting in negative levels of contribution throughout 2020/21 as follows:

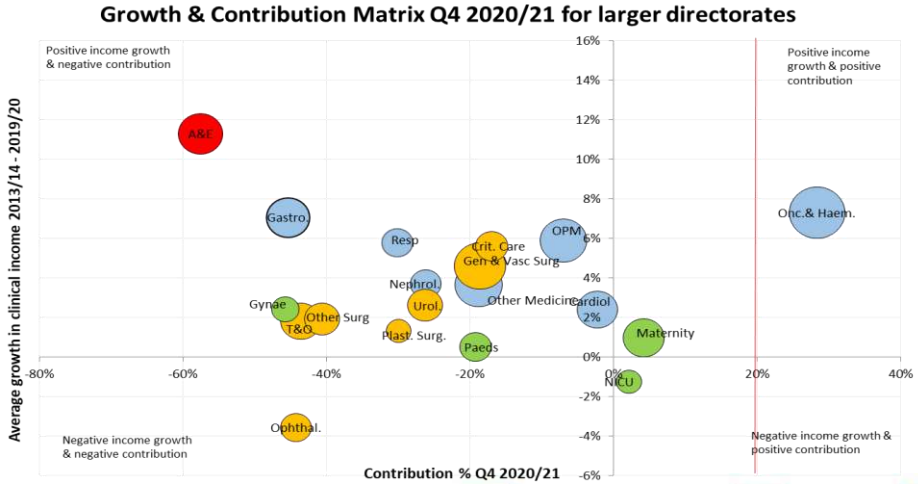
Division	% of 'PbR' Income	19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	20/21 Contribution
Medicine	6.4%	14%	(26%)	(4%)	1%	(16%)	(10%)
Emergency	47.0%	(35%)	(92%)	(35%)	(52%)	(58%)	(58%)
Surgery	27.4%	6%	(77%)	(29%)	(13%)	(13%)	(29%)
Women & Children's	18.9%	5%	(25%)	(5%)	1%	(5%)	(8%)
Clinical Support	0.4%	(61%)	(203%)	(100%)	(84%)	(219%)	(138%)

It is hard to compare with pre-COVID performance, so trends from quarter to quarter are 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

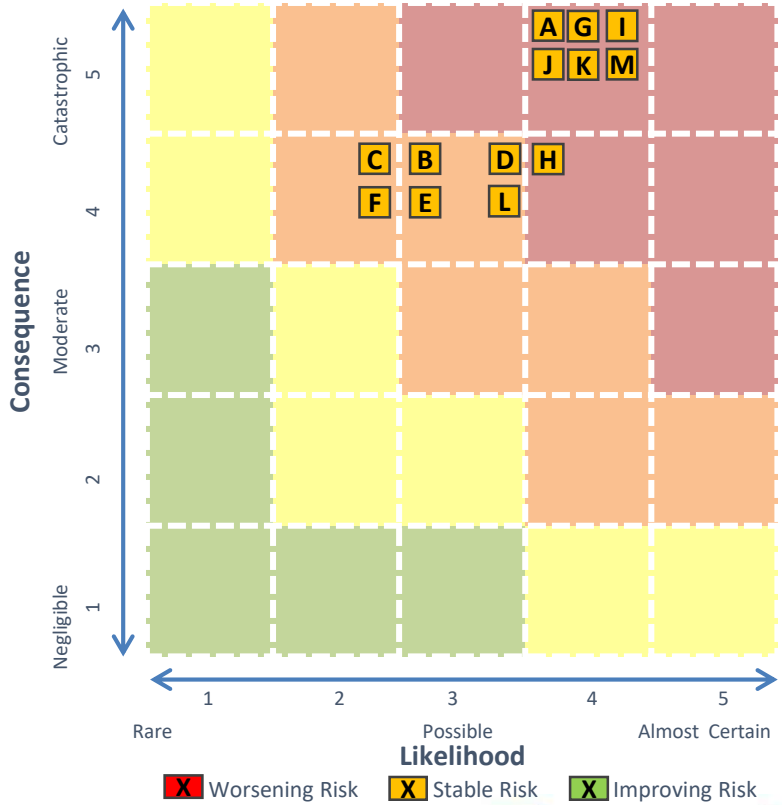
4. Strategic Financial Risks

The Trust's overall risk profile remains stable, with no changes in risk scoring in month.

As part of FY21/22 annual planning 13 key strategic and operational risks with an initial score of ≥ 12.

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

As part of the monthly review of the Financial Risk Register, there were no changes in risk scoring in the month.



	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	1534	IF the Trust is unable to generate the FY21/22 planned activity and case mix, THEN the income generated may be lower than planned levels.	12	12
C	1535	IF the Trust is unable to deliver the FY21/22 required activity levels per the national recovery framework, THEN additional funding available through the Elective Recovery Fund may not be available to invest back in recovering activity.	8	8
D	1536	IF the Trust's capacity plan does not reflect the available clinical space and workforce effective hours, THEN there is a risk that activity assumptions underpinning the FY21/22 plan are not valid, potentially leading to lower levels of income or higher levels of costs than planned through the use of third party capacity.	12	12
E	1539	IF the Trust does not deliver forecast activity growth levels within the identified cost envelope or IF there is a change in case mix to less profitable procedures, THEN this will lead to lower income as a proportion of cost levels driving a higher deficit than planned.	12	12
F	1540	IF the Trust creates additional capacity at additional cost to the Trust in order to reduce the waiting list, and does not secure the financial resources for this, THEN this will create additional cost pressures which will need to be mitigated through additional efficiency delivery, or the Trust will incur a higher deficit than planned.	8	8
G	1532	IF the Trust fails to control expenditure in line with the plan, including mitigation of identified but unfunded cost pressures, THEN the Trust will fail to deliver to plan, negatively impacting the I&E and cash position and increasing the distress funding requirement.	20	20
H	1533	IF the Trust enacts service developments or changes that result in an increase in cost that is not mitigated by a corresponding increase in the value of the Trust's income contracts, THEN the financial position will be negatively impacted.	16	16
I	1527	IF the efficiency requirement is not identified and delivered on an annual basis THEN the Trust is at risk of significantly failing its I&E and cash plans, alongside delivery of the Trust's Financial Strategy.	20	20
J	1529	IF the Trust does not deliver the financial improvements within its own control, THEN the access to technical solutions, including FRF, may no longer be available.	20	20
K	1526	IF the Trust is unable to manage its financial performance in line with the Operational Plan, THEN there is a risk that the Trust will require additional distress funding to meet its financial obligations.	20	20
L	1528	IF the Trust cannot secure sufficient emergency capital PDC to support the delivery of the capital programme, THEN the planned capital programme will be delayed, negatively impacting the ability to deliver planned activity levels and increasing costs leading to additional pressure to financial performance.	12	12
M	1548	IF additional or revised regulatory requirements do not align with the framework utilised in developing the Financial Strategy THEN additional financial pressures may arise, negatively impacting the Trust's ability to deliver sustainable financial improvement.	20	20

Norfolk and Norwich University Hospitals NHS Foundation Trust

5. Cash

Cash held at 30 June 2021 is £51.3m. The closing balance is £4.5m above plan for the following main reasons: cumulative operational underspends in 2020/21, exceptional capital creditors, accruals and levels of general debt. This is forecast to continue through H1, thus the cash position at 30 September is forecast to be £44.2m, £3.5m higher than plan.

Cash Financial Arrangements - financial envelope for 2021/22 – first half year to 30 September 2021

A financial settlement for the NHS has been agreed for the first half year of 2021/22. It is a fixed system envelope arrangement as was in place for the second six months of 2020/21. Our financial allocation has been confirmed and is consistent with that received in 2020/21, increased for inflation, growth and efficiency.

The settlement for the second half year will be finalised once there is greater certainty around the operational circumstances facing the NHS at that time.

The Trust draft operational plan for the six months to 30 September 2021 shows a break even position. As a result it is not expected that any revenue cash support will be required during H1. The cash flow plan for this period showed a closing cash balance at 30 September 2021 of £40.7m.

The twelve month rolling cash flow forecast before revenue funding support shows the cash balance reducing during the second half year to negative funds of £37.3m at end June 2022, thus revenue support would be required.

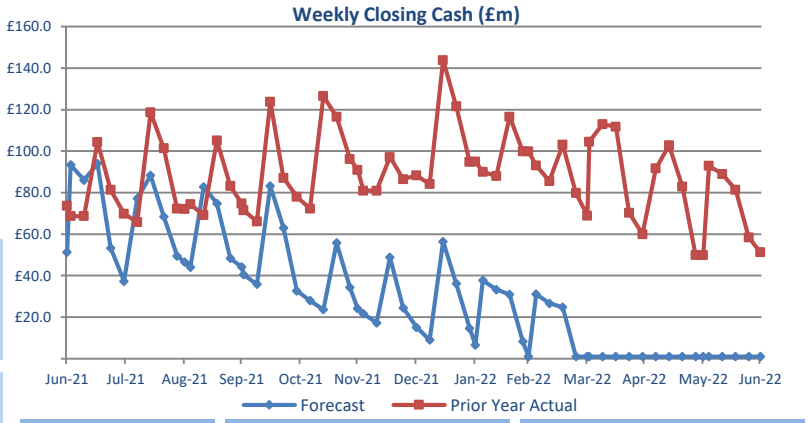
Cash balances are forecast to become negative in March 2022 thus revenue support would be required from that period onwards to ensure we have the minimum headroom of £1m at all times. This has been assumed and is reflected in the cash forecast graph alongside.
The deterioration in cash position in the second half year relates to the assumption that the block funding and top up arrangements will cease and will revert to PbR. This accounts for @ £38m of the reduction in funding assumed.

The availability of funding has been properly considered and guidance issued by NHSE/I in March 2021 stated that 'where providers do require supplementary revenue cash support providers will be able to apply for revenue cash support from DHSC via the NHSE/I capital and Cash team. Therefore should the Trust require additional support , there are mechanisms in place to access this.

The forecast will firm up as funding arrangements become more clear.

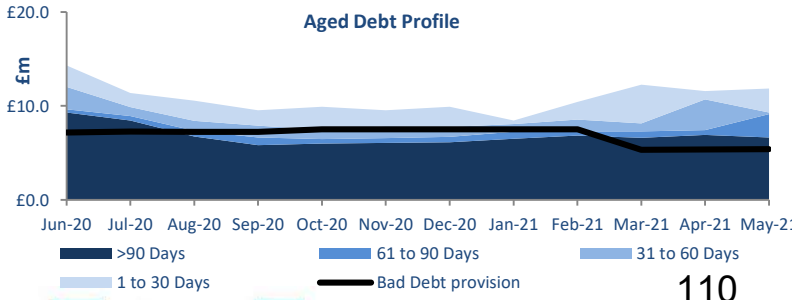
Capital - The Trust's draft capital plan includes identified funding streams for all expenditure. The receipt of funding is subject to a national process, therefore the cash flow forecast for capital is based on best understanding on the timing of approvals. Accordingly this may change, however it should not impact the cash flow significantly overall as expenditure can mostly be managed to align with funding.

Aged Debt - Debtors at June 2021 are £11.5m, of which £6.9m is over 90 days. Of the NHS debt greater than 90 days, £1.2m is JPUH, decrease of £0.4m 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 £1.0m relates to private/overseas patients. The Trust continues to focus on resolving these debts.



Debtors by Type	Total Debt			Debt > 90 days		
	Apr-21 £m	May-21 £m	Jun-21 £m	Apr-21 £m	May-21 £m	Jun-21 £m
NHS	3.91	4.40	4.88	1.81	1.95	1.94
Non NHS	7.68	7.45	6.64	5.09	4.68	4.99
Total	11.59	11.85	11.52	6.90	6.63	6.93

Better Payments Practice Code YTD	No. of Invoices			£m		
	Total Invoices Paid	Total Invoices paid within target	Performance %	Total Invoices Paid	Total Invoices paid within target	Performance %
NHS	800	686	85.8%	19,310	16,001	82.9%
Non NHS	31,051	29,618	95.4%	85,931	78,222	91.0%
Total	31,851	30,304	95.1%	105,241	94,224	89.5%



Norfolk and Norwich University Hospitals NHS Foundation Trust

6.1 Activity (Income PbR)

The Trust continues to be measured against the activity targets set by NHSE for 2021/22 H1. The target for June 2021 being 80% of 2019/20 activity levels. Provisional figures for the first quarter (Apr to Jun) indicate that the Trust has exceeded the targets overall, although not across every point of delivery – Elective Inpatient particularly still representing a challenge. Early estimates have also been calculated for the Elective Recovery fund and these also reflect that targets have been exceeded, this presents the possibility of the Trust receiving some additional funding, although still subject to overall system performance and NHSE/I sign-off. Overall elective activity levels are ahead of plan at Month 3.

Income for the first half of 2021/22 continues to be set nationally, in the form of block (fixed) funding. Whilst National Tariff guidance has been published with proposals for the 2nd half of the financial year there has still been no definitive guidance to detail what funding arrangements will be from October.

Whilst block funding remains in place, activity expectations have been set by NHSE/I, with targets for June being 80% of 2019/20 activity levels – across Elective (including Day Case) and Outpatients areas. In the event that these targets are exceeded there is potential for additional funding through the Elective Recovery Fund. It is important however to note that performance is calculated on value of activity , not activity count and case-mix will therefore be significant.

Performance v 2021/22 Base Plan

Despite being block funded, full contract monitoring processing and reporting will still be completed so that true levels of activity and income can be understood – i.e. had the Trust been paid on a Payment by Results (PbR) basis. Currently these figures are based on a mixture of the 2021/22 Consultation Tariffs and in the absence of negotiations with Commissioners, some assumptions around locally agreed pricing. A clinical income 'Base Plan' for 2021/22 has been derived from the 2020/21 draft annual plan, with some known changes reflected. A tariff inflator assumption of +1.4% has been used and demographic growth assumptions of +0.54% (based on expected population increase from ONS stats).

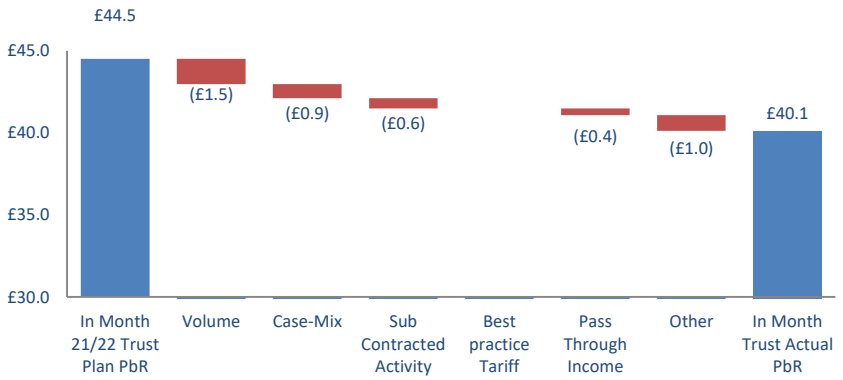
It must be noted that the figures on this and the next slide relate to NNUH activity only, and do not include any activity undertaken in the Independent Sector, nor Acute Service Integration.

