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

Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

MEETING OF THE TRUST BOARD IN PUBLIC

FRIDAY 29 JANUARY 2016

A meeting of the Trust Board in public will take place at 9am on Friday 29 January 2016 in the Boardroom of the Norfolk and Norwich University Hospital

AGENDA

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1	Apologies			
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3	Matters arising		Discussion	
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Date and Time of next Board meeting in public

The next Board meeting in public will be at 9am on Thursday 24 March 2016 in the Boardroom of the Norfolk and Norwich University Hospital

MINUTES OF TRUST BOARD MEETING IN PUBLIC

HELD ON 27 NOVEMBER 2015

Present:	Mr J Fry	- Chairman
	Mrs S Budd	- Acting Director of Finance
	Mr P Chapman	- Interim Medical Director
	Mr M Davies	- Chief Executive
	Mr M Fleming	- Non-Executive Director
	Mr T How	- Non-Executive Director
	Mr M Jeffries	- Non-Executive Director
	Mrs E McKay	- Director of Nursing
	Mr J Over	- Director of Workforce
	Professor D Richardson	- Non-Executive Director
	Mrs A Robson	- Non-Executive Director
	Miss S Smith QC	- Non-Executive Director
In attendance:	Ms F Devine	- Director of Communications
	Mr J P Garside	- Board Secretary
	Mr S Hackwell	- Interim Director of Strategy
	Mr R Parker	- Interim Chief Operating Officer
	Ms V Rant	- Assistant to Board Secretary
	Members of the public	

15/077 **APOLOGIES**

No apologies were received.

15/078 **MINUTES OF PREVIOUS MEETING HELD ON FRIDAY 25 SEPTEMBER 2015**

The minutes of the meeting held on Friday 25 September 2015 were agreed as a true record and signed by the Chairman.

15/079 **MATTERS ARISING**

The Board reviewed the Action Points arising from its meeting held on 25 September 2015 as follows:

15/063 The Board was informed that the draft Research Strategy has been reviewed by the NNUH/UEA Joint Research and Education Board and will inform the strategic proposals for the Trust Board to discuss in December.

15/064 The Board received data relating to the outcomes for nurse education at UEA/NNUH as assessed through the Quality Improvement and Performance Framework. This shows that the NNUH is consistently 'green' rated. Mr Over provided further information from an HEE analysis which shows that up to 25% of student nurses leave training during their studies. Professor Richardson explained that with the revision to the funding for nurse training it will be incumbent upon providers to offer courses that deliver student satisfaction and there will be a need to improve on a 25% drop out rate. The Board was informed that the change in funding arrangements is accompanied by a lifting of the cap on places that may be offered and the UEA may look to increase the number of students it can enrol.

15/064 Information concerning the number of staff leaving the NNUH nursing workforce is included in the IPR at item 15/081.

15/064 The Board was informed that the Executive Board has established a Capital Committee to plan and oversee implementation of the Capital Programme. An update report on this work will be provided to the Finance and Investments Committee meeting on 22 December 2015.

15/064 Information concerning outstanding vacancies is included in the CEO Report.

15/065 Information concerning the improvement in stroke performance is included in the Integrated Performance Report.

15/065 Information concerning the number of patients who have waited longer than the 18 week RTT target is included in the Integrated Performance Report.

15/065 Information concerning the nursing workforce is incorporated into the Integrated Performance Report.

15/069 The Board was informed that PWC have been engaged to assist review of the Trust's Risk Management structures and Strategy and the Board will be updated at its meeting in January. **Action: Mrs McKay**

15/069 The High Risk Tracker is included as part of the Integrated Performance Report.

15/070 An update quarterly BAF report will be prepared for the Audit Committee meeting on 11 December 2015 and the Board will be updated through the Audit Committee report accordingly.

15/071 The Audit Committee Work Schedule incorporates preparation of the Committee's Annual Report in advance of the Board meeting at which the Annual Accounts are approved.

15/074 At the last Board meeting, Mr Nye was thanked for his contribution to the Trust as Lead Governor.

15/075 Mr Over confirmed that updates concerning suspended staff will be provided at future meetings of the Board in private.

15/080 **CHIEF EXECUTIVE REPORT**

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

(a) CQC Inspection

The work undertaken to prepare for the CQC inspection has been valuable, leaving us with the feeling that the great work of the hospital had been demonstrated. It has been an opportunity to learn/improve our services for patients.

Following the main inspection the CQC have undertaken two unannounced visits and we have provided them with a substantial amount of documentation to inform their review. It is expected that the CQC will publish their report in February 2016.

Mr Davies congratulated all staff at a meeting on their conduct during the inspection and reported the comments of the inspection team about how impressed they were

with the care they witnessed for our patients. Governors and Directors were also thanked for their time and assistance in this process.

(b) Executive Team and Senior Appointments

Mr Davies informed the Board that interviews were held on 23 November 2015 for the Chief Operating Officer post and it is expected that an announcement will be made next week.

Interviews for Chief Finance Officer will be held on 15 December 2015.

Interviews for the Chief of Division positions are being held on 10 and 11 December 2015. It is expected that there will be four Divisions: Medical; Surgical; Clinical Support; and Women and Children. The Divisions will be different sizes, and this will allow for succession planning and different levels of support to be put in place.

(c) Staff Engagement and Communication

The level of staff engagement and communication continues to improve with regular 'Viewpoint' staff sessions and follow-up communication. A bi-monthly 'Viewpoint' session has been arranged for staff at Cromer and District Hospital.

Concerning recruitment, Mrs Robson asked what further action is taken if it is not possible to recruit to a consultant post. Mr Chapman explained that this depends on the individual circumstances. It was not possible to appoint to all vacant posts within the Respiratory Department and 2 vacant posts remain unfilled. Restorative Dentistry is a difficult post to recruit to as it is a very specialist area relating to reconstruction of the jaw following cancer. The Job Description for the consultant post in the Renal Department is being reviewed and it is planned that this will be re-advertised during 2016.

Mr Davies informed the Board that all Trusts experience difficulty recruiting in some specialties and it will vary between specialties. At recent interviews, it was felt that the attractiveness of working at NNUH has increased.

Mr Fleming asked if we are doing all that we can to actively promote and attract people to come and work at NNUH. Mr Davies confirmed that the new Chief of Divisions would be looking at those posts that have been difficult to fill in order to make them more attractive to prospective applicants.

(d) Education and Training

The Board was informed that Professor Dylan Edwards will succeed Professor Ian Harvey as Executive Dean of the Faculty at the end of January 2016.

(e) Research

The NNUH/UEA Joint Board have agreed to proceed with a joint appointment of a Director of Research and Innovation who will lead implementation of the joint research strategy.

The Joint Board has agreed to develop a bid to become an NIHR Biomedical Research Unit. NIHR Biomedical Research Units undertake translational research in priority areas of high disease burden and clinical need. If our bid is successful it would be a positive move in being recognised as an academic health centre. The competition to become an NIHR Biomedical Research Unit is undertaken approximately every four years and it is expected bids will be due for submission in April 2016.

(f) Vanguard Theatre

The building work to install the temporary Vanguard Theatre has commenced on the front plaza of the hospital. The theatre will provide additional day case capacity and the feedback from both staff and the public on this development has been positive.

(g) Electronic Prescribing and Medicines Administration (EPMA)
The introduction of the e-prescribing pharmacy system is making good progress. After a successful pilot of the system on several wards at NNUH, the system is being introduced into our medical wards. A phased implementation of the system in both the James Paget and NNUH is expected to be completed in 2016.

(h) Electronic Communication with Patients
A project has been initiated to look at ways to increase electronic communication with patients. Proposals to improve efficiency and communication will be reviewed by the Executive Board and the Board will be updated on any progress.

Mr How asked how substantial the savings might be if this project comes to its full fruition. It is too early to determine what the quality and efficiency gains will be but assessing this will form part of the business planning process. Safeguards for the protection of patient confidentiality will need be incorporated into any electronic communication processes.

(i) CCG Contract for Services
Mr Parker updated the Board on discussions that have commenced with the CCGs concerning the contract for clinical services in 2016/17. The majority of acute providers in the NHS are in deficit and there is a lot of pressure on the CCGs to enforce existing contracts and to control the cost of clinical services next year. The situation in Norfolk is complicated by the fact that there are five commissioning CCGs and although there is a single lead commissioner we have recently received instructions from South Norfolk CCG that a number of procedures should no longer be provided. It is uncertain that this position will remain particularly with regard to second eye cataract surgery.

15/081 **INTEGRATED PERFORMANCE REPORT**
The Board received and discussed the Integrated Performance Report (IPR) from the Executive Directors.

Mr Parker informed the Board that the IPR had been revised to incorporate transformation and recovery actions. The monthly summary of performance is used to inform staff at the Viewpoint meetings. Mr Fry asked if the target figures could be added to the monthly summary sheet and the monthly summary template in the IPR will be revised to include relevant targets for ease of reference. **Action: Mr Garside**

(a) Performance
Five new risks of 15 or above have been added to the High Risk Register in October. Performance against Monitor's Risk Assessment Framework is rated as 'Red' reflecting failure to achieve the A&E 4 hour, cancer 62 day GP referral and 18 Week RTT targets.

(i) Cancer, Stroke and Diagnostic Waits
The challenges to performance against these targets remains as previously reported. Cancer 62 day performance is being prioritised and we are on track to achieve this target in December 2015.

We continue to achieve the 31 day cancer target and this is now considered to be sustainable.

Stroke performance has improved with the targets for access to HASU, thrombolysis and CT within 60 minutes being achieved in October. Work will continue to maintain performance with regard to stroke patients and associated targets.

Diagnostic 6 week wait performance is expected to improve and compliance with this target is expected to be achieved by the end of March 2016. Additional capacity is being sourced via Medinet to respond to increasing demand.

(ii) 18 Week RTT

A formal remedial action plan process has been implemented for the recovery of the 18 Week RTT. Additional capacity in Norfolk is being utilised wherever possible and the Vanguard Theatre will be opening in December to treat day case patients. As it has been difficult to obtain private sector capacity we are exploring other solutions with the National RTT Recovery Team.

At the next Board meeting the Board will be provided with information concerning the Vanguard Project and whether this will provide sufficient additional capacity to enable recovery of the RTT performance. **Action: Mr Parker**

Mr Parker explained that in recent discussions the CCGs we have emphasised that recovery of RTT performance will not be possible until the summer of 2016. Mrs Robson asked when the Vanguard Theatre would be up and running. Mr Parker explained that following installation of the unit, there will be a two week period for the unit to 'settle' and be tested. It is expected that the unit will be fully operational in the week commencing 14 December.

Mr Fry asked how many operations were expected to be performed in the Vanguard Theatre each month. Mr Parker explained that as well as surgical capacity, the unit will also be providing some diagnostic capacity too. Mrs Budd explained that it is expected that there will be 3 to 4 cases per list and two lists per day. Support staff will be provided by Vanguard to assist our surgeons in theatre.

(iii) A&E 4 Hour Wait

Mr Parker explained that we experienced an improvement in performance in Quarter 1 following initial engagement of the recovery plan and refreshing of site operations. Improvements were also seen following introduction of the Patient Flow Transformation Project which reduced the number of breaches of the 4 hour target due to lack of beds. Since the introduction of a second decision maker at night, assessment times for patients have been reducing.

In the early part of the summer, we experienced difficulty recruiting sufficient additional decision making doctors and there was an increase in patients with more serious conditions arriving by ambulance. The 'discharge to assess' service was suspended in the late summer and this undermined bed capacity which had been released in the patient flow project. There has also been a lack of clear and consistent clinical leadership within the Emergency Department and this has not enabled improved ways of working to be introduced.

Mr How asked why the 'discharge to assess' service had been suspended. Mr Parker explained that the service had been introduced as a temporary service and that the CCGs had wanted to evaluate the effectiveness of this service and this had caused a significant backlog of patients.

Mr Fleming asked if the cause of the acuity shift in patients arriving in the Emergency Department had been determined. Mr Parker confirmed that we are working with the CCGs to identify any factors that may be causing this increase and the CCG are aware

that the acuity of our patients has been higher than that elsewhere. A Pre-Hospital Taskforce has been established to introduce schemes to help reduce the number of patients needing to be brought to the Emergency Department.

We are continuing to review and ensure our processes are as efficient as possible. Having senior clinicians working closer with the Emergency Department is helping in the evaluation of patients on arrival and establishing whether they can be seen elsewhere.

A number of immediate, short and medium term actions are being taken to recover performance against our revised Recovery Plan not least with regard to patients with a length of stay longer than 14 days.

Short term actions to prepare for the Christmas period are the re-launch of the discharge to assess service, implementation of the 'heightened response plan' to reduce the number of boarders. To lessen pressure during the post-Christmas period, every patient will receive a senior review on a daily basis.

Medium term actions in the period between January and April 2016 will be to launch the integrated discharge hub and exemplar ward programme and to identify improvements through our membership of the National Frailty & Ambulatory Care networks. Mr Parker explained that the process for complex discharge is very complicated. The discharge hub is intended to coordinate a number of agencies to support discharge of these patients.

Our trajectory is to achieve sustainable performance at 90% in December, 92% by March and 95% by April 2016.

Mr Fleming asked if the key specialties that had experienced an increase in waiting times and delays to diagnostics were different from those previously reported. Mr Parker explained that a detailed exercise is undertaken to map out the capacity in each specialty and this is used for the development of recovery plans. The specialties are fully engaged in performance recovery.

(b) Workforce

Mr Over reported there has been an increase in sickness absence due to cold/flu related illnesses and the rate in October was 4.91%. The sickness absence rate for the last 12 months is 4.2%.

Mrs Robson noted that there is variability in the sickness absence levels on different wards. It was explained that this may reflect a number of factors including higher acuity/demand or a smaller number of staff within that area. Sickness absence on wards is closely monitored and areas with increased levels will be discussed at the performance review meetings.

Professor Richardson commented on the variability of appraisal processes that is found in different organisations but one key aspect of all appraisals should be a discussion about performance.

Doctors are currently leading the way in completion of appraisals and this has happened since the revalidation process that was introduced. Mr Over explained that from April 2016 all nurses will have to undertake a revalidation process every 3 years to maintain their registration with the NMC. It is planned to give nursing staff dedicated/protected time for their appraisals for the new revalidation process. The new framework for appraisals includes discussion and rating of staff performance.

The 2015 staff survey closed on 26 November. Around 3,000 responses were received from our staff and the results are expected to be published in February 2016.

The total nursing spend as a percentage of agency spend was 14.4% in October (target 8%). Monitor is proposing to introduce hourly price caps on the total amount paid per hour for agency staff to basic pay plus 55% from April 2016.

The Board was informed that industrial action by the junior doctors is planned to take place on 1 December. Careful planning has been undertaken to minimise disruption and to ensure that safety of our patients is maintained. Emergency care for patients will not be affected.

Mr Jeffries queried why the percentage of unregistered care staff day hours and unregistered care staff nigh hours was higher than 100%. Mr Over explained that this was due to additional staff who have been requested for high acuity patients and because additional support has been required as it has not been possible to fill a registered nurse place. Between July and September, there was a higher acuity of patients. The target planned level would be 100%.

The mandatory training target will be reviewed to ensure that it is appropriately challenging. **Action: Mr Over**

(c) Non-Clinical Safety

The Non-Clinical Safety Sub-Board met in November. Issues reported and reviewed were in relation to HSE inspection (safer sharps), Risk Register, security management and fit testing.

(d) Quality and Safety

The HSMR was 98.5 in October 2015 and the year to date figure is 109.7.

One Never Event has been reported in November relating to diagnosis of a mis-placed nasogastric tube.

The Board received the NHS Safety Thermometer comparing performance with that of other local Trusts. Our higher rate of pressure ulcers indicates a high number of patients admitted with existing pressure ulcers.

The Board was informed of 3 Serious Incidents reported as having caused severe or catastrophic harm in October. Root Cause Analysis investigations are being undertaken.

The Board was informed that our SHMI has been below 100 since 2013. Mr Fry noted that the figures given for the SHMI were for 2013/14 and asked if there was more up to date information available. Mr Chapman explained that the data is released annually there is a delay in the data's release due to the degree of analysis undertaken by Dr Foster but he would look to see if more recent figures have been released.

Focus continues on reducing medication errors for insulin and those causing harm. All incidents are logged in Datix and data is reviewed to determine themes arising from reported incidents. The main trends of medication incidents related to medicine reconciliation and missed doses. Any learning themes arising from the RCAs are reported to staff through the monthly incident and Never Event OWL.

A business continuity plan for the EPMA has been approved. The plan has been designed to maintain patient safety and continuity of business in the event of system failure.

An ICE duplicates Risk Management Plan has been approved to enable 75,000 duplicate entries to be removed from the ICE pathology system and to facilitate adoption of ICE requesting across the 3 acute Trusts in this region who are part of the Eastern Pathology Alliance.

The Board was informed that work continues to improve our approach to end of life care. Training and support for end of life care is being provided for staff and revised guidance has been agreed. Regular audits of documentation are undertaken and there has been an improvement against 28 elements since July 2015.

The methodology for calculation of the Friends and Family Test Score has changed from October 2015 to a national percentage score and the scores for all areas have improved. Work continues to improve the score further in our Emergency Department.

5 hospital acquired C Difficile infections were reported in October – 4 were found to be non-trajectory in that they were acquired whilst under our care but the treatment that we provided was not faulted. 9 C Difficile infections have been reported to date in November. There have been 16 hospital acquired C Difficile infections in the year to date.

Ms McKay explained that the format of the Ward Dashboard is being revised to further improve its clarity and presentation.

(e) Productivity and Finance

Mrs Budd detailed the financial position at month 7 relative to the Financial Plan. There has been an increase in agency/locum costs which meant that pay was £1,057k higher than the budget. Our second half year plan has been changed following Monitor's request to revise and rebase plans for the first half of the year to 'actual costs'. Our forecast deficit remains unchanged at £9.5m.

The Cost Improvement Plan for 2015/16 is a target of £21.2m. Transformation projects alongside Newton expect to realise savings of £9m. Savings of £8.9m have been achieved to date in month 7 against the plan of £11m and this has been due to delays in the theatres and outpatient productivity projects (£1.5m).

The main risks to achieving the Financial Plan are from financial penalties and additional pay costs if we fail to deliver planned clinical activity. The CCG is entitled to enforce penalties if we do not achieve our planned recovery trajectories for the 18 Week RTT, cancer and A&E targets and penalty costs have been estimated at £8m. There is a financial risk of between £2m to £4 for failing to achieve CQUIN targets and the clinical teams are reviewing to look at ways of avoiding this.

The forecast assumes that clinical income will be achieved according to the Plan. A review has been undertaken of the underlying assumptions on timing of planned investments and existing provisions. The financial penalties and CQUIN targets have not been reflected in the forecast until clarification on the level of risk has been obtained from the CCG and clinical departments.

The closing cash balance at the end of October is £56,162k. In light of the forecast deficit, financial penalties and pressures in 2016/17 we will need to maintain tight control over cash for the foreseeable future.

An explanation will be provided of the BAF risk 17 and how the 'operational' element of this is distinguished from BAF risk 12. **Action: Mrs Budd**

(f) Effectiveness

Following introduction of a new system of reporting, recruitment to NIHR portfolio studies has improved and 700 patients have been recruited over the last month. Performance towards the trajectory in 2015/16 is anticipated to be below the target of 5,000.

Mr Jeffries asked if the 5,000 recruitment target was an achievable target for recruitment to studies. Mr Chapman informed the Board that there had been a decrease in levels of recruitment reported nationally but it should be possible to achieve this target. A consequence of not achieving these targets is a reduction of CRF funding but it will also affect our reputation and ability to attract research if our performance is below the required levels.

The intention to apply for BRU status is aimed at enhancing our research reputation, activity and income.

Good progress is being made towards completion of audits on the Audit Plan for 2015/16. Support is being provided to those directorates that are not doing as well as expected in order to look at ways of improving their performance.

There has been a slight increase over the last 2-3 years in the number of patients detained under Section 5(2) of the Mental Health Act.

An in-depth review of TKR PROMS patients has been completed by the Trauma and Orthopaedic Department. It was found that patients at NNUH had similar health gains compared to England but we were found to be negative after a population adjustment. Some patients were found to have been under recorded for comorbidity. A pilot project has commenced to determine the impact of intensive post-operative physiotherapy provision in the community.

15/082 **IMPLEMENTING THE BOARD LICENCE AND UNDERTAKINGS**

The Board received a report from Mr Garside concerning progress towards implementation of the Trust's Licence Undertakings.

The Trust's Licence Undertakings relate to three areas: operational, governance and strategy planning.

Progress in respect of operational performance is reported regularly through the Integrated Performance Report.

The Board will be receiving a presentation, following the meeting in public, from Mr Simon Hackwell (Interim Director of Strategy) concerning development of the Trust's strategic intent.

The Undertaking in relation governance was discussed with Monitor at the PRM on 3 November. The Trust has asked PWC to undertake a review of actions taken in response to their governance report and to offer advice on any further improvements that can be made.

It may be that Monitor will agree to issue a Certificate of Compliance with the governance Undertakings but this may need to await receipt of the CQC report.

15/083 **FEEDBACK FROM THE COUNCIL OF GOVERNORS**

Mr Fry informed the Board that elections were underway to fill vacant governor posts in the constituencies for Norwich, Broadland and Breckland. The Board will be kept informed of the outcome of these elections.

15/084 **ANY OTHER BUSINESS**

Mr Chapman confirmed that the latest SHMI figures had been released by Dr Foster and these will be included in the next IPR report.

15/085 **DATE AND TIME OF NEXT MEETING**

The next meeting of the Trust Board in public will be at 9am on Friday 29 January 2016 in the Boardroom of the Norfolk and Norwich University Hospital.

Signed by the Chairman: …… Date: ……

Action Points Arising:

	Action
15/079	The Board was informed that PWC have been engaged to assist review of the Trust's Risk Management structures and Strategy and the Board will be updated at its meeting in January. **Action: Mrs McKay**
15/081	The monthly summary template in the IPR will be revised to include relevant targets for ease of reference. **Action: Mr Garside**
15/081	At the next Board meeting the Board will be provided with information concerning the Vanguard Project and whether this will provide sufficient additional capacity to enable recovery of the RTT performance. **Action: Mr Parker**
15/081	The mandatory training target will be reviewed to ensure that it is appropriately challenging. **Action: Mr Over**
15/081	An explanation will be provided of the BAF risk 17 and how the 'operational' element of this is distinguished from BAF risk 12. **Action: Mrs Budd**

REPORT TO THE TRUST BOARD	
Date	**29 January 2016**
Title	**Chief Executive's Report**
Author(s)	**Mark Davies, Chief Executive**
Purpose	**To update the Board on matters relating to the Trust that are not covered elsewhere in the papers.**
Summary including Key Performance Issues/Risks	**Key points are noted regarding:** - **External Assessment** - **Staff matters** - **Strategic context** - **Education and Training** - **Research** - **Infrastructure Development** - **Liaison with Governors and Members**
Action Required (✓)	FOR INFORMATION ✓ FOR DISCUSSION FOR APPROVAL

CHIEF EXECUTIVE'S REPORT TO TRUST BOARD 29 January 2016

This report is intended to update the Board on matters relating to the Trust that are not covered elsewhere in the papers for our meeting.

1. EXTERNAL ASSESSMENTS

1.1 Care Quality Commission Inspection

Over the last month we have continued to receive requests for information from the CQC following their inspection in November. We have been informed that production of their report has been delayed slightly by the Christmas holiday period but this is still expected in February.

2. STAFF MATTERS

2.1 Senior Appointments

(i) As part of our divisional restructuring, interviews for the key leadership positions in our new Divisions have been held and the following appointments have been made:

Medical Division
Chief of Medicine – Dr Frankie Swords (Consultant Endocrinologist)
Divisional Nursing Director – Louise Sokalsky
Divisional Operations Director – Chris Cobb

Surgical Division
Chief of Surgery – Mr Milind Kulkarni (Associate Medical Director; Paed Surg/Urologist)
Divisional Nursing Director – external appointment made subject to references etc
Divisional Operations Director – Jo Beven

Women's and Children's Services
Chief of Women's and Children's Services - Dr David Booth (Consultant Neonatologist)
Divisional Nursing Director – Lucy Weavers
Divisional Operations Director – Amy Eagle

Diagnostics and Therapeutics
Chief of Diagnostics and Therapies – Professor Carol Farrow
Divisional Operations Director – TBC
Divisional Clinical Services Director - TBC

(ii) A number of consultant appointments have been confirmed since the last report, as below. We look forward to welcoming these new doctors to our team:

Nabil Hujairi	Radiology
Francoise Sheppard	Emergency Medicine
Parvez Moondi	Anaesthetics
Robert Major	Emergency Medicine

Tarek Kherbeck	Emergency Medicine

(iv) A number of consultant vacancies remain as below:

Speciality	No of posts	Position
Neurology	2	Dept relooking at advert and jd
Respiratory	2	Dept relooking at advert and jd
Restorative Dentistry	2	Recruitment underway
Renal	1	Dept relooking at advert and jd
Radiology	3	Recruitment underway
Haematology	1	Recruitment underway
ED	1	Recruitment underway
T&O (Hip Surgery)	1	Recruitment underway
T&O (Shoulder)	1	Out to advert
Cardiology	1	Recruitment underway
Microbiology	1	Recruitment underway

2.3 Staff engagement and communication:

We have continued our approach towards increased staff engagement, with regular 'Viewpoint' staff sessions and follow-up communication. Attendance at these sessions is healthy and they provide an opportunity to keep staff updated on developments in the Trust, with a Q&A session with the executive team.

Regular Viewpoint sessions have now also started at Cromer Hospital.

3 STRATEGIC CONTEXT

3.1 Norfolk Provider Partnership

Further to the Board's previous discussion, the Norfolk Provider Partnership has been formally established. This met with significant positive publicity and the EDP headline was "A new era dawns for our NHS".

There has also been an inevitable certain amount of concern and we have emphasised that the partnership is about working collaboratively to enhance and strengthen the clinical services available for our patients in Norfolk. .

Both Monitor and the CQC are aware of the NPP as indicative of the role played by the Trust in the broader healthcare system.

3.2 Strategy Update

Following the Board's discussion in December on the Trust's Strategy, our Strategy document was sent to Monitor in accordance with our agreed Undertaking.

This sets out our agreed priority areas of:

- Development of an elective ambulatory care centre;
- Investment in stroke, heart attack and cancer services;
- Redesign of the hospital's "front door";
- Development of step down facilities for elderly patients;
- Development of the Norfolk Provider Partnership.

Recent planning guidance from Monitor requires all providers and commissioners to submit two separate but interconnected plans in 2016:

1. by June 2016, a strategic, local health and care system Sustainability and Transformation Plan (STP) covering the period October 2016 to March 2021;
2. by 8 February, a draft operational plan by each organisation for 2016/17.

The first requirement is to decide the footprint for the Sustainability and Transformation Plan. The emerging consensus among partners is that our STP should cover Norfolk and Waveney and this will go forward to Monitor as our preferred option.

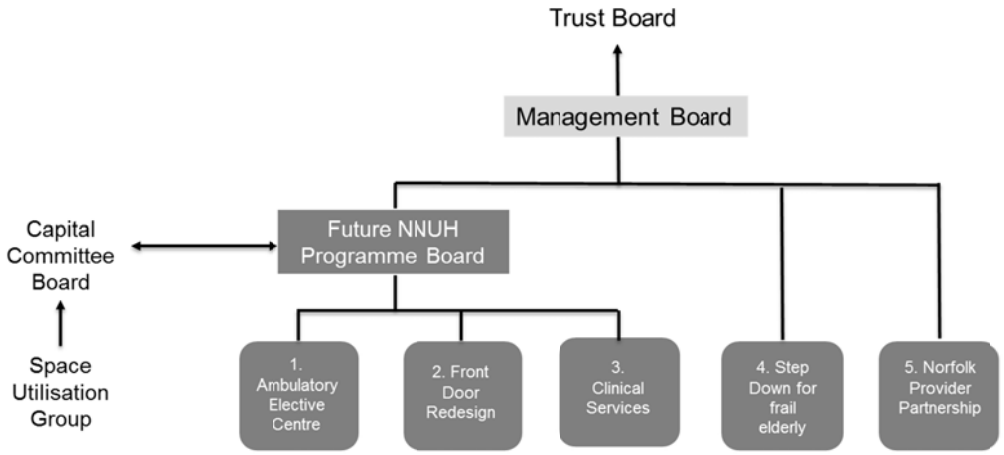
The Board will recall that we also have given an Undertaking in relation to development of a health economy-wide strategy by March 2016. We have had confirmation from Monitor that this Undertaking will be satisfied by the work that will take place on the STP over the next few months.

Clearly we are about to enter into a different environment with regard to planning. There is now an expectation that a health economy wide plan will be agreed by all partners in a short period of time. This will be linked to accessing money. How we will go about doing this and how we might reach a consensus in Norfolk have yet to be determined; it is a significant system leadership challenge. As the largest healthcare organisation in the county our position is pivotal.

Turning to our own recently agreed strategy, progress has been made on a number of fronts:

- we have liaised with the Chiefs of Divisions and confirmed that the clinical priorities for development are around cardiology, stroke and cancer (together with associated support services in interventional radiology and critical care).

- the Management Board has agreed a formal programme of work to implement the strategy under the established 'Future NNUH Programme'. The Management Board will oversee the detailed arrangements around this programme (scoping, governance, resources etc.) For the initial period the Interim Director of Strategy will be the SRO for the programme. The high-level arrangements are set out below:



- We are preparing a 'Strategy on a page' briefing for our staff and this will be available for distribution shortly.
- We have also shared the key priorities with our partners in the Norfolk Provider Partnership.

3.3 CQC and NHS Improvement Letter concerning Quality and Finance

Attached is a letter dated 15 January 2016 sent jointly by the Chief Executive of NHS Improvement and the Chief Inspector of Hospitals at CQC.

The letter indicates that there has been a perception of potentially unhelpful mixed messages from regulators in the past. The intention is that new staffing guidance will be prepared to include a new metric looking at care hours per patient day and that this will reflect a balanced approach towards "delivering the right quality outcomes within the resources available".

4. EDUCATION AND TRAINING

4.1 Physician Associate Course

As reported to the Board in September, in partnership with NNUH, UEA has established a two year MSC physician associate course. In January, 29 students registered for the course which has now commenced.

5. RESEARCH

5.1 Research Strategy and NNUH/UEA Joint Board

As previously reported to the Board, we have been developing a Research Strategy, as part of our Trust-wide Strategic Intent. A key part of this concerns a proposal to develop a Research Directorate in the Trust – to foster a research culture and enhance research activity. The joint appointment with the UEA of a Director of Research and Innovation is currently out to advert.

6. INFRASTRUCTURE DEVELOPMENT

6.2 Electronic Prescribing and Medicines Administration (EPMA)

The Board will be aware that the Trust was successful in a bid to the national Technology Fund for funding to a combined EPMA process across this Trust and the JPUH. The system has now been successfully introduced across NNUH medical wards. Introduction onto the surgical wards is planned for the week commencing 22 February 2016 and the project is being carefully planned and monitored by the Pharmacy Team.

7. LIAISON WITH GOVERNORS AND MEMBERS

As previously reported to the Board elections have been held for a number of public governors to fill vacancies on the Council of Governors, in the Norwich, Broadland and Breckland Constituencies. Four new governors have been appointed as follows:

- Janet King (Broadland)
- Peter Kemp (Norwich)
- Erica Betts and Nina Duddleston (Breckland)

Superintendent Radiographer Ed Aldus has been re-elected by the Clinical Support constituency.

An induction meeting for the new governors will be held on 11 February 2016.

8. RECOMMENDATION

The Board is asked to note the content of this report for information.

NHS Improvement
(Monitor and the NHS Trust Development Authority)

Wellington House
133-155 Waterloo Road
London
SE1 8UG

020 3747 0000

15 January 2016

Letter to: CEOs Trusts and Foundation Trusts
Finance Directors Trusts and Foundation Trusts
Medical Directors Trusts and Foundation Trusts
Directors of Nursing Trusts and Foundation Trusts

Dear Colleague,

We are all aware that the NHS, and providers specifically, have been under great pressure as we seek to improve quality outcomes for patients within the financial resources available. However, the size of this year's provider sector deficit makes it clear that, collectively, we need to focus more on financial rigour as one of the routes to excellent quality.

We recognise that both our organisations – NHS Improvement and the CQC – have an important role in enabling every trust to deliver that balance. We also recognise that how we do our work, the signals we send and how we work together, are an important influence on whether you can deliver that balance or not.

We have therefore been discussing between ourselves, and with senior provider colleagues, what more we can do to help and support you and we wanted to share the early outcomes of that work. 'Early outcomes' because, at this point, this is a strategic statement of intent and we want you to tell us what we have to do differently to secure the right finance/quality balance that we all need.

Success is delivering the right quality outcomes within the resources available

We want to start off by being clear that, from our perspective, quality and financial objectives cannot trump one another. We know that, in the past, there was a perception that delivering financial targets was more important than delivering the right quality outcomes; and that, more recently, improving quality was more important than staying in financial surplus.

We want to clearly and unequivocally state, with the full support of our other arms' length body colleagues, that your task as provider leaders is to deliver the right quality outcomes within the resources available.

That is how we will both measure success and that is how the NHS Improvement regulatory framework and the CQC inspection regime will be framed going forward. Some changes will be needed to make this happen in exactly the way we now want.

We will involve you in how we make those changes – for example through the consultations that we will shortly be launching on the CQC's future strategy and a single new NHS Improvement regulatory framework for providers.

CQC and NHS Improvement working together on a single national framework

We recognise that it is particularly important that you get a single clear, consistent message from both of us on this issue. There has been a perception in the past that our organisations have had greater focuses on different sides of the quality/finance balance, potentially creating unhelpful mixed messages.

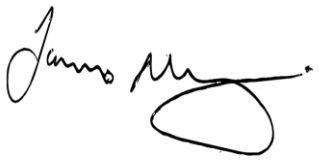
So, we will jointly design the approach the CQC will use to assess trusts' use of resources. We are also looking at how the CQC can use the financial data NHS Improvement holds and use the expertise of NHS Improvement staff in reaching its judgements on use of resources. Similarly, as NHS Improvement develops its view of the role of quality in the new, single, provider regulatory framework, we will do this jointly with the CQC and NHS England. We will also be sharing revised National Quality Board staffing guidance and a new metric looking at care hours per patient day that we will both use in looking at how trusts manage staffing resources.

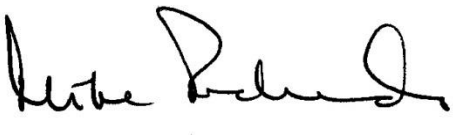
In practical terms, we want regulators and commissioners to rely on each other's work, rather than duplicating effort, and we want to create a single unified framework with a single way of measuring success that we all use. We want this to bring greater clarity and consistency and reduce the regulatory burden, as you have asked for.

NHS Improvement and CQC working together on turnarounds

One of NHS Improvement's early priorities will be to work with organisations with large deficits to help them return to surplus. There is an incorrect assumption that this can only be done at the expense of quality. So we will, again, be working together closely so that we can all be sure that, even in the trusts facing some of the biggest financial challenges, it is possible to balance finance and quality.

We hope this gives you a clear statement of our joint intent – success is delivering the right quality outcomes within the resources available – and how we want to translate that intent into the way we work in future. Please provide us with any comments you have on this letter and tell us what more we can do – our email addresses are below. It would help if you used "JOINT NHSI/CQC LETTER" as the subject of any email you send us.





Jim Mackey
Chief Executive
NHS Improvement
Jim.Mackey@monitor.gov.uk

Professor Sir Mike Richards
Chief Inspector of Hospitals
Care Quality Commission
Mike.Richards@cqc.org.uk

Integrated Performance Report

December 2015 Data

Contents

December Summary

Performance

Cancer 2 WW - all	98.2%
MRSA	0
Cancer 31 day target compliance	99.1%
Cancer 62 day target - Screening	90.2%
Cancer 2WW - Breast Symptomatic	98.8%
Cancer 31 day target - ACD	100.0%

Cancer 62 day target - GP Referral	78.2%
18 week RTT target - incomplete	84.6%
A&E four hour compliance	85.0%
RTT Admitted Backlog	2801
RTT Non-admitted Backlog	2998
Monthly Average DTOC	51

Workforce

Vacancy Rate	7.7%
% unregistered ward staff filled as planned	109.5%
Staff recommendation of NNUH as place to receive care	74%

Non-Medical Appraisals Completed	56.8%
Staff Turnover	10.6%

Quality

Grade 4 Pressure Ulcers	0
HSMR (September 2015)	92.6
Patient FFT scores inpatients	97%
Patient falls causing harm	0

Serious Incidents (which include Grade 3 pressure ulcers)	8
Grade 2 pressure ulcers	10
Grade 3 pressure ulcers	4

Productivity/ Finance

In month increase in deficit	£2.0m
In month pay overspend (agency/locum)	£0.5m
Cumulative CIP underdelivery	£3.0m
Full year penalty and CQUIN risk	@£12m
Forecast excluding penalty & CQUIN risk deficit	£14.4m

High Risk Register 15+ Tracker

This high risk tracker highlights all current risks on the Risk Register that have a Residual Risk Rating of 15+. and trend data. This is reviewed by the Executive Board on a monthly basis.

1 new 15+ risk was added to the High Risk Tracker on the 12/12/2015. This is highlighted in blue in the table below.

Ref	Risk Name	Current RR score			RRR Score			Date Risk added	Executive Lead	Governance Domain	Date of Last review on REGISTER
		C	L	R	1mth ago	2mth ago	3mth ago				
BAF 17	BAF Achievement of the operational and financial plan	4	5	20	20	16	12	13/10/2015	S.Budd	Responsiveness	10/12/2015
BAF 12	BAF Key local and national perfomance targets	4	4	16	16	16	16	13/10/2015	R.Parker	Responsiveness	12/012016
BAF.18	BAF.18 Ensure sufficient numbers of staff are in place to deliver the services.	4	4	16	16	16	12	03/04/2014	J. Over	Workforce	14/12/2015
RR 359	Outpatient capacity Ophthalmology	4	4	16	16	16	16	29/04/2015	R.Parker	Responsiveness	11/12/2015
RR 384	Chemotherapy demand & capacity	4	4	16	16	16	16	26/06/2013	R.Parker	Responsiveness	06/01/2016
RR 393	Vascular waits for IRU	4	4	16	12	12	12	03/06/2014	R.Parker	Responsiveness	11/12/2015
RR 476	IRU capacity	4	4	16	16	16	16	03/06/2014	R.Parker	Responsiveness	07/01/2016
RR 604	Inpatient diabtes insulin errors	4	4	16	16	16		06/11/2015	P.Chapman	Clinical Safety	06/01/2016
RR 605	Renal fistula waits for IRU	4	4	16	16	16		06/11/2015	P.Chapman	Clinical Safety	07/01/2016
RR 425	PPCI lab for escalation	5	3	15	15	15	15	18/11/2013	P.Chapman	Clinical Safety	06/012016
RR 492	Access to Winterton roof for DSH	5	3	15	15	15	15	01/08/2015	J. Over	Non Clinical Safety	06/01/2016
RR 509	Deferral of annual refurbishment programme A&E	3	5	15	15	15	15	06/11/2014	J.Over	Non Clinical Safety	06/01/2016
RR 510	Deferral of annual refurbishment programme - Pharmacy production	3	5	15	15	15	15	06/11/2014	J.Over	Non Clinical Safety	06/01/2016
RR 511	Deferral of annual refurbishment programme - Wards	3	5	15	15	15	15	06/11/2014	J.Over	Non Clinical Safety	06/01/2016
RR 538	Waiting times for pacemaker implantation - Cardiology	5	3	15	15	15	15	03/06/2015	R.Parker	Responsiveness	07/01/2016
RR 624	Space in Paediatric area of ED	3	5	15	15	15		06/11/2015	E.McKay	Caring and Patient Experience	05/012016
NEW RR 635**	Capacity for O&G Ultrasound	3	5	15	15			12/12/2015	P. Chapman	Effectiveness	12/12/2015

Performance - Monitor KPI's

Lead Director - Richard Parker

Performance	Outturn 14/15	Annual Target	Dec-15 Actual	6 month trend	YTD 15/16
C Difficile cases ceiling (excluding successful appeals)	57	49	0		19
MRSA Bacteraemias	0	0	0		0
Cancer 31 day target for subsequent treatments - Surgery *	86.%	94.%	96.2%		91.2%
Cancer 31 day target for subsequent treatments - Anti Cancer Drugs *	98.6%	98.%	100.%		99.2%
Cancer 31 day target for subsequent treatments - Radiotherapy *	96.7%	94.%	99.5%		97.8%
Cancer 62 day target for referral to treatment- GP Referral *	73.%	85.%	79.%		76.4%
Cancer 62 day target for referral to treatment - Screening *	94.2%	90.%	90.5%		92.5%
18 week RTT target - Patients on an incomplete pathway	91.6%	92.%	84.6%		87.8%
Cancer 31 day target compliance *	95.7%	96.%	99.1%		97.4%
Cancer 2 week wait - all cancers *	94.9%	93.%	98.4%		96.2%
Cancer 2 week wait - symptomatic breast cancers *	96.2%	93.%	98.8%		98.7%
A&E 4 hour target compliance	90.1%	95.%	85.%		88.4%
Diagnostics	98.3%	99.%	92.8%		96.%
Cancelled Operations	1503		135		795
Number of Cancelled Op 28 day breaches	199	0	18		131
RTT Admitted Backlog	1870	981	2801		2801
RTT Incomplete Non Admitted Backlog	1690	1000	2998		2998
% of patients with 90% of their LoS on the stroke unit	79.6%		80.8%		80.8%
Patients with primary diagnosis of stroke admitted to a HASU within 4 hrs	74.6%	80.%	73.2%		75.6%
% of urgent Stroke patients with access to brain scan within 60 mins	84.5%	85.%	84.4%		84.3%
% Door to needle time of <= 60 minutes for eligible thrombolysis patients	76.7%	75.%	87.5%		77.8%
% of high risk TIA patients treated within 24 hour of first contact	94.%	90.%	93.8%		93.4%
Monthly Average Delayed Transfers of Care	52	30	51		42
Arrival to Handover time (>15 minutes)	73%	100%	76.2%		76.3%
Number of 30 minute handover breaches	102	0	32		149
Number of 60 minute handover breaches	8	0	12		60
Recording of Handover Times	95.2%	95%	96.5%		97.5%
*** Please note these figures are provisional**					

- The Trust has a projected risk rating of '3' against Monitor's Risk Assessment Framework for Qtr. 3, giving it an expected 'red' rating.
- Failures across the A&E, cancer 62 day GP referral, and 18 weeks incomplete targets contribute to this rating.
- Revised remedial action plans have been produced and agreed for A&E and Cancer. The18-weeks RAP iremains in discussion with commissioners. Further commentary on the reasons for failure are listed within.

Responsive (including performance recovery)

Lead Director – Richard Parker

Monitor and associated KPI's

Performance domain challenges remain unchanged.

Cancer 62-day GP referral performance remains a priority for recovery – failure to deliver the backlog reduction required for delivery of the 85% target in December related to delays in access to CT Colonography driven by unprecedented levels of demand. This has been resolved and good progress (illustrated by slide 4) is being made. It is anticipated a sustainable backlog (20 patients) will be achieved in February with the associated delivery of this critical performance target.

The main capacity challenges affecting achievement of the diagnostic 6-week standard relate to endoscopy. A solution using a third-party provider (Medinet) and commencing work at Turnstone court will solve this issue and return us to full compliance by **31 March 2016**.

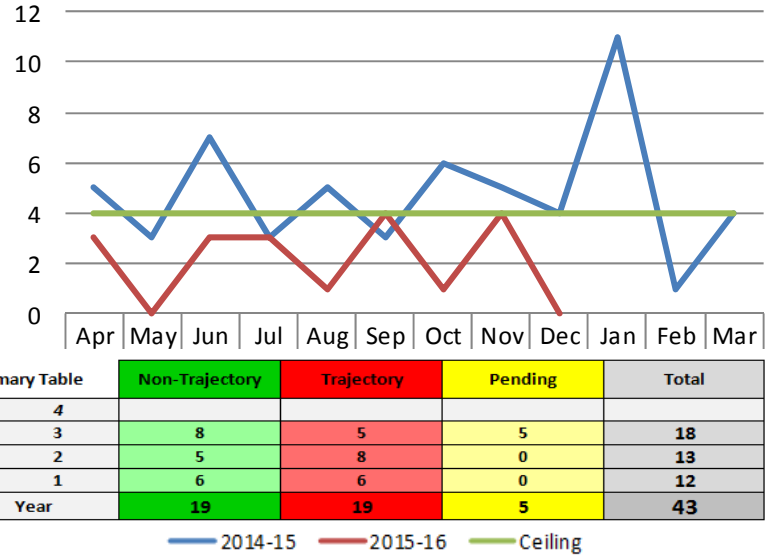
Whilst significant progress had been made against the Stroke care standards. Access to CT scanning with 60minutes showed a sharp decline in November. This improved in December however this is an area subject to close internal scrutiny and remedial action. Bed congestion has affected timely access to a HASU bed but again this is subect to case by case scrutiny and action

RTT recovery is subject to a formal contractual remedial action plan process; agreement of a recovery trajectory is a key part of that process. A revised recovery plan was submitted to NHSE on 31 December. Further details are included in subsequent slides.

The ED transit time revised recovery plan continues to make progress. Whilst high level 4-hr performance remains less than expected, measures to maintain resilience over the Christmas and New Year period were successful. Specifically the Trust was self sustaining (no diversions to other providers were required) and we were able to offer assistance to other organisations in the Norfolk Provider Partnership (QEKL and JPUH) in order for them to manage pressures over the New Year weekend. Contextual information regarding the scale of the challenge relating to ambulance demand plus improvement to overall ambulance delay reduction is included in this performance section.

Lead Director - Emma McKay

C Difficile cases ceiling (excluding successful appeals)



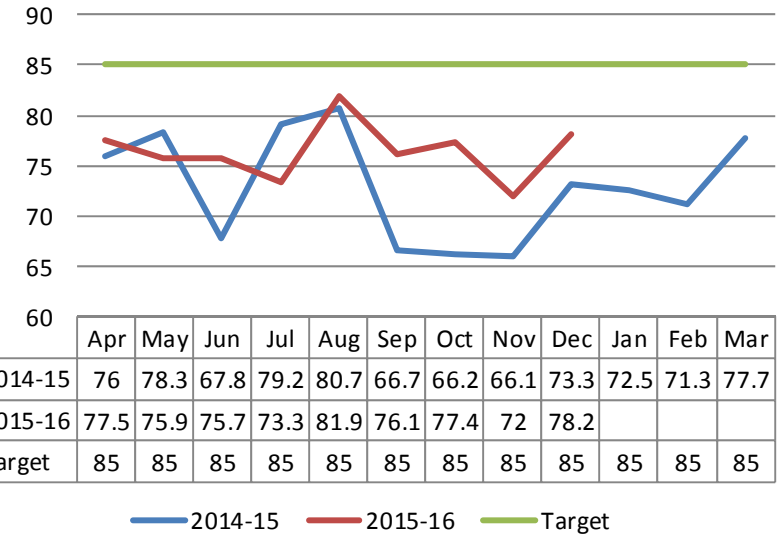
Summary Table		Non-Trajectory	Trajectory	Pending	Total
Quarter	4				
	3	8	5	5	18
	2	5	8	0	13
	1	6	6	0	12
Year		19	19	5	43

Issues
- 4 Cases of C Difficile were identified as Hospital acquired infection in December
- 3 are pending the post infection review appeal process

Planned Actions
- Teams are reminded to be vigilant in its detection, sampling and isolation of patients presenting with symptoms

Lead Director - Richard Parker

Cancer 62 day target for referral to treatment- GP Referral *

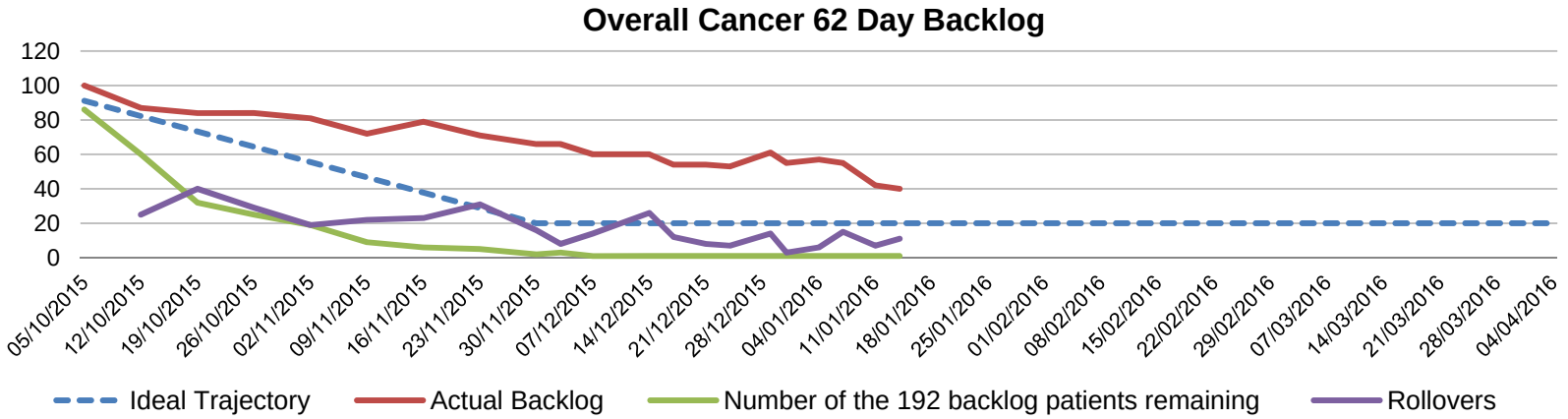


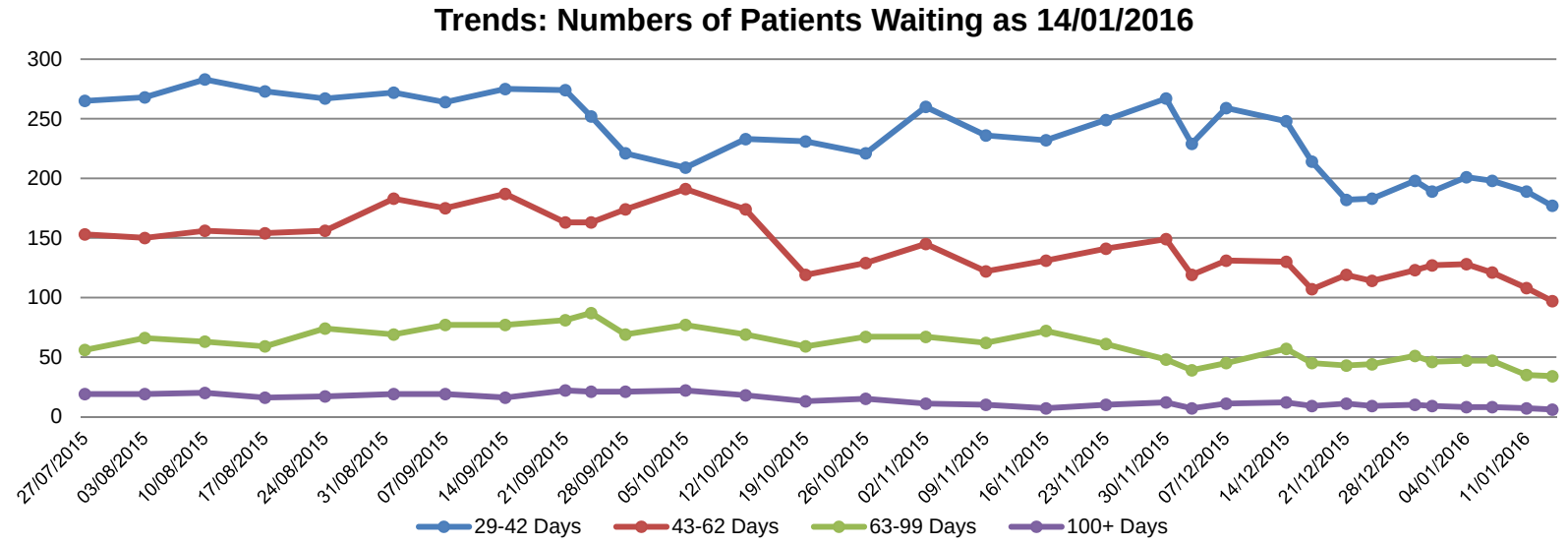
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-15	76	78.3	67.8	79.2	80.7	66.7	66.2	66.1	73.3	72.5	71.3	77.7
2015-16	77.5	75.9	75.7	73.3	81.9	76.1	77.4	72	78.2			
Target	85	85	85	85	85	85	85	85	85	85	85	85

Issues
- Backlog clearance remains a priority for the 62 day target
- Drop in performance expected in as part of **planned backlog clearance**.

Planned Actions
- Backlog clearance continues into January
- Cancer cases are being prioritised in theatre for a number of specialities
- CT colonoscopy waits reduced to 2 weeks
- Additional mobile CT being installed

*Denotes provisional figure for previous month

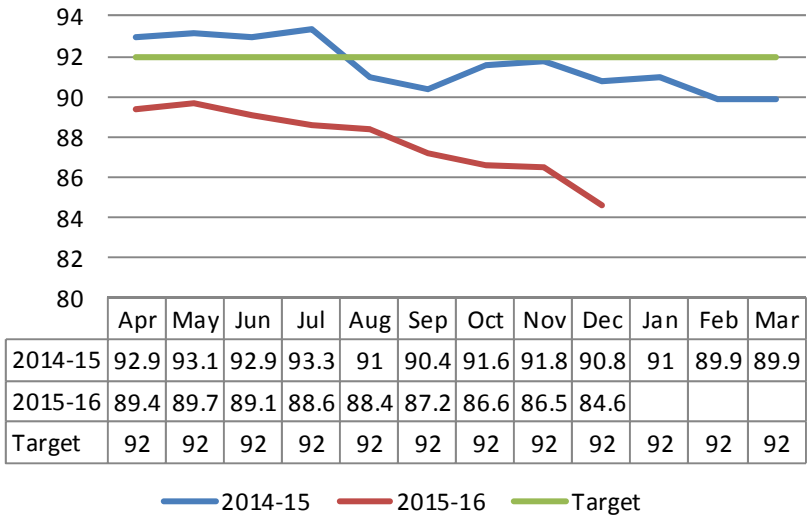




- Backlog reduction and overall numbers of patients on the PTL noticeable in a number of specialities, particularly Gynae and head and neck
- Colorectal, plans to clear surgical backlog in January with improvement in numbers on the PTL expected as CT colonoscopy waits reduce.
- Cancer performance remains under close scrutiny from Local commissioners and NHS England.

Lead Director - Richard Parker

18 week RTT target - Patients on an incomplete pathway



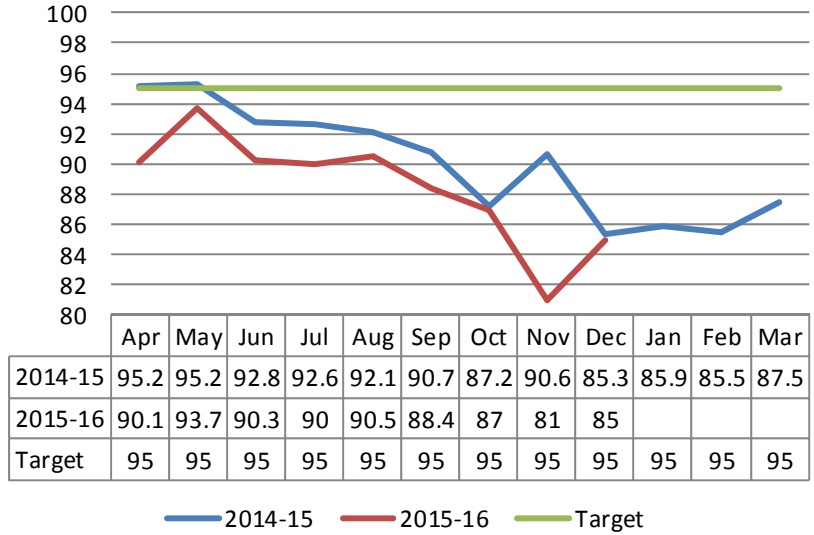
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-15	92.9	93.1	92.9	93.3	91	90.4	91.6	91.8	90.8	91	89.9	89.9
2015-16	89.4	89.7	89.1	88.6	88.4	87.2	86.6	86.5	84.6			
Target	92	92	92	92	92	92	92	92	92	92	92	92

Issues
- Remedial action plan not accepted by CCG.
- Delay to recruitment in key specialities will further delay recovery.

Planned Actions
- Discussion on going with Medinet for ENT and Gynaecology to reduce non-admitted waiting list
- Other specialities reviewing recovery plans and taking additional actions
- External support for Validation of waiting lists to be implemented in January. Impact on performance to be identified

Lead Director - Richard Parker

A&E 4 hour target compliance



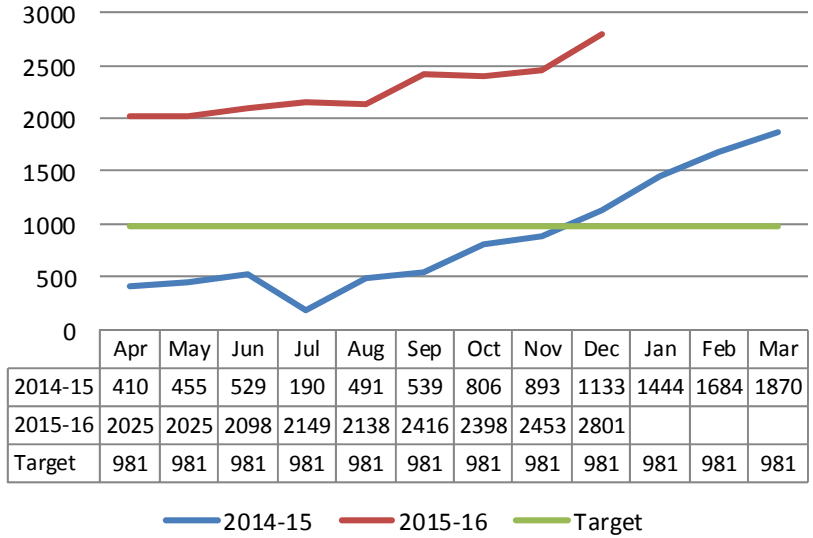
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-15	95.2	95.2	92.8	92.6	92.1	90.7	87.2	90.6	85.3	85.9	85.5	87.5
2015-16	90.1	93.7	90.3	90	90.5	88.4	87	81	85			
Target	95	95	95	95	95	95	95	95	95	95	95	95

Issues
- Bed availability main reason for failure.
- Removal of Placement Without Prejudice (PWP) protocol continued to restrict flow out of ED and increased breaches due to bed availability.

Additional Planned Actions
- Focus on delayed discharge. Twice weekly exec review of patients requiring complex discharge with escalation to system partners
- All other RAP actions continue

Lead Director - Richard Parker

RTT Admitted Backlog



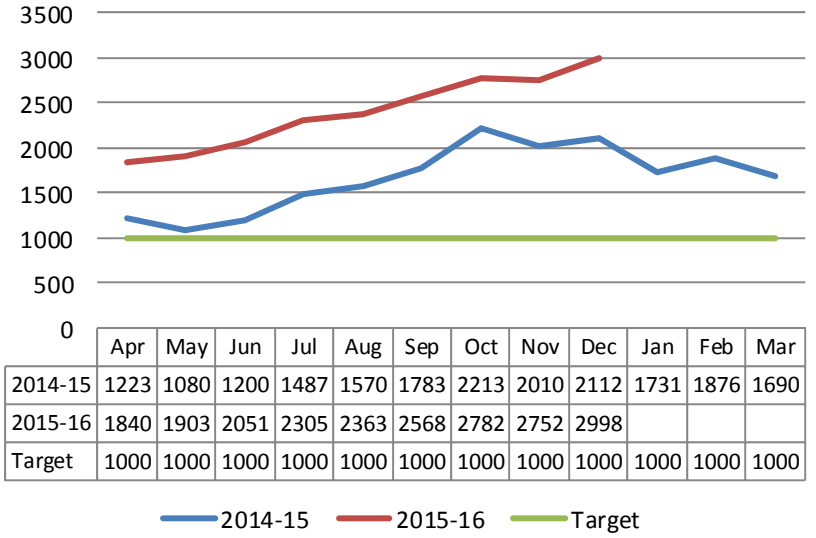
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-15	410	455	529	190	491	539	806	893	1133	1444	1684	1870
2015-16	2025	2025	2098	2149	2138	2416	2398	2453	2801			
Target	981	981	981	981	981	981	981	981	981	981	981	981

Issues
- Recovery trajectories are under review from NHS England, plans to increase activity through the remainder of the year are being overseen by commissioners.
- Increasing number of cancellations due to bed pressures impacting on elective activity

Planned Actions
- Optimise Vanguard theatre, additional capacity provided for T&O, ENT, Gynaecology, Urology, General Surgery
- Recruitment into posts identified in RTT recovery business case to reduce reliance on WLI spend.
- Continue to booking in turn

Lead Director - Richard Parker

RTT Incomplete Non Admitted Backlog



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-15	1223	1080	1200	1487	1570	1783	2213	2010	2112	1731	1876	1690
2015-16	1840	1903	2051	2305	2363	2568	2782	2752	2998			
Target	1000	1000	1000	1000	1000	1000	1000	1000	1000	1000	1000	1000

Issues
- Increasing waiting times and delays to diagnostics in key specialities have lead to an increasing backlog.