The graphs opposite shows that 'actual' performance would be below the base plan for June 2021, and 2021/22 year to date (Apr and May). The variance to plan remains much improved from that seen in 2020/21, With percentage of plan achieved being 90% in June (92% in May). The case-mix variance is provided for illustrative purposes, but it is currently very difficult to forecast what the actual case-mix will be with varying priorities and factors associated with recovery causing the case-mix to be different to what was seen prior to the start of the COVID pandemic.

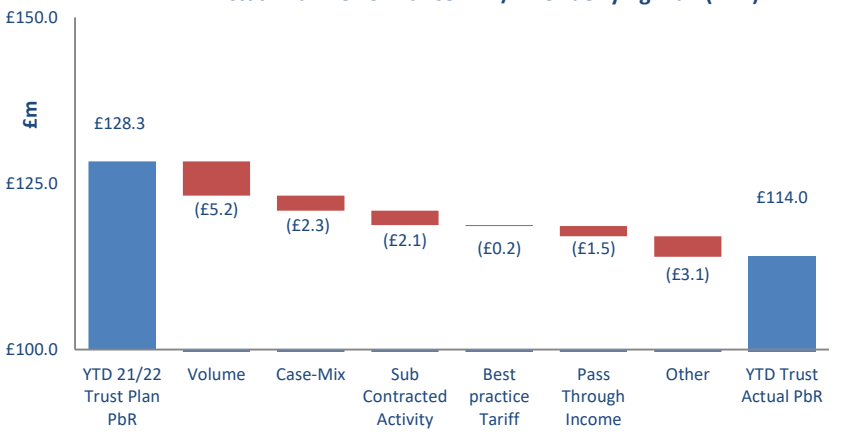
Elective Recovery Fund

Calculations have been undertaken based on NNUH performance against the NHSE requirements which indicate that there is the potential for additional funds to be received, estimates are for April and May are £2.4m and £2.3m respectively, figures which have been validated with system colleagues. Early provisional figures for June shows potential for additional funds of £0.8m. It must be noted however that this is still subject to system wide performance and NHSE/I sign-off before we have a finalised result. A recent notification has been received from NHSE and the threshold for additional funding has increased to 95% of 2019 levels with effect from 1st July 2021.

In Month PbR Performance v 21/22 Underlying Plan (YTD)



Actual PbR Performance v 21/22 Underlying Plan (YTD)



Norfolk and Norwich University Hospitals NHS Foundation Trust

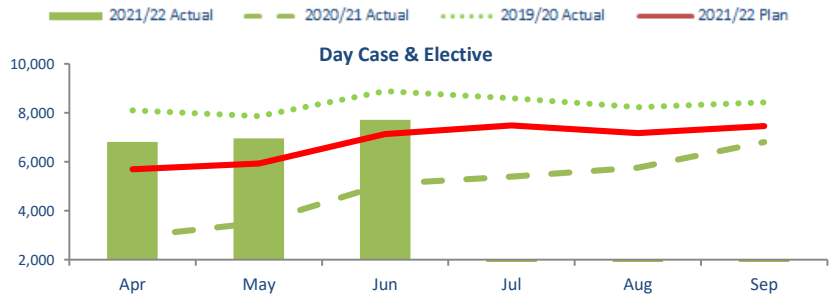
6.2 Activity - POD

Activity in the first half of 2021/22 is to be measured against 2019/20 base-line, with expectations set by NHSE as a percentage of 2019/20 levels (adjusted for working days) Starting with 70% target in April rising by 5% each month, with 85% being highest target. The Trust has developed its own recovery plan. Actual results to be measured against both, with comparisons to 2019/20 and 2020/21 activity levels also provided for information.

Day Case & Elective Inpatient Spells

Provisional figures for June indicate that Day Case activity levels will exceed both NHSE expectations, and the Trust's recovery plan. Both Medical and Women & Children Divisions exceeded the NHSE targets, but Surgical Division falling short of the NHSE target. The graph opposite does however reflect that activity levels continue to fall short of those in 2019/20.

The number of Elective Inpatient spells however does remain much lower than that seen in 2019/20, with the NHSE compliance targets not being met across most specialties, exception being Gynaecology. In terms of the Trust's own activity plan, over performance in Day Case activity is masking the fact that the Elective Inpatient plan is not being met.



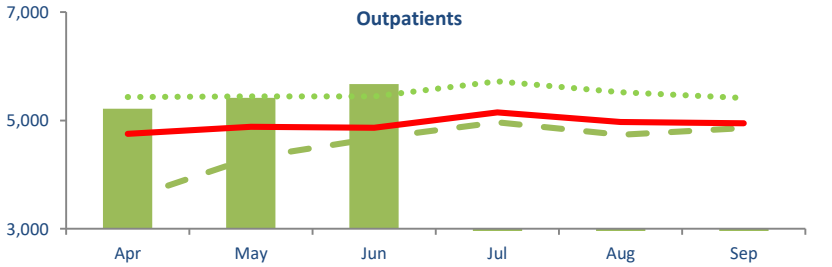
Outpatient Activity

Provisional figures for June indicate that outpatient activity levels will exceed the NHSE expectations (80%), including the target for attendances at which a procedure is undertaken.

Appointments with a procedure are expected to be 88% of 2019/20 levels. New attendances, without a procedure are expected to be 82% of 2019/20 levels and Follow Up 96%.

Strong performances seen in Cardiology and Urology. ENT is still finding it challenging to reach previous levels of outpatient procedures. Ophthalmology is seeing mixed results with over performance expected for attendances where a procedure is undertaken, but under performance in general attendances.

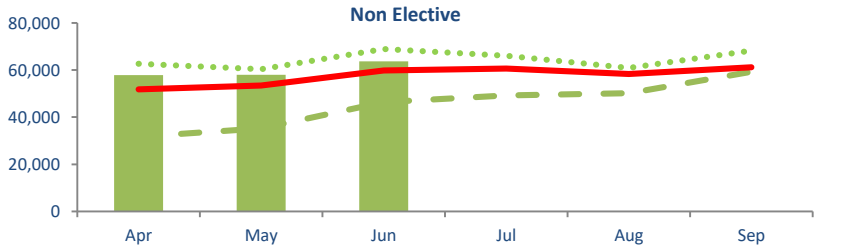
It is noticeable that the estimates indicate that the Trust's internal plan will not be met for new (97% of Trust's plan) or follow up (99%) attendances without a procedure.



Non Elective Spells (Including Maternity)

It can be seen from the graph opposite that non elective activity has increased from that seen in 2020/21. The graph opposite shows that activity in May and June exceeded that seen in 2019. Activity levels overall are very much back in line with the monthly average seen in 2019.

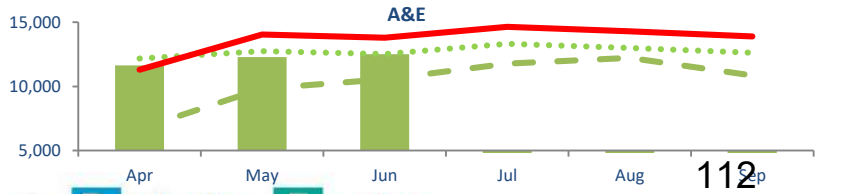
When comparing non-elective spell count in June 2021 to that seen in 2019/20 it is noticeable that Women & Children division is seeing a significant increase on 2019/20 levels. Medical Division is seeing similar levels to those in 2019/20 and Surgical Division, once allowing for a change in recording of EAUS activity, is seeing higher demand than in 2019/20, although not to the extent seen in Women & Children.



A&E (Emergency Department

A&E activity levels in June 2021 have continued the recent trend of increasing activity levels, returning to near 2019 levels. Activity levels in June were in 99.7% of June 2019 levels.

The Trust's recovery plan for A&E shows an expected increase in activity from May onwards, with expectations of increase in attendances as COVID lockdown restrictions are eased over the coming weeks.



Norfolk and Norwich University Hospitals NHS Foundation Trust

7. CIP

Year to date the Trust has delivered £2.5m of CIPs against a budgeted plan of £1.4m, a positive variance of £1.1m, comprised of: a planning variance of nil; and a performance variance of £1.1m. This has arisen through accelerated delivery of additional CIP above budgeted plan offset by adverse performance in pay and discretionary spend initiatives. The risk adjusted forecast outturn CIP delivery is currently £13.1m against a CIP target of £26.4m presenting a significant risk to achievement of the target.

FY21/22 CIP Performance:

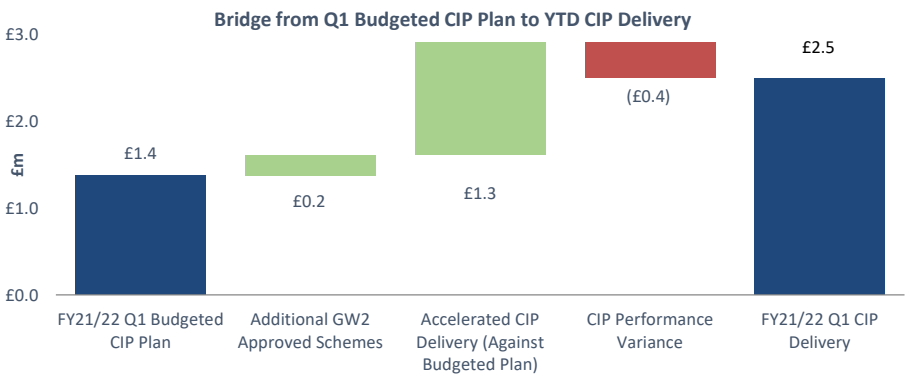
YTD the Trust has delivered £2.5m of CIPs against a budgeted plan of £1.4m, a positive variance of £1.1m, comprised of:

- A planning variance of nil; and
- A performance variance of £1.1m, see bridge below. This has arisen through:
  - £1.3m of accelerated CIP delivery above budgeted plan;
  - £0.2m of additional delivery through schemes developed since finalising budgeted plan;
  - Offset by £0.4m of adverse performance against budgeted schemes across pay and discretionary spend initiatives.

The risk adjusted forecast outturn CIP delivery for FY21/22 is currently calculated as £13.1m based on the latest forecast financial performance of Gateway 2 schemes, progress against milestone delivery and performance against quality and performance indicators.

FY21/22 CIP Plan Development

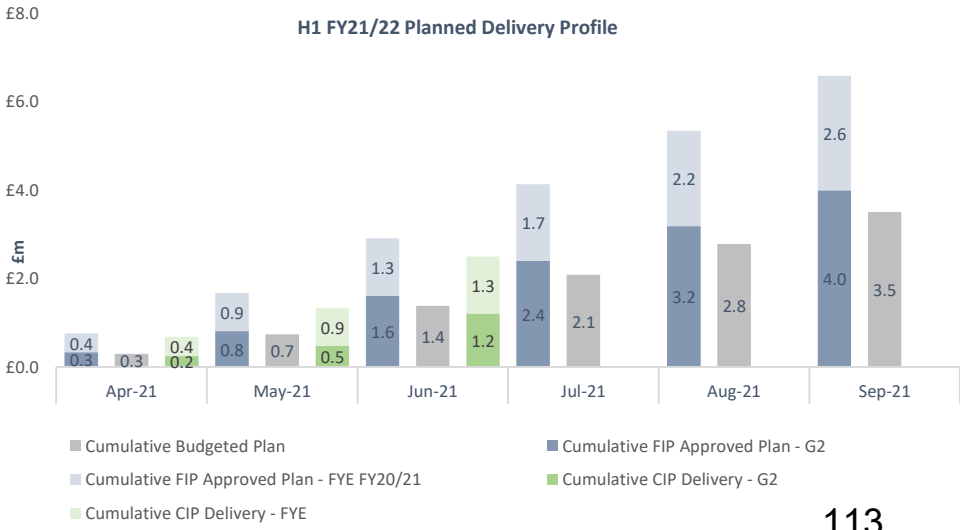
Due to the significant planning risk surrounding the efficiency programme as the Trust continues to develop plans, a CIP hedge of £13.8m has been offset against the £26.4m programme within the annual plan (Cycle 4).



As at 12 July 2021, the programme consists of £10.9m of Gateway 2 approved schemes; £5.2m of FYE of FY20/21 schemes; £2.9m of Gateway 1 approved schemes, which are being reviewed and developed to be progressed or removed from the programme; and £0.9m of schemes within the CIP development pipeline (Gateway 0).

The initiatives that comprise these values are subject to revision as a result of any revisions to planning guidance or national priorities.

FY21/22 CIP Plan - Divisional Breakdown	FY21/22 Indicative Target £m	FY21/22 FIP Board Approved £m	FYE FY20/21 £m	Gap £m	FY21/22 RAG Adj. Forecast Delivery £m	Gap £m
Medicine	7.2	6.0	2.4	1.2	7.0	(0.2)
Emergency & Urgent Care	1.1	0.8	0.3	0.0	0.9	(0.2)
Surgery	7.8	2.5	1.5	(3.8)	3.0	(4.8)
Women's & Children's	2.7	0.7	0.2	(1.8)	0.6	(2.1)
CSS	4.1	0.6	0.5	(3.0)	1.1	(3.0)
Corporate	3.5	0.3	0.2	(3.0)	0.5	(3.0)
Total	26.4	10.9	5.1	(10.4)	13.1	(13.3)



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 programme as at 30 June 2021. The programme was approved by the Trust Board via cycle 4 of the financial planning process, totalling £52.4m.

A number of minor variations resulting from 2020/21 year-end adjustments were incorporated into the Trust's capital programme as part of cycle 4 budget setting. These represent a change to the programme submitted to NHSE/I on 12 April 2021.

YTD NHSEI Plan £'000	YTD Actual £'000	YTD Variance £'000	YTD Re-profiled Plan £'000	YTD Actual £'000	YTD Variance £'000	FY Plan £'000	FY OT £'000	FY Variance £'000
25,691	21,715	(3,976)	21,910	21,715	(195)	52,434	52,433	(1)

Year to date performance – 30 June

The Trust has underspent against the Plan by £0.2m YTD. The key driver of the YTD variance is an underspend of £0.1m on the CT and MR replacement programme.

Forecast Outturn

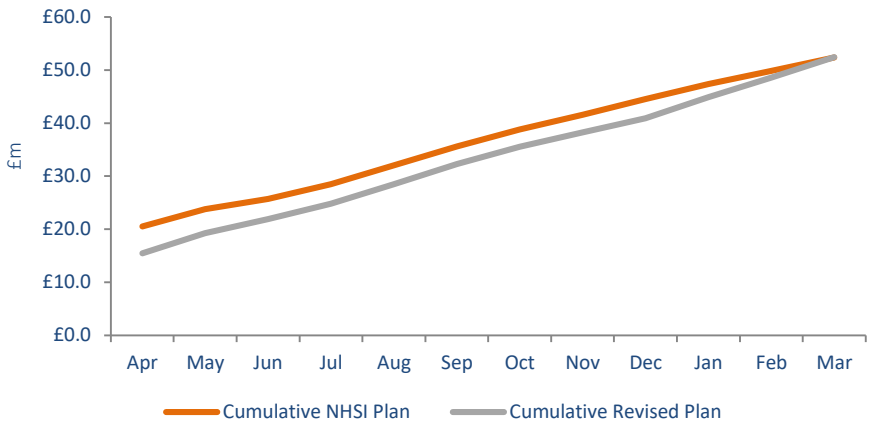
The current forecast is to deliver an outturn of £52.434m (unchanged from the previous month), against an initial plan of £52.372m. The difference of £0.061m is as a result of the Trust receiving a revised MOU for the Diagnostic and Assessment Centres, which is centrally funded and does not impact the Trust's allocation of system CDEL. The funding to back the plan is currently at risk as the Trust is unable to draw down the PDC assumed in the plan of £3.301m due to cash balances held and has been advised it will need to defer this application with the impact being the Theatre and backlog works would be proceeding at risk.