Planned Actions
- Increased Outpatient activity, key specialities
- External Validation team, commenced on site 11th Jan
- Medinet to provide weekend clinics Jan/Feb for ENT

18-weeks Key Issues

- Significant compound growth, especially cancer and urgent work displacing 18-wk activity e.g. 2ww referrals – 68% growth since 2008/9 and 9% compound annual growth
- Significant growth in diagnostic demand is extending pathways - with associated 6-week standard failure. The overall waiting list size is relatively static however the list 'aging'
- Historic reliance upon flexible capacity solutions is risky and increasingly unreliable - circa 50 additional sessions per week required to sustainably meet 65th-85th percentile demand in key specialties
- Workforce challenges – recruiting locum and substantive staff is a challenging and lengthy process
- Shifting delayed-planned patients to an 18-wk pathway as per best practice has increased the admitted backlog / clouded progress
- Focus on Cancer-First combined with emergency growth has reduced internal performance improvements

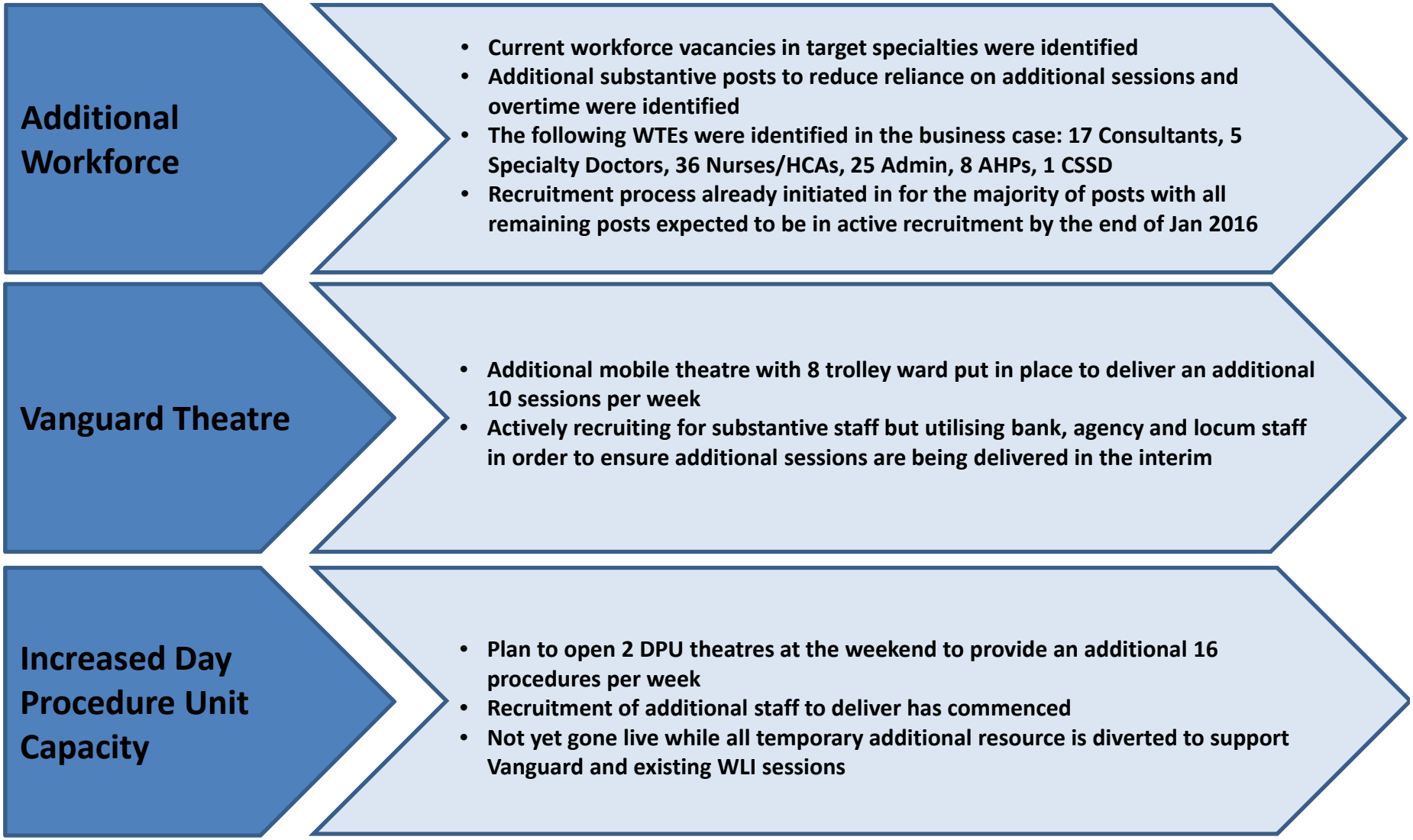
NHS IMAS Intensive Support Team

Top 5 Most Challenging Specialties
Additional Capacity Required to Achieve Sustainable RTT Incomplete Performance

	Outpatient Clinics			Theatre Sessions		
Specialty	**Regular Extra New clinics Required / Week to meet demand 85th percentile**	**Regular Extra New clinics Required / Week to meet demand 65th percentile**	**Physical Extra Clinic requirements/ week**	**Regular Extra Theatre sessions required/ week to meet demand 85th percentile**	**Regular Extra Theatre sessions required/ week to meet demand 65th percentile**	**Physical Extra theatre session requirements/ week**
T&O	11	6	6	15	20	12
Dermatology	9.4	6.9	9	10	7	10
Urology	2.2	2	2	18	11	15
ENT	11	8	11	10	7	9
Gynaecology	2	0	2	5	0	5
Total	**35**	**23**	**30**	**58**	**44**	**50**

- Illustrates the capacity ‘challenge’
- Modelling for all specialities nearing completion (based on the IST Capacity tool & undertaken with IST help)
- A significant amount of the ‘gap’ is currently being filled by ad-hoc, WLI etc. activity

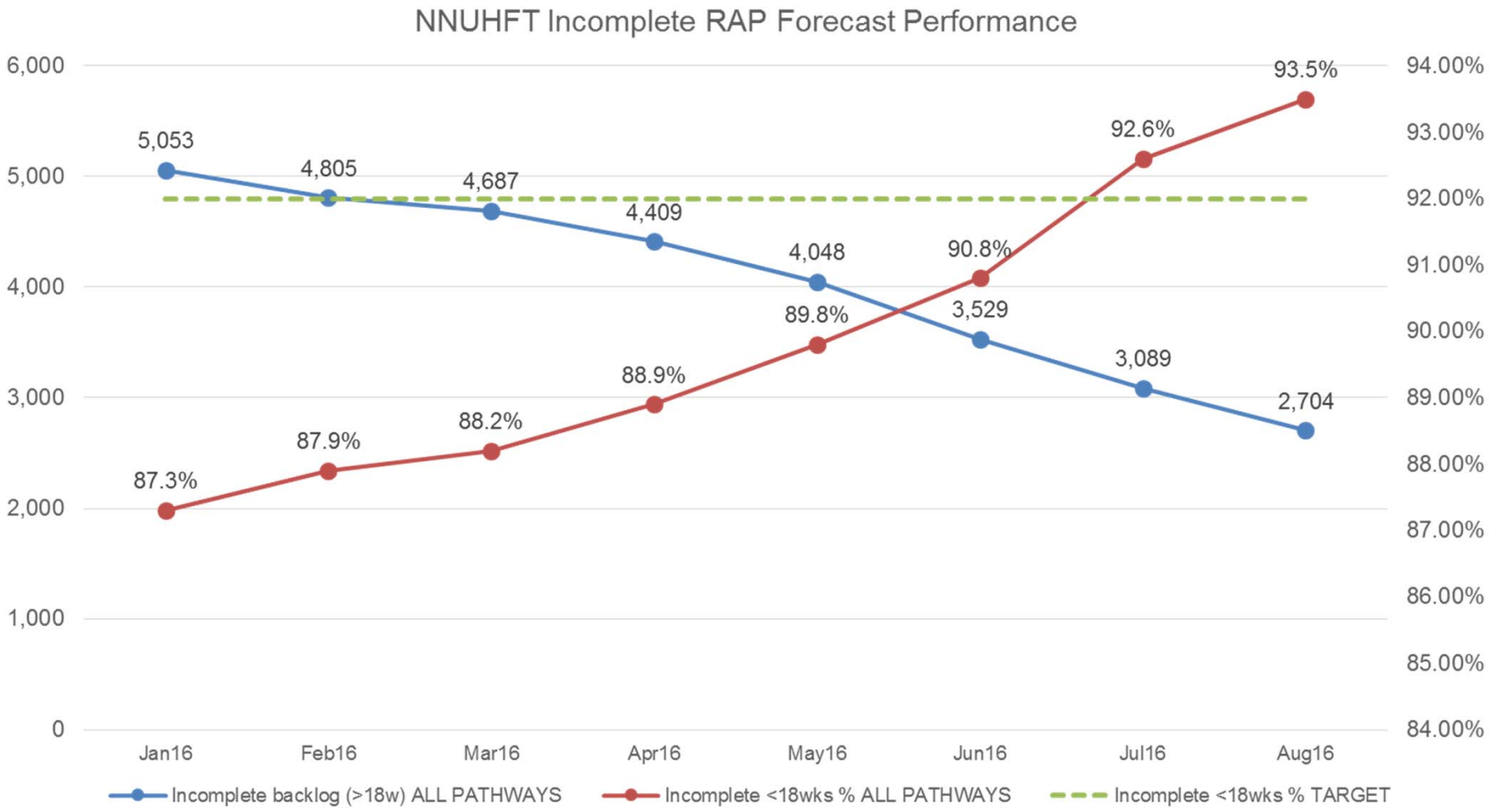
Summary of High Impact Recovery Interventions



Summary of High Impact Recovery Interventions cont.

18 week RTT recovery trajectory

HR-PTM4



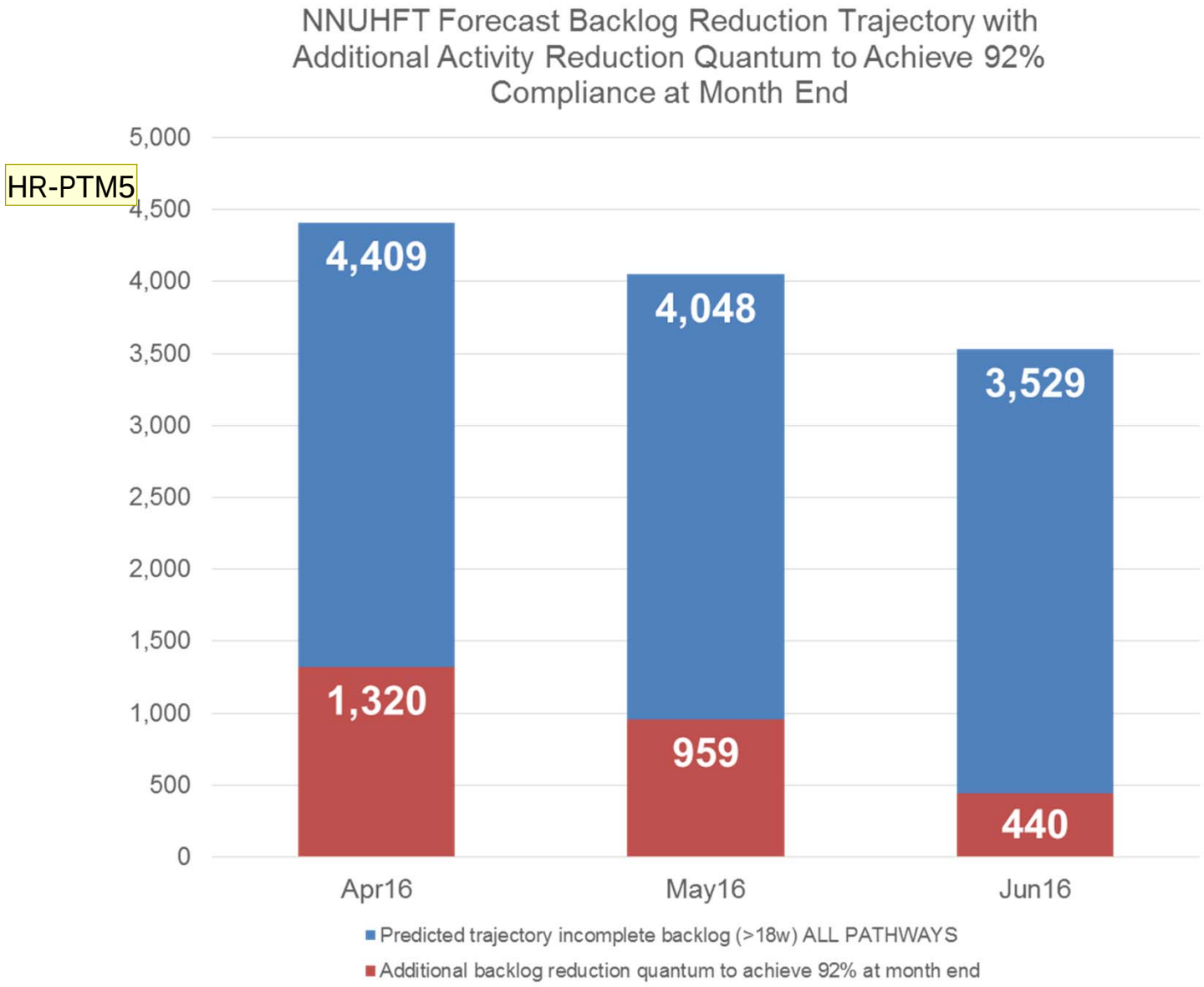
Slide 15

HR-PTM4 Insert Chart showing the current planned trajectory at Trust level

Holmes, Rob - Performance Team Manager, 31/12/2015

18 week RTT recovery trajectory

HR-PTM5



Slide 16

HR-PTM5 Insert Chart showing the additional activity required to bring compliance forward by month

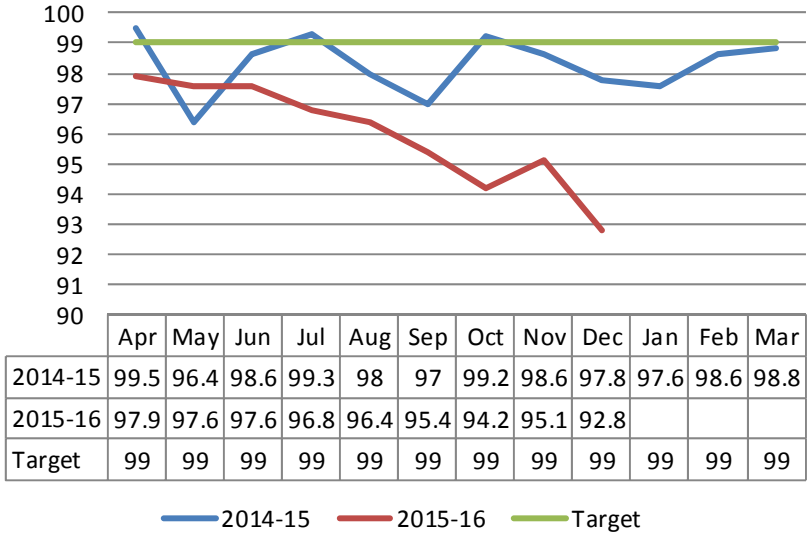
Holmes, Rob - Performance Team Manager, 31/12/2015

Additional Actions following Escalation Meeting

Second Mobile Theatre - Cost Benefit Analysis	Review List Validation & Outpatient Capacity / Booking	Additional Outsourcing and Use of the National PMO
Outcome	**Outcome**	**Outcome**
• Lead in time approx 8 weeks which includes ground preparation and installation • Initial costs 2 million offset by activity • Significant additional workforce risk i.e. Requires the recruitment of more surgeons over and above current plan • With workforce issues this is not a viable option until current posts recruited. So impact would be delayed up to 6 months <u>Alternative options being pursued:</u> • Additional Vanguard / mobile cath-lab. More focussed solution that releases capacity for Interventional Radiology (highest clinical long-wait risk and highest operational risk (52-wk challenge) – 29th Jan deadline to complete planning phase • Running the existing Vanguard at weekends / 7-days. Staffing by Vanguard & Medinet being explored to mitigate workforce risk..	• External validation team (RTT Solutions Ltd) engaged- start on site 11th Jan • Meeting 8th January to review booking system for outpatient patient areas. 'Overbooking' already in place however opportunity to use 'fallow' capacity (e.g. clinics not used due to leave etc.) not optimised • Meeting 15th January with Global for additional clinic space on the Global Site • Site review meeting in January of Turnstone Court for additional clinic & procedure space	• All existing private provider and local NHS capacity explored and is being utilised • Met & now working closely with Kelvyn Price (National RTT PMO lead) to ensure access to all relevant capacity • Fitzwilliam Hospital, Colchester identified & being explored for South Norfolk residents Significant risks include: • Patients unwilling to travel • Private providers not able to offer required procedures
Estimated Impact	**Estimated Impact**	**Estimated Impact**
• Clearance of IRU backlog – circa 100 patients • Vanguard / Medinet impact tbc **<u>w/c 18 January</u>**	• Estimated 10% reduction in overall waiting list size through validation. Impact on backlog &/or incompletes **<u>unquantifiable at this stage</u>** • OPD clinic re-lets, Global & Turnstone Court capacity impact tbc **<u>w/c 25 January</u>**	• Access to / uptake of additional National PMO capacity tbc by **<u>w/c 18 January</u>**

Lead Director - Richard Parker

Diagnostics



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-15	99.5	96.4	98.6	99.3	98	97	99.2	98.6	97.8	97.6	98.6	98.8
2015-16	97.9	97.6	97.6	96.8	96.4	95.4	94.2	95.1	92.8			
Target	99	99	99	99	99	99	99	99	99	99	99	99

Issues

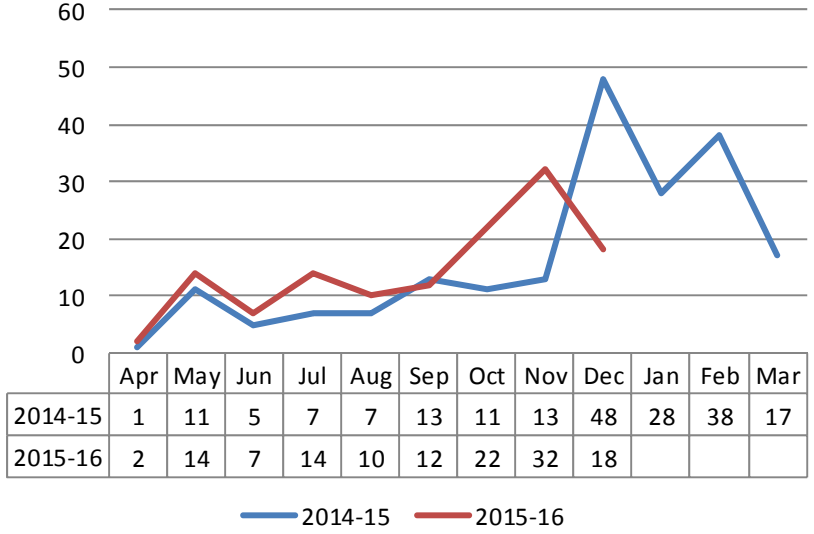
- A formal Remedial Action Plan (with weekly commissioner scrutiny) has been submitted to and accepted by the Commissioners.
- The trajectory aims for full recovery by 31 March 16.

Planned Actions

- Recruitment to fill vacancies in Urology, Audiology and Gastro continues
- Mobile CT scanner to be installed
- Gastro to expand into Turnstone court

Lead Director - Richard Parker

Number of Cancelled Op 28 day breaches



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-15	1	11	5	7	7	13	11	13	48	28	38	17
2015-16	2	14	7	14	10	12	22	32	18			

Issues

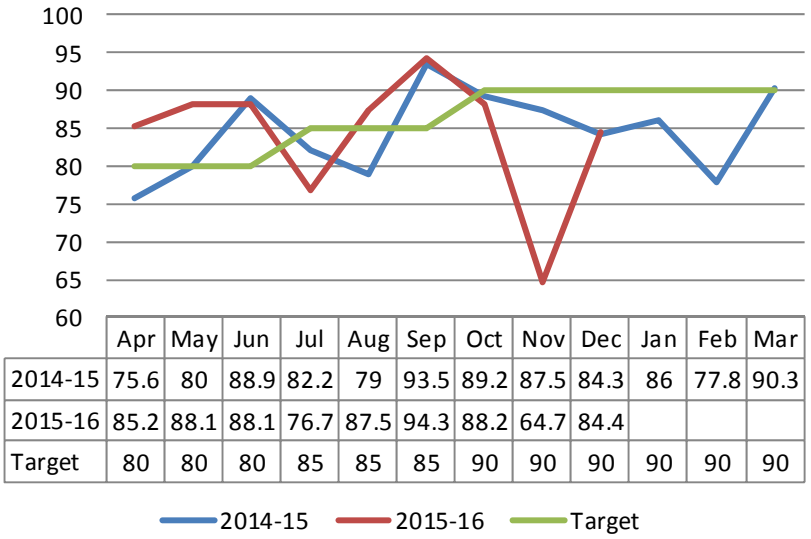
- The number of 28-day cancellations failing to be re-booked in time is partly a consequence of increase in cancellations but also as a consequence of capacity being prioritised for clinical urgent & cancer patients

Planned Actions

- All on the day cancellations are reviewed by Theatre Project with lessons learnt built into the scope of that project
- Pre-emptive cancellations, day before being considered in accordance with hospital escalation plane.

Lead Director - Richard Parker

% of urgent Stroke patients with access to brain scan within 60 mins



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-15	75.6	80	88.9	82.2	79	93.5	89.2	87.5	84.3	86	77.8	90.3
2015-16	85.2	88.1	88.1	76.7	87.5	94.3	88.2	64.7	84.4			
Target	80	80	80	85	85	85	90	90	90	90	90	90

Issues

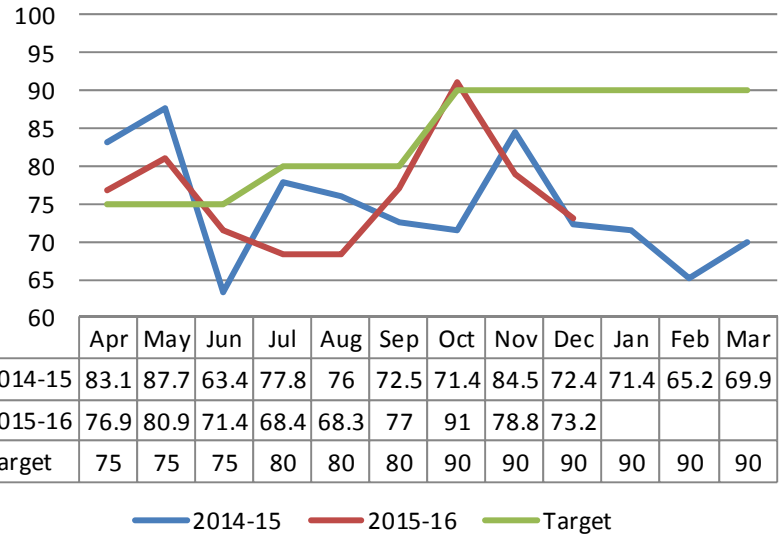
- 7 of 45 did not get an urgent scan within 60 minutes
  - 5 – Stroke team busy with other patients in A&E
  - 1 – Not diagnosed as stroke by Stroke team
  - 1 – Stroke not alerted in time by ward

Planned Actions

- Stroke team to embed process with A&E when more than 2 stroke patients arrive.

Lead Director - Richard Parker

Patients with primary diagnosis of stroke admitted to a HASU within 4 hrs



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-15	83.1	87.7	63.4	77.8	76	72.5	71.4	84.5	72.4	71.4	65.2	69.9
2015-16	76.9	80.9	71.4	68.4	68.3	77	91	78.8	73.2			
Target	75	75	75	80	80	80	90	90	90	90	90	90

Issues

- 25 of 96 patients were not admitted within 4 hours.
  - 17 – No Beds
  - 2 – Not diagnosed as stroke by Stroke team
  - 5 – Stroke not alerted in time (A&E, Neurology, Wards)
  - 1 - Breach in A&E

Planned Actions

- Review RCAs and agree actions to address process failures

Sum of No of transports into A&E department only

Hospital	2014/15 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	14/15 Total	2015/16 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Comparing Yearly Volumes Change	%
Addenbrookes Hospital	2482	2636	2483	2510	2479	2456	2709	2690	2740	23185	2458	2641	2651	2797	2565	2686	2758	2727	938	4.0%
Basildon & Thurrock Hospital	2241	2294	2143	2347	2304	2235	2385	2455	2596	21000	2382	2429	2368	2528	2343	2308	2272	2372	527	2.5%
Bedford Hospital South Wing	1381	1404	1428	1403	1406	1378	1402	1503	1690	12995	1551	1524	1418	1576	1517	1483	1568	1572	936	7.2%
Broomfield Hospital	1948	2073	1989	1994	2032	1956	2032	1990	2204	18218	1955	2140	2107	2225	2287	2197	2276	2218	1511	8.3%
Colchester General Hospital	2266	2417	2389	2448	2521	2326	2433	2410	2470	21680	2342	2432	2470	2558	2515	2474	2493	2529	625	2.9%
Hinchingbrooke Hospital	891	976	934	1025	990	956	1022	1038	1175	9007	1019	1027	1013	1065	998	1056	1066	1061	461	5.1%
Ipswich Hospital	1892	1951	1891	2037	1974	1818	1977	1937	2277	17754	2121	2094	2061	2169	2207	2072	2121	2182	1580	8.9%
James Paget Hospital	1743	1814	1812	1875	1927	1826	1818	1789	1902	16506	1750	1831	1785	1816	1817	1759	1831	1691	-329	-2.0%
Lister Hospital	2365	2583	2532	2497	2472	2386	2640	2666	2773	22914	2455	2553	2342	2545	2578	2484	2470	2547	-233	-1.0%
Luton And Dunstable Hospital	2361	2424	2378	2302	2308	2230	2351	2515	2776	21645	2379	2565	2482	2566	2562	2527	2676	2643	1660	7.7%
Norfolk & Norwich University Hospital	3218	3374	3289	3466	3424	3286	3510	3461	3666	30694	3482	3774	3779	3911	3822	3643	3885	3784	3138	10.2%
Peterborough City Hospital	1772	1893	1898	1965	1930	1769	2032	2033	2192	17484	1951	2059	2020	2043	2125	2019	2128	2196	1403	8.0%
Princess Alexandra Hospital	1863	1816	1801	1861	1830	1785	1882	1861	2185	16884	1856	1915	1835	1986	1928	1797	1938	1789	71	0.4%
Queen Elizabeth Hospital	1592	1666	1579	1651	1601	1547	1632	1572	1796	14636	1643	1685	1724	1731	1777	1704	1773	1686	801	5.5%
Southend University Hospital	2164	2162	2125	2253	2287	2289	2446	2462	2539	20727	2361	2417	2465	2559	2466	2416	2551	2395	1487	7.2%
Watford General Hospital	1961	2127	2241	2229	2062	2104	2218	2287	2328	19557	2188	2226	2254	2365	2361	2157	2243	2270	889	4.5%
West Suffolk Hospital	1431	1443	1461	1598	1463	1392	1562	1501	1700	13551	1543	1696	1632	1689	1696	1690	1760	1698	1612	11.9%
Grand Total	33571	35053	34373	35461	35010	33739	36051	36170	39009	318437	35436	37008	36406	38129	37564	36472	37809	37360	17077	5.4%

Lister Data for 2014/15 now includes QE2 volumes for comparative purposes

Information sourced from EEAST.

Handover Hours Lost

Handover hours lost	Difference in Handover Hours lost - positive means more hours lost than last year										Journeys for each handover hour lost	%Vol Change into A&E from 14/15
Hospital	April	May	June	July	August	September	October	November	December	YTD		
Addenbrookes Hospital	110	126	86	84	33	61	-44	-124	-172	**161**	17	4.5%
Basildon & Thurrock Hospital	56	26	33	55	32	101	78	106	48	**538**	13	4.3%
Bedford Hospital South Wing	4	15	17	-17	-9	-20	16	1	-59	**-52**	25	8.5%
Broomfield Hospital	176	79	21	125	27	42	149	99	-83	**640**	7	8.3%
Colchester General Hospital	98	-9	16	201	84	414	193	301	-224	**1076**	6	2.9%
Hinchingbrooke Hospital	8	4	12	15	2	8	4	11	-4	**63**	21	6.6%
Ipswich Hospital	20	-3	47	13	67	53	45	70	7	**323**	23	9.6%
James Paget Hospital	-4	13	4	50	6	14	29	4	33	**153**	23	-1.8%
Lister Hospital	-82	77	70	118	128	90	7	194	101	**707**	8	-0.3%
Luton And Dunstable Hospital	19	33	8	3	21	21	58	40	-61	**145**	16	8.6%
Norfolk & Norwich University Hospital	-52	-110	-60	-108	-166	-158	-194	191	46	**-614**	14	11.6%
Peterborough City Hospital	91	29	7	-5	80	43	-74	19	80	**272**	15	8.2%
Princess Alexandra Hospital	7	-15	-13	6	89	10	4	-60	-350	**-321**	11	3.2%
Queen Elizabeth Hospital	38	59	-23	-22	25	88	215	130	-93	**419**	9	6.8%
Southend University Hospital	-45	-14	56	79	18	93	100	25	-58	**257**	11	9.6%
Watford General Hospital	417	176	44	46	33	60	173	62	5	**1022**	7	5.7%
West Suffolk Hospital	29	53	43	35	73	51	53	66	-20	**386**	13	13.1%
Grand Total (Regional Acutes)	**893**	**544**	**373**	**684**	**551**	**980**	**819**	**1159**	**-802**	**5181**	11	6.4%

Lister Data for 2014/15 now includes QE2 volumes for comparative purposes

Information sourced from EEAST.

Workforce

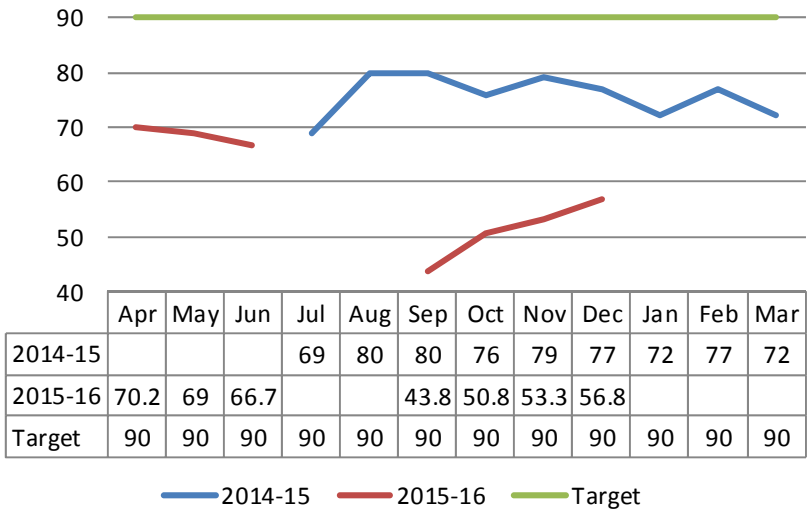
Lead Director - Jeremy Over

Workforce	Outturn 14/15	Annual Threshold	Dec-15 Actual	6 month trend	YTD 15/16
Planned establishment (WTE) *	6529	6722	6795		6795
Actual Substantive WTE	6328	6346	6273		6273
Vacancy maximum (%)	3.1%	10.%	7.7%		7.7%
Non-Medical Appraisals Completed (%)	72.%	80.%	56.8%		56.8%
Sickness Levels	4.3%	3.5%	TBC		4.2%
Mandatory Training (%)	71.9%	90.%	77.5%		77.5%
Staff Turnover (%)	10.3%	10.%	10.6%		10.6%
Pay spend - % employed (%) *	94.8%		92.9%		92.4%
Pay spend - % bank (%) *	2.4%		1.9%		2.3%
Pay spend - % agency (%) *	2.8%		5.2%		5.3%
% of registered nurse day hours filled as planned			93.8%		93.3%
% of unregistered care staff day hours filled as planned			109.%		103.8%
% of registered nurse night hours filled as planned			93.2%		90.5%
% of unregistered care staff night hours filled as planned			117.3%		111.9%
Staff FFT – recommendation of NNUH as a place to receive care			74%		
Staff FFT – recommendation of NNUH as a place to work			57%		

*** Please note these figures are provisional**

Lead Director - Jeremy Over

Non-Medical Appraisals Completed (%)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-15				69	80	80	76	79	77	72	77	72
2015-16	70.2	69	66.7			43.8	50.8	53.3	56.8			
Target	90	90	90	90	90	90	90	90	90	90	90	90

Lead Director - Jeremy Over

Non-Medical Appraisal Completion	Compliance %
Trustwide	**56.80%**
Cancer Services Division	77.10%
Corporate Areas	52.90%
Emergency Services	46.20%
Medicine & Clinical Support	54.80%
Surgery & Cromer Division	58.50%
Women, Children & Sexual Health Division	62.20%

Issues

- The new appraisal system went live on 6 July 2015.
- To date, 1,561 appraisals have been completed using the new appraisal system.
- In total, 3,098 appraisals have been undertaken within timescales – as such there are more active appraisals using the new system than the old process.

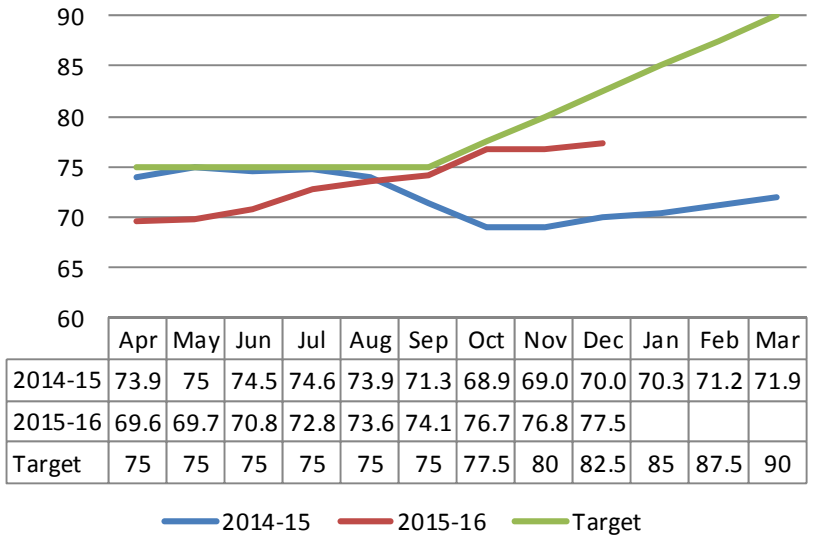
Planned Actions

- The importance and value of appraisal continues to be raised by senior managers throughout the organisation.
- Appraisal rates are discussed with divisions at monthly performance committee meetings.
- Divisions have been asked to verify data and plan appraisals accordingly.