The chart to the right provides details of confidence ratings of delivery across two domains:

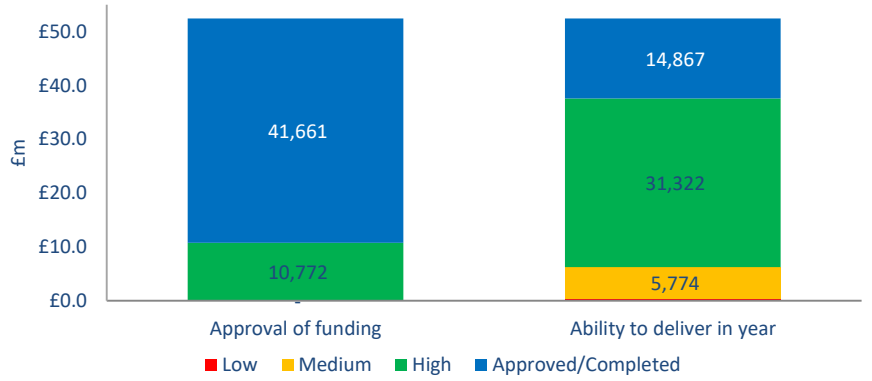
- An assessment based on approval of funding - £41.7m has been approved (unchanged from the previous month), which includes internally generated funding and the distress PDC already secured. £3.8m is yet to be approved for Digital Aspirant and is risk rated as high confidence of approval as the Trust has agreed the LOA. The remaining £7m is yet to be approved and risk rated a medium confidence of approval. This includes £6.3m of distress funding, being £3.2m carried forward from 20/21 and £3.1m for new funding. The £7m also includes £0.7m of DAC PDC for the FBC development. This is unchanged from the previous month.
- An assessment based on the ability to deliver the projects – at present, four schemes have a medium deliverability rating and another four have a low deliverability rating.

Scheme leads have reviewed each scheme within the programme and assessed delivery, which is reflected in the charts to the right. Based on their assessments, overall there is high confidence of the forecast programme as being deliverable. However, given the 2020/21 performance, the Finance team have implemented a new forecast process. The M3 forecast reflects scheme lead input into this revised process to date. To date, five schemes have been completed, being the PFI lifecycle capitalisation of £14.7m, £0.01m for Ward Block MTX Variations, £0.03m for planting around the Isolation Unit/Ward Block, £0.143m for Fetal Medicine and £0.007m for the paediatric intercom.

NHSI Plan v Revised Plan



Confidence Rating



Norfolk and Norwich University Hospitals NHS Foundation Trust

9.1 Statement of Comprehensive Income

The year to date position on a control total basis as at June 2021 is a surplus of £4.9m. This is a £3.8m favourable variance to the planned £1.1m surplus. The favourable variance of £3.8m is made up of an underspend in Pay of £1.7m, clinical & non clinical supplies of £1.4m and clinical income of £1.5m. £1.6m of out of system COVID expenditure is offset by £1.6m of income. The headline surplus which includes donated income of £1.0m and donated asset depreciation of £0.4m is £5.5m.

	In Month Month 3 - June 2022			Year to Date			Forecast Outturn April 2021 - September 2021		
	Actual £m	Trust Plan £m	Variance £m	Actual £m	Trust Plan £m	Variance £m	FOT £m	Trust Plan £m	Variance £m
Clinical Income	48.0	47.0	0.9	142.6	141.1	1.5	282.3	282.3	0.0
NT Drugs Income	1.5	0.9	0.6	4.4	2.8	1.6	5.6	5.6	0.0
Total Clinical Income	**49.5**	**48.0**	**1.5**	**147.0**	**143.9**	**3.1**	**287.8**	**287.8**	**0.0**
Other Income Incl. Non NHS Clinical Income	16.9	17.6	(0.6)	51.5	52.1	(0.6)	108.3	108.3	0.0
Total Operating Income	**66.5**	**65.5**	**0.9**	**198.5**	**196.0**	**2.5**	**396.2**	**396.2**	**0.0**
Medical Staff	(11.4)	(10.9)	(0.5)	(34.4)	(32.8)	(1.5)	(65.6)	(65.6)	0.0
Nursing	(13.5)	(13.8)	0.3	(40.8)	(41.7)	0.9	(83.0)	(83.0)	0.0
A&C	(4.3)	(4.3)	0.1	(12.5)	(13.1)	0.6	(26.0)	(26.0)	0.0
Other Staffing Groups	(6.1)	(6.4)	0.2	(18.5)	(19.1)	0.6	(38.2)	(38.2)	0.0
Other Employee Expenses	(0.3)	(0.7)	0.4	(0.8)	(1.8)	1.1	(4.4)	(4.4)	0.0
Total Employee Expenses	**(35.5)**	**(36.1)**	**0.6**	**(106.9)**	**(108.5)**	**1.7**	**(217.3)**	**(217.3)**	**0.0**
Drugs Costs	(7.8)	(6.9)	(0.8)	(22.5)	(20.8)	(1.7)	(41.6)	(41.6)	0.0
Clinical Supplies	(6.4)	(6.6)	0.2	(18.6)	(19.5)	0.9	(40.3)	(40.3)	0.0
Non Clinical Supplies	(8.5)	(8.8)	0.3	(25.0)	(25.5)	0.5	(54.4)	(54.4)	0.0
PFI	(2.4)	(2.2)	(0.2)	(6.7)	(6.7)	(0.0)	(13.4)	(13.4)	0.0
Total Expenditure Excl. Employee Expenses	**(25.1)**	**(24.6)**	**(0.5)**	**(72.7)**	**(72.4)**	**(0.3)**	**(149.6)**	**(149.6)**	**0.0**
Total Operating Expenditure	**(60.6)**	**(60.7)**	**0.1**	**(179.6)**	**(181.0)**	**1.4**	**(366.9)**	**(366.9)**	**0.0**
Total Operating Surplus/(Deficit)	**5.9**	**4.9**	**1.0**	**18.9**	**15.1**	**3.9**	**29.2**	**29.2**	**0.0**
Total Non Operating Expenditure	(4.7)	(4.7)	(0.0)	(14.0)	(14.0)	(0.0)	(29.2)	(29.2)	0.0
Total Surplus/(Deficit)	**1.2**	**0.2**	**1.0**	**4.9**	**1.1**	**3.8**	**(0.0)**	**(0.0)**	**0.0**
COVID (Out of System) Income	0.3	0.0	0.3	1.6	0.0	1.6	1.6	0.0	1.6
COVID (Out of System) Expenditure	(0.3)	0.0	(0.3)	(1.6)	0.0	(1.6)	(1.6)	0.0	(1.6)
Total Surplus / (Deficit)	**1.2**	**0.2**	**1.0**	**4.9**	**1.1**	**3.8**	**(0.0)**	**(0.0)**	**(0.0)**
Control Total Adjustments									
Donated Income & Equipment	0.0	0.3	(0.3)	1.0	2.4	(1.4)	2.7	2.7	0.0
Donated Assets Dep'n	(0.1)	(0.1)	(0.0)	(0.4)	(0.3)	(0.1)	(0.5)	(0.5)	0.0
Headline Surplus / (Deficit)	**1.1**	**0.4**	**0.6**	**5.5**	**3.2**	**2.3**	**2.2**	**2.2**	**0.0**
NHSEI Adjustments									
Donated Income & Equipment	(0.0)	(0.3)	0.3	(1.0)	(2.4)	1.4	(2.7)	(2.7)	0.0
Donated Assets Dep'n	0.1	0.1	0.0	0.4	0.3	0.1	0.5	0.5	0.0
Provider Top Up Funding	0.0	1.7	(1.7)	0.0	1.7	(1.7)	0.0	3.4	(3.4)
System Envelope Planning Adjustment	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(3.4)	3.4
Adjusted Financial Performance Surplus/(Deficit) (NHSEI Reporting)	**1.2**	**1.9**	**(0.7)**	**4.9**	**2.8**	**2.1**	**(0.0)**	**(0.0)**	**0.0**

Norfolk and Norwich University Hospitals NHS Foundation Trust

9.2 Pay Expenditure

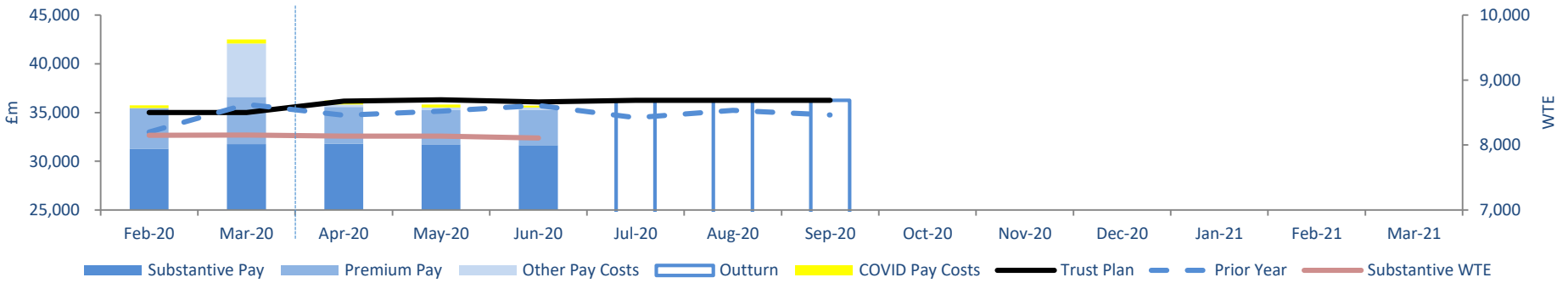
Year to date expenditure is £106.9m, a favourable position to plan of £1.4m. Predominantly as a result of vacancies against establishment in CSS.

Pay Expenditure (Excl. Out of System COVID)	Feb-21 £m	Mar-21 £m	Apr-21 £m	May-21 £m	Jun-21 £m	Jul-21 £m	Aug-21 £m	Sep-21 £m	FY £m
Substantive staff	**31.3**	**31.8**	**31.8**	**31.7**	**31.7**				**95.2**
Medical Internal Locum Staff	1.2	1.6	1.0	1.0	0.6				2.6
Medical External Locum Staff	0.2	0.2	0.1	0.1	0.2				0.5
Additional Medical Sessions	0.5	0.4	0.3	0.5	0.5				1.2
Nursing Bank Staff	1.2	1.5	1.3	0.0	0.0				1.3
Nursing Agency Staff	0.1	0.1	0.1	0.0	0.0				0.1
Nursing Overtime	0.3	0.2	0.4	0.2	0.3				
Other Bank (AHPs/A&C)	0.2	0.3	0.2	1.4	1.4				3.0
Other Agency (AHPs/A&C)	0.2	0.5	0.2	0.3	0.4				0.9
Other Overtime (AHPs/A&C)	0.2	0.2	0.1	0.1	0.2				0.4
Premium Pay	**4.2**	**4.8**	**3.8**	**3.5**	**3.6**				**10.9**
Total Direct Pay Costs	**35.5**	**36.6**	**35.6**	**35.3**	**35.3**				**106.1**
Redundancy	0.0	0.0	0.0	0.0	0.0				0.0
Apprenticeship Levy	0.1	0.1	0.1	0.1	0.1				0.4
Local CEA	(0.2)	0.4	0.1	0.1	0.1				0.3
Annual Leave, Flowers & Other	0.0	4.8	0.0	0.0	0.0				0.0
Total Other Pay Costs	**(0.1)**	**5.3**	**0.2**	**0.3**	**0.3**				**0.8**
Total Pay Costs - Actual	**35.4**	**41.9**	**35.8**	**35.5**	**35.5**				**106.8**
Total Pay Costs - Plan	**35.9**	**35.9**	**36.2**	**36.3**	**36.1**	**36.3**	**36.3**	**36.3**	**217.3**
Favourable / (Adverse) v Plan	**0.5**	**(6.0)**	**0.3**	**0.8**	**0.6**				**1.7**

Substantive WTE	Feb-21 WTE	Mar-21 WTE	Apr-21 WTE	May-21 WTE	Jun-21 WTE	Jul-21 WTE	Aug-21 WTE	Sep-21 WTE	Mar-22 WTE
A&C	1,566	1,566	1,563	1,564	1,569				
Medical	1,175	1,169	1,181	1,173	1,170				
Nursing	3,703	3,711	3,694	3,696	3,681				
Other	1,707	1,706	1,699	1,703	1,688				
Total	**8,151**	**8,152**	**8,136**	**8,136**	**8,109**				

Premium Source (Excl. Out of System COVID) YTD			Total Trust Total £m	Total Trust *Premium Cost* £m*
Medical	**Source**	Internal Locum	2.6	*0.5*
		External Locum	0.5	*0.2*
		WLI/NAG	1.2	*0.6*
		Total	**4.3**	***1.4***
Nursing	**Source**	Bank	3.7	*0.0*
		Overtime	0.9	*0.3*
		Agency	0.4	*0.1*
		Total	**4.9**	***0.4***
A&C & Other	**Source**	Bank	0.7	*0.0*
		Overtime	0.4	*0.1*
		Agency	0.7	*0.2*
		Total	**1.7**	***0.3***
Total	**Source**	Bank/Internal Locum	6.9	*0.5*
		Overtime	1.2	*0.4*
		Agency/External Locum	1.5	*0.5*
		WLI/NAG	1.2	*0.6*
		Total	**10.9**	***2.0***

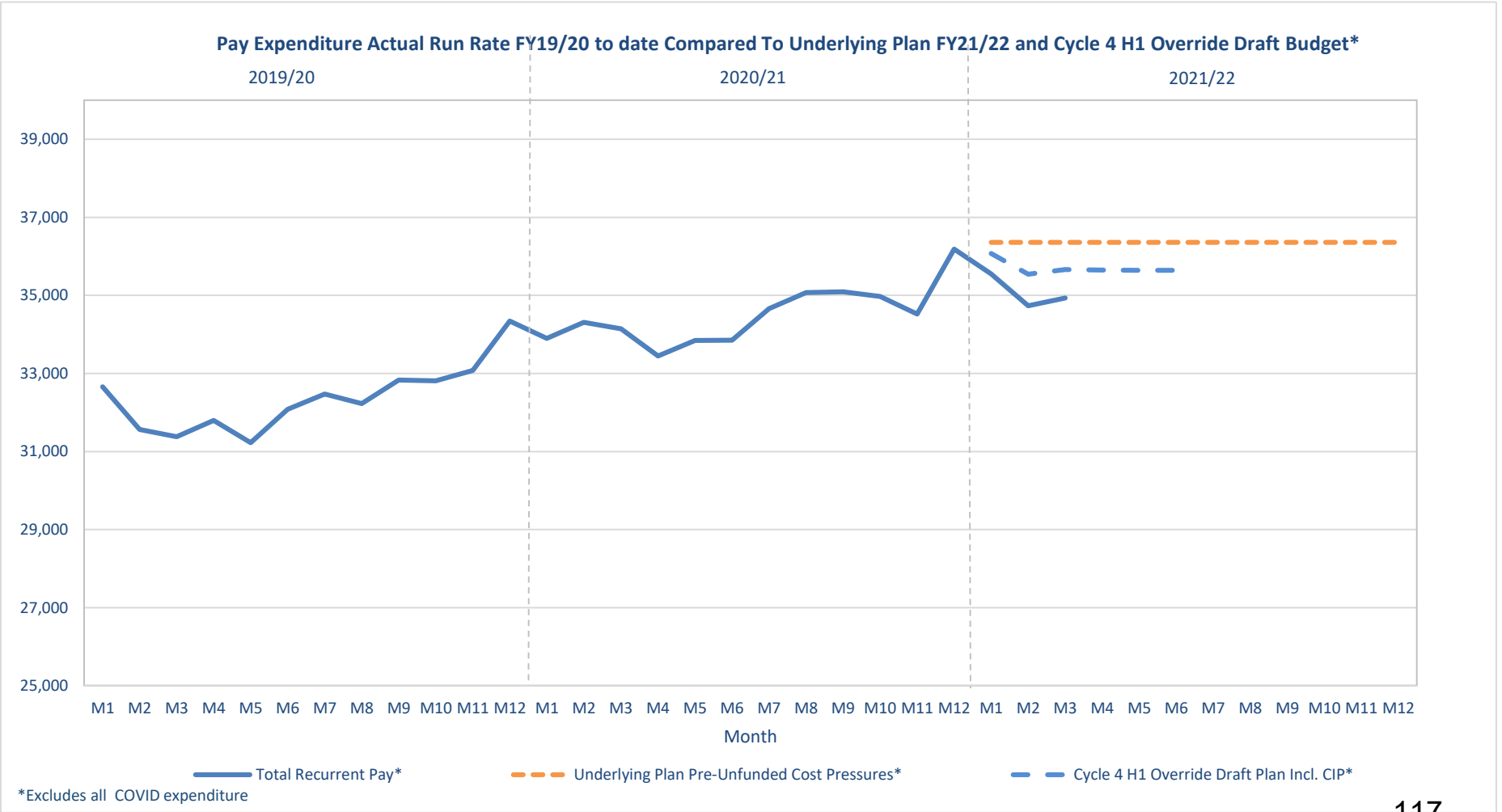
** Incremental cost of premium staff over substantive staff*



Norfolk and Norwich University Hospitals NHS Foundation Trust

9.3 Pay Expenditure Run Rate

Pay expenditure run rate is favourable to both the Underlying Plan and Cycle 4 H1 Override plan for April, May and June. Pay in May and June has returned to similar levels seen through H2 2020/21 after slight increases in March 2021 and April 2021.



*Excludes all COVID expenditure

Norfolk and Norwich University Hospitals NHS Foundation Trust

9.4 Statement of Financial Position

The Statement of Financial Position at the end of June has increased by £5.5m compared to the opening balance, this reflects the £4.9m surplus to date on a control total basis in addition to £0.6m of donated asset additions & depreciation.

Property, plant and equipment
This balance is £16.7m higher than the opening balance. The key items are capital expenditure of £7.0m offset in part by depreciation of £5.1m, together with a £14.7m transfer from trade and other receivables relating to the capitalisation of a lifecycle maintenance prepayment.

Trade and Other Receivables – non current
This balance is £15.0m lower than the opening balance, with the key item being a transfer of £14.7m to PPE for the capitalisation of a lifecycle maintenance prepayment.

Trade and Other Receivables - current
This balance is £10.5m higher than the opening balance. The key items are £8.0m of income accruals, and £1.9m of prepayments.

Cash
This is £17.8m lower than the opening balance. The key reasons are a reduction in capital creditors and capital accruals of £6.4m, together with other working capital movements - in particular a reduction in trade payables of £18.4m offset in part by an increase in accruals of £9.1m.

Trade and other payables
This is £15.5m lower than the opening balance. The key reason is the settlement of 2 credit notes (totalling £15.3m) raised to N&W CCG relating to repatriation of COVID unspent funds and a regional true-up of resources.

Provisions
This balance is £3.1m higher than the opening balance. The key reason is a reclassification of £3.2m relating to VAT reclaims.

Borrowings
The £1.2m decrease in non-current borrowings relates to capital repayment for the PFI contract and Fuji PACS finance lease.

Deferred Income
This balance is £3.0m higher than the opening balance. The key items are £1.4m of which relates to education funding received in advance of costs, £3.0m of drugs income, £1.1m of devices, and £1.6m relating to independent sector work. This is offset in part by a reclassification of £3.2m relating to VAT reclaims.

June 2021	Actual Mar-21 £m	Actual Jun-21 £m	Movement £m	Prior Month £m
Property, plant and equipment	349.0	365.7	16.7	365.0
Trade and other receivables	62.5	47.5	(15.0)	47.1
Total non-current assets	**411.5**	**413.2**	**1.7**	**412.1**
Inventories	13.1	13.6	0.5	13.1
Trade and other receivables	31.3	41.8	10.5	42.1
Cash and cash equivalents	68.9	51.1	(17.8)	49.8
Total Current assets	**113.3**	**106.5**	**(6.8)**	**105.0**
Trade and other payables	(114.3)	(98.8)	15.5	(98.3)
Borrowings - PFI & Finance Lease	(5.0)	(5.0)	0.0	(5.0)
Provisions	(0.5)	(3.5)	(3.0)	(0.3)
Deferred Income	(15.8)	(22.9)	(7.1)	(21.4)
Total current liabilities	**(135.6)**	**(130.2)**	**5.4**	**(125.0)**
Total assets less current liabilities	**389.2**	**389.5**	**0.3**	**392.1**
Borrowings - PFI & Finance Lease	(182.4)	(181.2)	1.2	(181.6)
Borrowings - Revenue Support	0.0	0.0	0.0	0.0
Provisions	(4.8)	(4.9)	(0.1)	(4.9)
Deferred Income	(5.3)	(1.2)	4.1	(4.5)
Total non-current liabilities	**(192.5)**	**(187.3)**	**5.2**	**(191.0)**
Total assets employed	**196.7**	**202.2**	**5.5**	**201.1**
Financed by				
Public dividend capital	290.7	290.7	0.0	290.7
Retained Earnings (Accumulated Losses)	(121.1)	(115.4)	5.7	(116.5)
Revaluation reserve	27.1	26.9	(0.2)	26.9
Total Taxpayers' and others' equity	**196.7**	**202.2**	**5.5**	**201.1**

Norfolk and Norwich University Hospitals NHS Foundation Trust

Appendix

Appendix A – System Financial Position

Year to Date (M3) N&WHCP is reporting a surplus of £5.0m against a planned surplus of £1.1m, £4.0m favourable to plan. Forecast outturn for H1 is breakeven as per plan.

	Year to Date			Forecast Outturn April 2021 - September 2021		
	Actual £m	Plan £m	Variance £m	Actual £m	Plan £m	Variance £m
JPUH	1.8	1.0	0.9	0.0	0.0	0.0
NNUH	4.9	1.1	3.8	0.0	0.0	0.0
NSFT	0.0	0.0	0.0	0.0	0.0	0.0
NCHC	0.5	(0.3)	0.8	0.1	0.1	0.0
QEHKL	(0.6)	(0.7)	0.0	0.0	0.0	0.0
Syb Total - Providers	**6.6**	**1.1**	**5.6**	**0.1**	**0.1**	**0.0**
N&W CCG	(7.7)	0.0	(7.7)	(11.1)	0.0	(11.1)
Reimbursement Due - HDP	6.1	0.0	6.1	11.1	0.0	11.1
Sub Total - CCG	**(1.6)**	**0.0**	**(1.6)**	**0.0**	**0.0**	**0.0**
Total N&WHCP	**5.0**	**1.1**	**4.0**	**0.1**	**0.1**	**0.0**

Appendix B – Corporate Reserve

The H1 override plan included £0.5m of corporate reserves of which £0.4m has been assigned leaving £0.1m unallocated. The underlying position included £1.0m of corporate reserves of which £0.7m has been assigned recurrently leaving £0.3m unallocated.

	Receiving Division / Department	H1 Override Plan £k	Underlying Position £k
Opening Plan		**0.50**	**1.00**
Nurse Roster Rebasing	ALL / Nursing	(0.22)	(0.45)
HR Resourcing - Priorities	Corporate / HR	(0.08)	(0.16)
Sustainability Plan	Corporate / Trust Management	(0.04)	0.00
Intranet	Corporate / Communications	(0.06)	(0.06)
Latest Plan / Remaining Budget		**0.10**	**0.33**

REPORT TO TRUST BOARD

Date	**4 August 2021**
Title	**Use of Resources Update**
Author & Exec Lead	**Rob Marshall (Associate Director of Finance) and Roy Clarke (Chief Finance Officer)**
Purpose	**For Information**

This paper provides an update on the progress against the three strategic enablers and an updated position for the Tactical Action Plan, including a variation to include the GIRFT recommendations.

1. Background/Context

The Use of Resources Response paper acknowledged the outcome of the CQC Use of Resources review and provided an overview of the Trust's planned response both in relation to the recommendations raised and the wider, more strategic actions to be delivered.

2. Financial Governance Review (FGR)

The independent Financial Governance Review was completed in October 2020, following a detailed factual accuracy review.

The Trust has developed an action plan in response to the recommendations raised within the Financial Governance Review, comprising of 68 individual actions. As at the 30 June 2021, 61 actions have been completed, 23 of which are 'Must Do'; two are on track; and five remain overdue. These actions are being monitored through Hospital Management Board and Finance, Investments & Performance Committee.

An external review of the Trust's progress against the identified recommendations has been completed by RSM in February 2021 with a formal Exit Review held with the Trust and NHSE/I.

Overall, the Trust has made good progress in implementing the actions outlined within the FGR and each of the five domains reviewed have moved from a negative assurance positon pre-COVID to a positive assurance position.

3. Financial Strategy & UoR Annual Assessment

An assessment of how the Trust is progressing in its aim to improve its use of resources, by considering the current evidence for how effectively the Trust is using its resources, whether performance has improved, and which areas for improvement the Trust should focus on.

Thematic analysis of improvement areas indicated by the UoR Framework, Model Health System, and internal analysis of deficit deterioration (Drivers of the Deficit) finds significant overlap in workforce productivity and PFI costs. These are proposed to be key areas of focus for improvement.

The opportunities identified through the report are being scoped to drive a discussion surrounding prioritisation of initiatives to reduce the financial deficit. Additional focus is required to drive further initiatives to inform the next iteration of the Financial Strategy, due in September 2021.

The review identified two key recommendations:

- Targeted change programmes around identified opportunity themes should be developed and incorporated into the Financial Strategy, with delivery overseen by the Transformation Steering Group; and
- The Use of Resources Tactical Action Plan should be refreshed to reflect the findings and reset delivery expectations.

4. Tactical Action Plan Update

An Evidence Group Deep Dive was held on 9th July 2021. The meeting continued to provide support and challenge to delivery leads and monitor progress against the individual recommendations that comprise the Tactical Action Plan. Three recommendations, in relation to workforce, UoR 12, UoR 14 and UoR 15 remain within formal SRO Intervention. There is now a plan for all three of the recommendations to be removed from SRO Intervention by October 2021.

As at 30 June 2021, the position shows that of the 290 individual actions within the Tactical Action Plan (see table below): 237 have been completed; 29 are currently on track; 14 have become overdue by less than 30 days and 10 remain overdue by greater than 30 days. **The overdue actions have been followed up with the responsible officers and the current status understood, see *Section 4.***

There is a significant risk around completion of actions given the volume of actions due in July and August 2021 of 18. **The volume of actions requiring change control in the month is high which represents a significant delay in the completion of the UoR Tactical Action Plan.**

5. Getting It Right First Time (GIRFT)

Following June's visit to Oral and maxillofacial Surgery, there has been 9 new actions added. The Cardiothoracic visit and a Deep Dive with Cardiothoracic are planned with dates to be confirmed. The NNUH GIRFT platform is now live within the FutureNHS Collaboration Platform.

To improve performance the following action has been identified:

- Continue the enhanced monitoring reviews with individual specialties of their GIRFT recommendation performance, with concentrated focus on actions that are not currently accepted.

Recommendations:

The Board is recommended to:

- Note the contents of the report

Norfolk and Norwich University Hospitals NHS Foundation Trust

Use of Resources Update

Trust Board

4 August 2021

1. Executive Summary

This paper provides an update on the progress against the strategic enablers and an updated position for the Tactical Action Plan, including an update on the performance against GIRFT recommendations.

Financial Governance Review (FGR)

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The Trust has developed an action plan in response to the recommendations raised within the Financial Governance Review, comprising of 68 individual actions. As at the 30 June 2021, 61 actions have been completed, 23 of which are 'Must Do'; two are on track; and five remain overdue. These actions are being monitored through Hospital Management Board and Finance, Investments & Performance Committee.

An external review of the Trust's progress against the identified recommendations has been completed by RSM in February 2021 with a formal Exit Review held with the Trust and NHSE/I.

Overall, the Trust has made good progress in implementing the actions outlined within the FGR and each of the five domains reviewed have moved from a negative assurance positon pre-COVID to a positive assurance position.

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The opportunities identified through the report are being scoped to drive a discussion surrounding prioritisation of initiatives to reduce the financial deficit. Additional focus is required to drive further initiatives to inform the next iteration of the Financial Strategy, due in September 2021.

The review identified two key recommendations:

1. **Targeted change programmes around identified opportunity themes should be developed and incorporated into the Financial Strategy, with delivery overseen by the Transformation Steering Group; and**
2. **The Use of Resources Tactical Action Plan should be refreshed to reflect the findings and reset delivery expectations.**

Tactical Action Plan Update

An Evidence Group Deep Dive was held on 9 July 2021. The meeting continued to provide support and challenge to delivery leads and monitor progress against the individual recommendations that comprise the Tactical Action Plan. Three recommendations, in relation to workforce, UoR 12, UoR 14 and UoR 15 remain within formal SRO Intervention. There is now a plan for all three of the recommendations to be removed from SRO Intervention by October 2021.

As at 30 June 2021, the position shows that of the 290 individual actions within the Tactical Action Plan (see table below): 237 have been completed; 29 are currently on track; 14 have become overdue by less than 30 days and 10 have become overdue by greater than 30 days. **The overdue actions have been followed up with the responsible officers and the current status understood, see *Section 4.***

There is a significant risk around completion of actions given the volume of actions due July and August 2021 of 18. The volume of actions requiring change control in the month is high which represents a significant delay in the completion of the UoR Tactical Action Plan.

Getting It Right First Time (GIRFT)

Following June's visit to Oral and maxillofacial Surgery, there has been 9 new actions added. The Cardiothoracic visit and a Deep Dive with Cardiothoracic are planned with dates to be confirmed. The NNUH GIRFT platform is now live within the FutureNHS Collaboration Platform.