Workforce

Lead Director - Jeremy Over

Mandatory Training (%)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-15	73.9	75	74.5	74.6	73.9	71.3	68.9	69.0	70.0	70.3	71.2	71.9
2015-16	69.6	69.7	70.8	72.8	73.6	74.1	76.7	76.8	77.5			
Target	75	75	75	75	75	75	77.5	80	82.5	85	87.5	90

Issues

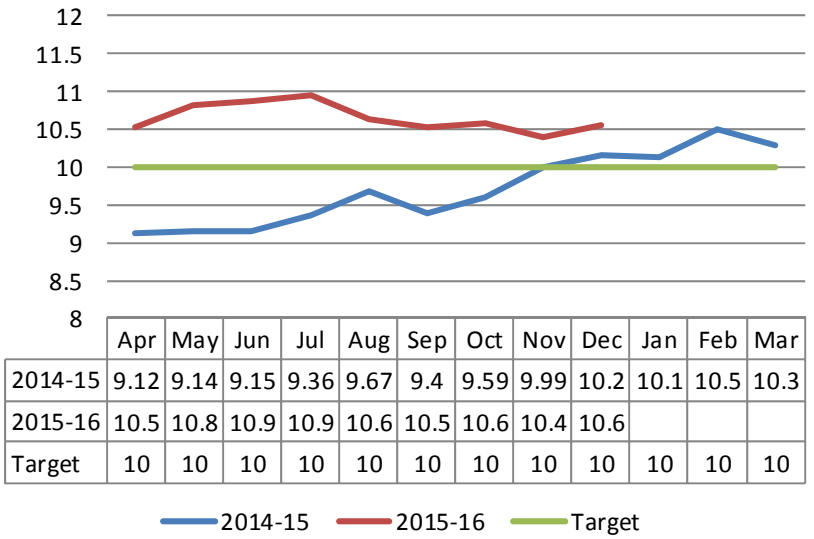
- The trajectory and target for year-end has been adjusted to 90%
- Compliance rates continue to improve as individuals complete outstanding training requirements, although is behind target

Planned Actions

- Work is currently ongoing to ensure that provision of Mental Capacity Act and Deprivation of Liberty Standards training is reflective of feedback from CQC following their recent inspection

Lead Director - Jeremy Over

Staff Turnover (%)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-15	9.12	9.14	9.15	9.36	9.67	9.4	9.59	9.99	10.2	10.1	10.5	10.3
2015-16	10.5	10.8	10.9	10.9	10.6	10.5	10.6	10.4	10.6			
Target	10	10	10	10	10	10	10	10	10	10	10	10

Issues

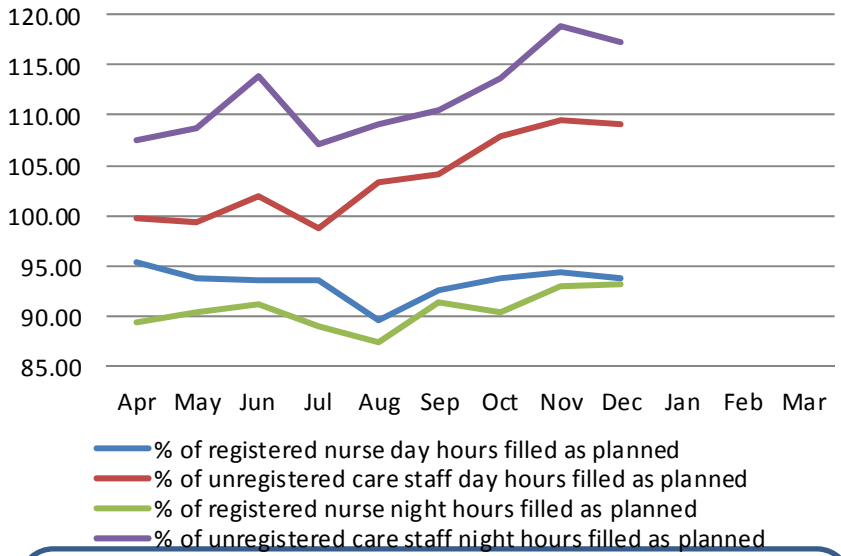
- Staff turnover has continued in the range 10.4% to 10.6% for the past 5 months.
- This is down from the peak of 10.9% in June and July.
- It is currently 0.4% higher than at this stage last year

Planned Actions

- The current trajectory is positive, as Turnover moves towards the target of 10%
- The newly-formed Staff Experience and Well-being Committee, will have a mandate to focus on Turnover

Lead Director - Jeremy Over

NHS Options Statistics



Issues

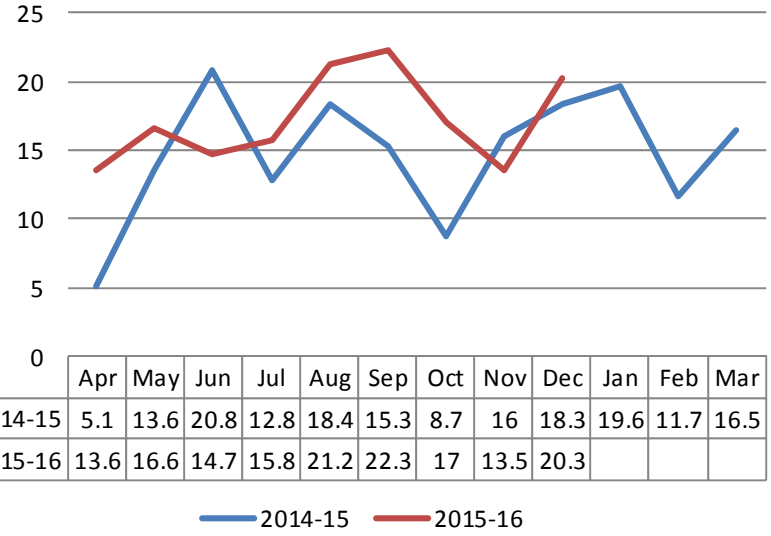
- The graph shows our nursing planned versus actual staffing levels.
- The percentage of shift hours worked versus planned may be greater than 100% where additional staff have been deployed to meet the needs of patients requiring 1-to-1 care

Planned Actions

- The impact of the nursing agency price cap/ rules are being closely monitored by HR and Senior Nurses

Lead Director - Jeremy Over

Turnover - Registered Nursing & Midwives



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-15	5.1	13.6	20.8	12.8	18.4	15.3	8.7	16	18.3	19.6	11.7	16.5
2015-16	13.6	16.6	14.7	15.8	21.2	22.3	17	13.5	20.3			

Issues

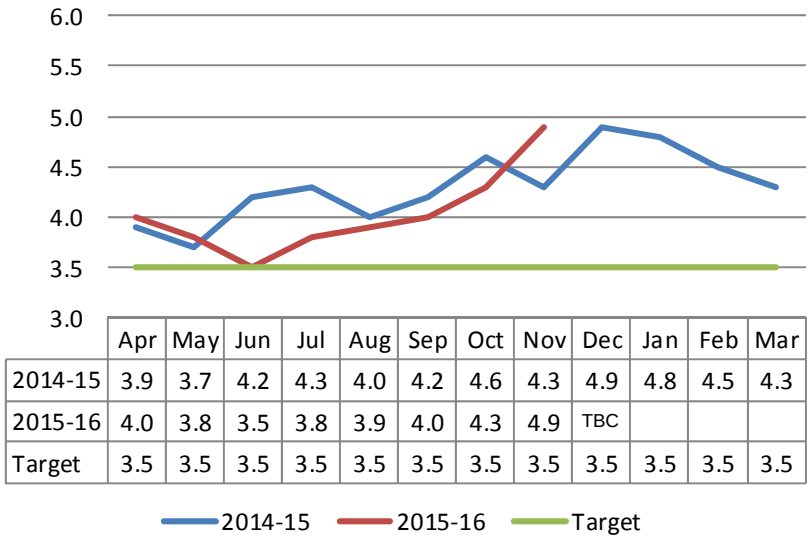
- The number of nursing/ midwifery leavers is averaging 17 per month.
- In December, the equivalent of 10 (50%) of the leavers were due to retirement and 6 (30%) were due to promotion/ relocation

Planned Actions

- Recruitment pipelines are closely monitored. The potential contribution of international nurse recruitment in 2016 is currently being planned
- 28 newly-qualified nurses commence at NNUH during January 2016

Lead Director - Jeremy Over

Sickness Levels



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-15	3.9	3.7	4.2	4.3	4.0	4.2	4.6	4.3	4.9	4.8	4.5	4.3
2015-16	4.0	3.8	3.5	3.8	3.9	4.0	4.3	4.9	TBC			
Target	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5	3.5

Issues

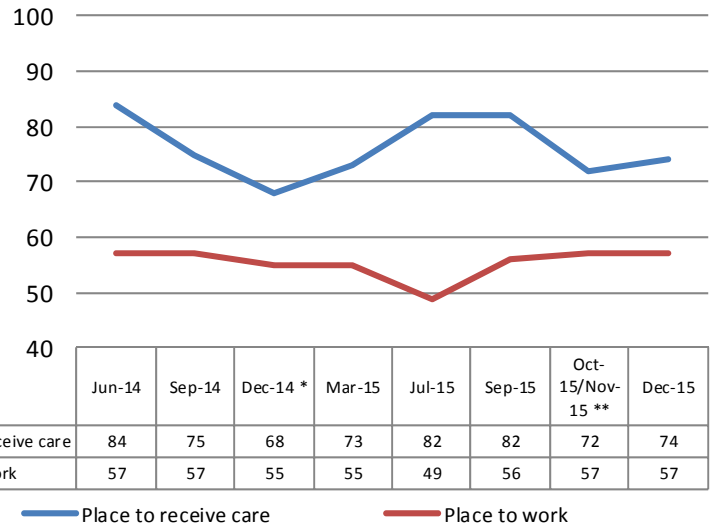
- At the time of producing this report, the December figures were not available.
- The provisional figures for previous months has seen the sickness rates adjusted positively – in October from 4.9% to 4.3% and in November from 5.1% to 4.9%.

Planned Actions

- Sickness is discussed in detail at divisional Performance Committees
- Managers are encouraged to intervene at every opportunity in order to maximise attendance at work

Lead Director - Jeremy Over

Friends and Family Test Scores



	Jun-14	Sep-14	Dec-14 *	Mar-15	Jul-15	Sep-15	Oct-15/Nov-15 **	Dec-15
Place to receive care	84	75	68	73	82	82	72	74
Place to work	57	57	55	55	49	56	57	57

Issues

- Place to receive care has reduced since July although is higher than 12 months ago. Place to work has stabilised at 57 following dip to 49 in July

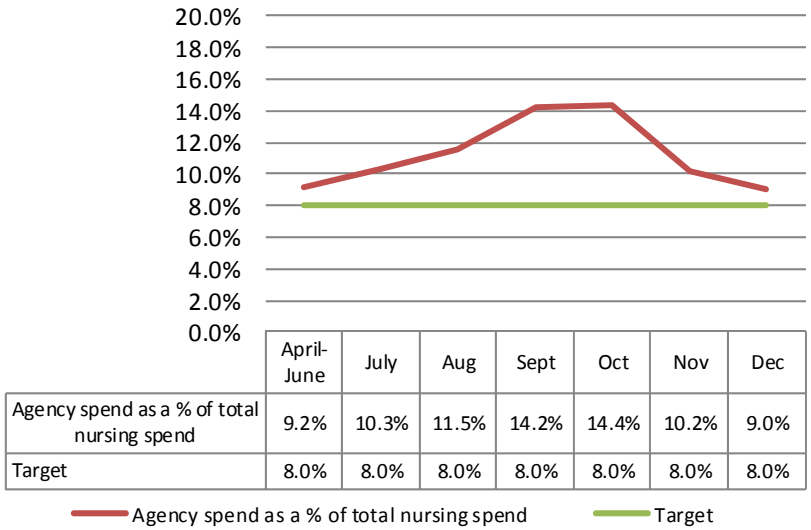
** December 14 – National Staff Survey*
*** Combined metric due to National Staff Survey*

Planned Actions

- Provisional national staff survey results to be shared when available.
- Ongoing monitoring of comments relating to 'bullying' in the survey – reduction from 12 to 3% of comments falling into this category between July and December 2015

Lead Director - Jeremy Over

Registered Nursing - Agency Spend



	April-June	July	Aug	Sept	Oct	Nov	Dec
Agency spend as a % of total nursing spend	9.2%	10.3%	11.5%	14.2%	14.4%	10.2%	9.0%
Target	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%

Issues

- As can be seen from the above graph, although agency expenditure for registered nursing is high against a target trajectory of 8% (for the second half of 2015/16) there has been considerable progress in reducing the % spend to 9.0% in December 2015.

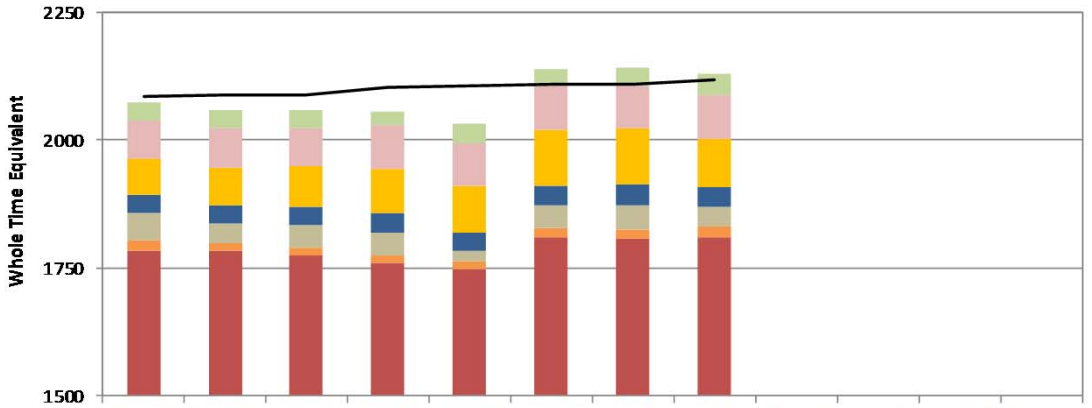
Planned Actions

- Compliance with Monitor's registered nursing agency rules relating to 'frameworks' with 78% of shifts attributed to framework agencies (it was just 26% in May 2015). Furthermore, Monitor has granted the Trust permission to utilise two named agencies who account for 98% of non-framework usage.

Workforce

Lead Director - Jeremy Over

Registered nursing metrics – all areas



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
Establishment	2084.5	2086.8	2089.1	2101.9	2105.8	2107.5	2109.5	2116.1
Resourcing - surplus(+) gap(-)	-10.0	-28.2	-29.5	-45.5	-74.8	+31.8	+31.2	+12.7
SIP - Long Term Sick*1	35.4	34.6	35.6	28.8	38.9	33.4	34.5	41.2
SIP - Maternity & Other*2	75.7	76.7	75.5	84.8	82.4	85.1	84.4	84.3
Agency*3	70.0	76.6	79.5	86.1	91.1	110.5	109.6	97.0
Bank*3	36.1	34.6	36.6	38.7	35.3	37.0	38.9	37.0
Overtime*3	53.3	38.3	42.5	42.4	19.2	46.9	48.9	37.2
Excess Hours*3	19.1	14.7	14.4	15.4	16.0	15.4	18.4	20.8
'Attending' Staff in Post *4	1784.8	1783.1	1775.5	1760.2	1748.2	1811.1	1806.1	1811.3
Staff in Post (SIP)	1895.9	1894.4	1886.7	1873.7	1869.5	1929.6	1924.9	1936.7
'Vacancy' level interpretations								
Establishment less SIP	188.6	192.4	202.5	228.2	236.3	177.9	184.6	179.4
Establishment less attending SIP	299.7	303.7	313.6	341.7	357.6	296.5	303.5	304.8

*1 Long term sick defined as 28+ calendar days *2 Figure includes maternity leave, career break and external secondments

*3 Bank, Overtime, Excess Hours and Agency figures are illustrative, based on a conversion to WTE

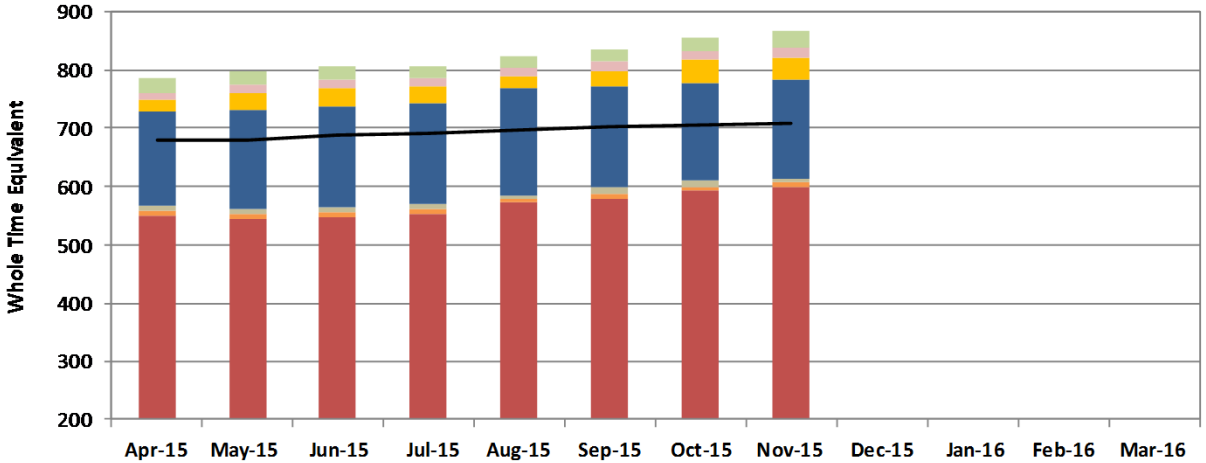
*4 The 'attending' figure includes all staff in post, with the exception of those on Maternity or LTS, but includes staff absent on short term sickness

Source - Establishment from Finance 9/12/2015, Staff in post from ESR 21/12/2015, Bank & Agency from e-Roster 7/12/2015, OT & excess hours from Finance 9/12/2015

- This analysis reflects nursing workforce data incorporating equivalent figures for employed, bank, agency, overtime and excess hours. December data is not available at the time these slides were produced.
- Reliance on agency nurses remains high.

Lead Director - Jeremy Over

Unregistered nursing metrics – all areas



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15
Establishment	679.2	680.5	689.3	690.7	697.2	701.8	704.5	708.5
Resourcing - surplus(+) gap(-)	+107.8	+118.2	+115.7	+115.7	+127.2	+134.6	+152.1	+159.3
SIP - Long Term Sick*1	26.8	23.9	23.2	21.6	22.1	22.7	23.2	30.9
SIP - Maternity & Other*2	11.6	15.0	14.0	13.7	13.4	15.3	16.1	16.7
Agency*3	18.8	28.8	30.1	26.9	20.6	25.3	38.8	37.6
Bank*3	162.1	170.0	173.6	172.9	183.3	174.0	167.2	169.4
Overtime*3	9.7	7.4	8.1	9.4	4.7	10.2	10.8	5.8
Excess Hours*3	8.6	9.2	7.4	8.0	7.5	8.4	8.4	7.2
'Attending' Staff in Post *4	549.4	544.4	548.7	553.9	572.8	580.6	592.1	600.4
Staff in Post (SIP)	587.8	583.4	585.9	589.2	608.3	618.6	631.4	647.9
'Vacancy' level interpretations								
Establishment less SIP	91.4	97.2	103.4	101.5	88.9	83.2	73.1	60.6
Establishment less attending SIP	129.8	136.1	140.6	136.8	124.4	121.2	112.3	108.1

*1 Long term sick defined as 28+ calendar days *2 Figure includes maternity leave, career break and external secondments

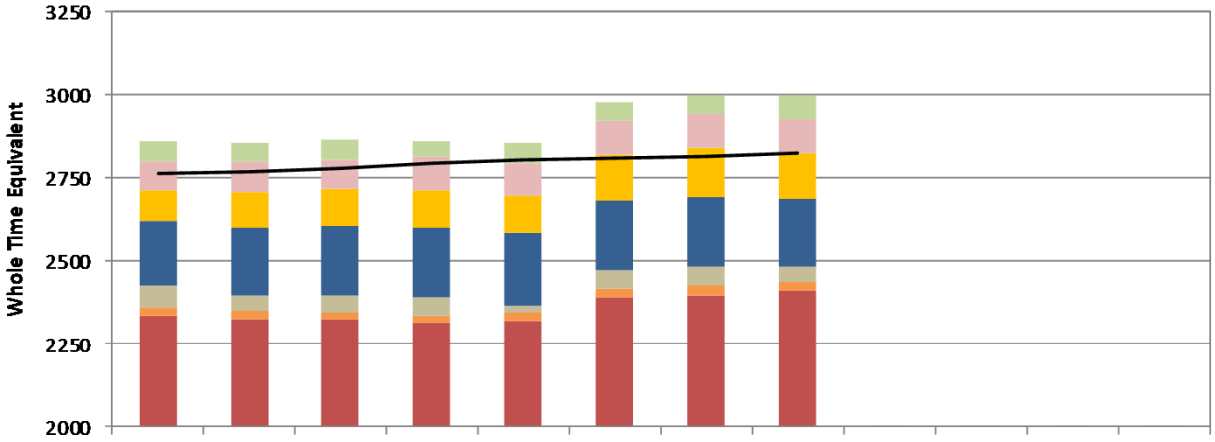
*3 Bank, Overtime, Excess Hours and Agency figures are illustrative, based on a conversion to WTE

*4 The 'attending' figure includes all staff in post, with the exception of those on Maternity or LTS, but includes staff absent on short term sickness

Source - Establishment from Finance 9/12/2015, Staff in post from ESR 21/12/2015, Bank & Agency from e-Roster 7/12/2015, OT & excess hours from Finance 9/12/2015

Lead Director - Jeremy Over

Registered and Unregistered nursing metrics – all areas



	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Establishment	2763.8	2767.3	2778.5	2792.6	2803.0	2809.3	2814.0	2824.6				
Resourcing - surplus(+) gap(-)	+97.8	+90.0	+86.2	+70.1	+52.3	+166.5	+183.2	+172.0				
SIP - Long Term Sick*1	62.1	58.5	58.8	50.4	61.0	56.1	57.6	72.0				
SIP - Maternity & Other*2	87.4	91.7	89.5	98.5	95.9	100.4	100.5	101.0				
Agency*3	88.9	105.4	109.6	113.0	111.6	135.8	148.3	134.6				
Bank*3	198.2	204.5	210.2	211.6	218.6	211.0	206.1	206.4				
Overtime*3	63.0	45.8	50.6	51.8	23.9	57.1	59.7	43.0				
Excess Hours*3	27.7	23.9	21.8	23.5	23.5	23.8	26.8	28.0				
'Attending' Staff in Post *4	2334.3	2327.5	2324.2	2314.1	2320.9	2391.7	2398.2	2411.6				
Staff in Post (SIP)	2483.8	2477.8	2472.6	2462.9	2477.8	2548.2	2556.3	2584.6				
'Vacancy' level interpretations												
Establishment less SIP	280.0	289.6	305.9	329.7	325.2	261.1	257.7	240.0				
Establishment less attending SIP	429.5	439.8	454.2	478.5	482.0	417.6	415.8	413.0				

*1 Long term sick defined as 28+ calendar days *2 Figure includes maternity leave, career break and external secondments

*3 Bank, Overtime, Excess Hours and Agency figures are illustrative, based on a conversion to WTE

*4 The 'attending' figure includes all staff in post, with the exception of those on Maternity or LTS, but includes staff absent on short term sickness

Source - Establishment from Finance 9/12/2015, Staff in post from ESR 21/12/2015, Bank & Agency from e-Roster 7/12/2015, OT & excess hours from Finance 9/12/2015

Speak Up Issues

The NNUH Speak Up Policy exists to provide ways for staff to raise any concerns that they may have about things they see or hear in the workplace. Importantly we want staff to feel safe and secure to do so, and feel confident in the process. We are grateful for when staff raise concerns as it ensures an awareness of the issue and enables us, where possible, to remedy the situation.

An anonymous letter of concern was received on 04 November from an individual member of staff who reported that they worked on Gateley Ward. The concern relates to a high level of turnover on the ward and made allegations as to what might be the cause of this. A matron from outside the division, supported by HR, is investigating the matter in line with the Speak Up Policy. It should be noted that, as a result of other related concerns arising in respect of Gateley, supportive measures are already in place which are ongoing.

An externally-facilitated review is currently underway following receipt of a Speak Up complaint in 2015 relating to the handling of a conduct issue. Terms of reference are agreed and it is expected that this will conclude by the end of January.

Developing organisational culture

Following a period of focused engagement with staff representatives (union representatives and staff governors) over the summer to address feedback within recent staff surveys and the CQC report published in June the executive board agreed a set of actions that had been proposed in partnership with representatives. The workforce sub-board reviewed progress against the action plan which is on track. This includes the establishment of a Staff Experience & Well-being Committee, through broadening the role of the existing Health & Well-being Committee. The actions also include proposals and options around the establishment of the Freedom to Speak Up Guardian role which are being worked-up and will be reported to hospital management board in February.

Non-clinical Safety

Lead Director - Jeremy Over

Highlight report:

- The Non-Clinical Safety sub-board met on 13 January 2016 and is now chaired by the Director of Workforce.
- Information Governance is now incorporated into the terms of reference and Ben Everitt has been included in the membership of the group
- The group reviewed the action plan to address concerns in relation to availability of safer devices for administration of insulin, following HSE inspection in the autumn of 2015. This action plan is now complete, with the exception of an audit which will be undertaken imminently.
- Equipment to monitor access to the Winterton Unit roof is planned to be installed by the end of January (relates to RR 492)
- A meeting to review specific safety risks related to deferral of refurbishment programme is to take place (relates to RR 511)
- A further 40 pressure mattresses have been requisitioned and delivered during first week of January to address concerns around availability
- An updated version of the Prevention and Management of Needlestick (Inoculation) and Sharps Injuries policy was ratified by the sub-board
- Significant progress has been made in Health Records, with 793 metres of shelving being liberated as a result of their scanning, culling and case note conversion project. This has involved the capturing of 1.3 million scanned images during 2015, the highest annual figure.

Quality and Safety

Lead Directors - Peter Chapman and Emma McKay

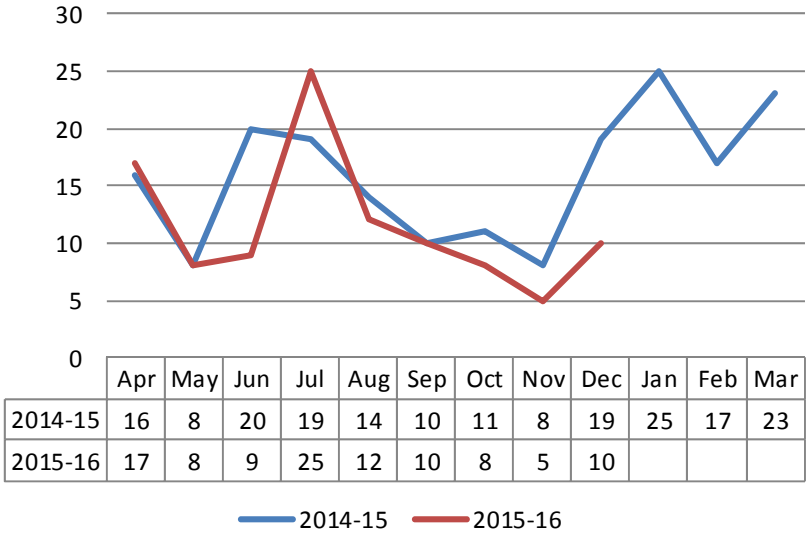
Quality	Outturn 14/15	Dec-15 Actual	6 month trend	YTD 15/16
Serious Incidents	99	8		102
Patient FFT score inpatients	83.8%	97.%		89
Complaints	838	73		668
Deaths / 100 admissions	1.35	1.34		1.16
Patient Falls causing moderate harm or above	30	0		28
Grade 2 hospital acquired pressure ulcers	190	10		83
Grade 3 hospital acquired pressure ulcers	53	4		32
Grade 4 hospital acquired pressure ulcers	1	0		1
HSMR (September 2015)	109.8	92.6		109.4
Incident Reporting		1241		11394
Harm Free Care - NHS Saferty Thermometer		92.8%		91.3%
Electronic Discharge Letters - within 24 hours		76.3%		74.5%
Never Events	0	0		4
Insulin incidents causing moderate harm or above		1		2

Medication Errors - December 2015	125
Review by Senior clinician (Quarter 2)	87.7%
Screening for sepsis (Quarter 2)	80.6%

- The Clinical Safety Board provides assurance of risk and safety review.
- HSMR for September is 92.6 (within expected range) but for the whole year to Sept 2015 is 109.8 (higher than expected due to high HSMR earlier in Dec 2014 and Jan 2015)
- Rates of incident reporting per bed day onto Datix in NNUHFT are high and are in the top 25% for all Acute Trusts.
- There have been No Events reported in December 2015
- Q2 sepsis screening within 15 minutes of arrival was 80.5% and is slightly improved from Q1 (79%). Q4 Target 90%.
- Q2 Senior Clinician daily review of acute admissions within 12 hours is 87.7%. CQUIN Q2 target 87.5% ;Q4 Target 90%.

Lead Director -Emma McKay

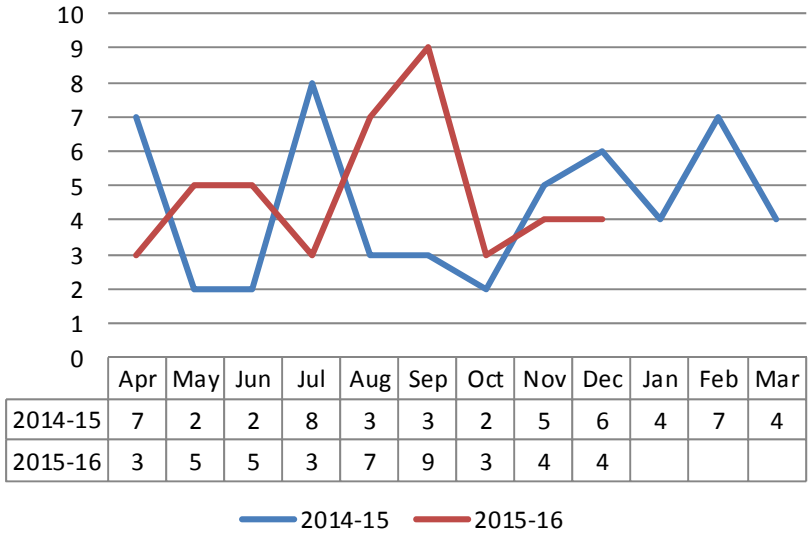
Grade 2 hospital acquired pressure ulcers



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-15	16	8	20	19	14	10	11	8	19	25	17	23
2015-16	17	8	9	25	12	10	8	5	10			

Lead Director -Emma McKay

Grade 3 hospital acquired pressure ulcers



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-15	7	2	2	8	3	3	2	5	6	4	7	4
2015-16	3	5	5	3	7	9	3	4	4			

Issues

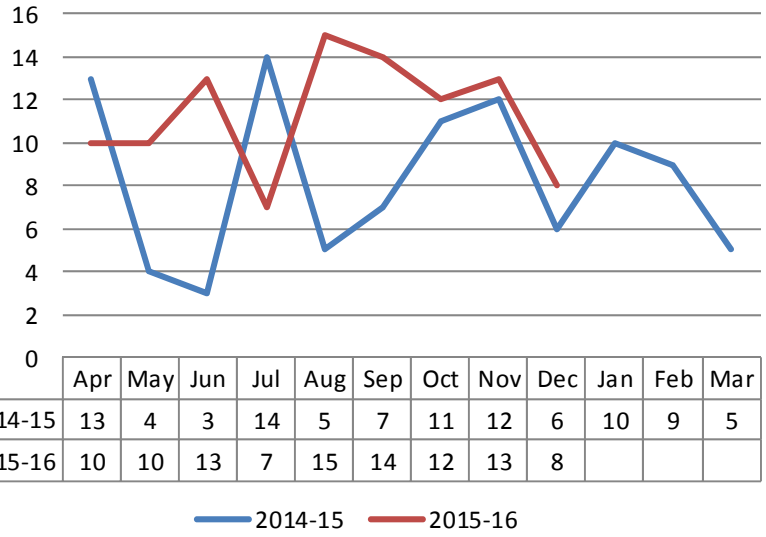
- 4 grade 3 hospital acquired pressure ulcers in December. 3 were AVOIDABLE on RCA and 1 was unavoidable.
- 10 grade 2 hospital acquired pressure ulcers. 4 were AVOIDABLE on RCA and 6 were unavoidable.
- Rates of HAPUs have been broadly similar for the last three years.
- The numbers of Grade 2 HAPUs in November were the lowest this year.

Planned Actions

- The issues identified on RCAs have been disseminated back to the wards and to matrons for learning and to the organisation through the OWL.
- Particular learning for this month
    - All bandages should be removed on admission to allow assessment of pressure areas and pre-existing ulcers
    - All staff must use a wound care plan for all patients requiring wound dressings
    - Increased training and awareness of staff on correct use of Waterlow assessment

Lead Director - Peter Chapman

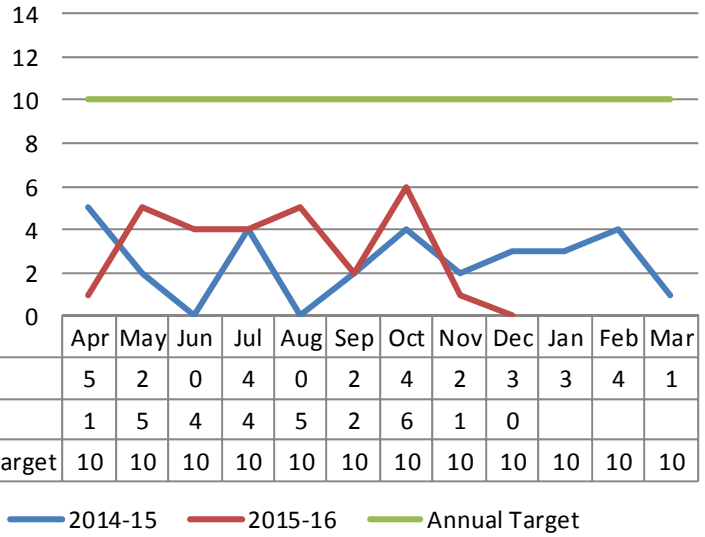
Total Serious incidents (which include falls with moderate harm or above and Grade 3 or above HAPU's)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-15	13	4	3	14	5	7	11	12	6	10	9	5
2015-16	10	10	13	7	15	14	12	13	8			

Lead Director - Peter Chapman

Patient Falls causing moderate harm or above



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-15	5	2	0	4	0	2	4	2	3	3	4	1
2015-16	1	5	4	4	5	2	6	1	0			
Annual Target	10	10	10	10	10	10	10	10	10	10	10	10

Serious Incidents and Never Events

- There were 0 Never Events to report in December
- There were 4 Serious Incidents in December in addition to falls and Pressure Ulcers
  - 1 Stilbirth (O&G)
  - 1 Unexplained arm fracture in 3 week old (ED/CAU)
  - 1 Unexplained neonatal death (O&G)
  - 1 unexpected death (EAUS/General Surgery)
- Duty of candour has been observed for all
- RCAs are undertaken for all

Issues

- There were 258 reported inpatient falls in December.
- 0 of these resulted in moderate or above harm to patients.

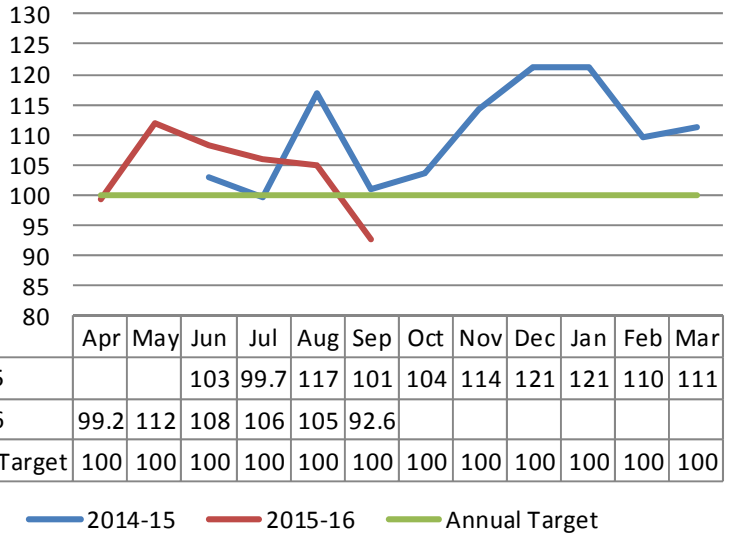
Planned Actions

- As for pressure ulcer care and SIs the lessons learned from RCAs are disseminated back to the wards and matrons for learning and to the organisation through the OWL

Quality & Safety

Lead Director - Peter Chapman

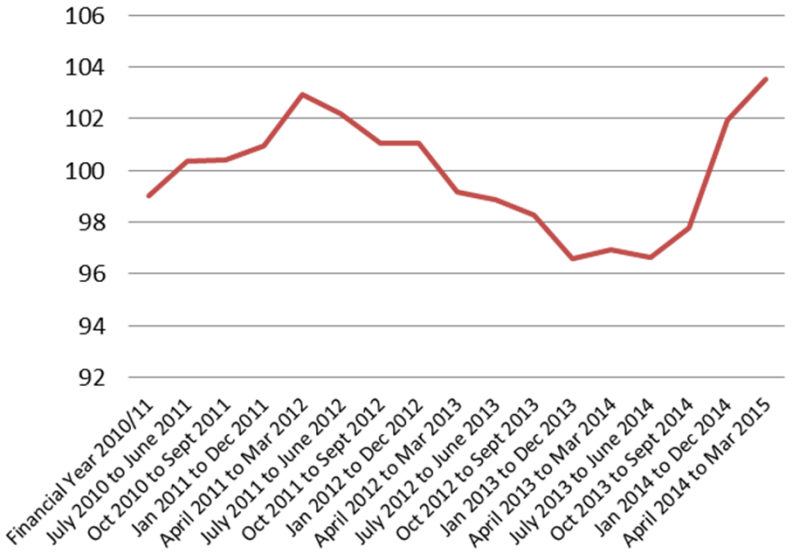
HSMR (September 2015)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-15			103	99.7	117	101	104	114	121	121	110	111
2015-16	99.2	112	108	106	105	92.6						
Annual Target	100	100	100	100	100	100	100	100	100	100	100	100

Lead Director - Peter Chapman

SHMI



- HSMR is the risk adjusted ratio of observed to expected in-hospital deaths within 56 clinical groups. Rebased each month.
  - HSMR is below expected (92.6) for September 2015 but still remains above expected for the year
  - Note the readjustment (rebasing) of the previously reported HSMR for Aug 2015 from 82.2 to 105
- SHMI is the ratio between the actual number of people who die following hospitalisation at a Trust and the number who would be expected to die on the basis of England average figures given the characteristics of patients treated there
  - SHMI has risen from below 100 to above 100 for the year to Mar 2015 consistent with rise in HSMR during this period
- Notes audit of 50 emergency admissions showed multiple “missed” comorbidity on coding and 15% with missed Charleston Index comorbidity. Coding of Charleston Index mean diagnoses per episode has increased since June 2015.
- Pick up rate of coding for sepsis has increased markedly since June 2015. New sepsis guidelines are to me launched this month which should continue to increase awareness
- Changes to the mortality review process have been agreed pending admin support to improve numbers and consistency of deaths subject to mortality review (currently 49% of all deaths undergo mortality review). SI policy will be amended

NHS Safety Thermometer Dashboard Comparison Table

Safety Thermometer Dashboard Comparison Table

NNUH Norfolk & Norwich University Hospital | CAT Cambridge Acute Trust | JPH James Paget Hospital, GY | QEKL Queen Elizabeth, KL | All acute All Acute Trusts

	NNUH	Jul-15					Aug-15					Sep-15					Oct-15					Nov-15					Dec-15				
		All Acute	NNUH	CAT	JPH	QEKL	All Acute	NNUH	CAT	JPH	QEKL	All Acute	NNUH	CAT	JPH	QEKL	All Acute	NNUH	CAT	JPH	QEKL	All Acute	NNUH	CAT	JPH	QEKL	All Acute	NNUH	CAT	JPH	QEKL
Harm Free		94.28	**90.68**	96.78	91.96	93.85	94.13	92.03	98.24	**91.26**	94.16	94.31	**91.57**	97.89	93.09	91.99	94.24	89.93	98.23	94.64	94.88	94.08	92.53	92.26	93.01	95.44	94.23	**92.80**	98.32	93.65	93.63
Pressure Ulcers - All		3.95	**7.30**	1.11	4.83	4.81	3.91	**6.50**	0.41	6.28	4.82	3.80	**6.50**	0.80	5.32	5.58	3.96	**7.40**	0.42	3.49	3.90	4.04	**5.39**	1.21	3.37	2.51	4.33	**5.38**	0.90	4.76	4.95
Pressure Ulcers - New		0.83	1.06	0.20	0.80	**1.60**	0.80	0.98	0.00	1.09	**1.27**	0.76	1.12	0.20	0.80	**1.21**	0.81	**1.09**	0.10	1.07	0.98	0.84	0.47	0.36	0.26	**0.68**	0.93	0.86	0.65	**1.06**	0.47
Falls with Harm		0.41	0.58	0.50	**1.34**	0.27	0.49	0.20	0.31	0.00	**0.51**	0.47	0.10	0.50	0.27	**0.73**	0.43	**1.18**	0.42	0.27	0.00	0.45	0.28	1.21	0.78	**1.37**	0.56	0.38	0.39	0.00	**0.71**
Catheters & UTI's		1.03	**1.92**	0.80	1.34	1.07	1.09	1.18	0.21	**3.01**	0.51	1.08	**1.83**	0.40	1.60	1.21	1.04	**1.68**	0.10	1.34	0.73	1.09	**1.99**	0.60	1.55	0.68	0.69	0.96	0.26	**1.32**	0.71
Catheters & New UTI's		0.39	**1.06**	0.10	0.80	0.53	0.43	0.10	0.10	**0.82**	0.25	0.43	0.20	0.10	0.27	**0.73**	0.41	**0.30**	0.10	1.07	0.24	0.46	0.66	0.36	**0.78**	0.68	0.30	0.19	0.13	**0.53**	0.47
New VTE's		0.56	0.48	**0.90**	0.54	0.80	0.60	0.20	**0.83**	0.27	0.00	0.52	0.30	0.50	0.27	**0.97**	0.52	0.20	**0.94**	0.27	0.73	0.54	0.47	0.72	**1.55**	0.46	0.36	**0.67**	0.13	0.26	0.00
New Harms		2.16	3.17	1.71	**3.49**	2.94	2.27	1.48	1.24	**2.19**	2.03	2.14	1.73	1.31	1.60	**3.16**	2.13	2.76	1.46	**2.68**	1.95	2.24	1.89	2.65	**3.37**	2.76	2.11	**2.11**	1.68	**1.85**	1.65

NNUH Safety Thermometer Dashboard

	2014	2015											
	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Harm Free	91.45	90.75	90.95	92.88	91.22	90.44	89.88	90.68	92.03	91.57	89.93	92.53	92.80
Pressure Ulcers - All	6.62	7.59	7.45	5.78	7.35	7.63	7.45	7.30	6.50	6.50	7.40	5.39	5.38
Pressure Ulcers - New	1.29	1.11	1.60	0.80	0.71	1.10	0.74	1.06	0.98	1.12	1.09	0.47	0.86
Falls with Harm	0.28	0.46	0.85	0.44	0.20	0.37	0.64	0.58	0.20	0.10	1.18	0.28	0.38
Catheters & UTI's	1.38	1.30	1.04	0.89	1.12	1.38	1.38	1.92	1.18	1.83	1.68	1.99	0.96
Catheters & New UTI's	0.46	0.19	0.00	1.18	0.31	0.37	0.18	1.06	0.10	0.20	0.30	0.66	0.19
New VTE's	0.55	0.37	0.00	0.30	0.20	0.64	0.92	0.48	0.20	0.30	0.20	0.47	0.67
New Harms	2.57	2.13	2.36	1.78	1.43	2.30	2.48	3.17	1.48	1.73	2.76	1.89	2.11

- This table shows comparative performance against other acute Trusts in the region, against all acute Trusts, and over the last 6 months
- There is no significant change in performance against other acute trusts in Decembers figures
- NNUH has tended to have higher rates of Pressure Ulcers (All) but equivalent rates of pressure Ulcers (New). This indicates the higher rate of patients presenting to NNUH with pressure ulcers already present.
- NNUH has tended to have lower rates of falls with harm
- NNUH has tended to have higher rates of catheters and UTIs but lower or equivalent rates of catheters and new UTIs
- With the exception of December new VTE rates have been relatively low
- Rates of new harms are generally equivalent between organisations

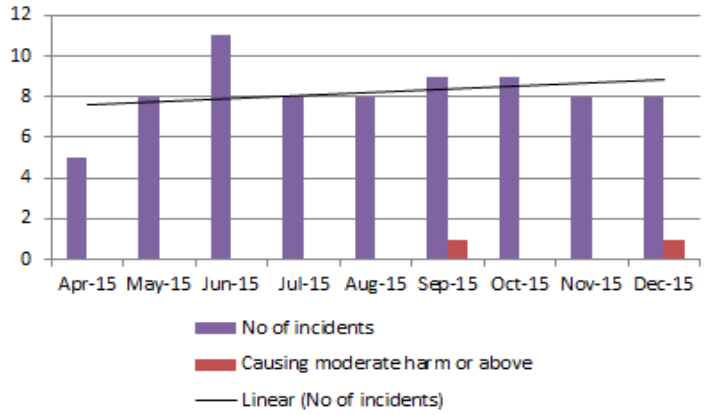
Our Vision
To provide every patient with the care we want for those we love the most

Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

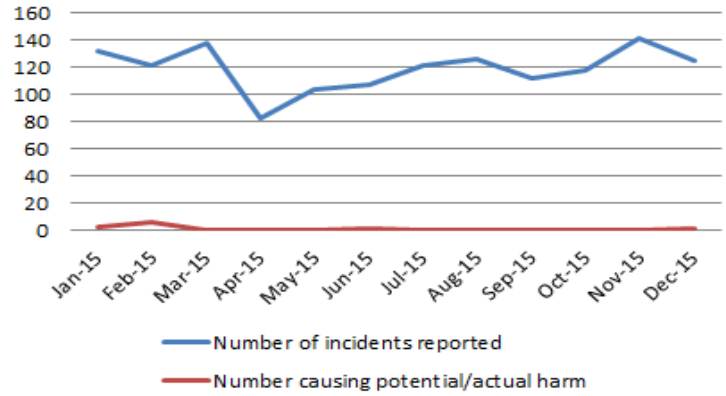
Quality & Safety

Lead Director - Peter Chapman

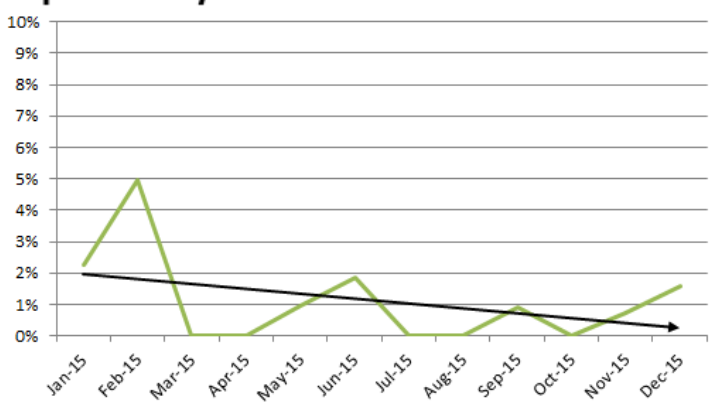
Insulin incidents by month - 2015/16



Medication Incidents – January 2015 to December 2015



Medication incidents causing potential/actual harm as % of total



- We will focus on increasing reporting of medication errors whilst reducing those causing harm and those in relation to insulin
- The numbers of reported medication errors has remained constant but the percentage of those causing harm has reduced over the last year
- We have reported one insulin error causing temporary harm in Dec 2015 (T&O patient with diabetic ketoacidosis). RCA is underway.
- Previous insulin errors resulting in temporary harm were in Sept ‘15 (1), Jan ‘15 (2), Oct ‘14 (2)
- NNUH an outlier in CQC Overview pack for National In-Patient Diabetes Survey from 2013. 2015 Survey just completed. Results not published yet.
- Draft inpatient diabetes strategy and action plan in progress

Quality & Safety

Lead Director - Peter Chapman

Radiation protection

- The requirement to inform the Radiation Protection Advisor where any works or projects may either directly or indirectly affect radiology / radiotherapy has been emphasised
- All notifiable events have been correctly managed

Risk Register - Safety

- The Safety Board reviews in detail all relevant risks 12 and above. All risks have been updated or are in the process of being updated..

Drugs, Therapeutics and Medicines Management

- EPMA. Largest ever roll-out of EPMA in one go successfully completed on medical wards
  - •Implementation of mandatory Thrombosis Risk Assessment as part of this package has led to a significant improvement in both monitoring accuracy and compliance – over 95% on EPMA wards.
- Applications for drugs for compassionate use programs
  - •Somatropin (Growth Hormone) not approved – 3 unsuccessful applications previously made to CCGs for funding. Compassionate use only agreed by company for 1 year so this would cease at 12 months but treatment would require continuing for years beyond this.

Learning from incidents

- Local learning through directorate governance meetings, ward meetings and noticeboards
- RCAs are undertaken for all SIs and the outcome and action plan provided to AMDs, CDs and Governance Leads.
- Monthly Incident and Never Event OWL produced.
- Clinical Incidents, Complaints and Claims Review Committee
  - Reviews trends for all SIs and NEs for previous 12 months
  - Draws themes for SIs, complaints, claims, mortality and inquests

Quality & Safety

Lead Director - Peter Chapman

Divisional Board reporting

Surgery

- NNUH in lower quartile for time between screening identification of abdominal aortic aneurysm and decision to treat due to delay in CT scanning. Clarification and action plan required from Division
- Vascular Surgery not meeting national target for amputation within 48 hours (NNUH 72 hours). Clarification and action plan sought from Division – Emergency Surgery Capacity
- Safety Concerns in relation to nature of proposed pre-approval process for intravitreal injections in ophthalmology have been brought to the attention of CCGs through the Clinical Quality Review Meeting

Women and Children

- Maternity Dashboard. Summary version with comments to be discussed at Safety and Quality Committee for future inclusion in IPR Red Ratings for November
    - •Capacity
    - •Three Unit Closures
    - •Supervising midwife to midwife ratios (1:32)

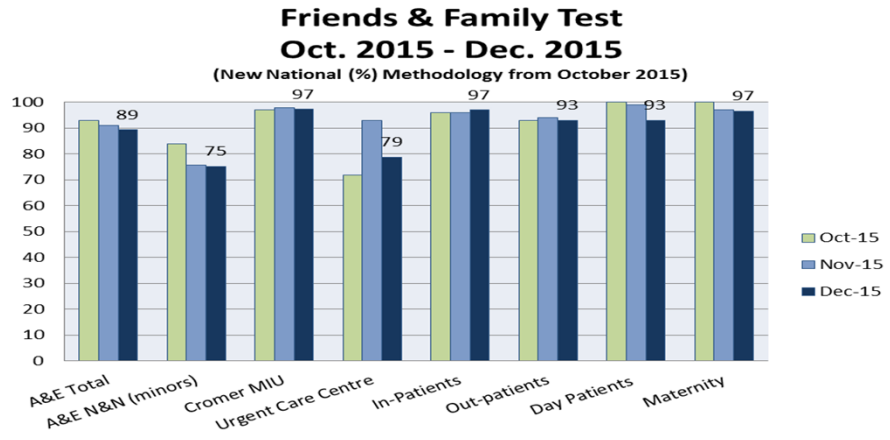
Nursing Red Flags

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	
Division 1	281	299	384	386	660	431	404	345	321	
Division 2	197	183	244	398	868	629	746	519	630	
Division 3	43	32	31	67	84	72	68	66	66	
Maternity	-	321	481	496	683	523	722	568	376	

•The majority of the red flags for the month of December have been consistent with previous months' reports. Recommended measures:

- •Re-evaluation of the provision of nurse bank and HCA specials cover
- •Review of recruitment processes to reduce time to hire.

Caring and Patient Experience



Patient Feedback

The In-patient Friends & Family (FFT) score has improved further to 97%. FFT feedback responses within out-patient areas have improved again with 18 areas receiving more than 10 responses. Of these 18 areas, the average score was 95% (range 77% - 100%).

#hellomynameis feedback from patients was that 97.3% of Trust staff gave their name, role and description of planned care.

Patient Opinion & NHS Choices

There were 17 Patient Opinion posts in December. These are rated from Level 0 (not critical) to Level 4 (very critical). One was rated at Level 1; two at Level 2 (one of which related to commissioning issues). Eleven patients commented on NHS Choices, all giving the highest rating of five stars.

Dementia Carers' CQUIN

There was one negative carer's comment in relation to a patient's poor mobility following admission. The other was in relation to a perception of a discharge being too swift. These were both escalated to the relevant staff for review and action. Other comments were extremely positive.

Dementia FAIRI CQUIN

- The 90% compliance target across all elements of the process within the FAIRI National Dementia CQUIN has been maintained and a snap-shot audit of compliance is required and planned during this final quarter.
- A business case is in development to support Tier 2 dementia training and is one which incorporates learning disability and dementia care.
- A total of 23 staff have attended tier 3 training (with 1 more session to be held).
- Training in basic dementia training awareness to 31/12/2015 is detailed within the following table:

Division	Staff who are required to Fulfil Competence Requirements for Basic Dementia Awareness	% Staff that Fulfil Competence Requirements for Basic Dementia Awareness *(previous Q.)*
Trust Overall		91.5% (89.79%) ↑
Cancer Services Division	175	96% (94.83%) ↑
Corporate Areas	759	68.6% (68.98%) ↓
Emergency Services	374	96.5% (94.75%) ↑
Medicine & Clinical Support Division	1640	97.3% (94.32%) ↑
Surgery & Cromer Division	1371	94.7% (93.68%) ↑
Women, Children & Sexual Health Division	120	96.7% (92.04%) ↑

Patient Advice & Liaison Service Queries

- There were 216 PALS queries during December 2015. Excluding 'General Queries' and 'Thank You / Best wishes', 'Clinical Treatment' (n.23) and 'Communications' (n.29) were the highest criteria reported.
- Of all queries, 18% related to in-patient care.

Caring and Patient Experience

Learning Disabilities & Autism

- The Learning Disabilities & Audit team has been enhanced and substantively recruited into.
- Reasonable adjustment audits and supporting governance processes continue to highlight the need to enhance staff awareness and training in relation to the Mental Capacity Act as well as associated documentation around rationales in relation to decision making reasonable adjustments for patients and their carers.

Dementia Strategy

- There are now over 100 Dementia Links in the Trust who are contributing to positive audit findings in relation to the use of visual identifiers on the wards and in the Emergency Department.
- Dementia person-centred care audits replace previous 'This is Me audits' and are undertaken monthly.
- As the NNUH dementia team has been recognised as providing good practice care it has partnered another Trust to assist in their desire to improve their own practice.
- Active research activity continues.

Nutrition Steering Group

- The Hospital Food Standards (DH, 2014) – gap analysis is now complete and meetings being held with representatives with Serco to ensure achieving deadlines on action plan. We are currently achieving 236 of the 323 standards and are gradually increasing our compliance, with no risks in relation to these escalated at the present time.
- The Trust-wide Protected Mealtimes Guideline has been updated.
- A diet sign audit was piloted on one ward. Of the 22 patients audited, all had the appropriate diet sign displayed.
- The annual audit of MUST scoring compliance is complete and results being formulated.

Discharge

- Updates to the sub-board were confined to patient feedback in relation to complaints. Future reports have been requested that cover all aspects of discharge policy and performance against its key elements.

Complaints

- The overall number of complaints received during 2015 continues to show a decreasing trend compared with the previous year.
- Communication continues to be the category for most complaints.
- Complaints relating to consent process will be presented next month to coincide with the development of a new suite of consent forms.

Patient Information Leaflets

The work undertaken to identify the 6 most commonly distributed patient information leaflets and to ensure their translation into our top 3 most required alternative languages is now complete and the leaflets available

Escalated Issues from the Divisions

- There were no specific issues raised from the Divisions in relation to caring and patient experience.

Risks

- There are no new >12 risks in relation to caring or patient experience on the Risk Register.

Productivity & Finance

Lead Director - Sheila Budd

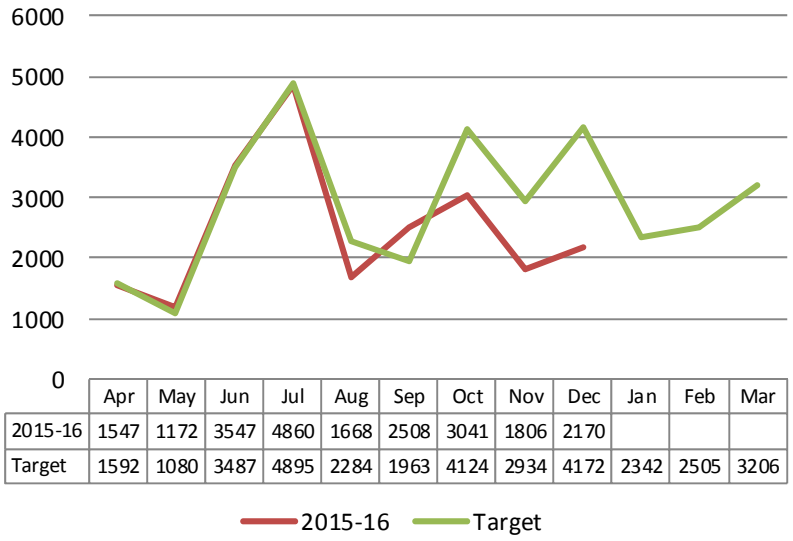
Productivity & Finance	Outturn 14/15	Full Year Plan	Dec-15 Actual	6 month trend	YTD 15/16
Total income excluding interest	£514,811k	£542,786k	£46,854k		£406,831k
Total expenditure - Employee Benefit Expenses	£285,870k	£299,227k	£25,846k		£225,389k
EBITDA	£33,263k	£34,585k	£2,170k		£22,319k
CIP Savings Achieved		£21,200k	£1,100k		£12,200k
Closing Cash balance	£74,138k	£46,875k	£44,354k		£44,354k
Capital expenditure	£3,297k	£12,373k	£510k		£4,130k
Non-Elective Activity - marginal rate - Financial Impact *	£15,643k	£6,493k	£553k		£5,241k
Emergency readmissions penalties: Following Elective *	£1,029k	£1,125k	£95k		£824k
Emergency readmissions penalties: Following Non Elective *	£584k	£474k	£40k		£735k
Theatre Utilisation		90.%	87.%		88.6%
A&E Activity (attendances)	111,958	119,869	9,449		90,489
Emergency Admissions *	50,639	50,639	4,320		39,321
Elective Activity - Day case spells *	83,719	85,578	6,515		62,868
Elective Activity - Elective inpatient spells *	14,898	15,339	1,090		10,804
Outpatient Activity (consultant led & non-consultant led) *	693,149	690,093	55,651		512,874
***Please note these figures are provisional**					

- Clinical Income on a monthly basis has a significant impact on the result for the month.
- For December, Clinical Income plan was £35.0m, and the fast track movement for the month was £34.4m, overall being behind plan. A key reason is the preparation work for Christmas which impacted Outpatient activity in particular.
- The in month result was an adverse variance of £1,960k, bringing the cumulative financial position at month 9 to an adverse variance of £4,061k – i.e. worse than plan.
- The main drivers in month are Clinical Income £0.6m, Pay £0.5m, Clinical Supplies £0.5m and Non-Clinical Supplies £0.4m. Of this c.£1m was not forecast, explained as: Clinical Income - £0.6m and Non-Pay - £0.4m - costs associated with Gastro Medinet (£0.1m) and UCC (£0.2m).
- Agency costs were £1.3m in month being £137k less than the previous month. However still high being £126k more than month 1 - 6 average and £24k more than 1-8 average.
- Locum costs were £941k in month being £118k less than in month 8 and £197k more than 1-8 average.
- The forecast has been reviewed to reflect the experience of the last three months and known changes. A Clinical Income forecast has been requested nationally and this is included within the forecast. Overall, the forecast deficit position of £14.4m has not changed. The key risk to the forecast is considered to be Clinical Income and impact of emergency demand. The forecast does not reflect all of the penalty and CQUIN risk.

Productivity & Finance

Lead Director - Sheila Budd

EBITDA



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015-16	1547	1172	3547	4860	1668	2508	3041	1806	2170			
Target	1592	1080	3487	4895	2284	1963	4124	2934	4172	2342	2505	3206

Issues

- At the end of month 9, EBITDA is £4,213k behind plan due to costs being greater than plan, mainly Pay costs. The key items are agency and locum costs - please see graphs on the next slide.

Planned Actions

- Agency and locum costs are reducing. Operational management are focusing on this area.
- Other costs – operational management have met with all budget holders to emphasise the cost control requirements. This is ongoing.

Lead Director - Sheila Budd

Cost Improvement Plan

Issues

- At month 9 the CIP has achieved savings of £12.2m compared to a plan of £15.2m.
- The main reason is slippage in timing on the theatres and outpatients productivity projects of £2.4m at M09.

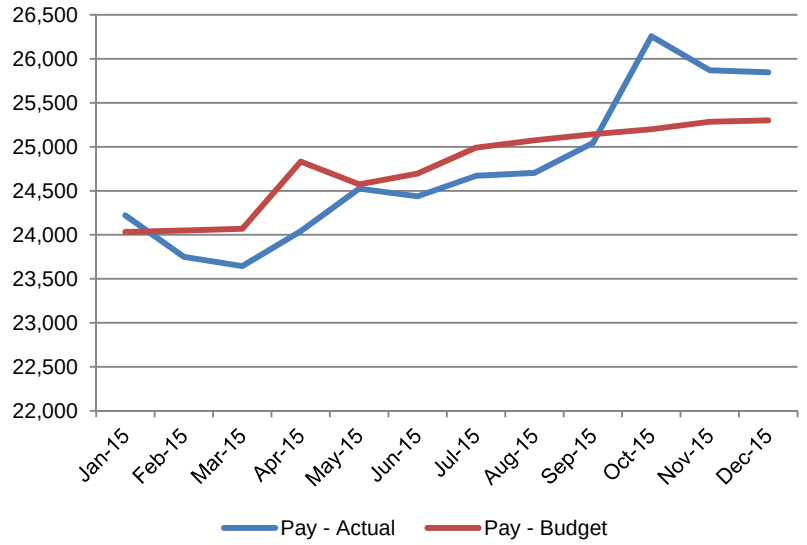
Planned Actions

- Our cost improvement target for 2015/16 is £21.2m (3.9% of turnover). This target is supported by a number of specific projects, with £9m relating to the transformation projects alongside Newton.
- The transformation teams are aware of their target and need to deliver the plan.

Productivity & Finance

Lead Director - Sheila Budd

Pay – Budget & Actuals rolling 12 months



Issues

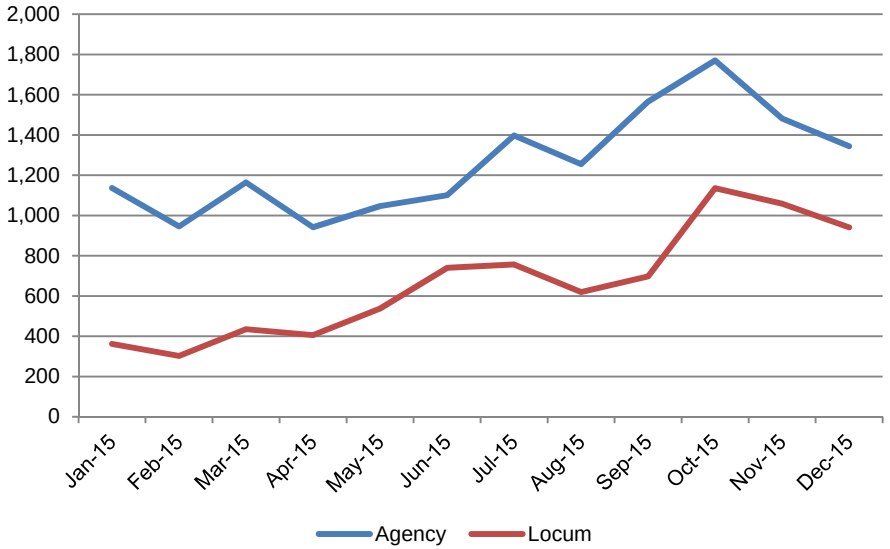
- Pay costs have historically been underspent as a result of slippage on business cases within Reserves.
- In December, Pay was overspent by £547k.
- The drivers for this were continued high levels of expenditure within Locums and Agency.

Planned Actions

- Continued recruitment to vacant posts to limit reliance on locums, agency & other premium payroll costs
- Active planning for every locum post in order to displace with substantive cost.

Lead Director - Sheila Budd

Pay – Locums & Agency (actuals) rolling 12 months



Issues

- Agency spend in M09 was £1,344k. The average cost of agency (month 1-8) for 15/16 has been £1,320k pm.
- Agency spend in M09 reduced compared to M07 & M08 due to increasing compliance with new rules and filling of vacancies.
- Locum spend in M09 was £941k. The average cost (month 1-8) for agency in 15/16 has been £744k pm. It is slowly reducing.

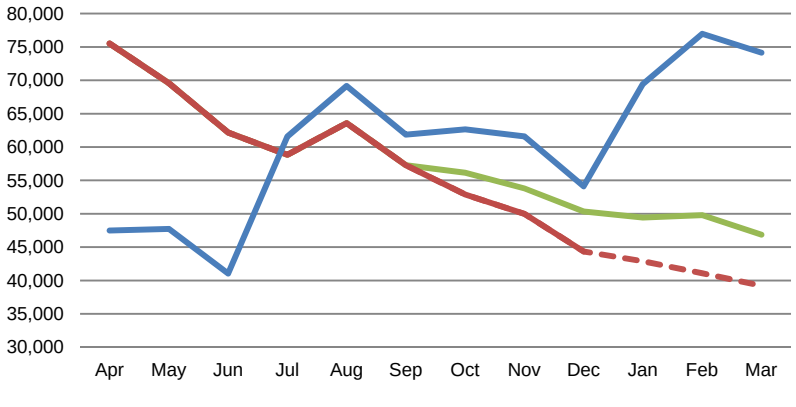
Planned Actions

- Continued focus to move towards the use of framework agencies to minimise shift premium payments
- High Locum spend remains an issue, there needs to be a drive towards usage of usage of internal locums and recruitment to vacancies.