To improve performance the following action has been identified:

- Continue the enhanced monitoring reviews with individual specialties of their GIRFT recommendation performance, with concentrated focus on actions that are not currently accepted.

Norfolk and Norwich University Hospitals NHS Foundation Trust

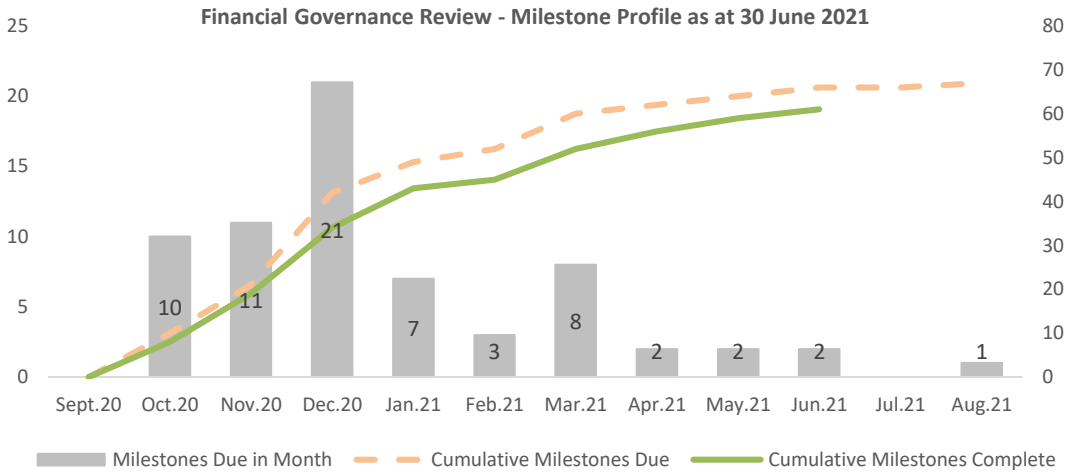
2. Financial Governance Review – Action Plan Progress

The Trust has developed an action plan in response to the recommendations raised within the Financial Governance Review, comprising of 68 individual actions. As at the 30 June 2021, 61 actions have been completed, 23 of which are 'Must Do'; two are on track; and five remain overdue. These actions are being monitored through Hospital Management Board and Finance, Investments & Performance Committee.

The independent Financial Governance Review was completed in October 2020, following a detailed factual accuracy review. The FGR identified 53 recommendations, 23 of which were designated as 'Must Do' and 30 as 'Should Do'. This has led to the development of an FGR action plan consisting of 65 actions for completion (now 68 due to Change Control).

As at 30 June 2021, 61 actions have been completed, two are on track and the remaining five remain overdue (see table in Section 2a). The overdue actions continue to be monitored through Hospital Management Board.

A formal review of the progress against the action plan is due to be performed by Internal Audit in quarter three. The revised implementation dates support the completion of the action plan ahead of this date.



Financial Domain		Position as at 30 June 2021					Position as at 31 May 2021				
		Blue	Green	Amber	Red	Total	Blue	Green	Amber	Red	Total
Financial Planning & Budgeting	Must Do	7	1	0	2	10	7	0	0	3	10
	Should Do	8	1	0	0	9	8	1	0	0	9
Culture of Financial Sustainability	Must Do	3	0	0	0	3	2	0	1	0	3
	Should Do	9	0	0	0	9	9	0	0	0	9
Financial Reporting	Must Do	0	0	0	0	0	0	0	0	0	0
	Should Do	9	0	0	0	9	9	0	0	0	9
Framework of Financial Control	Must Do	7	0	0	3	10	6	0	0	4	10
	Should Do	9	0	0	0	9	9	0	0	0	9
Investment Decision Making	Must Do	6	0	0	0	6	6	0	0	0	6
	Should Do	3	0	0	0	3	3	0	0	0	3
Total		**61**	**2**	**0**	**5**	**68**	**59**	**1**	**1**	**7**	**68**

Norfolk and Norwich University Hospitals NHS Foundation Trust

2a. Financial Governance Review – Overdue Actions

The Trust has developed an action plan in response to the recommendations raised within the Financial Governance Review, comprising of 68 individual actions. As at the 30 June 2021, 61 actions have been completed, 23 of which are 'Must Do'; two are on track; and five remain overdue. These actions are being monitored through Hospital Management Board and Finance, Investments & Performance Committee.

The table below provides an update on the current overdue actions (five as at 30 June 2021) and the identified actions to ensure that these are completed.

Overdue Action	Due Date	Days Overdue	Executive Sponsor	Explanation and Next Steps
2.1 The Trust will ensure that demand and capacity tools are completed as part of the business planning process each financial year. Where existing capacity is not sufficient to meet demand, divisional requests will be made to support the delivery of demand commitments during operational planning. A formal log of identified capacity constraints will be maintained.	31/03/2021	92	Chief Operating Officer	**Ongoing** – The Trust will ensure that demand and capacity tools are completed as part of the business planning process each financial year: Demand & Capacity tools were used in 2020/21. External support was provided by Grant Thornton. The N&WHSC System are exploring a single capacity and demand model for each of the acute Trusts to be implemented for 21/22. If progress is not sufficient to deliver the single demand/capacity process, the NNUH will ensure its own process is in plans annually. The annual process concludes in March therefore this action is closed in 2021 and will repeat annually. Where existing capacity is not sufficient to meet demand, divisional requests will be made to support the delivery of demand commitments during operational planning. A formal log of identified capacity constraints will be maintained. Operational Planning was completed for H1 21/22, the Trust capacity plan met the demands of the NHSE planning guidance. For H2, the demands are expected to increase and capacity plans will be refreshed. Divisions will submit information to a central log and raise business cases to address shortfalls. **Proposed Revised Implementation Date:** TBC
33.1 A review of the current structure and content of papers will be undertaken. This will look to ensure that where a decision is required quality, operational, workforce and financial implications have been identified and noted for consideration.	31/03/2021	92	Chief Executive Officer	**Ongoing** – A formal review has commenced led by the Board Secretary and Head of Legal Services. **Proposed Revised Implementation Date:** 31 July 2021

Norfolk and Norwich University Hospitals NHS Foundation Trust

2b. Financial Governance Review – Overdue Actions

The Trust has developed an action plan in response to the recommendations raised within the Financial Governance Review, comprising of 68 individual actions. As at the 30 June 2021, 61 actions have been completed, 23 of which are 'Must Do'; two are on track; and five remain overdue. These actions are being monitored through Hospital Management Board and Finance, Investments & Performance Committee.

The table below provides an update on the current overdue actions (five as at 30 June 2021) and the identified actions to ensure that these are completed.

Overdue Action	Due Date	Days Overdue	Executive Sponsor	Explanation and Next Steps
42.2 The outcomes of the workforce management work will feed into the Trust's 2021/22 workforce planning and beyond, and the Trust's financial strategy.	31/01/2021	151	Chief People Officer	**Delayed** – High level workforce plans for Divisions have commenced. Focussed work on retention has commenced with key milestones to be agreed at RRIG on 22nd July 2021, along with agreement on Hard to Fill posts. The draft Divisional Workforce Plans will be discussed and confirmed at RRIG on 26th August 2021. **Proposed Revised Implementation Date:** 26 August 2021
42.3 The outcomes of the workforce management work will be reported through HMB, FI&P Committee and Trust Board	28/02/2021	123	Chief People Officer	**Delayed** – The People & Culture Committee meets bi-monthly and the next meeting will be in July 2021. The Agenda for July 2021 will include a summary update on the Workforce Plans. The detailed Divisional Workforce Plans to go to the People & Culture Committee and HMB in September 2021. **Proposed Revised Implementation Date:** 30 September 2021
4.1 A triangulation exercise will be performed to ensure that agreed establishments are reflected within both ESR and e-Roster. Once completed, the outputs from this exercise will be used in the Trust's annual planning process.	31/10/2020	243	Chief Nurse & Chief People Officer	**Ongoing** – The nursing and midwifery establishment review has been completed and the establishment rebasing agreed by HMB, following agreement by both senior nursing leadership and the finance department. Finance have, as of the 6 July, shared all of the revised ward inpatient area budgeted establishments with the rostering team. From an initial review it would appear that further clarification is required to enable these to be introduced into HealthRoster. The HealthRoster Team will liaise with Finance and the senior Divisional managers to understand and address this. Once the clarifications are resolved the templates and finance budgets will be introduced into HealthRoster. The magnitude of this work is difficult to accurately quantify at present but we would be aiming to complete the template review and update within 6 weeks. We recognise that the delivery of the update is beyond the previous deadline (31 July) but would sight that this is as a consequence of the additional work identified. **Proposed Revised Implementation Date:** 16 August 2021

Norfolk and Norwich University Hospitals NHS Foundation Trust

2b. Financial Governance Review – On Track Actions

The Trust has developed an action plan in response to the recommendations raised within the Financial Governance Review, comprising of 68 individual actions. As at the 30 June 2021, 61 actions have been completed, 23 of which are 'Must Do'; two are on track; and five remain overdue. These actions are being monitored through Hospital Management Board and Finance, Investments & Performance Committee.

The table below provides an update on the current on track actions (two as at 30 June 2021) and the identified actions to ensure that these are completed.

Action	Due Date	Days Overdue	Executive Sponsor	Explanation and Next Steps
1.1 As part of an internal Trust-wide capacity planning exercise, divisions will review their clinic and theatre capacity taking into consideration workforce availability, service developments and seasonality to arrive at their capacity plan.	31/08/2021	-	Chief Operating Officer	**Ongoing** – Initial Trust capacity planning exercises were undertaken in November 2020 and February 2021. "Divisions will review their clinic and theatre capacity taking into consideration workforce availability, service developments and seasonality to arrive at their capacity plan" the management actions related to this action were completed and are not overdue. However, Cycle 3 and Cycle 4 of the Financial Planning process, identified issues in triangulating between workforce/activity and capacity plans. Following the COVID-19 pandemic, activity planning was conducted in April 21 however capacity plans were paused in order to respond to H1 and the operational planning guidance demands. Ahead of H2 21-22 and in conjunction with national planning guidance and Cycle 5, a Trust capacity plan will be completed with divisional level detail, with aims to reach improved levels of productivity and triangulate with finance, workforce and activity plans. This will be supported with a dedicated workstream within Safer Efficient Transformative (SET) elective care improvement programme, that will focus on efficiency and capacity. Due to conclude ahead of H2 (31/08/2021)
14.2 The Trust has £10.3m approved through Gateway 2 against the hedged £12.6m Target as per Cycle 4 Annual Planning. The CIP Target in H1 is £3.5m and therefore with the approved schemes and FYE of FY20/21 schemes the Trust has sufficient schemes to meet the H1 requirement. A further action is proposed to be added to monitor the Trust's progress against the H2 target of £9.1m.	30/08/2021	-	Chief Finance Officer	**Ongoing** – CIPs continue to be developed through the Governance Gateways. At the end of Q1, the budgeted plan is £12.6m, with a current RAG adjusted delivery of £13.0m. Propose to close this action once the H2 National Efficiency Requirement has been confirmed, should the RAG adjusted delivery value exceed the requirements.

Norfolk and Norwich University Hospitals NHS Foundation Trust

3. Financial Strategy

An assessment of how the Trust is progressing in its aim to improve its use of resources, by considering the current evidence for how effectively the Trust is using its resources, whether performance has improved, and which areas for improvement the Trust should focus on. Thematic analysis of improvement areas indicated by the UoR Framework, Model Health System, and internal analysis of deficit deterioration (Drivers of the Deficit) finds significant overlap in workforce productivity and PFI costs. These are proposed to be key areas of focus for improvement. The opportunities identified through the report are being scoped to drive a discussion surrounding prioritisation of initiatives to reduce the financial deficit. Additional focus is required to drive further initiatives to inform the next iteration of the Financial Strategy, due in September 2021.

Annual Review of Use of Resources

The Trust has undertaken an annual review of its Use of Resources against the national framework (KLOEs), including a review of the latest Model Hospital data. This was presented to HMB on 1st June 2021.

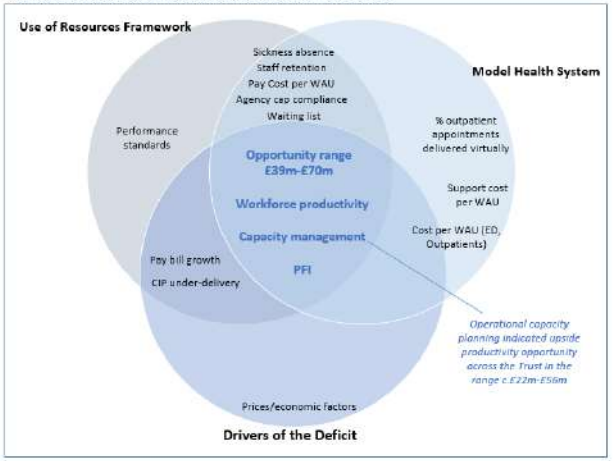
The review was performed by considering the current evidence across the following questions:

1. How effectively is the Trust using its resources?	This is considered according to: • The CQC / NHS Improvement **Use of Resources framework;** • Benchmarking data available to us through the **Model Health System** (previously *Model Hospital*) and recently refreshed to include 2019/20 data; • Internal analysis from the **Drivers of the Deficit diagnosis** provided to support the Financial Strategy development.	**Key findings:** • The outcome of the self-assessment against the UoR framework is **Requires Improvement** • Model Hospital shows **variable benchmarking performance** compared to national median and selected peers across a wide range of metrics. **Productivity opportunity is estimated in the range £39m - £70m.** • Deficit driver analysis and Model Health System data indicates the Trust has delivered **reducing productivity** over the past 5-6 years.
2. Have we improved since our last assessment?	• Would we expect to see an improved **Use of Resources rating** if we were re-assessed by NHS Improvement now? • Have we completed our previously agreed improvement actions (Use of Resources Tactical Action Plan) and can we now demonstrate **improved outcomes?**	**Key findings:** • The last NHSI UoR assessment (January 2020) rated the Trust as Requires Improvement. The self assessment at May 2021 is **unchanged in terms of overall rating,** although we have made progress. • We have not fully delivered our UoR Tactical Action Plan, and 10.5% of actions are overdue. This contributes to the unchanged rating. • There is some evidence of improved outcomes but not yet at a level that would secure an improved overall assessment.
3. What are the key areas for improvement that we should focus on now?	• Are there some clear **areas of focus** that the analysis points us towards?	**Key findings:** • All sources of analysis point towards key themes for improvement: **workforce productivity, capacity management and estate (PFI) costs**

The review identified two key recommendations:

1. **Targeted change programmes around identified opportunity themes should be developed and incorporated into the Financial Strategy, with delivery overseen by the Transformation Steering Group; and**
2. **The Use of Resources Tactical Action Plan should be refreshed to reflect the findings and reset delivery expectations.**

Thematic analysis of improvement opportunities from alternative sources



Following the presentation of the report to HMB, a number of actions have been determined for completed ahead of the next iteration of the Financial Strategy, due in September 2021.

	Timescale	Status
Prepare and issue Divisional Opportunity Packs	17 June 2021	Completed
Hold Divisional Engagement Sessions	30 June 2021	Completed
Refresh of UoR Tactical Action Plan	31 July 2021	Ongoing
Top Down Financial Improvement Initiatives Developed	31 July 2021	Ongoing
Draft Financial Strategy	30 September 2021	Ongoing

Norfolk and Norwich University Hospitals NHS Foundation Trust

3. Delivery of Tactical Action Plan – Evidence Groups

The latest Evidence Group Deep Dive was held on 9 July 2021. The meeting continued to provide support and challenge to delivery leads and monitor progress against the individual recommendations that comprise the Tactical Action Plan. Three recommendations, in relation to workforce, UoR 12, UoR 14 and UoR 15 remain within formal SRO Intervention. There is now a plan for all three of the recommendations to be removed from SRO Intervention by October 2021.

Quality Programme Board

The progress against the individual Use of Resources recommendations continues to be monitored and scrutinised through the use of Quality Improvement Evidence Groups, feeding in to Quality Programme Board.

A formal, rolling programme for a deep dive across each recommendation has been developed to ensure that each recommendation is reviewed and challenged at least once every three months, alongside ensuring that any recommendation in SRO intervention is reviewed monthly.

Evidence Groups

A UoR Deep Dive Evidence Group was held on Friday 4th June to review progress against the granular action plans.

During this meeting, the following recommendations were discussed:

Recommendation	Current Status	Decision at Evidence Group	Review Date
UoR 3.1		Deferred	09/07/2021
UoR 10.1		Deferred	09/07/2021
UoR 12.1			09/07/2021
UoR 13.1			06/08/2021
UoR 14.1			09/07/2021
UoR 15.1			09/07/2021
UoR 16.1			06/08/2021
UoR 18.1			03/12/2021

A further UoR Deep Dive Evidence Group was held on 9th July and covered the following recommendations:

Recommendation	Current Status	Decision at Evidence Group	Review Date
UoR 3.1			
UoR 8.1			06/08/2021
UoR 9.1			06/08/2021
UoR 10.1			06/08/2021
UoR 11.1			06/08/2021
UoR 12.1			06/08/2021
UoR 14.1			06/08/2021
UoR 15.1			06/08/2021

The meeting received detailed updates in relation to the three schemes which were placed into formal SRO intervention at the last Evidence Group:

- UoR 12 – Continue working to embed effective use of e-Rostering (Chief People Officer)
- UoR 14 – Consider use of modern systems in payroll to ensure faster and traceable transactions (Chief People Officer)
- UoR 15 – Progress implementation of improvements in HR operations (Chief People Officer).

It was concluded within the meeting that significant work had been performed in relation to the three action plans and progress had been made. There is now a plan in place for these to be removed from SRO Intervention by October 2021.

The progress of each individual recommendation, alongside the dates of Change Controls raised, can be seen within Appendix 2.

Norfolk and Norwich University Hospitals NHS Foundation Trust

4. Tactical Action Plan - Performance

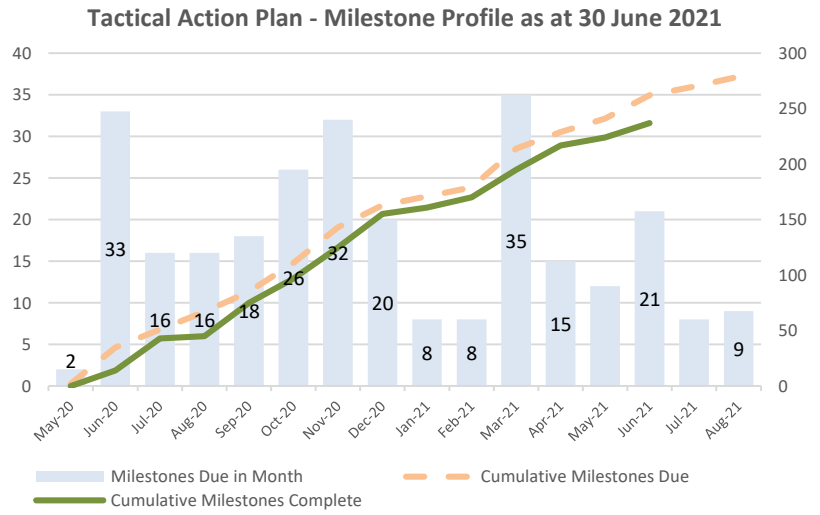
The Trust has completed 237 individual actions, with a further 24 showing as overdue. These have been followed up with the responsible officers and the current status understood. These must be completed or subject to Change Control ahead of the next Evidence Group.

There is a significant risk around completion of actions given the volume of actions due July and August 2021 of 18.

As at 30 June 2021, the position shows that of the 290 individual actions within the Tactical Action Plan (see table below): 237 have been completed; 29 are currently on track; 14 have become overdue by less than 30 days and 10 have become overdue by greater than 30 days.

The overdue actions are outlined on the following pages, alongside the proposed route to resolution. The actions subject to change control in the month are listed within Appendix 1 for approval.

There are 18 actions that are due within the next 60 days. This volume of actions presents a significant risk around completion of the actions in line with agreed timescales, especially with the number of overdue actions particularly across the recommendations under SRO intervention.



Strategic Enabler/Recommendation	Evidence Group RAG	Position as at 30 June 2021					Position as at 31 May 2021				
		Blue	Green	Amber	Red	Total	Blue	Green	Amber	Red	Total
Financial Governance Review		5	0	0	0	**5**	5	0	0	0	5
Financial Strategy		5	0	0	0	**5**	5	0	0	0	5
Alignment of Improvement Functions		1	0	0	0	**1**	1	0	0	0	1
GIRFT Governance		8	0	0	0	**8**	7	0	0	1	8
UoR 3 - Consideration should be given to regular use of service line reporting	BLACK	10	0	0	0	**10**	10	0	0	0	10
UoR 4 - Investigate and address the drivers of the high spend on non-high cost drugs	GREEN	0	1	0	0	**1**	0	1	0	0	1
UoR 8 - Deliver expected reductions in long length of stay and better utilisation of non-elective beds	GREEN	15	0	1	0	**16**	15	1	0	0	16
UoR 9 - Improve performance against constitutional operational standards	AMBER	38	0	0	0	**38**	38	0	0	0	38
UoR 10 - Improve internal capacity and capability to drive CIPs	AMBER	14	0	4	0	**18**	14	4	0	0	18
UoR 11 - Review operational and business planning processes to reduce reliance on temporary capacity	RED	24	0	0	0	**24**	23	0	1	0	24
UoR 12 - Continue working to embed effective use of e-Rostering	RED	42	8	2	4	**56**	39	8	6	3	56
UoR 13 - Ensure that revised job planning processess translates into optimisation of consultant workforce	GREEN	22	0	1	0	**23**	20	3	0	0	23
UoR 14 - Consider use of modern systems in payroll to ensure faster and traceable transactions	RED	14	0	4	5	**23**	9	7	1	6	23
UoR 15 - Progress implementation of improvements in HR operations	GREEN	12	12	0	0	**24**	11	13	0	0	24
UoR 16 - Continue working to develop procurement collaboration with NHS partners	GREEN	9	7	0	0	**16**	9	7	0	0	16
UoR 17 - Implement identified actions to reduce the cost of its PFI	GREEN	5	1	2	1	**9**	5	3	1	0	9
UoR 18 - Review the workforce model and recruitment strategies	BLACK	13	0	0	0	**13**	13	0	0	0	13
Total		**237**	**29**	**14**	**10**	**290**	**224**	**47**	**9**	**10**	**290**

Blue Action is signed off as completed. **Green** Action is on track to deliver in line with its due date. **Amber** Action is overdue, but by less than 30 days. **Red** Action is overdue by greater than 30 days.

Norfolk and Norwich University Hospitals NHS Foundation Trust

4. Tactical Action Plan – Overdue Actions

The Trust has completed 237 individual actions, with a further 24 showing as overdue. These have been followed up and the current status understood. These must be completed or subject to Change Control ahead of the next Evidence Group.

The table below provides an update on the current overdue milestones (24 as at 30 June 2021) and the identified actions to ensure that these are completed.

Overdue Action	Due Date	Days Overdue	Executive Sponsor	Explanation and Next Steps
8.2.7 Ensure data capture processes are in place to capture patients with a 'criteria to reside status'	14/06/2021	17	Chief Operating Officer	**Ongoing** - Initial work to add C2R to the patient handover to enhance our data and recording of the patients discharge status has commenced, however digital development and the scope of the enhancement has extended to review other elements of the handover. This includes removing duplicate processes in recording data other systems (e.g. SafeCare) up to three times a day. The expanded scope has increased the period in which the enhancement will be added, will aim to remove duplicate processes and input for nursing and clinical teams, freeing up additional clinical care time. All relevant stakeholders are aware of the objective to add this into the handover. RITS requests have been completed and are progressing pending further engagement with clinical teams.
10.1.6 Perform a formal review of the resource profile and remit of the Programme Management Office to ensure that the function is adequately resourced to deliver transformational CIP.	30/06/2021	1	Chief Operating Officer	**Ongoing** - The PMO has been subject to change with the appointment of a new Associate Director taking over leadership for the team and responsibility for the transition from a PMO to a Transformation and Efficiency Office (TEO). Initial discussions with PMO team members have been conducted to explore existing skillsets and areas of individual interest. Further similar conversations combined with a view of capacity will help inform how resources are aligned for future projects. Fortnightly meetings have been setup with fellow Associate Directors under the Improvement umbrella to explore areas of potential collaboration.
10.1.6a Perform analysis of requirements	30/06/2021	1	Chief Operating Officer	
10.1.6b Review alignment with Improvement Team and other Transformational Functions	30/06/2021	1	Chief Operating Officer	
10.1.6c Provide report on recommendations to Hospital Management Board	30/06/2021	1	Chief Operating Officer	
12.1.3.2 Identification of IS support with the development of the dashboard into Power BI	31/05/2021	31	Chief People Officer	**Ongoing** - Following discussions with the management team which supports the PAF (Performance Assurance Framework) reporting, a request will now be progressed with IS to develop the BI dashboard to enable the identified metrics to be included within the PAF.

Norfolk and Norwich University Hospitals NHS Foundation Trust

4. Tactical Action Plan – Overdue Actions (Cont.)

The Trust has completed 237 individual actions, with a further 24 showing as overdue. These have been followed up and the current status understood. These must be completed or subject to Change Control ahead of the next Evidence Group.

The table below provides an update on the current overdue milestones (24 as at 30 June 2021) and the identified actions to ensure that these are completed.

Overdue Action	Due Date	Days Overdue	Executive Sponsor	Explanation and Next Steps
12.16.03 Clinical/Non Clinical Skills mapped to Healthroster (in a way consistent across the STP)	01/06/2021	30	Chief People Officer	**Ongping -** Single source of truth for the management and updating of skills. Functional skills to be assigned to employees to enable rostering by skill set. Ensuring right skill, right place, right time.
12.17.01 Creation of e-learning roster course Masterclasses - Reporting - Roster Analysis - Rules/ Roster Policy - Safecare	01/06/2021	30	Chief People Officer	**Ongoing** - Masterclasses sessions are being updated with clear learning objectives and creation of 1 hour divisional "Drop in sessions" and bitesize sessions for "Finalisation" and "Roster Best Practice". Skill's have been created and added to staff who have attend training to support training analysis. monthly training evaluation sessions to be held and administration support agreed to manage feedback forms and inform future training sessions. Exploring the option of utilising the Digital Health training room for roster sessions.
12.21.01 Healthroster/Bankstaff - 247 Time Interface	01/05/2021	61	Chief People Officer	**Ongoing** - Implementation timeline to be supplied by Allocate. Mapping exercise to be undertaken.
12.23.05 Annual leave management for Medical staff via Healthroster	26/03/2021	97	Chief People Officer	**Ongoing** - This has to be implemented in line with the overall Medical Rostering project. The delivery date will be in line with the medical rostering rollout plan.
12.23.06 Study leave management for Medical staff via Healthroster	26/03/2021	97	Chief People Officer	**Ongoing** - Following discussions with the management team which supports the PAF (Performance Assurance Framework) reporting, a request will be progressed with IS to develop the BI dashboard to enable the identified metrics to be included within the PAF.
13.1.1 To complete outstanding actions in the medical staffing work plan.	30/06/2021	1	Chief People Officer	**Ongoing** - Job planning is at 81.1% overall for the Trust. Corporate 100%, W&Cs 96.8%, CSS 88.2%, Surgical 80.5%, Medical Division 73.8%, ED is 68.8%.
14.1.1 Introduction of an electronic expenses solution.	30/06/2021	1	Chief People Officer	**Ongoing** - Business Case for E-expenses was approved by Management Board 22.06.2021. With this approval the implementation of e-expenses will now commence. The company providing the software has been informed and the project to implement the system is expected to take between six and eight weeks. Expectations are that the system, subject to the company being available to support, could be made available to staff commencing September 2021.
14.1.1.4 Implementation of e-expenses	30/06/2021	1	Chief People Officer	
14.1.3 Introduction of e-forms to minimise / replace paper-based ESR forms	30/06/2021	1	Chief People Officer	No update provided

Norfolk and Norwich University Hospitals NHS Foundation Trust

4. Tactical Action Plan – Overdue Actions (Cont.)

The Trust has completed 237 individual actions, with a further 24 showing as overdue. These have been followed up and the current status understood. These must be completed or subject to Change Control ahead of the next Evidence Group.

The table below provides an update on the current overdue milestones (24 as at 30 June 2021) and the identified actions to ensure that these are completed.

Overdue Action	Due Date	Days Overdue	Executive Sponsor	Explanation and Next Steps
14.1.3.1 Scripting of the business case options for e-forms, to include options from Allocate, SBS and in-house	31/03/2021	92	Chief People Officer	**Ongoing** – To be reviewed whether this supports the overall objective of 90% automation. Whilst opportunities to consider improvements to the use of electronic forms may exist through linking in with the system wide Digital Health and development teams, the resource implications are unclear at this time.
14.1.3.2 Approval by the SRO (CPO) of the business case for e-forms	07/04/2021	85	Chief People Officer	
14.1.3.3 Approval of the business case for e-forms	30/04/2021	62	Chief People Officer	
14.1.3.4 Implementation of e-forms	30/06/2021	1	Chief People Officer	**Ongoing -** A review of the E-Forms project has identified an opportunity to engage with the system- wide Digital Health team and explore options to use MS Forms to create an electronic forms solution. Whilst this option is likely to be less expensive, it is not without resource implications for the development team and delivery time which need to be resolved before we can progress. Given this, we feel it may be appropriate to review how this workstream interacts with the rest of this project. Contact to be made with Digital Health lead to see if required resources can be made available.
14.1.5 Interventions which will support achieving and sustaining 90% electronic payroll processing	31/03/2021	92	Chief People Officer	**Ongoing** - To align 14.1.5 with the rollout of rostering (UoR 12.1) - to new departments/teams a change control will be requested . With the rollout of rostering to new teams taking place over the next three months we would request that this due date is revised to 30/09/2021.
14.1.5.5 Removal of those manual payroll transactions which will support the achievement of 90% e-payroll	31/03/2021	92	Chief People Officer	
17.1.2b Trust to decide to accept Alternative Procedure offer or commence Market Testing	01/06/2021	30	Chief Finance Officer	No update provided
17.1.3 Dilapidations Survey	21/05/2021	41		
17.1.3b Commence Dilapidations Survey	21/06/2021	10		

Norfolk and Norwich University Hospitals NHS Foundation Trust

5. Getting It Right First Time – Performance Update

Following June's visit to Oral and maxillofacial Surgery, there has been 9 new actions added. The Cardiothoracic visit and a Deep Dive with Cardiothoracic are planned with dates to be confirmed. The NNUH GIRFT platform is now live within the FutureNHS Collaboration Platform.