Productivity & Finance

Lead Director - Sheila Budd

Closing Cash balance



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-15	47490	47727	41036	61565	69145	61856	62654	61599	54101	69432	76964	74138
Actual	75506	69552	62183	58846	63594	57282	52898	49995	44354			
Target	75506	69552	62183	58846	63594	57282	56162	53805	50353	49435	49804	46875

Issues

- The actual closing cash position at the end of the month is £44.4m compared to the planned position of £50.4m being a difference of £6.0m.
- The forecast closing cash position is unchanged from month 8 and reflects the forecast deficit of £14.4m. It does not penalties or CQUIN risk.
- It reflects slippage in the capital programme of £3.5m to 2016/17. The key item is monitoring equipment for £2m.

Planned Actions

- Tight focus and controls over cash are required especially in the light of our forecast deficit and pressures for 2016/17.

Lead Director - Sheila Budd

Key Risks to Financial Plan

- Failure to deliver planned clinical activity has significant financial consequences – penalties and additional pay costs in particular.
- Current assessment of penalty costs are £8.6m arising from a review of our more likely trajectory for RTT, cancer and A&E. This is being discussed with CCGs.
- CQUIN delivery risk has been assessed as between £2m and £4m. Clinical teams are looking at how to reduce the likelihood of this materialising.
- Recovery and transformation programmes do not deliver expected outcomes.
- Locum and agency costs are not managed and continue at current rates and volumes.
- CCGs have proposed moving to a block amount for clinical activity for the year. We await details and suggested quantum.

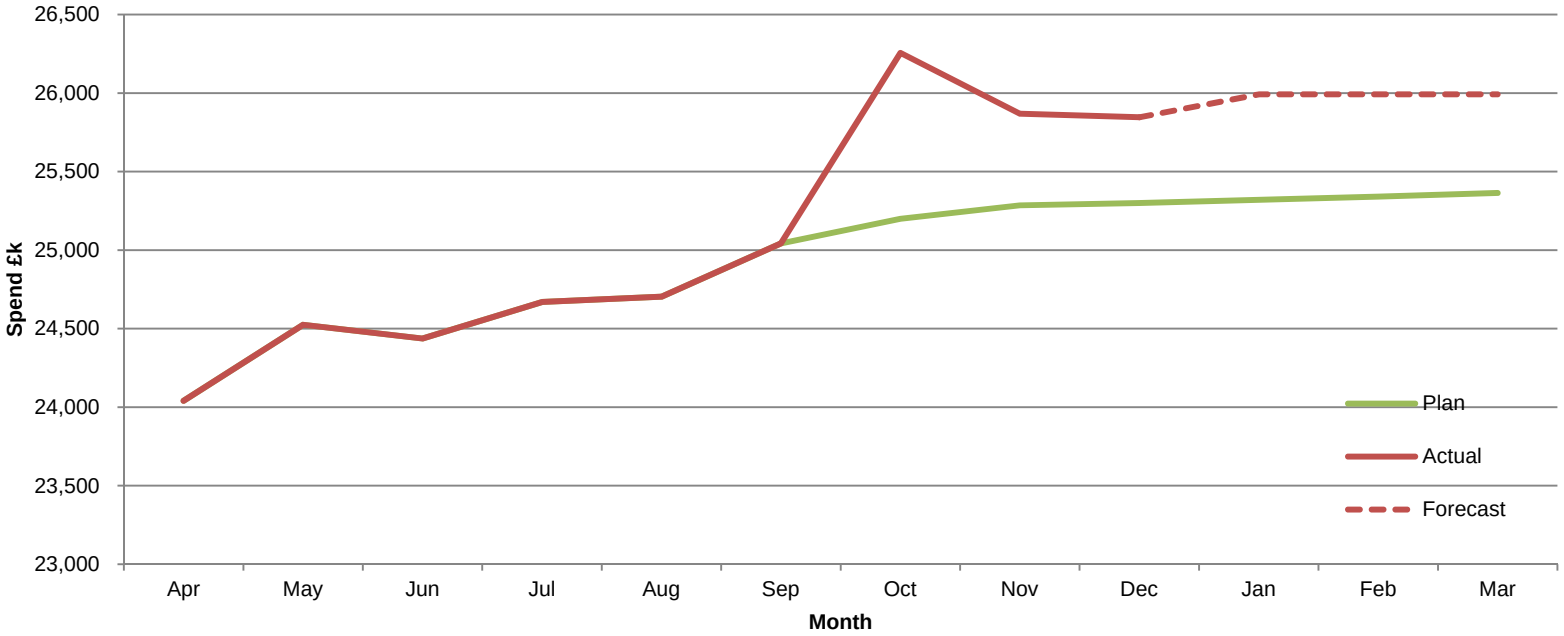
Lead Director - Sheila Budd

Forecast

- Clinical Income forecast reflects seasonal trends and has been refreshed following a national requirement by Monitor.
- In assessing the forecast for expenditure we have extrapolated the trend for the last three months and adjusted for known items, e.g. – Vanguard.
- We have reviewed the underlying assumptions on timing of planned investments, and existing provisions.
- We have not reflected the penalty and CQUIN risk described above pending CCG discussions and clinical dialogue.
- The draft forecast position remains a deficit of £14.4m.

Lead Director - Sheila Budd

Pay Forecast

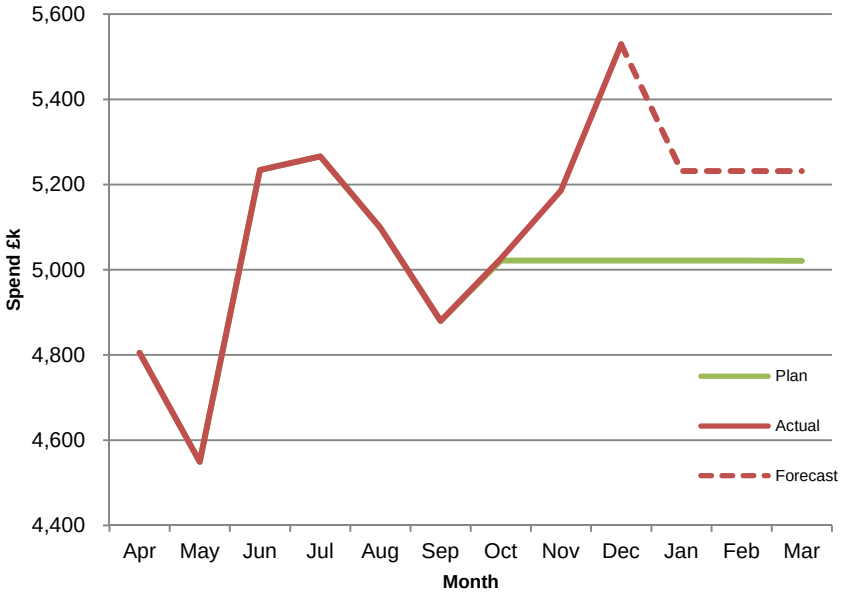


- The projection for Pay for months 10 – 12 assumes that the expenditure will be at the level of the average of the previous three months with an increase for RTT recovery.
- Expenditure on agency and locum is expected to reduce on the levels seen in the previous two months, c.£250k per month.

Productivity & Finance

Lead Director - Sheila Budd

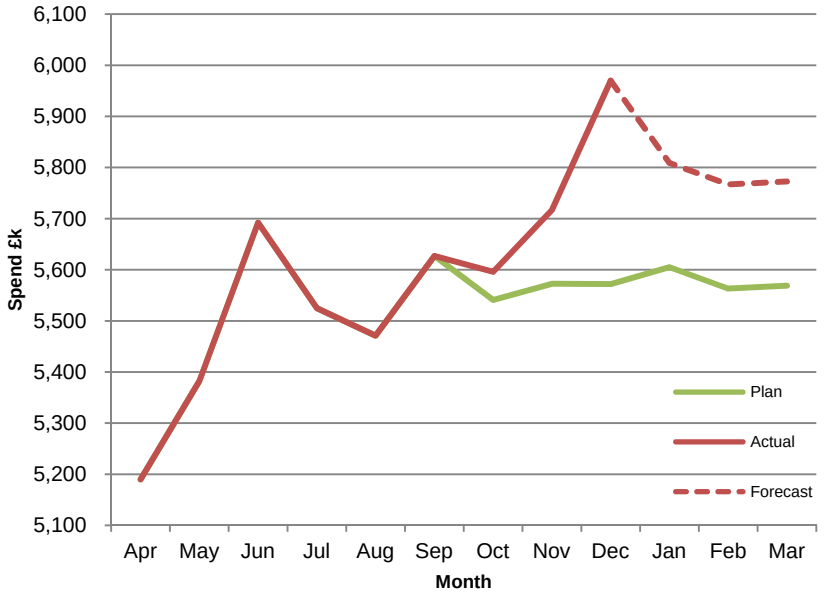
Clinical Supplies Forecast



- The projection for Months 10 – 12 assumes that the expenditure will be at the level of the average of the previous three months.

Lead Director - Sheila Budd

Non Clinical Supplies Forecast

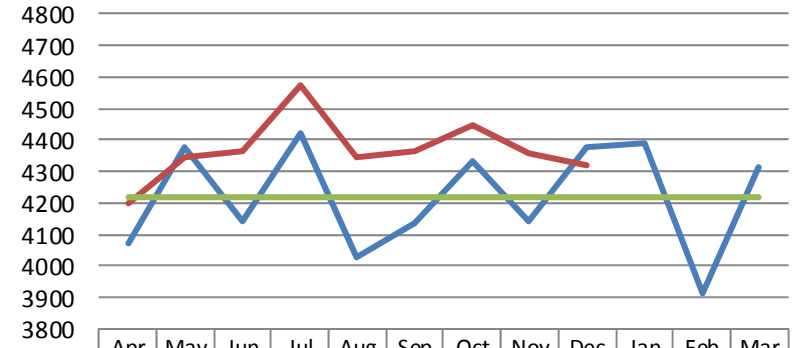


- The projection for Months 10 – 12 assumes current trends in expenditure will continue in line with the average of Months 1 to 9, adjusted for known items.

Productivity & Finance

Lead Director - Chris Cobb

Emergency Admissions *



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-15	4070	4378	4141	4423	4030	4135	4331	4140	4379	4389	3912	4311
2015-16	4200	4347	4366	4576	4344	4364	4449	4355	4320			
Target	4220	4220	4220	4220	4220	4220	4220	4220	4220	4220	4220	4220

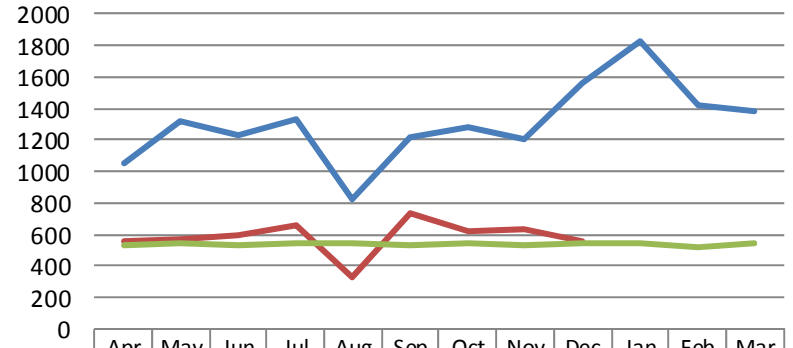
2014-15 2015-16 Target

Issues
- There was a 0% variation in Emergency Admissions - Dec 15 v Dec 14.
- The conversion rate of ED attendance to admission was 29.3%: 2.4% lower than Dec 14.
- The significant variation was an increase in GP referrals to AMU

Planned Actions
Admissions breakdown:
- ED 2772: average.
- AMU 745: above average.
- EAUS 502: average.
- Direct to wards 313: average.

Lead Director - Sheila Budd

Non-Elective Activity - marginal rate - Financial Impact *



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-15	1046	1319	1232	1331	829	1220	1284	1202	1555	1820	1425	1377
2015-16	563	564	592	658	323	733	622	634	553			
Target	532	550	532	550	550	532	550	532	550	550	514	550

2014-15 2015-16 Target

Issues
- The reduction in income relating to the marginal rate associated with the volume of non-elective admissions is £5,240k to date. This is £362k worse than plan, prior month £326k worse than plan.
- The reduction in income relating to readmissions within 30 days is £1,559k to date. This is £357k worse than plan.

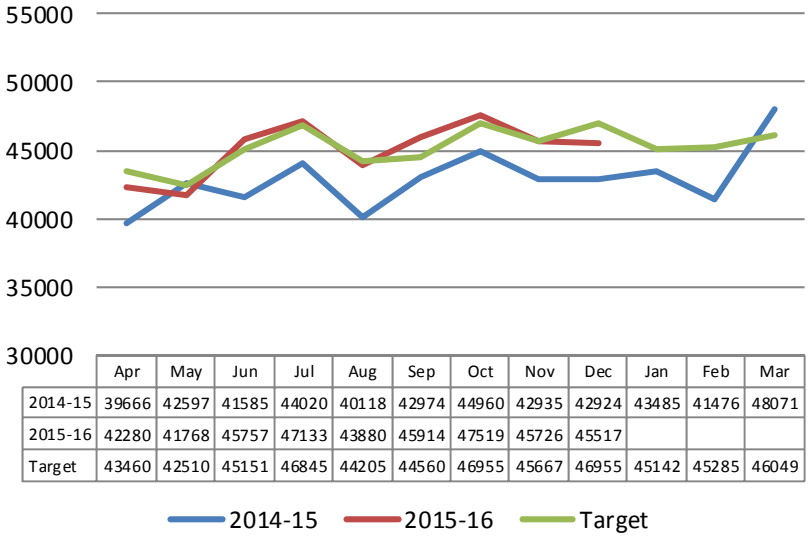
Planned Actions
- Consideration should be given to analysing the cause of readmissions and determining whether the loss of income can be reduced.

* Denotes provisional figure for most recent month

Productivity & Finance

Lead Director - Sheila Budd

Total income excluding interest



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-15	39666	42597	41585	44020	40118	42974	44960	42935	42924	43485	41476	48071
2015-16	42280	41768	45757	47133	43880	45914	47519	45726	45517			
Target	43460	42510	45151	46845	44205	44560	46955	45667	46955	45142	45285	46049

Issues

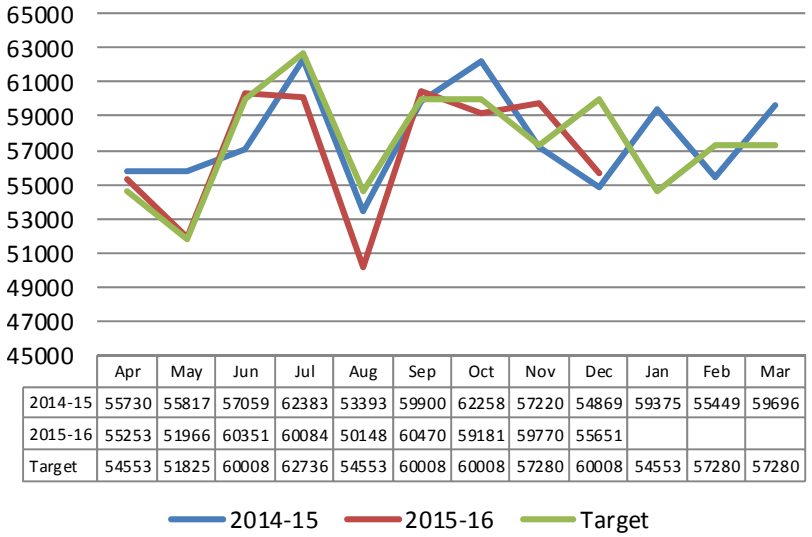
- Total income at £406.8m is £521k ahead of plan of which £960k relates to non-tariff drugs, matched by additional drug costs.
- Excluding drugs, income is slightly behind plan.

Planned Actions

- Focus on delivering activity to overcome the loss experienced over the Christmas period and requirement to have a min of 200 empty beds.
- Maximise use of Vanguard day case facility.

Lead Director - Richard Parker

Outpatient Activity (consultant led & non-consultant led) *



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-15	55730	55817	57059	62383	53393	59900	62258	57220	54869	59375	55449	59696
2015-16	55253	51966	60351	60084	50148	60470	59181	59770	55651			
Target	54553	51825	60008	62736	54553	60008	60008	57280	60008	54553	57280	57280

Issues

- Activity tracking broadly ahead of 2014/15. December is traditionally a lower activity month.

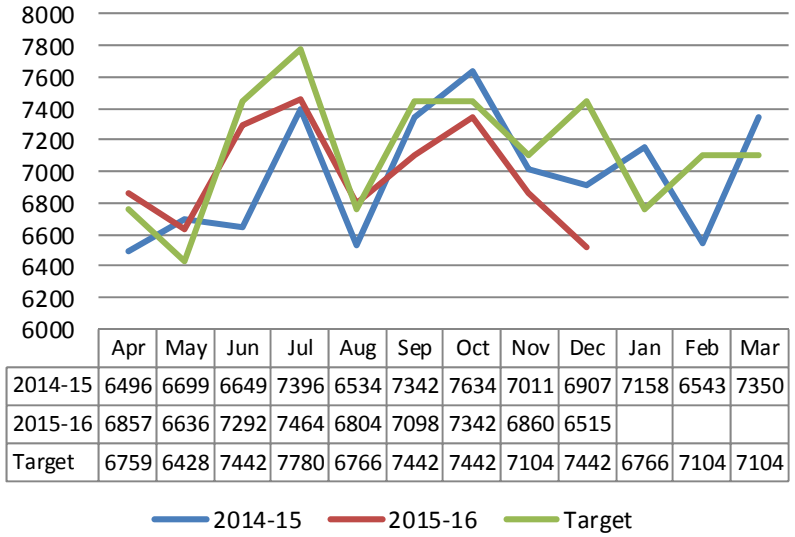
Planned Actions

- Recovery plan agreed to baseline flexible capacity and increase the overall capacity quantum

Productivity & Finance

Lead Director - Richard Parker

Elective Activity - Day case spells *



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-15	6496	6699	6649	7396	6534	7342	7634	7011	6907	7158	6543	7350
2015-16	6857	6636	7292	7464	6804	7098	7342	6860	6515			
Target	6759	6428	7442	7780	6766	7442	7442	7104	7442	6766	7104	7104

Issues

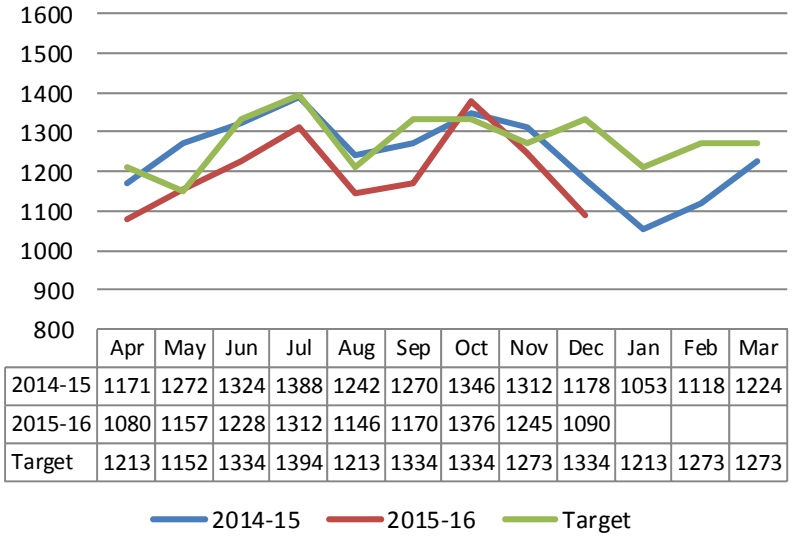
- Changes in recording of ophthalmology activity from day case to outpatient

Planned Actions

- Vanguard fully on line from January
- Roll out theatre efficiencies tool and performance process to Cromer and Ophthalmology theatres.

Lead Director - Richard Parker

Elective Activity - Elective inpatient spells *



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-15	1171	1272	1324	1388	1242	1270	1346	1312	1178	1053	1118	1224
2015-16	1080	1157	1228	1312	1146	1170	1376	1245	1090			
Target	1213	1152	1334	1394	1213	1334	1334	1273	1334	1213	1273	1273

Issues

- Planned theatre maintenance programme over the Christmas period
- Cancer cases and urgent cases prioritised. These are complex cases so less overall activity as a result

Planned Actions

- Detailed in the performance RTT slide deck
- Bed congestion post the New Year is creating a risk to elective activity in January. Actions to resolve delays in discharge discussed in earlier performance slides

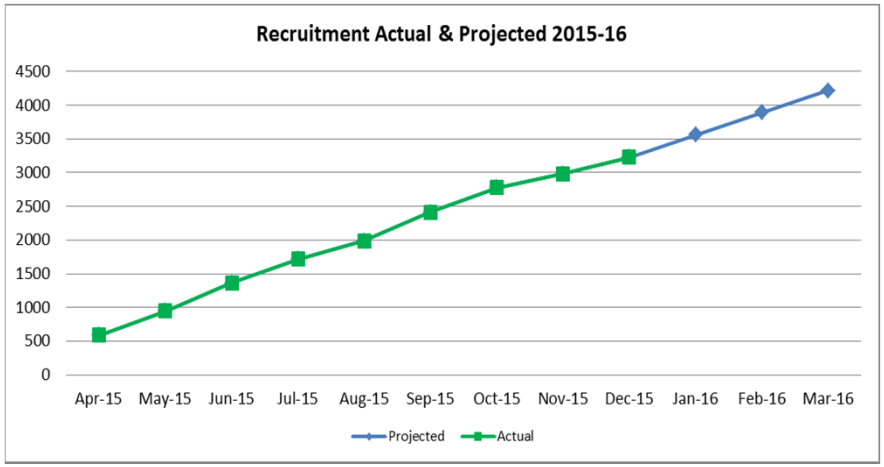
Lead Director - Peter Chapman

Effectiveness

RESEARCH AND DEVELOPMENT

•Anticipated year end recruitment >4000 (2014-15: 3535).
• 2014-15 3535 / NNUH Target 5000 / CRN Target 4134
•Year to date recruitment 3232. Data incomplete for December
•Job Description for Research and Innovation Director finished and will be advertised shortly. Interviews Feb
•2 Investigations into previous prescription related study errors completed and actions taken
•7 new Serious Adverse Events reported
- 6 hospitalisations
- 1 Life threatening event (lung Ca diagnosis)

•None classified as attributable to research study
•None reportable as SIs.

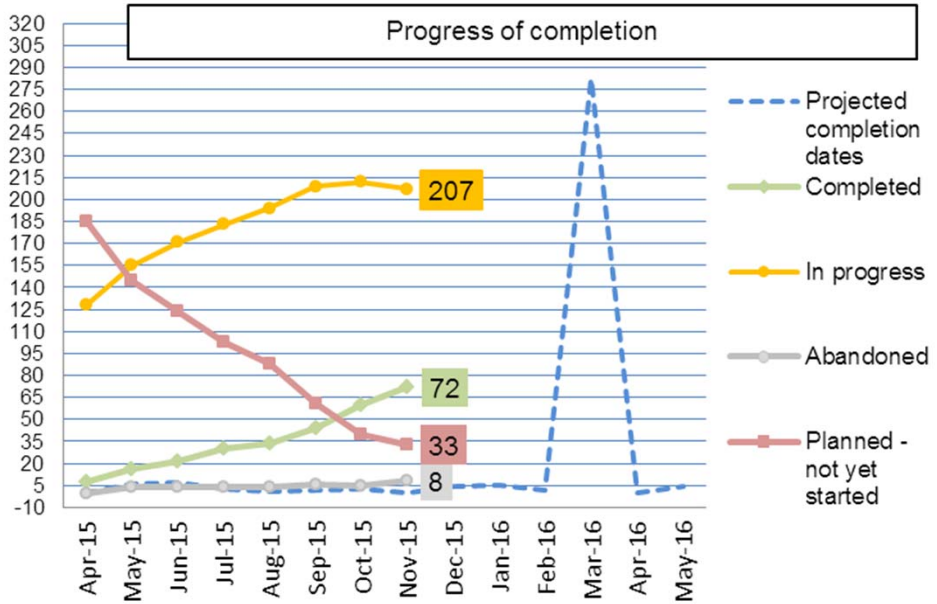


ORGAN DONATION

• Marked increase compared to last year
• Year to date 53 (Previous year at same time 29)

CLINICAL AUDIT

- Satisfactory progress against plan
- Improvement in directorates where progress slow before
- Consultation with teams to develop plans for 2016-17 underway



Lead Director - Peter Chapman

Effectiveness

100,000 GENOMES PROJECT

Genomics England
•Company owned by Department of Health
•Announced by Sec State July 2013 as part of NHS 65th birthday celebrations
•To Carry out 100,000 Whole Genome Sequences on NHS patients with specific rare diseases or cancers
•Bring together the NHS in England, academics and industry to make UK a world leader in genomic medicine
•Transform the NHS so that Whole Genome Sequencing can become a routine investigation
•Leave a legacy of human capacity and capability

East of England Genomic Medicine Centre
•11 Genome Medicine Centres were announced in December 2014 supported by NHS England through Genomics England
•East of England GMC is a collaboration between Cambridge as the central hub with partners: Leicester, Nottingham and Norwich
•Target to sequence 6000 cases with rare diseases and 3000 cancers by end 2017
•Opportunity to lead in rare diseases, cancer and clinical transformation.
•Monthly Executive Group Teleconferences (Directors R&D, Medical Directors, CEOs)

Norwich
•Target samples from 625 patients with cancer from Feb 2016 to Feb 2019 (ovary, colorectal, prostate, lung, breast)
•Three samples from each (blood, formalin fixed and frozen)
•Funded retrospectively £200 per sample – potential total income £360,000
•Lead locally by Prof Colin Cooper, and Prof Krishna Sethia
•Dry and wet runs to test capabilities planned in Feb
•Significant project for the success of the Biorepository and future of NNUH as a specialist academic centre.

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

Norfolk and Norwich University Hospitals NHS
Nursing Dashboard
NHS Foundation Trust

Lead Director -Emma McKay

Caring and Patient Experience

Caring & Patient Experience	Outturn 2014/15	Annual Target	Dec-15	6 month trend	YTD 2014/15	YTD 2015/16
Same Sex Breach	0	0	0		0	0
Complaints Received (Monthly)	674	N/A	47		500	428
Friends and Family Test (no. of responses)	983	1200	97		734	807
PALS (concerns)	434	0	35		309	346

Well Led

Well Led	Outturn 2014/15	Annual Target	Dec-15	6 month trend	YTD 2014/15	YTD 2015/16
Meeting Nutritional and Hydration Needs (% green)		N/A	69%			71%
Dignity and Respect and Person-Centred Care (% green)		N/A	81%			79%
Receiving and Acting on Complaints (% green)		N/A	90%			92%
Cleanliness and IP&C (% green)		N/A	83%			79%
Medicines Management (% green)		N/A	67%			69%
Premises and Equipment (% green)		N/A	90%			88%
Documentation (% green)		N/A	79%			72%
Safeguarding (% green)		N/A	86%			86%
Need for consent (% green)		N/A	85%			85%
Staffing (including learning & leadership) (% green)		N/A	79%			79%

Historic Data not available

Please note this is provisional data and up for discussion as to whether it should be included in future reports.

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NHS Foundation Trust

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Clinical Safety

Clinical Safety	Outturn 2014/15	Annual Target	Dec-15	6 month trend	YTD 2014/15	YTD 2015/16
C Diff cases (hospital acquired)	57	37	4		41	41
MRSA bacteraemias (hospital acquired)	0	0	0		0	0
Norovirus (confirmed cases)	84	1	3		67	79
Elective MRSA Screening Breaches	333	0	39		267	292
Emergency MRSA Screening Breaches (Provisional)	1943	0	172		1411	1541
Hand Hygiene Compliance	98%	100%	99.2%		98.0%	97.9%
Dress Code Compliance	98%	100%	99.8%		97.8%	99.0%
Commode Audits	96%	100%	92.7%		95.8%	93.7%
Needlestick Incidents	106	0	3		81	74
Medication Incidents (total reported)	1043	N/A	95		722	839
Medication incidents with potential to cause harm (IHI)	24	0	1		15	5
Total Number of Datix Incidents in month	11663	N/A	1024		8680	9288
Datix Incidents (reported in month) Finally Approved within 14 Days	6764	N/A	644		5114	5814
Number of Datix Incidents reported in month not closed within 14 Days	4913	0	175		3550	3058
Total Open Datix Incidents: 2010 to month end (incl incidents that have been open for under 14 days)	7863	N/A	665		5473	5777
C4C Audit Results	95%	95%	96.1%		95.3%	95.7%
C4C Audit Results if Re-Audited	96%	95%	95.8%		96.2%	96.4%
Day Wandsworth Call Bell: Patient Call (total if not separated)	02:47:50	N/A	03:09:30		02:43:35	02:55:56
Day Wandsworth Call Bell: Bathroom Call (total if not separated)	01:52:39	N/A	01:55:09		01:47:57	01:54:18
Night Wandsworth Call Bell: Patient Call	01:54:28	N/A	01:47:55		01:52:29	01:54:30
Night Wandsworth Call Bell: Bathroom Call	01:20:20	N/A	01:15:10		01:17:05	01:15:40

Please note this is provisional data and up for discussion as to whether it should be included in future reports.

Norfolk and Norwich University Hospitals NHS Foundation Trust **Appendix 1**

Income Statement

Nine month position to 31 December 2015

	Ledger Plan £'000	YT Dec-14 Actual £'000	Year to date Actual £'000	Year to date Budget £'000	Year to date Variance £'000	Forecast to 31st March 2016 Forecast £'000	Forecast to 31st March 2016 Budget £'000	Forecast to 31st March 2016 Variance £'000
INCOME								
NHS clinical income								
Clinical Income	403,655	291,125	301,392	303,135	(1,743)	403,934	403,655	279
NT Drugs	52,266	34,463	40,159	39,199	960	55,135	52,266	2,869
Total NHS clinical income	**455,921**	**325,588**	**341,551**	**342,334**	**(783)**	**459,069**	**455,921**	**3,148**
Non NHS clinical income								
Private patients	1,930	1,399	1,548	1,447	101	2,132	1,930	202
Other - RTA	1,378	1,218	994	1,033	(39)	1,378	1,378	
Total Non NHS clinical income	**3,308**	**2,617**	**2,542**	**2,480**	**62**	**3,510**	**3,308**	**202**
Other Income								
R&D	22,813	16,056	16,813	16,967	(154)	22,813	22,813	
Education & Training	19,643	13,993	14,680	14,644	36	19,643	19,643	
Other non patient care income	41,101	23,525	31,245	29,885	1,360	42,842	41,101	1,741
Total other Income	**83,557**	**53,574**	**62,738**	**61,496**	**1,242**	**85,298**	**83,557**	**1,741**
TOTAL OPERATING INCOME	**542,786**	**381,779**	**406,831**	**406,310**	**521**	**547,877**	**542,786**	**5,091**
EXPENDITURE								
Employee benefit expenses	(299,227)	(212,505)	(225,389)	(223,203)	(2,186)	(304,230)	(299,227)	(5,003)
Drugs	(62,140)	(41,395)	(48,041)	(46,659)	(1,382)	(65,637)	(62,140)	(3,497)
Clinical supplies	(59,961)	(42,543)	(45,573)	(44,897)	(676)	(61,267)	(59,961)	(1,306)
Non clinical supplies	(66,309)	(44,531)	(50,170)	(49,572)	(598)	(67,518)	(66,309)	(1,209)
PFI operating expenses	(20,564)	(15,283)	(15,339)	(15,447)	108	(20,049)	(20,564)	515
TOTAL OPERATING EXPENSES	**(508,201)**	**(356,257)**	**(384,512)**	**(379,778)**	**(4,734)**	**(518,701)**	**(508,201)**	**(10,500)**
Profit/(loss) from operations	**34,585**	**25,522**	**22,319**	**26,532**	**(4,213)**	**29,176**	**34,585**	**(5,409)**
Non-operating income								
Interest	227	159	194	183	11	231	227	4
Profit/(loss) on asset disposals	(15)	17	5	(5)	10	(15)	(15)	
Total non-operating income	**212**	**176**	**199**	**178**	**21**	**216**	**212**	**4**
Non-operating expenses								
Interest on PFI and Finance leases	(17,918)	(13,666)	(13,435)	(13,434)	(1)	(17,918)	(17,918)	
Depreciation	(14,168)	(10,119)	(10,237)	(10,369)	132	(13,848)	(14,168)	320
PDC	(2,260)	(1,073)	(1,695)	(1,695)		(2,101)	(2,260)	159
Other - Contingent Rent	(9,946)	(7,475)	(7,423)	(7,423)		(9,946)	(9,946)	
Total non operating expenses	**(44,292)**	**(32,333)**	**(32,790)**	**(32,921)**	**131**	**(43,813)**	**(44,292)**	**479**
Surplus (deficit) after tax from continuing operations	**(9,495)**	**(6,635)**	**(10,272)**	**(6,211)**	**(4,061)**	**(14,421)**	**(9,495)**	**(4,926)**
Memo:								
Donated Asset Additions	192	222	271	192	79	271	192	79
Surplus (deficit) after tax and Donated Asset Additions	**(9,303)**	**(6,413)**	**(10,001)**	**(6,019)**	**(3,982)**	**(14,150)**	**(9,303)**	**(4,847)**

Important Note:
The forecast excludes penalties and CQUIN risks at £8m and £4m* respectively.
* Range between £1.6m and £4.0m.

Norfolk and Norwich University Hospitals NHS Foundation Trust **Appendix 2**

Statement of Position

Position as at 31 December 2015

	2015/16 £'000 Actual Year to Date	2015/16 £'000 Budget Year to Date	2015/16 £'000 Plan Full Year	2014/15 £'000 Audited Actual Full Year
Assets				
Assets, Non-Current				
Property, Plant and Equipment, Net	72,707	73,696	77,599	72,112
PFI: Property, Plant and Equipment, Net	213,281	213,068	211,193	218,692
NHS Trade Receivables, Non-Current				
Non NHS Trade Receivables, Non-Current	1,601	1,886	1,886	2,001
Prepayments, Non-Current	60,934	61,123	62,727	56,252
Assets, Non-Current, Total	**348,523**	**349,773**	**353,405**	**349,057**
Assets, Current				
Inventories	8,886	8,244	8,244	8,244
NHS Trade Receivables, Current	13,416	8,528	8,528	7,314
Non NHS Trade Receivables, Current	2,306	4,167	4,167	4,167
PDC Receivables, Current				147
Accrued Income	8,758	9,417	2,944	2,944
Prepayments, Current, non-PFI related	4,602	3,565	2,067	2,067
Cash	44,354	50,353	46,875	74,138
Assets, Current, Total	**82,322**	**84,274**	**72,825**	**99,021**
ASSETS, TOTAL	**430,845**	**434,047**	**426,230**	**448,078**
Liabilities				
Liabilities, Current				
Deferred Income, Current	(25,678)	(24,964)	(22,241)	(29,532)
Provisions, Current	(861)	(884)	(884)	(884)
Current Tax Payables	(5,530)	(5,594)	(5,594)	(5,440)
Trade Creditors, Current	(12,304)	(12,794)	(15,664)	(16,724)
Other Creditors, Current	(4,050)	(4,846)	(4,846)	(4,846)
Capital Creditors, Current	(1,858)	(994)	(994)	(994)
Accruals, Current	(30,951)	(30,120)	(26,451)	(26,451)
Finance Leases, Current	(172)	(172)	(162)	(172)
PFI leases, Current	(3,540)	(3,540)	(3,360)	(3,540)
Liabilities, Current, Total	**(84,944)**	**(83,908)**	**(80,196)**	**(88,583)**
NET CURRENT ASSETS (LIABILITIES)	**(2,622)**	**366**	**(7,371)**	**10,438**
Liabilities, Non-Current				
Deferred Income, Non-Current	(7,110)	(7,360)	(7,333)	(7,802)
Provisions, Non-Current	(3,841)	(3,845)	(3,803)	(3,971)
Finance Leases, Non-current	(368)	(368)	(335)	(497)
PFI leases, Non-Current	(199,795)	(199,797)	(199,079)	(202,437)
Liabilities, Non-Current, Total	**(211,114)**	**(211,370)**	**(210,550)**	**(214,707)**
TOTAL ASSETS EMPLOYED	**134,787**	**138,769**	**135,484**	**144,788**
Taxpayers' and Others' Equity				
Taxpayers Equity				
Public dividend capital	25,090	25,090	25,090	25,090
Retained Earnings (Accumulated Losses)	42,122	45,940	42,655	51,780
Revaluation Reserve	67,575	67,739	67,739	67,918
TAXPAYERS EQUITY, TOTAL	**134,787**	**138,769**	**135,484**	**144,788**
TOTAL ASSETS EMPLOYED	**134,787**	**138,769**	**135,484**	**144,788**

Cash Flow Statement

Position as at 31 December 2015

	£'000 Actual Year to Date	2015/16 £'000 Budget Year to Date	£'000 Variance Year to Date	2015/16 £'000 Plan Full Year	2014/15 £'000 Audited Actual Full Year
(Deficit) after tax including donated assets	**(10,001)**	**(6,019)**	**(3,982)**	**(9,301)**	**(9,615)**
Non-cash flows in operating surplus					
Finance income/charges	20,664	20,674	(10)	27,637	27,636
Depreciation and amortisation, total	10,237	10,369	(132)	14,168	13,844
(Loss) on disposal of property plant and equipment	(5)	5	(10)	15	539
PDC dividend expense	1,695	1,695	0	2,260	891
Non-cash flows in operating surplus, Total	**32,591**	**32,743**	**(152)**	**44,080**	**42,910**
Operating Cash flows before movements in working capital	**22,590**	**26,724**	**(4,134)**	**34,779**	**33,295**
Increase/(Decrease) in working capital					
(Increase) in inventories	(642)	0	(642)	0	(532)
(Increase) in NHS Trade Receivables	(6,102)	(1,214)	(4,888)	(1,214)	3,288
Decrease in Non NHS Trade Receivables	1,861	0	1,861	0	(1,236)
(Increase) in accrued income	(5,814)	(6,473)	659	0	(380)
(Increase) in prepayments	(2,535)	(1,527)	(1,008)	110	(228)
(Decrease) in Deferred Income (excluding Donated Assets)	(4,546)	(5,010)	464	(7,760)	9,761
(Decrease) in provisions	(153)	(126)	(27)	(168)	(254)
Increase in tax payable	90	154	(64)	154	(81)
(Decrease) in Trade Creditors	(4,922)	(4,463)	(459)	(1,058)	5,742
(Decrease) in Other Creditors	(796)	0	(796)	0	(1,813)
Increase in accruals	4,500	3,668	832	(0)	1,177
Increase in other Other Financial liabilities	0	0	0	0	324
(Decrease) in working capital, Total	**(19,059)**	**(14,991)**	**(4,068)**	**(9,936)**	**15,768**
Net cash inflow/(outflow) from operating activities	**3,531**	**11,733**	**(8,202)**	**24,843**	**49,063**
Net cash flow from investing activities					
Property, plant and equipment - non-maintenance expenditure	(4,129)	(6,312)	2,183	(12,182)	(3,297)
Proceeds on disposal of property, plant and equipment	10	10	0	10	22
(Decrease) in Capital Creditors	(433)	0	(433)	0	(886)
Other cash flows from investing activities	(4,682)	(4,841)	159	(6,474)	(6,182)
Net cash (outflow) from investing activities, Total	**(9,234)**	**(11,143)**	**1,909**	**(18,646)**	**(10,343)**
Net cash inflow/(outflow) before financing	**(5,703)**	**590**	**(6,293)**	**6,197**	**38,720**
Net cash inflow/(outflow) from financing activities					
PDC Dividends paid	(1,046)	(1,046)	0	(2,113)	(815)
Interest element of finance lease rental payments - *other*	(13)	(14)	1	(19)	(24)
Interest element of finance lease rental payments - *On-balance sheet PFI*	(13,422)	(13,421)	(1)	(17,900)	(18,145)
Capital element of finance lease rental payments - *other*	(129)	(128)	(1)	(171)	(490)
Capital element of finance lease rental payments - *On-balance sheet PFI*	(2,642)	(2,641)	(1)	(3,539)	(3,354)
Interest received on cash and cash equivalents	194	183	11	228	228
Movement in Other grants/Capital received	0	0	0	0	1,233
Decrease in non-current receivables	400	115	285	0	(239)
Other cash flows from financing activities	(7,423)	(7,423)	0	(9,946)	(9,695)
Net cash (outflow) from financing activities, Total	**(24,081)**	**(24,375)**	**294**	**(33,460)**	**(31,301)**
Net increase/(decrease) in cash and cash equivalents	**(29,784)**	**(23,785)**	**(5,999)**	**(27,263)**	**7,419**
Closing cash and cash equivalents	**44,354**	**50,353**	**(5,999)**	**46,875**	**74,138**

Norfolk and Norwich University Hospitals NHS Foundation Trust **Appendix 4**

CASH FLOW FORECAST ROLLING 12 MONTHS SUMMARY

	2015/16				2016/17								
	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Opening Cash balance	**49,995**	**44,354**	**42,891**	**41,078**	**39,217**	**37,052**	**34,888**	**32,724**	**30,559**	**28,394**	**24,941**	**22,776**	**20,612**
Receipts													
Clinical Income	37,460	41,563	39,207	40,364	36,465	36,466	36,465	36,466	36,465	36,466	36,465	36,466	36,465
Other Income	8,704	8,342	8,436	9,533	8,588	8,588	8,588	8,588	8,588	8,588	8,588	8,588	8,588
Interest	18	15	15	14	15	15	15	14	15	15	15	14	15
Total Receipts	**46,182**	**49,920**	**47,658**	**49,911**	**45,068**	**45,069**	**45,068**	**45,068**	**45,068**	**45,069**	**45,068**	**45,068**	**45,068**
Payments													
Pay Expenditure	25,279	25,361	25,451	25,451	25,433	25,433	25,433	25,433	25,433	25,433	25,433	25,433	25,433
Non Pay Expenditure	26,035	23,885	22,975	23,759	20,766	20,766	20,766	20,766	20,766	20,766	20,766	20,766	20,766
Capital	509	2,137	1,045	1,654	1,033	1,033	1,033	1,033	1,033	1,033	1,033	1,033	1,033
PDC Dividends	0	0	0	908	0	0	0	0	0	1,289	0	0	0
Total Payments	**51,823**	**51,383**	**49,471**	**51,772**	**47,233**	**47,233**	**47,233**	**47,233**	**47,233**	**48,522**	**47,233**	**47,233**	**47,233**
Closing Cashbook Balance	**44,354**	**42,891**	**41,078**	**39,217**	**37,052**	**34,888**	**32,724**	**30,559**	**28,394**	**24,941**	**22,776**	**20,612**	**18,447**

Notes to cash flow:
The Trust is currently experiencing considerable time delays in the settlement of key NHS invoices including drugs by CCGs.
The above anticipated cash flow balance at 31 March 2016 assumes a considerable improvement in the next 3 months but still assumes that some of the outstanding balance will slip into 2016/17. It is based on the current time lag being reduced by the end of the year.
Consistent with the forecast outturn position, the above cash flow does not reflect any cash risk for penalties.

Norfolk and Norwich University Hospitals NHS Foundation Trust **Appendix 5**

2015/16 Capital Programme - Reforecast in Month 6

Position as at 31 December 2015

	Original Plan	Reforecast Plan	Slippage to 2016/17	Reforecast Capital Plan: 2015/16 Planned Spend - Reforecast Phasing					Actual Spend YTD 2015/16	Variance to Reforecast Plan (over) / under
	2015/16 £'000	2015/16 £'000	2016/17 £'000	Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total 2015/16 £'000	£'000	£'000
Strategic Projects										
Improving the quality of emergency care: A&E	8,500	74	8,426	-	-	53	21	**74**	64	10
Space Labs Monitoring Equipment	2,000	2,000	-	-	-	-	2,000	**2,000**	-	-
Pathology (Eastern Pathology Alliance - EPA)	636	240	396	-	57	73	110	**240**	57	73
WDU expansion	881	705	176	-	-	176	529	**705**	3	173
eHealth Record / ePatient Record *	3,700	87	3,613	-	-	27	60	**87**	-	27
Theatres stacks *	600	-	600	-	-	-	-	**-**	68	(68)
IRU	2,000	-	2,000	-	-	-	-	**-**	-	-
Institute of Food, Health and Gut *	-	-	-	-	-	-	-	**-**	-	-
Fit out / convert Mattishall ward	3,000	78	2,922	-	-	78	-	**78**	8	70
Satellites *	-	-	-	-	-	-	-	**-**	-	-
Urgent Care Centre	750	745	5	201	353	77	114	**745**	554	77
Urgent Care Centre - 'Transformation Funding'	(750)		(750)							
Total Strategic Projects	**21,317**	**3,929**	**17,388**	**201**	**410**	**484**	**2,834**	**3,929**	**754**	**363**
Capital - Business as usual										
IT	1,479	1,077	402	92	372	49	564	**1,077**	472	41
Med & Surg	5,287	5,407	(120)	100	1,020	2,109	2,178	**5,407**	2,096	1,127
Estates including £0.5m for AMU Expansion	1,821	1,391	430	1	38	1,311	41	**1,391**	209	1,147
Other - to include movements in Contingency	227	377	(150)	25	14	135	203	**377**	328	(154)
Total - Trust Funded Capital	**30,131**	**12,181**	**17,950**	**419**	**1,854**	**4,088**	**5,820**	**12,181**	**3,859**	**2,524**
Charitable or Other Funded Items										
Donated Assets	-	192	-	27	165	-	-	**192**	271	(79)
TOTAL CAPITAL	**30,131**	**12,373**	**17,950**	**446**	**2,019**	**4,088**	**5,820**	**12,373**	**4,130**	**2,445**

Note: Reassessment of the 2016/17 capital plan is ongoing.

* These projects span more than 1 year - only the original 2015/16 component is shown above

Application of ratings system to current NNUH Performance

FSRR Metrics

	Financial criteria	Weight (%)	Metric	Rating categories** 1*	2***	3	4
Continuity of services	Balance sheet sustainability	25	Capital service capacity (times)	<1.25x	1.25 - 1.75x	1.75-2.5x	>2.5x
	Liquidity	25	Liquidity (days)	<(14) days	(14)-(7) days	(7)-0 days	>0 days
Financial efficiency	Underlying performance	25	I&E margin (%)	≤(1)%	(1)– 0%	0-1%	>1%
	Variance from plan	25	Variance in I&E margin as a % of income	≤(2)%	(2)-(1)%	(1)-0%	≥0%

What This Means

Net Current Assets Excluding Inventories x 360 / Total Operating Expenses

Profit/(loss) from operations + Interest Receivable / Non-Operating Expenses (Excluding Depreciation) + Capital Elements of Finance & PFI Leases

Surplus/(Deficit) + (Gains)/losses on Asset Disposal / Operating Income + Non-operating Income

Actual I&E Margin - Planned I&E Margin

Calculation of a FSRR score

Financial sustainability risk rating	Description	Regulatory activity
4	No evident concerns	None
3	Emerging or minor concern potentially requiring scrutiny	Potential enhanced monitoring
2*	Level of risk is material but stable	Potential enhanced monitoring
2	Material risk	Potential investigation (see Chapter 5)
1	Significant risk	Likely investigation (see Chapter 5) Potential appointment of contingency planning team

Current Performance to 31 December 2015

Capital Service Capacity Metric

Profit / Loss from Operations	(Appendix 1)	22,319
Interest Receivable	(Appendix 1)	194
Total		**22,513**
Non-Operating Costs	(Appendix 1)	32,790
Less: Depreciation	(Appendix 1)	(10,237)
Add: Capital Elements of Lease Payments	(Appendix 3)	2,771
Total		**25,324**

Revenue generated covers commitments 0.89 times

Liquidity Metric

Net Current Assets	(Appendix 2)	(2,622)
Less: Inventories	(Appendix 2)	(8,886)
Total		**(11,508)**
Total Operating Expenses	(Appendix 1)	384,512
Annualised (x 12/9)		**512,683**

-8.1 Days worth of expenses held as cash equivalents

I&E Margin Metric

Surplus/(Deficit)	(Appendix 1)	(10,001)
(Gains)/losses on Asset Disposal	(Appendix 1)	(5)
Total		**(10,006)**
Operating Income	(Appendix 1)	407,102
Non- Operating Income	(Appendix 1)	199
Total		**407,301**

Actual I&E Margin is -2.46%

Variance in I&E Margin Metric

Surplus/(Deficit)	(Appendix 1)	(6,019)
(Gains)/losses on Asset Disposal	(Appendix 1)	5
Total		**(6,014)**
Operating Income	(Appendix 1)	406,502
Non- Operating Income	(Appendix 1)	178
Total		**406,680**

Planned I&E Margin is -1.48%

I&E Margin Variance is -0.98%

Summary - Score is 2/2*

Current Capital service capacity of 0.89 gives a score of 1 for this metric.
Current Liquidity of -8.1 days gives a score of 2 for this metric.
Current I&E Margin of -2.46% gives a score of 1 for this metric.
Current Variance in I&E Margin of -0.98% gives a score of 3 for this metric.

The overall score is 2/2*, resulting in either potential enhanced monitoring or a potential investigation depending on Monitor's assessment.

Capital service capacity is hard to change the rating due to the high level of fixed financial commitment in relation to revenue generated by the business.

Liquidity is more prone to change as it is influenced by any change in financial performance, or additional cash outgoings such as capital.

Norfolk and Norwich University Hospitals NHS Foundation Trust **Appendix 7**

Income Statement Comparison - for the Month of December

	For the month			Variances Fav / (Adv)			
	Actual	Budget	Prior year	To budget		To prior year	
	£'000	£'000	£'000	£'000	%	£'000	%
INCOME							
NHS clinical income							
Clinical Income	34,420	34,971	31,956	(551)	(2%)	2,464	8%
NT Drugs	4,637	4,355	4,314	282	6%	323	7%
Total NHS clinical income	**39,057**	**39,326**	**36,270**	**(269)**	**(1%)**	**2,787**	**8%**
Non NHS clinical income							
Private patients	204	160	80	44	28%	124	155%
Other - RTA	91	115	94	(24)	(21%)	(3)	(3%)
Total Non NHS clinical income	**295**	**275**	**174**	**20**	**7%**	**121**	**70%**
Other Income							
R&D	1,867	1,949	1,796	(82)	(4%)	71	4%
Education & Training	1,627	1,666	1,519	(39)	(2%)	108	7%
Other non patient care income	4,008	3,739	3,165	269	7%	843	27%
Total other Income	**7,502**	**7,354**	**6,480**	**148**	**2%**	**1,022**	**16%**
TOTAL OPERATING INCOME	**46,854**	**46,955**	**42,924**	**(101)**	**(0%)**	**3,930**	**9%**
EXPENDITURE							
Employee benefit expenses	(25,846)	(25,299)	(24,058)	(547)	2%	(1,788)	7%
Drugs	(5,638)	(5,160)	(5,220)	(478)	9%	(418)	8%
Clinical supplies	(5,529)	(5,022)	(4,881)	(507)	10%	(648)	13%
Non clinical supplies	(5,970)	(5,572)	(5,334)	(398)	7%	(636)	12%
PFI operating expenses	(1,701)	(1,730)	(1,744)	29	(2%)	43	(2%)
TOTAL OPERATING EXPENSES	**(44,684)**	**(42,783)**	**(41,237)**	**(1,901)**	**4%**	**(3,447)**	**8%**
Profit/(loss) from operations	**2,170**	**4,172**	**1,687**	**(2,002)**	**(48%)**	**483**	**29%**
Non-operating income							
Interest	18	15	19	3	20%	(1)	(5%)
Profit/(loss) on asset disposals		(3)		3	(100%)		
Total non-operating income	**18**	**12**	**19**	**6**	**50%**	**(1)**	**(5%)**
Non-operating expenses							
Interest on PFI and Finance leases	(1,486)	(1,495)	(1,513)	9	(1%)	27	(2%)
Depreciation	(1,186)	(1,213)	(1,172)	27	(2%)	(14)	1%
PDC	(189)	(189)	(91)		0%	(98)	108%
Other - Contingent Rent	(841)	(841)	(739)		0%	(102)	14%
Total non operating expenses	**(3,702)**	**(3,738)**	**(3,515)**	**36**	**(1%)**	**(187)**	**5%**
Surplus (deficit) after tax from continuing operations	**(1,514)**	**446**	**(1,809)**	**(1,960)**	**(439%)**	**295**	**(16%)**
Memo:							
Donated Asset Additions			55			(55)	(100%)
Surplus (deficit) after tax and Donated Asset Additions	**(1,514)**	**446**	**(1,754)**	**(1,960)**	**(439%)**	**240**	**(14%)**

Notes:

Calendar Days	31	31	31
Working Days	21	21	21

Income Statement Comparison - Nine month position to 31 December 2015

	Year to Date			Variances Fav / (Adv)			
	Actual	Budget	Prior year	To budget		To prior year	
	£'000	£'000	£'000	£'000	%	£'000	%
INCOME							
NHS clinical income							
Clinical Income	301,392	303,135	291,125	(1,743)	(1%)	10,267	4%
NT Drugs	40,159	39,199	34,463	960	2%	5,696	17%
Total NHS clinical income	**341,551**	**342,334**	**325,588**	**(783)**	**(0%)**	**15,963**	**5%**
Non NHS clinical income							
Private patients	1,548	1,447	1,399	101	7%	149	11%
Other - RTA	994	1,033	1,218	(39)	(4%)	(224)	(18%)
Total Non NHS clinical income	**2,542**	**2,480**	**2,617**	**62**	**3%**	**(75)**	**(3%)**
Other Income							
R&D	16,813	16,967	16,056	(154)	(1%)	757	5%
Education & Training	14,680	14,644	13,993	36	0%	687	5%
Other non patient care income	31,245	29,885	23,525	1,360	5%	7,720	33%
Total other Income	**62,738**	**61,496**	**53,574**	**1,242**	**2%**	**9,164**	**17%**
TOTAL OPERATING INCOME	**406,831**	**406,310**	**381,779**	**521**	**0%**	**25,052**	**7%**
EXPENDITURE							
Employee benefit expenses	(225,389)	(223,203)	(212,505)	(2,186)	1%	(12,884)	6%
Drugs	(48,041)	(46,659)	(41,395)	(1,382)	3%	(6,646)	16%
Clinical supplies	(45,573)	(44,897)	(42,543)	(676)	2%	(3,030)	7%
Non clinical supplies	(50,170)	(49,572)	(44,531)	(598)	1%	(5,639)	13%
PFI operating expenses	(15,339)	(15,447)	(15,283)	108	(1%)	(56)	0%
TOTAL OPERATING EXPENSES	**(384,512)**	**(379,778)**	**(356,257)**	**(4,734)**	**1%**	**(28,255)**	**8%**
Profit/(loss) from operations	**22,319**	**26,532**	**25,522**	**(4,213)**	**(16%)**	**(3,203)**	**(13%)**
Non-operating income							
Interest	194	183	159	11	6%	35	22%
Profit/(loss) on asset disposals	5	(5)	17	10	(200%)	(12)	(71%)
Total non-operating income	**199**	**178**	**176**	**21**	**12%**	**23**	**13%**
Non-operating expenses							
Interest on PFI and Finance leases	(13,435)	(13,434)	(13,666)	(1)	0%	231	(2%)
Depreciation	(10,237)	(10,369)	(10,119)	132	(1%)	(118)	1%
PDC	(1,695)	(1,695)	(1,073)		0%	(622)	58%
Other - Contingent Rent	(7,423)	(7,423)	(7,475)		0%	52	(1%)
Total non operating expenses	**(32,790)**	**(32,921)**	**(32,333)**	**131**	**(0%)**	**(457)**	**1%**
Surplus (deficit) after tax from continuing operations	**(10,272)**	**(6,211)**	**(6,635)**	**(4,061)**	**65%**	**(3,637)**	**55%**
Memo:							
Donated Asset Additions	271	192	222	79	41%	49	22%
Surplus (deficit) after tax and Donated Asset Additions	**(10,001)**	**(6,019)**	**(6,413)**	**(3,982)**	**66%**	**(3,588)**	**56%**

Notes:

Calendar Days to Date	275	275	275
Working Days to Date	190	190	190

REPORT TO THE TRUST BOARD	
Date	**29 January 2016**
Title	**Lord Carter Review of Operational Productivity and Performance in NHS Hospitals**
Author(s)	**John Paul Garside, Board Secretary**
Purpose	**For discussion**

Summary including Key Performance Issues/Risks

- Lord Carter is leading a national team looking at potential opportunities for efficiency gains in the NHS.
- Attached is a letter dated 14 January 2016 from Lord Carter to the Secretary of State summarising his views. Perhaps of particular note is the indication of a need to make 2-3% efficiency savings per annum over the next 5 years.
- Lord Carter's team has gathered national data with a view to establishing benchmarks and potential efficiency opportunities based on a notional NHS "model hospital".
- Also attached is the initial analysis of the Lord Carter team concerning this Trust. This reports that using nationally available reference cost data the Trust's "adjusted treatment cost" is £0.93 which means that the Trust is approximately 7 pence less expensive per £1 of the national Cost Weighted Output.
- Notwithstanding that the Trust is therefore viewed as being cost efficient by comparison with national benchmarks there are still a number of potential savings opportunities. These have been initially reviewed by the Management Board and we are meeting shortly with the Lord Carter team.
- The saving opportunities identified by Lord Carter will form key elements of our Cost Improvement Programme for 2016/17 and the Executive will be reviewing these with the Divisions accordingly.

Recommendations:

The Board is recommended to note the findings of the Lord Carter team and the potential for efficiency gains to be reflected in our future financial planning.

LORD CARTER OF COLES

SECRETARY OF STATE FOR HEALTH

14 January 2016

Dear Secretary of State

Unwarranted variation: review of operational productivity and performance in English NHS acute hospitals

In June 2014 you asked me to look at what could be done to improve efficiency in NHS hospitals in England. Since then we have seen the publication of the NHS Five Year Forward View and the outcome of the 2015 Spending Round, both of which stressed the urgent need for the NHS to make 2-3% efficiency savings per annum over the next five years.

In my interim report of June last year I described the widely varying resource utilisation between NHS acute hospitals. I estimated that if we reduced unwarranted variation at least £5bn of the £55bn spent annually by acute hospitals could be saved. Through my work I am now able to confirm that trusts can save £5bn per annum by the end of the decade and I will be setting out how these efficiencies can be achieved in my report due to be published at the end of this month.

Since June 2015 I have engaged with all 136 acute hospital trusts in England to share with them specific areas where their data indicates they could reduce variation relative to the NHS average or their peers. I have personally visited nearly 40 acute trusts – around a third of all acute spend – to hear first-hand the challenges they face in delivering improved productivity and making efficiency savings. The value in meeting senior executives face-to-face cannot be overstated, and in the great majority of cases I have been impressed by the dedication and commitment shown by senior executives and their boards in facing up to the task; however, it is apparent that most trusts need help and support if the £5bn of efficiency is to be realised over the next 3-4 years. Given this challenge there are five points from my forthcoming report I wish to highlight.

HOUSE OF LORDS LONDON SW1A 0PW

Firstly, my experience of the best of the NHS and other health care systems internationally shows that the provision of high quality clinical care and good resource management go hand-in-hand. All trusts should therefore grasp the use of their resources more effectively, the most important of which is their people. I will set out in my report where and how this clinical and administrative management 'grip' should be focussed.

Secondly, a single reporting framework should be adopted across all trusts, which pulls together clinical quality and resource performance data and compares it to the 'best in class'. This constant analysis of performance for trusts, commissioners and regulators will identify areas of variation (good and bad) that they need to improve. The framework will also help trust boards hold their executive teams to account. However, there must be only one version of the truth that everybody, locally and nationally, will use to drive improvements, so we must endeavour to reduce and rationalise the plethora of reporting burdens currently placed on providers by commissioners and regulators.

This mandates on-going development of the NHS 'model hospital'. Leading international healthcare systems have a clear, consistent approach to monitoring and managing the performance of their hospitals against expected standards of service and efficiency. Key performance metrics are rigorously benchmarked against plans and peer performance to a regular reporting cycle, daily, weekly and monthly.

My third point relates to delayed transfers of care for patients out of the acute hospital setting. Nearly all trusts wrestle with the problem of moving those who are medically fit into settings that are more appropriate for the delivery of their care or rehabilitation, and for the families and carers. This failure results in sub-optimal use of high acuity clinical resources and delays to treatments for other patients. The resultant loss of income to trusts cannot be offset as costs are still incurred relating to clinicians, operating theatres and other overheads. Consequently, trusts: are having to care for patients in the wrong clinical setting, find it more challenging to meet national standards for patient access, have poor clinical productivity, and incur operating losses. Some work well with their local partners to tackle the issues and the Department and NHS are working on a range of initiatives to help those trusts for which this is becoming a major problem. Nevertheless, a significant proportion of the £5bn cannot be unlocked unless delays in transfer are managed more effectively.

My fourth point relates to the issue of local and national collaboration and coordination. Nearly every trust I have spoken to recognises the efficiency opportunities and quality improvements open to them if they could change the way their clinical services were delivered or could share some supporting services so they can better meet the clinical needs of their local community. However, these are rarely realised owing to the considerable time and

effort needed to present and explain the benefits to their local partners and communities. The Vanguards and Success Regime initiatives are leading the way in this respect, but all trusts should be enabled to pursue these opportunities routinely and the recommendations I have made in my report are designed to help local health economies demonstrate to their partners and communities the case for these improvements. National support is again critical, or another significant proportion of the £5bn of efficiencies will not be unlocked.

Finally I will be reiterating that the biggest challenge for the NHS in 2016 is to deliver the changes needed to achieve the efficiency and productivity improvements required by 2020. Rapid effective adoption and implementation of the recommendations by the leaders of our acute hospitals and those that work with them will be imperative if we are to achieve this aim; as will be the engagement of NHS Improvement (NHSI) when it comes into being in April this year. Many trusts have already embraced our work and are reaping the benefits, for example, trusts in our cohort of 32 hospitals shared and adopted best practices around the management of nursing staff to improve productivity. To maintain this momentum, the Department of Health must continue to work with the NHS and existing regulators to implement the recommendations I make pending their transition to NHSI.

We should also not lose sight of the non-acute sector and primary care. I have been contacted by many mental health and community trusts expressing their wish to be involved in a similar approach. I believe the methodology and tools we have developed are transferable to these sectors, so I see no reason why the same approach should not be taken.

I look forward to submitting my full report and recommendations to you at the end of the month.

Lord Carter of Coles

ADJUSTED TREATMENT COST

DATA PACK

Norfolk And Norwich University Hospitals NHS Foundation Trust

Autumn 2015

For internal purposes only.
This information will be made public at a date to be confirmed in the future.

INTRODUCTION

This data pack has been produced for your Trust in preparation for the forthcoming engagement with Lord Carter of Coles and his team.

In his interim report Lord Carter highlighted that hospitals and hospital chains all over the world have adopted a common set of metrics to monitor and improve the productivity of their operations, and that until now we have not had a suitable metric for the NHS. Since the publication of his report, we have been developing such a metric – the Adjusted Treatment Cost (ATC) and this pack is the first output of the application of this metric to your Trust.

A full explanation of the methodology behind the metric is contained in the ATC explanation guide that accompanies this pack. The main benefit of the ATC is that it allows trusts to see how they vary in their costs for a given output. As the ATC is developed and adopted by the NHS it can be used to identify the most efficient practices and where the greatest efficiency opportunities exist.

The ATC is based on a trust's reference costs. Trusts need to improve the way they collect reference cost data[1] and in time we expect the use of the ATC to encourage trusts to be more accurate in their approach to reference costing. While cost data collection improves the ATC can still be used for comparison between trusts and peer groups and provides lines of enquiry to identify where potential savings opportunities might exist.

CONTENTS

This data pack contains:

1. An overall summary of ATC findings and how they compare with other NHS acute providers.

2. A summary of potential ATC-based savings opportunities including:
   - how the headline potential savings opportunity compares to your peers;
   - the areas that appear to perform well against the national mean;
   - the areas that appear to have savings opportunities against the national mean; and,
   - top 10 potential savings opportunities by area.