Delivering the GIRFT programme is integral to the Trust achieving improved Use of Resources and to drive the development of the efficiency programme.

Performance against the GIRFT recommendations, continues to be reported monthly to the Clinical Effectiveness Operational Group (CEOG), which is a sub group of the Clinical Safety & Effectiveness Sub Board (CSESB).

The Trust GIRFT workspace on the Future Collaboration platform has had approval from Information Governance and is live. It has been designed to support specialities with all GIRFT activity.

The table below outlines the performance against the GIRFT recommendations as at 30th June 2021:

- 234 completed actions (+12 from previous month);
- 85 actions are on track (+23);
- 17 actions are overdue by less than 30 days (+16);
- 118 actions are overdue by greater than 30 days (+1), which are all in relation to the GIRFT programme and will be subject to revision and
- 169 (-14) actions do not yet have an agreement status or delivery date, of which 70 actions have been proposed to be marked as not accepted due to the service not being provided by the Trust.

Next Steps

- Continue the enhanced monitoring reviews with individual specialties of their GIRFT recommendation performance, with concentrated focus on actions that are not currently accepted.

Area	Position as at 30 June 2021						
	Awaiting Agreement	Blue	Green	Amber	Red	Total	Grand Total
Surgery	95	166	34	5	89	294	389
Breast Surgery	1	8	1	0	12	21	22
Dermatology	2	9	1	0	5	15	17
General Surgery	2	20	0	0	8	28	30
Hospital Dentistry	9	0	0	0	0	0	9
Intensive and Critical Care	0	6	1	0	1	8	8
Ophthalmology	8	28	7	0	8	43	51
Oral and Maxillofacial	9	14	5	0	5	24	33
Orthopaedic Surgery	7	27	3	0	1	31	38
Paediatric Surgery	0	9	0	0	0	9	9
Spinal Surgery	12	6	5	0	15	26	38
Urology	1	17	5	4	2	28	29
Vascular	3	19	0	0	26	45	48
Ear, Nose and Throat	24	1	5	0	4	10	34
Paediatric T&O	6	0	1	0	0	1	7
Plastic Surgery and Burns	7	0	0	0	0	0	7
T&O (Trauma)	4	2	0	1	2	5	9
Medicine	44	50	37	12	25	124	168
Cardiology	3	3	0	3	0	6	9
Diabetes	0	10	7	2	2	21	21
Endocrinology	1	7	0	0	5	12	13
Neurology	0	5	0	0	4	9	9
Renal	1	6	2	1	6	15	16
Respiratory	5	1	0	0	0	1	6
Rheumatology	10	1	0	0	3	4	14
Stroke	9	1	23	2	0	26	35
Gastroenterology	10	12	5	0	0	17	27
Lung	5	4	0	4	5	13	18
W&C	11	15	1	0	2	18	29
Obstetrics and Gynaecology	0	15	1	0	2	18	18
Neonatology	10	0	1	0	0	1	11
CSS	18	11	2	0	2	15	33
Imaging and Radiology	7	3	2	0	2	7	14
Pathology	11	8	0	0	0	8	19
E&UC	1	4	5	0	0	9	10
Emergency Medicine	1	4	5	0	0	9	10
Grand Total	169	**246**	**79**	17	118	**460**	**629**

REPORT TO THE TRUST BOARD

Date	**4 August 2021**
Title	**Chair's Key Issues from People and Culture Committee Meeting on 26.07.21**
Lead	**Professor Richardson (Committee Chair)**
Purpose	**For Information and assurance**

1 Background/Context

The People and Culture Committee held its latest meeting on 26 July 2021. Papers for the meeting were circulated to Board members for information in the usual way. The meeting was quorate and was held in person and via MS Teams; it was attended by Mrs Janey Bevington and Mr Peter Bush (Public Governors) as observers.

2 Key Issues/Risks/Actions

The following items were identified to highlight to the Board:		
1	Departmental visit	The meeting began with a visit to the Benjamin Gooch Lecture Theatre (which is now used as a Covid PPE distribution point) and the Thomas Browne Library.
2	Workforce IPR	The Committee noted several positive issues arising from the Workforce IPR, notably: - Mandatory training – target achieved - Divisional leaders confirmed that staff are managing to take annual leave – whilst maintaining cover to protect safety – albeit against a background of operational challenge and the need for many staff to work additional shifts to maintain elective recovery
3	Freedom to Speak Up	The Committee received its regular report on FTSU. It was noted that this is a time of real pressure in the Trust, with national and regional imperatives around restoration of services. It is easy to see how this may be translated into behaviour that can be perceived as demanding. An issue has been raised through FTSU to suggest that staff are not always supported or released to undertake work on cultural improvement. The Committee identified that this represents a potential organisational risk.
4	Corporate Risk Register – P&C Extract	The Committee challenged the reduction in rating for risks associated with retention of staff, given previous discussions concerning turnover and retirements. It is recognised that a lot of good work is underway but it is not clear that the residual risk of recruitment and retention has significantly reduced.
5	People & Culture Strategy Development	The Committee was updated on staff engagement undertaken as part of establishing the Trust's People & Culture Strategy. The Committee emphasised the imperative for action resulting from staff feedback and requested that rapid action should be taken to

	Update	publicise how we have responded to what staff have said.

3 Conclusions/Outcome/Next steps

The next meeting of the Committee is scheduled for 25 October.

Recommendation:

The Board is recommended to:

- **note** the work of its People and Culture Committee

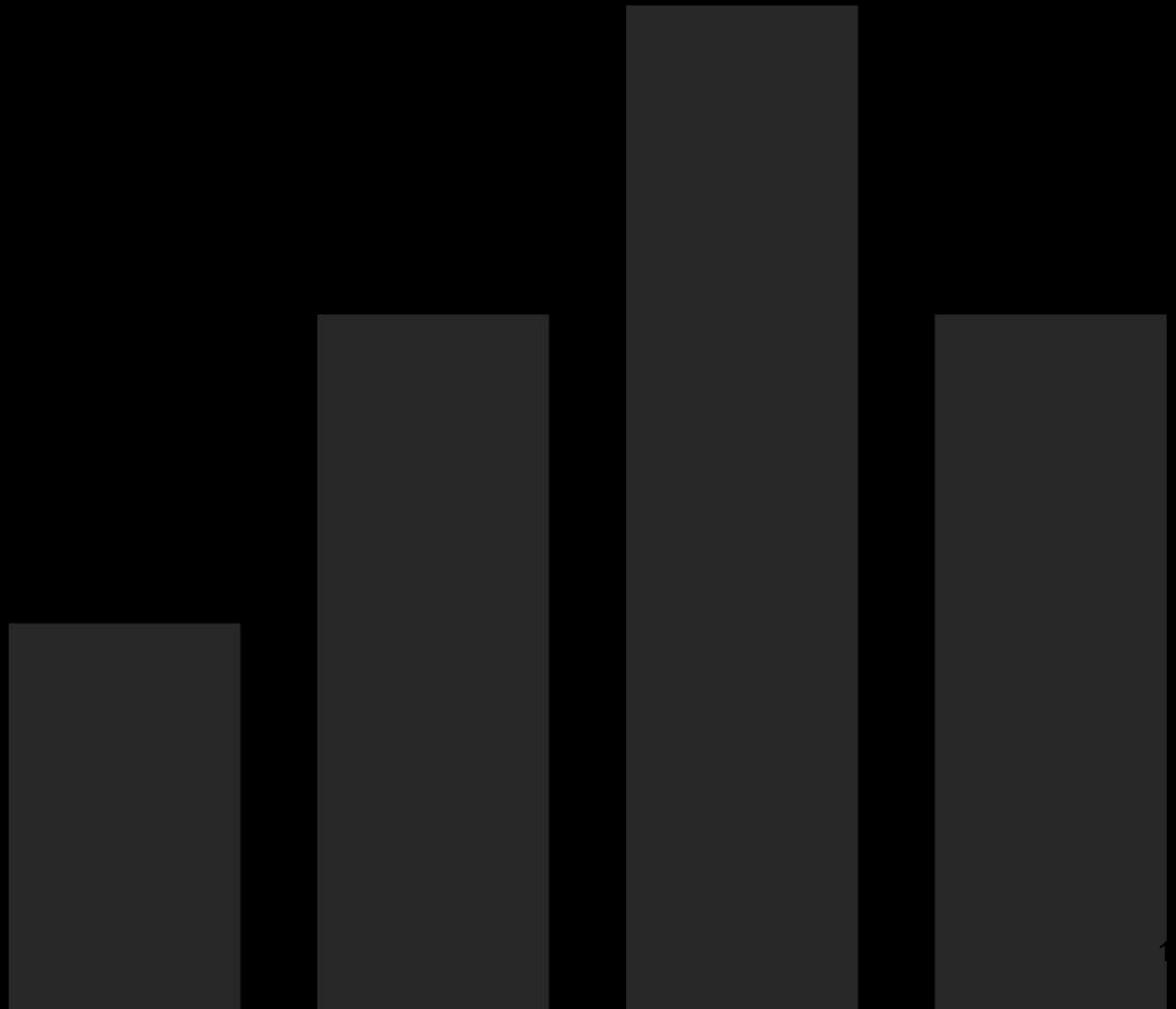
Microsoft | Power BI

Workforce

View in Power BI

Last data refresh:
16/07/2021 07:30:56 UTC

Downloaded at:
16/07/2021 13:16:18 UTC



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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Topic	Metric Name	Date	Result	Variation	Assurance
Staff in Post	Actual Substantive Headcount (WTE)	Jun 2021	8,138	Improvement (High)	No Target
Mandatory Training	Mandatory Training	Jun 2021	92.5%	Improvement (High)	Unreliable
Non-Medical Appraisals	Non-Medical Appraisal	Jun 2021	83.4%	Improvement (High)	Not capable

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

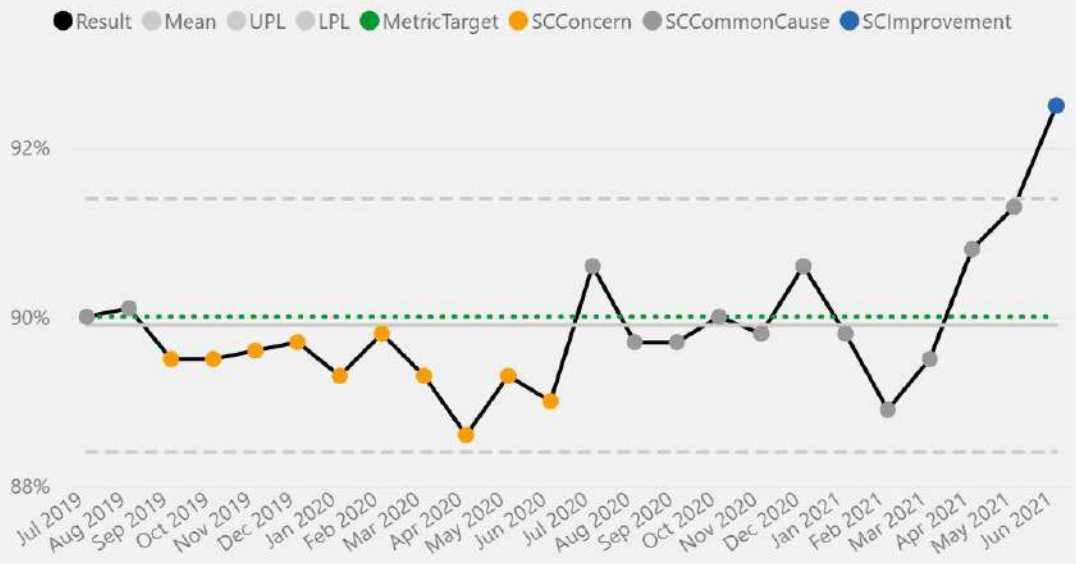
Jun 2021

Variation	Assurance		
H	?	92.5% Result	91.4% UPL
		90.0% Target	89.9% Mean
			88.4% LPL

Analytical Commentary

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

Mandatory Training



Assurance Commentary

As at the end of June, the compliance rate was 92.5% which is a consistent improvement from 88.9% in February 21.

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

NNUH Digital Health
business intelligence

Non-Medical Appraisal

Jun 2021

Variation	Assurance
H	F

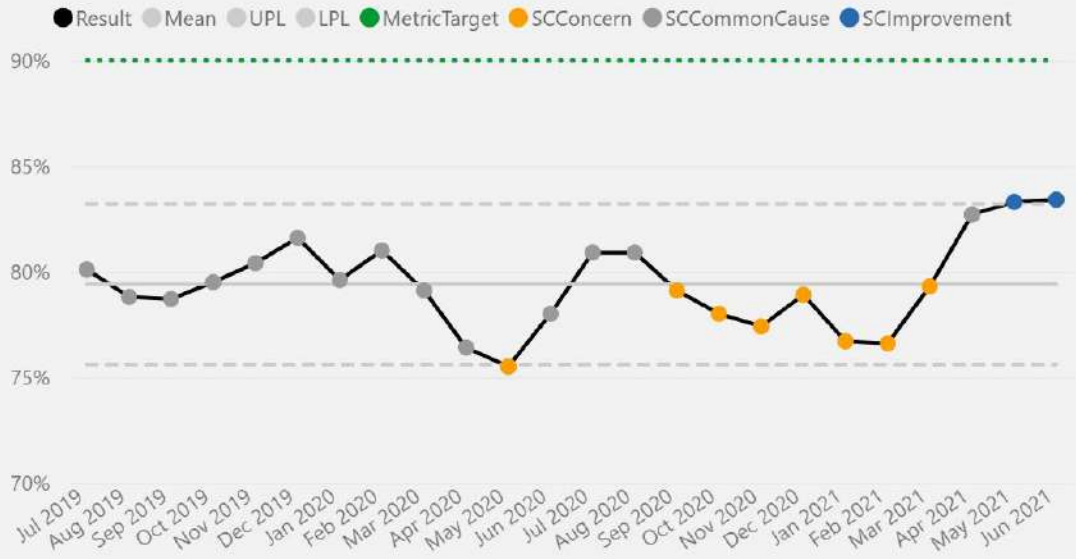
83.4% Result
90.0% Target

83.2% UPL
79.4% Mean
75.6% LPL

Analytical Commentary

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

Non-Medical Appraisal



Assurance Commentary

The Operating Plan for 2020/21 reflects an aspiration for 90% compliance and The Trust has agreed for this to be achieved by August 2022.

83.4% of eligible staff (Non-Medical appraisals) had an appraisal during the last 12 months; this is our highest reported compliance rate and remains on an upward trajectory. Divisions are improving with an overall upward trajectory. Actions for improvement in compliance for the Corporate areas has been put in place in the month of July.

To commence a quality review, a stakeholder panel will be formed in August to offer feedback on four key areas of quality improvement for appraisals along with compliance considerations. Feedback will be reviewed by a Stakeholder Panel to agree the required developments. It is proposed that this Panel will be made up of managers and staff from all disciplines to be identified via the Division along with staff side colleagues and representatives from our staff networks.

Improvement Actions

20/05/2021 – HR will lead a quality review, with key stakeholders, this summer to develop improvements in the appraisal process to support the target of achieving 90% compliance by August 2022.

Sickness Absence

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business intelligence

Monthly Sickness Absence %

Jun 2021

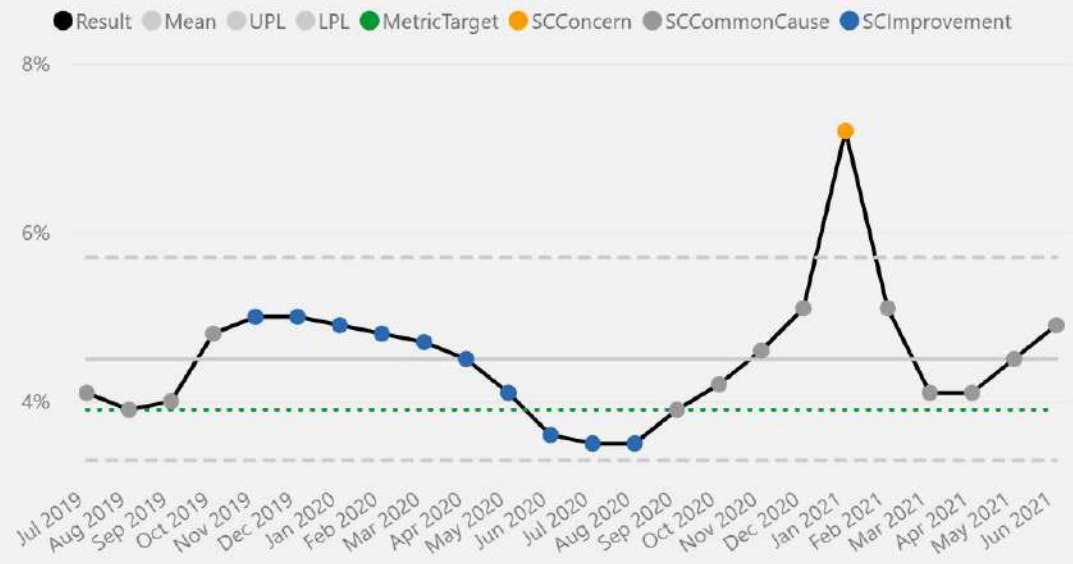
Variation | Assurance

4.9% Result	5.7% UPL
3.9% Target	4.5% Mean
	3.3% LPL

Analytical Commentary

Variation is Common Cause

Monthly Sickness Absence %



Assurance Commentary

The Operating Plan for 2020/21 has set a challenging 12 month rolling average target of 3.9% for sickness. As at 30 June 2021, that rate is 4.48%. The monthly absence figure for June is 4.89%.

All figures since March 2019 include Covid related sickness absence. Had Covid sickness been excluded the 12-month rolling average rate would be 3.79%.

The Norfolk and Waveney STP has recently provided key performance indicators for the STP as at 31st May 2021. The Trust's sickness absence rate, in comparison to the Trusts in the STP, is rag rated as red at 4.6%. In direct comparison with the Acute Trusts of QEH at 5.9% and JPUH at 4.9%.

Improvement Actions

Oct-2020 – A refresh of the attendance policy and toolkits were approved at PACS on 15/10/2020

May 2021 – The revisions to the attendance policy and supporting toolkits have been launched to all staff with follow up manager led training to be provided in future months.

July 2021 - Both the Covid sickness absence rate and the sickness absence rate are increasing and this will be discussed at the Attendance Improvement Group (AIG) in July to establish appropriate action plans for intervention and improvement.

Staff Turnover

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business intelligence

Monthly Turnover

Jun 2021

Variation | Assurance

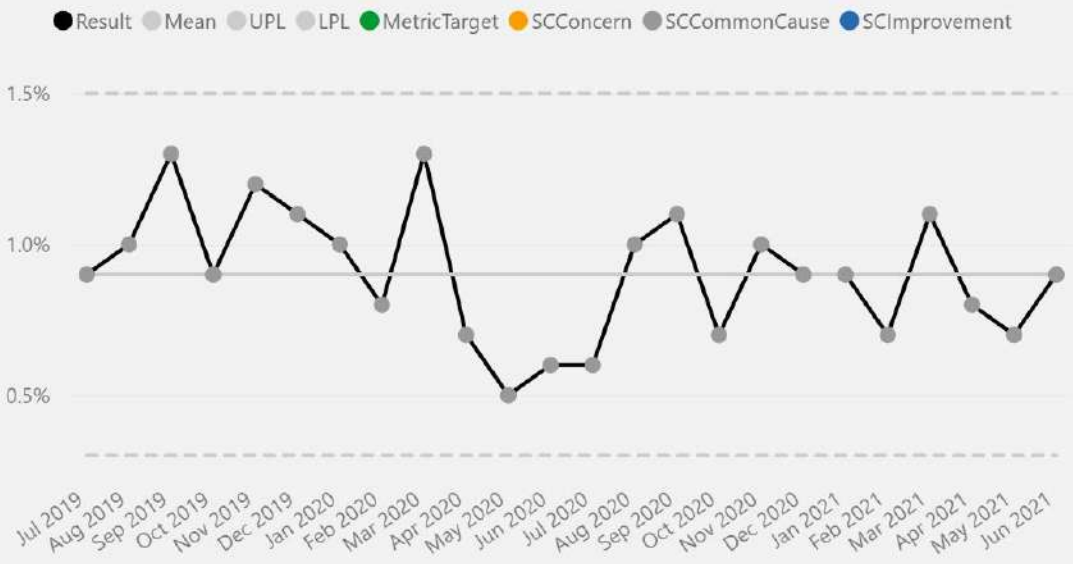
0.9% Result
N/A Target

1.5% UPL
0.9% Mean
0.3% LPL

Analytical Commentary

Variation is Common Cause

Monthly Turnover



Assurance Commentary

The monthly turnover rate for June 2021 is 0.94% - an increase from May (0.67%) and higher than June 2020 (0.57%). The actual number of leavers for June 2021 is 67.1 WTE compared to 48.2 WTE for May 2021.

The 12-month average turnover rate is 10.6%, an increase of 0.4% from May 2021. This increase will be reviewed and actions agreed. In comparison to the Acute Hospitals in the N&W area, JPUH is at 12.3% and QEH is at 9.7%.

The Trust is the Lead Provider for an STP Retention and Improvement Group which has focused review on three key areas; legacy nurses, exit interviews and career conversations. The Trust is also reviewing three potential flight risks areas to development action plans for preventative action. Specific Trust retention initiatives will be agreed and confirmed at the Recruitment and Resourcing Improvement Group.

Each Division are developing recruitment trajectories for focused resolutions for key identified areas.

Improvement Actions

May 21 - The turnover for the Trust has stabilised. The Trust's turnover, vacancy position, recruitment trajectories and retention plans will be developed for the Trust and will be actioned and monitored at the Recruitment and Resourcing Improvement Group.

July 21 – the Recruitment and Resourcing Improvement Group will agree the actions for retention in July.

Staff in Post

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business intelligence

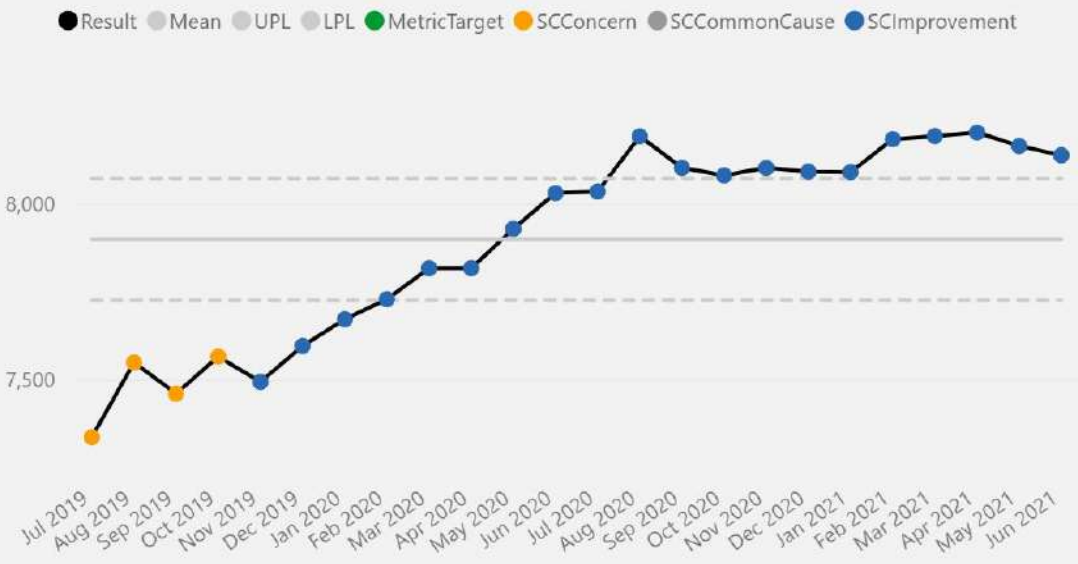
Actual Substantive Headcount (WTE)

Jun 2021

Variation | Assurance

8,138 Result	8,072 UPL
N/A Target	7,899 Mean
	7,725 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.

Due to the establishment review which has led to an increase in vacancies, it is expected that the substantive headcount will increase throughout this year.

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 4.4%, 337.5 WTE (7,730.2 staff in post 31-Mar-20)

Since April 2019 there has been an increase of 12.4%, 890.2 WTE (7,177.5 staff in post 31-Mar-19)

Since April 2018 there has been an increase of 18.9%, 1,280.6 WTE (6,787.1 staff in post 31-Mar-18)

Since April 2017 there has been an increase of 25.1%, 1,620.1 WTE (6,447.6 staff in post 31-Mar-17)

Vacancies

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business intelligence

Variance: Headcount (WTE)

Jun 2021

Variation	Assurance
	

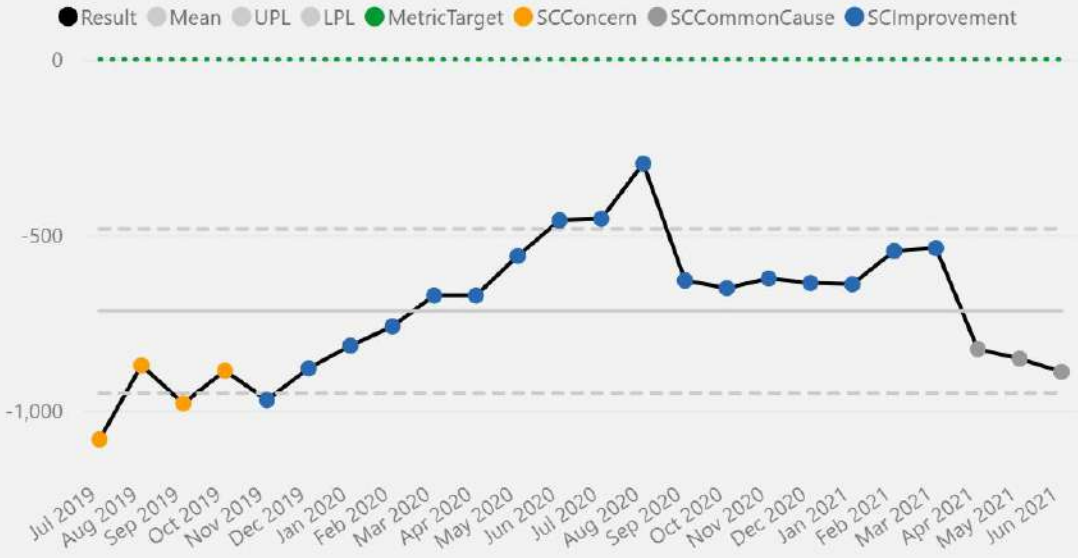
-890 Result
0 Target

-482 UPL
-716 Mean
-950 LPL

Analytical Commentary

Variation is Common Cause

Variance: Headcount (WTE)



Assurance Commentary

Due to the Nursing & Midwifery Establishment Triangulation and Rebasing exercise, there is an increased vacancy position for Registered Nursing with an additional 55 FTE and Unregistered with an additional 76 FTE. This has been made effective in May's Divisional budget. Recruitment actions will be agreed and monitored at the Recruitment and Resourcing Improvement Group.

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.

May 2021 – Due to varying recruitment and retention strategies reduced figure, only 33.6% of the identified hard to fill posts are now required to be actively recruited to.

Recruitment (Non-Medical)

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Time to Hire - Total

Jun 2021

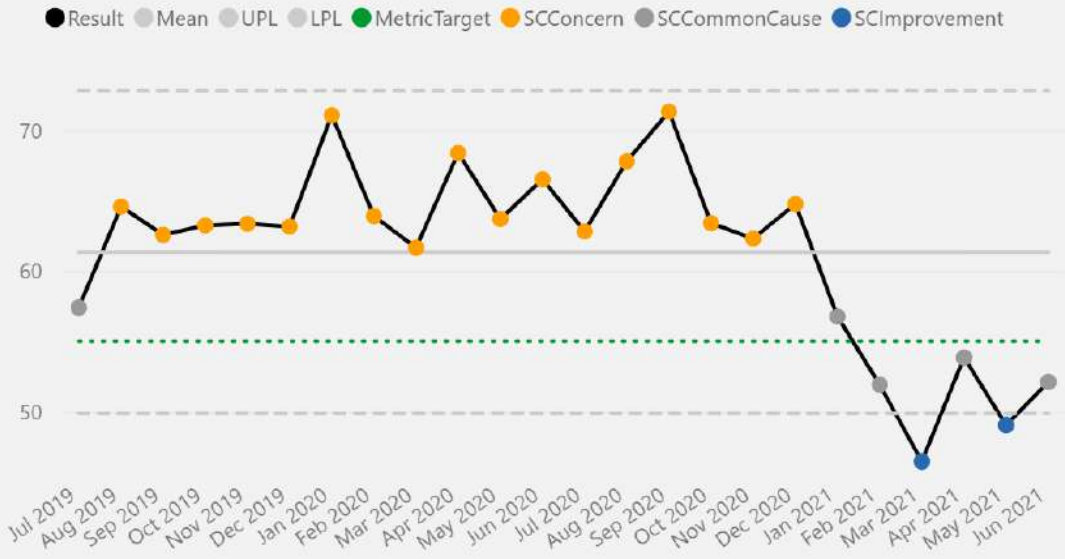
Variation	Assurance
	

52.1 Result	72.8 UPL
55.0 Target	61.3 Mean
	49.9 LPL

Analytical Commentary

Variation is Common Cause

Time to Hire - Total



Assurance Commentary

The 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. Additional escalations have been put in place to intervene to prevent the time to hire increasing.

For June 21 the time to hire figure is 52.1 days, an increase from May (49.0 days). One Division has increased above the 55 days and particular actions have been agreed where intervention is felt to be required and this is monitored in the Recruitment and Resourcing Improvement Group.

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	Jun 2021	16.9		Common Cause		No Target