3. A chart summarising how the top 10 areas compare with other trusts.

4. A chart summarising how the overall potential savings opportunity compares with trust types.

5. A chart summarising how the headline ATC compares with trust types and peers.

6. A chart summarising how the top 10 areas compare with peers.

1. For further information please see the below publication:
https://www.gov.uk/government/publications/nhs-reference-cost-assurance-programme-findings-from-the-201415-audit

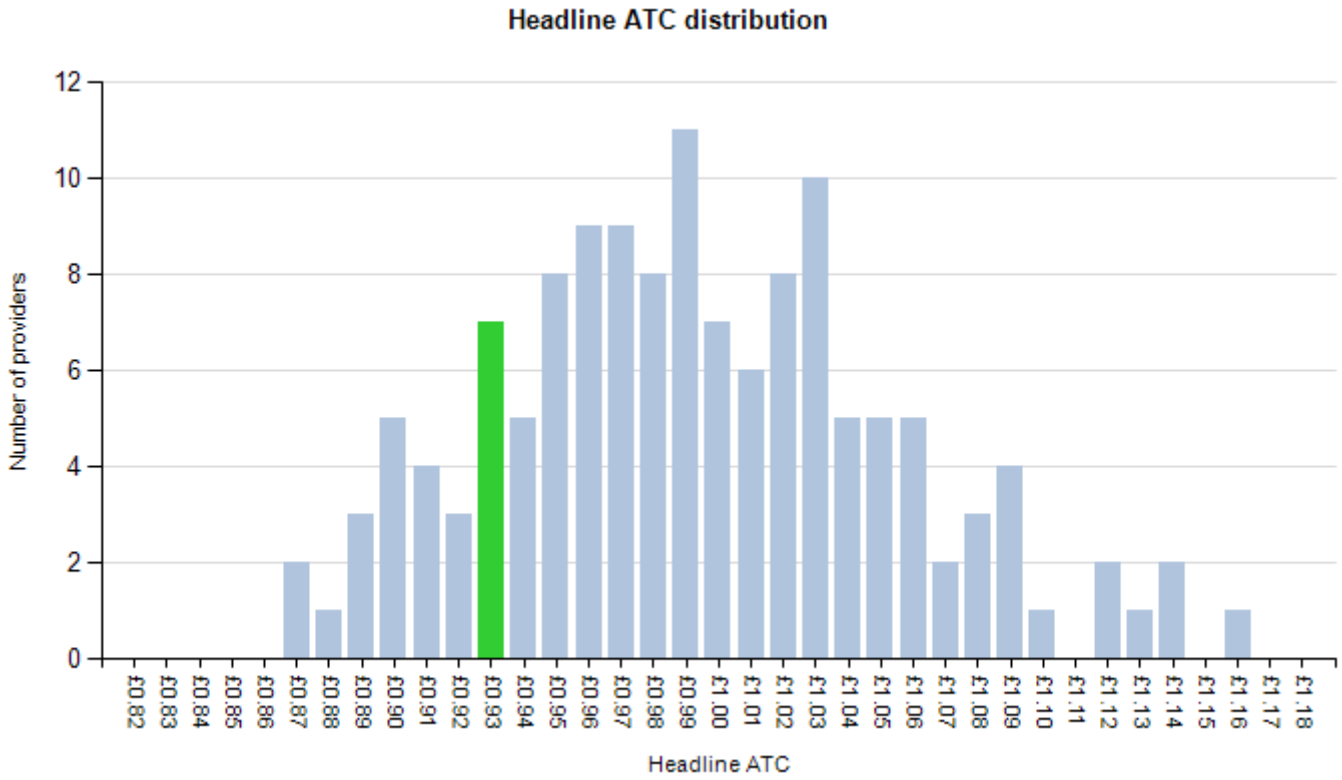
1. SUMMARY ATC FINDINGS

Your total operating expenses for 2014/15 were **£496.2m**[2], from this figure the total amount of expenditure submitted in your reference cost return is reported as **£419.7m.**

Using nationally available reference cost data from all providers, we have calculated your Cost Weighted Output (CWO)[3] at **£450.6m**. This is how much it would have cost to perform the same amount of output at the national mean price for each type of activity.

The current Cost Improvement Programme (CIP) figure[4] we hold for your 2015/16 plan is **£9.5m.** If this figure is incorrect or has recently been revised, please update us during our engagement.

Your organisation's headline ATC is **£0.93**, this means that your organisation is **approximately 7 pence less expensive** per £1 of national CWO.



The ATC distribution across the NHS provider acute sector ranges from £0.87 to £1.16. This chart identifies the number of providers within each range and highlights your organisation's overall ATC position. There are **6** other NHS acute providers who have the same ATC.

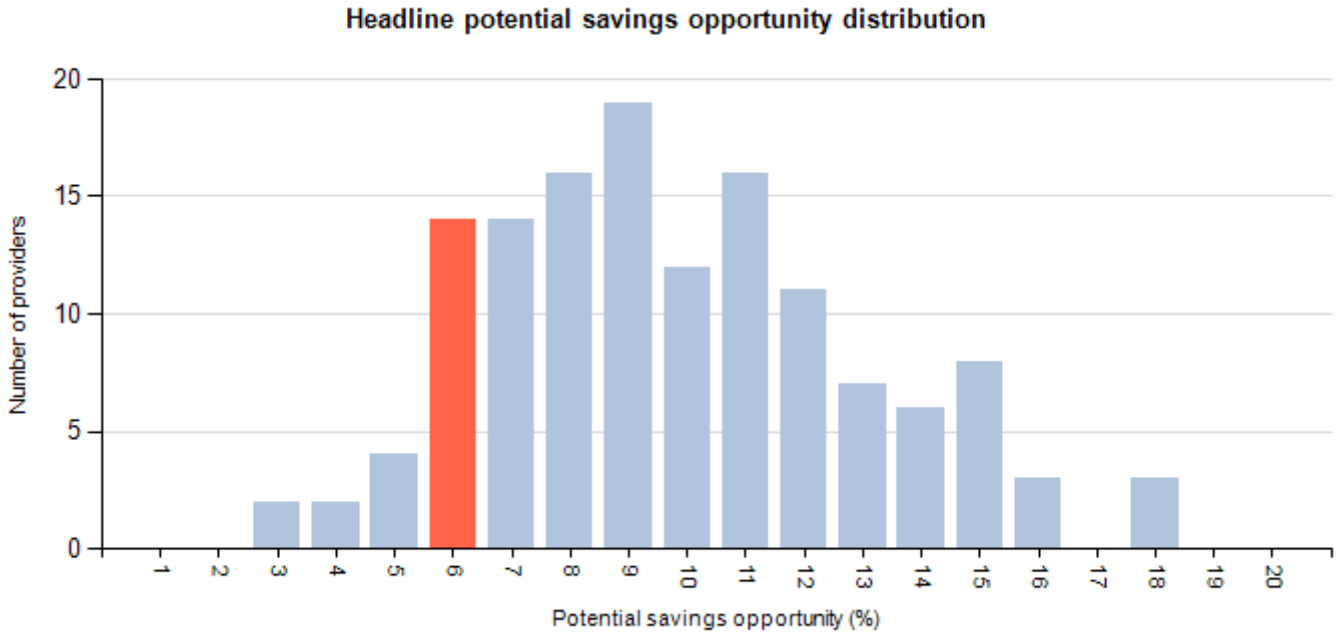
Education and training, research and development, and commercial or other activities not primarily related to providing care to NHS patients are funded from sources other than contracts with NHS commissioners, are not reimbursed through national prices, and therefore excluded from reference costs. In 2014/15, 85% of the total operating expenditure for non-specialist acute trusts was included in the reference cost dataset.

2. OpEx figures have been taken from your annual accounts supplied by you to TDA/Monitor.
3. Please see the attached methodology document to understand how we have arrived at your CWO value. Your MFF is 0.934370.
4. CIP figures have been supplied to us by TDA/Monitor.

2. POTENTIAL ATC-BASED SAVINGS OPPORTUNITIES

Your potential ATC savings opportunity has been calculated as **£25.8m** compared to the national mean. The methodology document sets out the detail of how we have arrived at this calculation.

This chart identifies the distribution of potential savings opportunities across all NHS acute providers, compared to the national mean. This highlights your organisation has a potential savings opportunity of approximately **6.2%** of total clinical expenditure and there are **13** other providers within this cluster.



The table below identifies the top 5 areas where you are performing well against the national mean.

The top 5 have been selected on the basis of low potential savings opportunity as a percentage of total expenditure by area*. Some of the top 5 may still present significant potential savings opportunities either due to their scale or a higher level of variation within individual areas. As such these areas may appear in the areas of opportunity in the table on the next page. For example an area with a cost of £40m and a savings opportunity of 3%, would have a larger savings opportunity (£1.2m) than an area with a cost of £4m and a savings opportunity of 20% (£0.8m).

*only areas with costs in excess of £1.0m have been included in the top 5.

Area	ATC	Actual cost	Potential saving opportunity (PSO)	PSO as % of actual cost
Diabetic Medicine	£0.67	£2,111k	£1k	0.03%
Urology	£0.85	£12,464k	£77k	0.61%
Renal Medicine	£0.77	£12,779k	£85k	0.67%
Gastroenterology and Hepatology	£0.81	£16,808k	£141k	0.84%
Cancer Services	£0.84	£14,546k	£203k	1.40%

This table shows your organisation's ATC per reference cost group; the actual cost in 2014/15 and the potential savings opportunities by achieving the national mean in each of these groups. The top 10 have been selected on the basis of the scale of monetary potential savings opportunity by area.

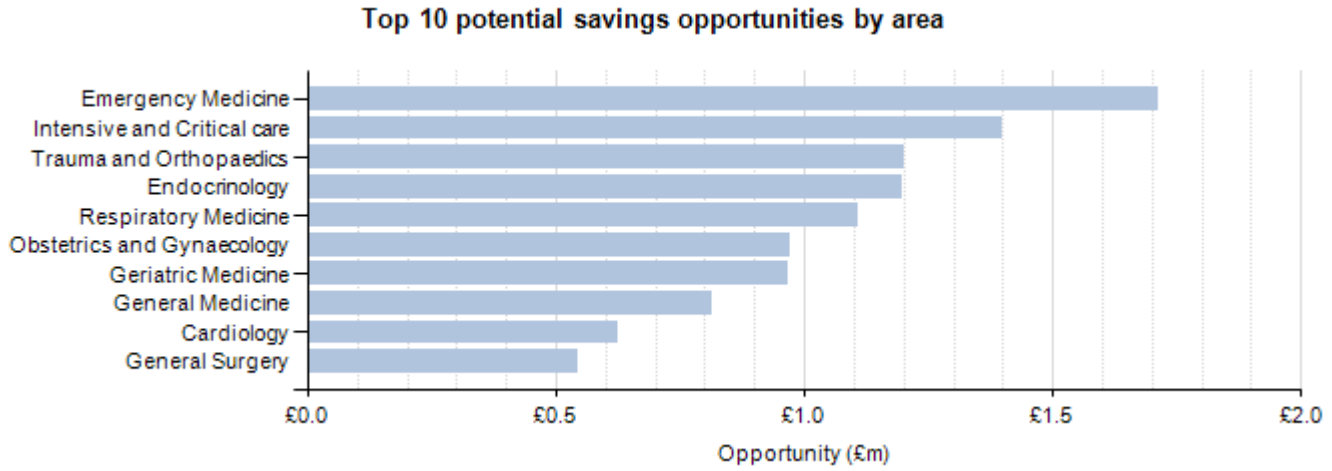
Area	ATC	Actual cost	Potential saving opportunity (PSO)	PSO as % of actual cost
Emergency Medicine	£1.03	£16,059k	£1,714k	10.67%
Intensive and Critical care	£1.05	£18,438k	£1,400k	7.59%
Trauma and Orthopaedics	£0.99	£34,930k	£1,202k	3.44%
Endocrinology	£1.16	£5,899k	£1,198k	20.30%
Respiratory Medicine	£1.03	£13,798k	£1,108k	8.03%
Obstetrics and Gynaecology	£0.91	£25,701k	£970k	3.77%
Geriatric Medicine	£0.88	£34,754k	£966k	2.78%
General Medicine	£0.95	£13,683k	£812k	5.94%
Cardiology	£0.90	£19,404k	£626k	3.23%
General Surgery	£0.91	£36,905k	£544k	1.47%
Top 10 areas total		**£219,572**	**£10,539**	
Pain Management	£0.99	£2,720k	£541k	19.88%
Dental Services	£1.04	£4,567k	£517k	11.32%
Plastic Surgery	£0.95	£11,433k	£493k	4.31%
Radiotherapy	£0.86	£14,181k	£405k	2.85%
Dermatology	£0.91	£5,914k	£359k	6.08%
Paediatrics	£0.87	£9,277k	£342k	3.69%
Otorhinolaryngology	£0.93	£7,375k	£327k	4.43%
Ophthalmology, Orthoptics and Optometry	£0.78	£13,056k	£254k	1.95%
Cancer Services	£0.84	£14,546k	£203k	1.40%
Gastroenterology and Hepatology	£0.81	£16,808k	£141k	0.84%
Neurology	£0.82	£5,987k	£139k	2.32%
Cardiothoracic Surgery	£0.98	£3,087k	£137k	4.43%
Renal Medicine	£0.77	£12,779k	£85k	0.67%
Urology	£0.85	£12,464k	£77k	0.61%
Rheumatology	£0.73	£3,712k	£61k	1.63%
Neurosurgery	£0.97	£36k	£1k	2.91%
Diabetic Medicine	£0.67	£2,111k	£1k	0.03%
Psychiatry and Mental Health Services	£0.62	£73k	£0k	0.35%
Vascular Surgery	£0.82	£178k	£0k	0.00%
Colorectal Surgery	£0.89	£216k	£0k	0.00%
Breast Surgery	£0.88	£40k	£0k	0.00%
Genitourinary Medicine	£0.50	£742k	£0k	0.00%
All areas total		**£360,875**	**£14,621**	
Other	£1.22	£45,435k	£10,363k	22.81%
Community - Other	£1.05	£2,933k	£496k	16.90%
Allied Health Professionals	£0.95	£4,266k	£306k	7.17%
Ungrouped	£1.25	£141k	£28k	19.68%
Community Nursing	£0.82	£6,093k	£21k	0.35%
Grand total		**£419,743**	**£25,835**	

Each of the 1608 department code and service code combinations (sub-groups) from reference costs have been allocated into 38 different parent groups, based on the type of activity performed. Any overspend in each of the 1608 sub-groups has been capped at 50% above the national mean and have been aggregated into all of the 38 groups.

Your organisation has activity in 36 of the 38 sub-groups. The remaining 2 sub-groups where no activity has been reported are Ambulance Services, Rehabilitation.

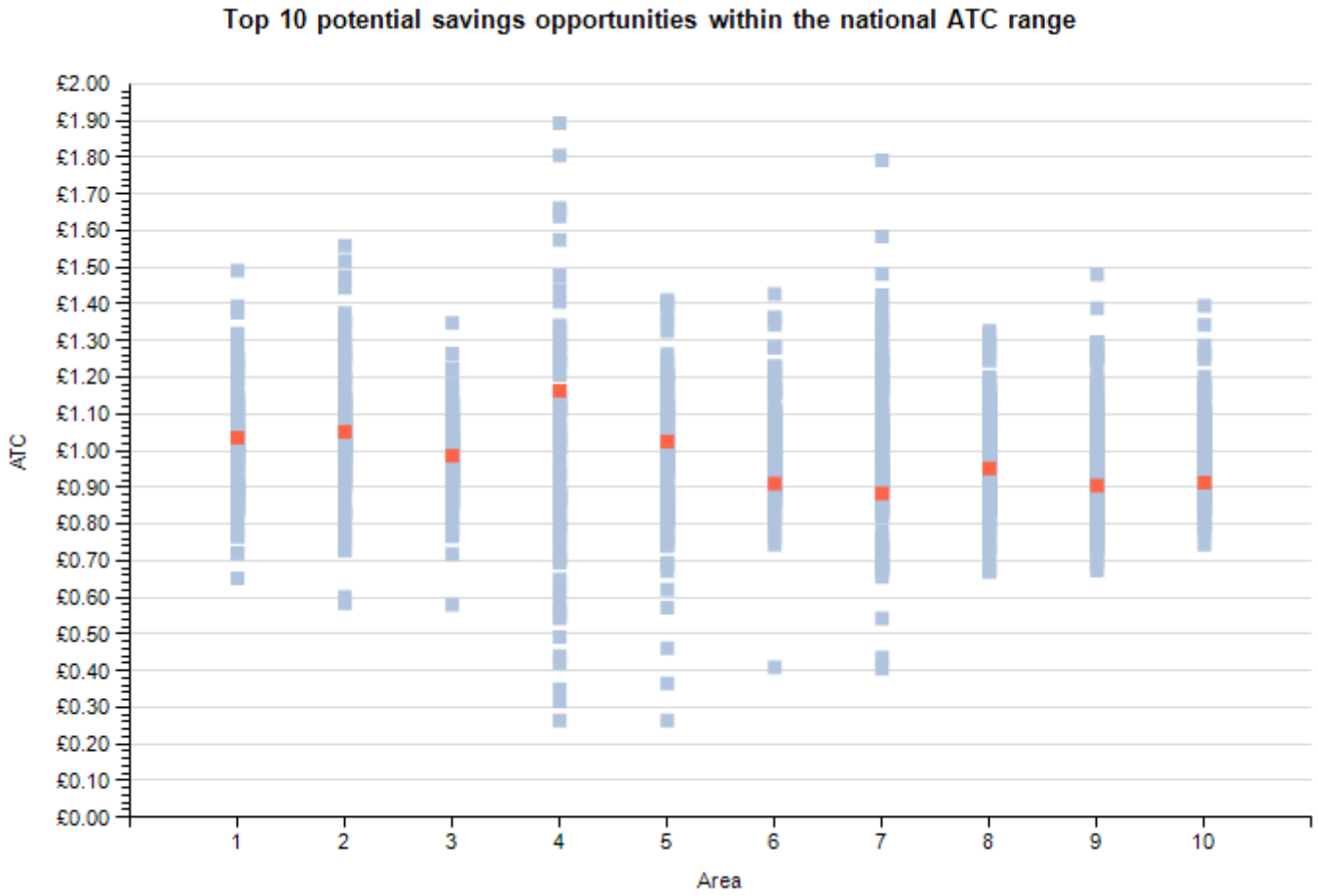
In areas where spend cannot be directly attributed to a clinical specialty through the reference cost return data set, such as High Cost Drugs and Diagnostics (Radiology & Pathology), this activity has been allocated into the 'other' group and has been placed at the bottom of the table.

This chart shows the top 10 highest potential savings opportunities by area.



3. HOW YOU COMPARE NATIONALLY FOR YOUR TOP 10 POTENTIAL SAVINGS OPPORTUNITIES BY AREA

The chart identifies your top 10 potential savings opportunities by area and the ATC distribution across the NHS acute provider sector from the minimum to the maximum. It highlights your organisations ATC within each area.

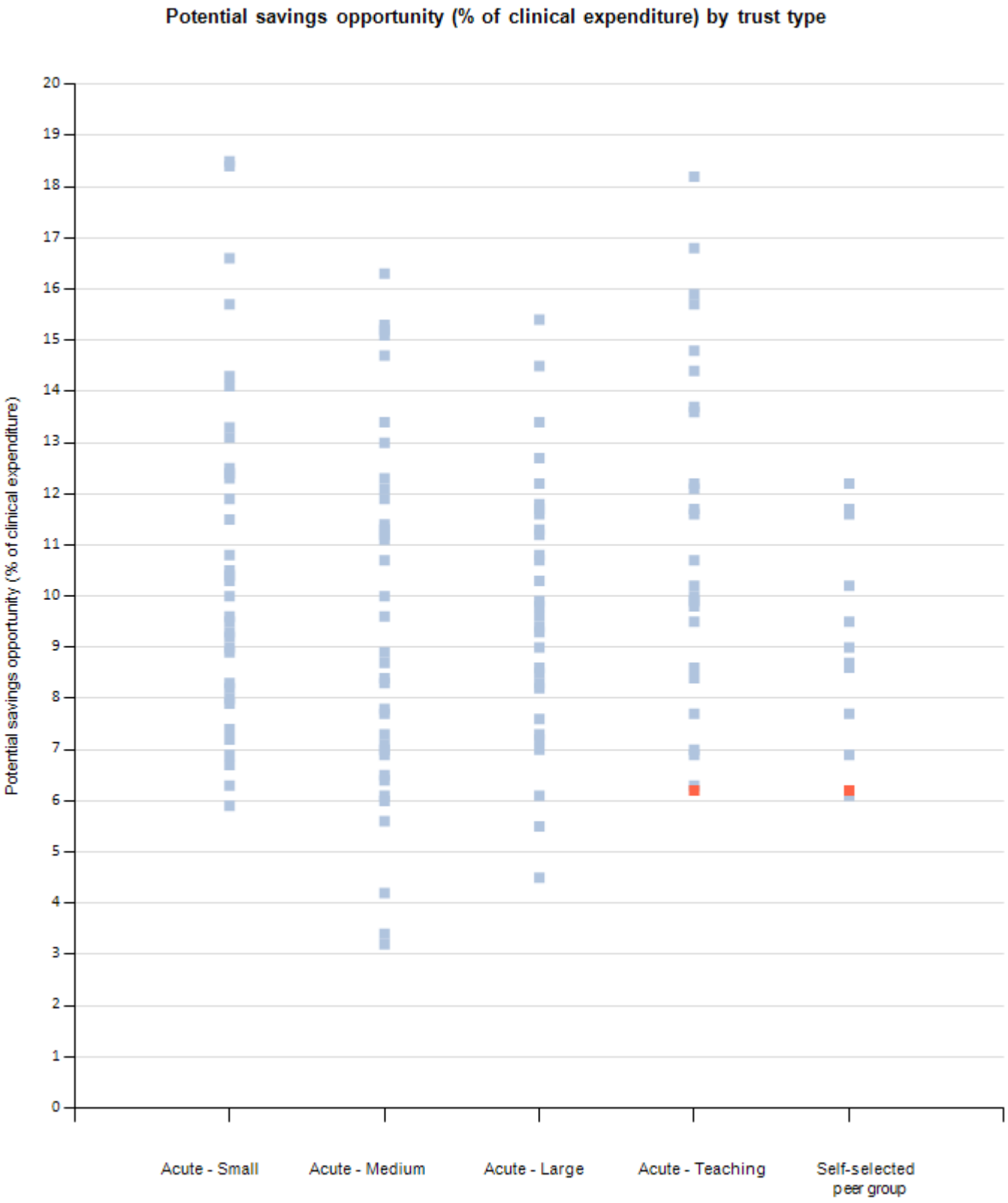


Key	Area
1	Emergency Medicine
2	Intensive and Critical care
3	Trauma and Orthopaedics
4	Endocrinology
5	Respiratory Medicine

Key	Area
6	Obstetrics and Gynaecology
7	Geriatric Medicine
8	General Medicine
9	Cardiology
10	General Surgery

4. YOUR POTENTIAL SAVINGS OPPORTUNITY COMPARED TO TRUSTS OF SIMILAR TYPE

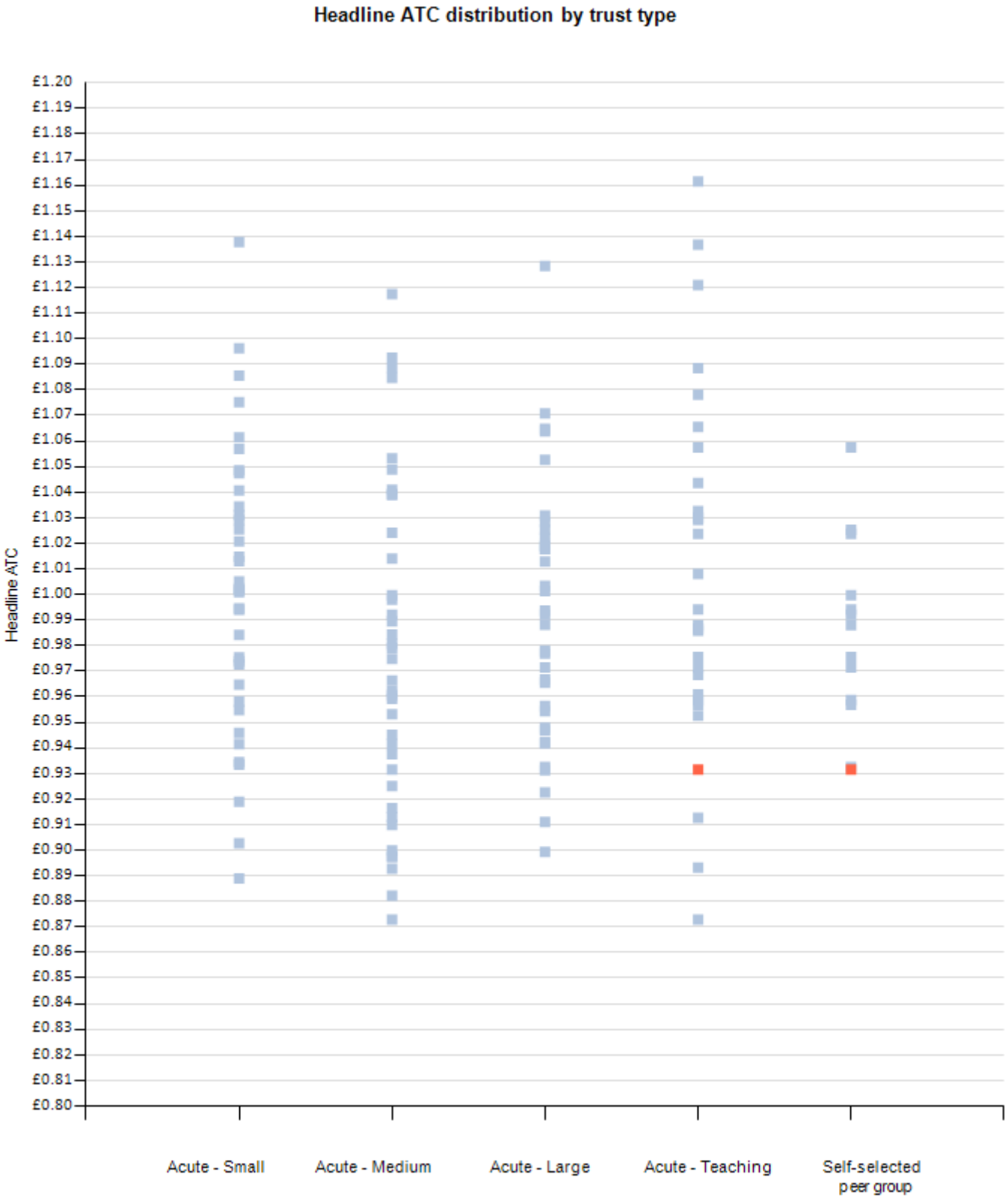
This chart shows the breakdown by trust type of the distribution of the potential savings opportunity as a % of reference cost expenditure[5]. Your organisation is highlighted in red.



5. Reference cost expenditure is the portion of your OpEx submitted in your reference cost return.

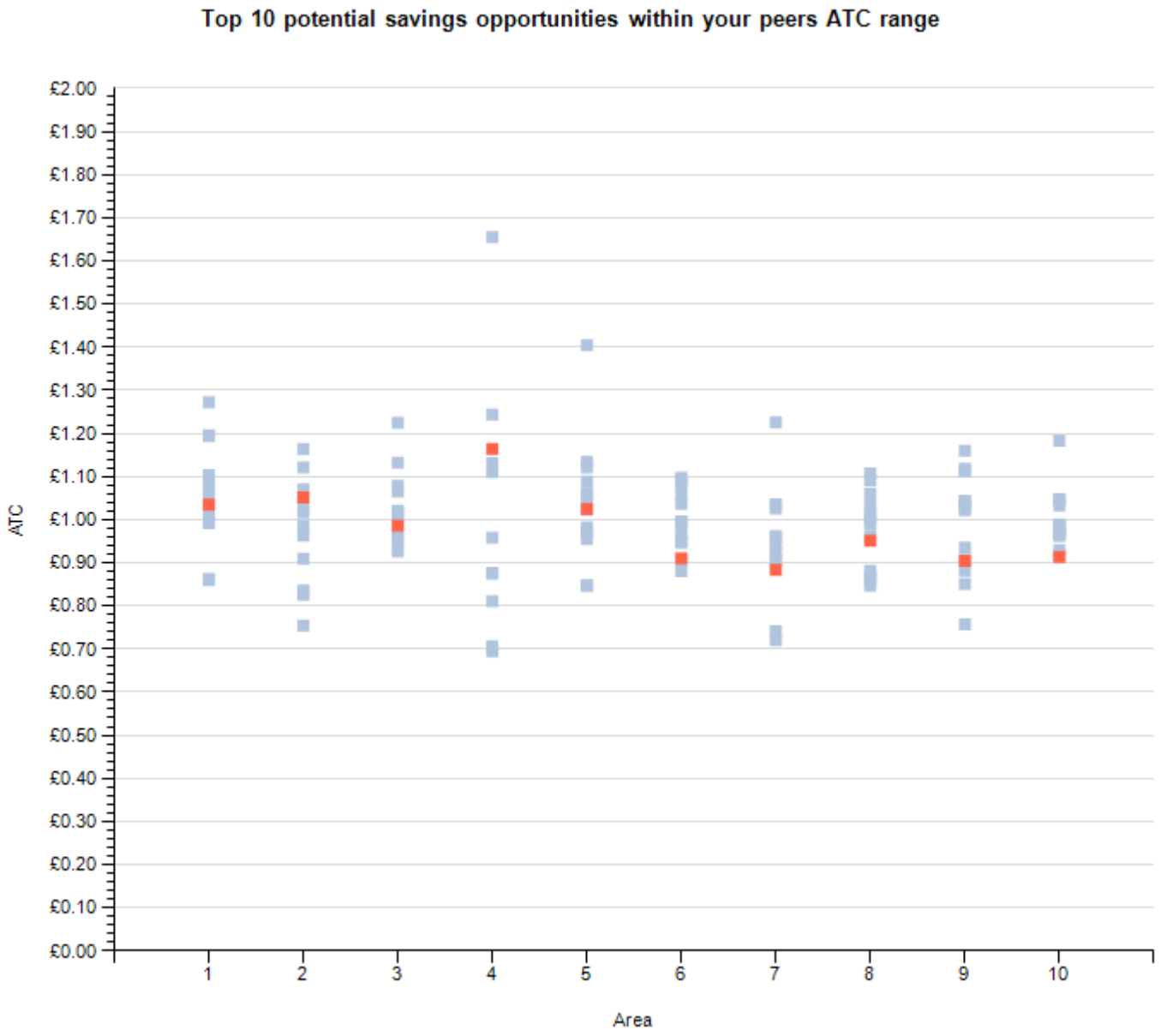
5. YOUR HEADLINE ATC COMPARED TO TRUSTS OF SIMILAR TYPE

This chart shows the breakdown by trust type of the distribution of the headline ATC metric. Your organisation is highlighted in red.



6. HOW YOU COMPARE AGAINST YOUR PEERS FOR YOUR TOP 10 POTENTIAL SAVINGS OPPORTUNITIES BY AREA

The chart identifies your top 10 potential savings opportunities by area and the ATC distribution across the peer group you have provided to us, from the minimum to the maximum. It highlights your organisations ATC within each area.



Key	Area	Key	Area
1	Emergency Medicine	6	Obstetrics and Gynaecology
2	Intensive and Critical care	7	Geriatric Medicine
3	Trauma and Orthopaedics	8	General Medicine
4	Endocrinology	9	Cardiology
5	Respiratory Medicine	10	General Surgery

REPORT TO THE TRUST BOARD

Date	**29 January 2016**
Title	**Use of Trust Seal**
Author(s)	**John Paul Garside, Board Secretary**
Purpose	**For information**

Summary including Key Performance Issues/Risks

- In accordance with its Standing Orders, the Board is required to receive periodic reports detailing use of the Trust's Seal (SO 15.4).

- The last such report was received by the Board in June 2015, since which time the Seal has been used on 8 occasions:

Seal Number	Description of Document Sealed	Date of Sealing
15/01	20 year Lease of Postgraduate seminar rooms and clinical practice area on the ground and first floor of the BCRE Building (15.11.14 – 14.11.34)	09.07.15
15/02	30 years Reversionary Lease of Postgraduate seminar rooms and clinical practice area on the ground and first floor of the BCRE Building (15.11.2034 – 14.11.2064)	09.07.15
15/03	Easement relating to underground electric lines at the BCRE Building	10.07.15
15/04	Supplemental Agreement to the Project Agreement for the installation of a Gamma Camera facility at NNUH	21.09.15
15/05	Supplemental Agreement to the Facilities Management Agreement dated 8 January 1998 to effect an alternative procedure to Market Testing.	23.12.15
15/06	Supplemental Agreement to the Project Agreement dated 8 January 1998 for installation of the Vanguard Unit to the Day Procedure Unit.	20.01.16
15/07	Re-sealing of 15/01 - 20 year Lease of Postgraduate seminar rooms and clinical practice area on the ground and first floor of the BCRE Building (15.11.14 – 14.11.34)	20.01.16
15/08	Re-sealing of 15/02 – 30 year Reversionary Lease of Post-graduate Seminar Rooms and Clinical Practice Area on the ground and first floor of the BCRE Building (15.11.2034 – 14.11.2064)	20.01.16

RECOMMENDATIONS

The Board is recommended to receive this report on the use of the Trust's Seal in accordance with its Standing Orders.