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

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

MEETING OF THE TRUST BOARD IN PUBLIC

FRIDAY 25 JANUARY 2019

A meeting of the Trust Board in public will take place at 09.45 on Friday 25 January 2019 in the Centrum Building, Norwich Research Park

The formal meeting will be preceded by clinical and departmental visits between 08.30 - 09.30 – schedule to follow

AGENDA

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4	Chief Executive's Report	CEO	Discussion	**14**
5	Quality Improvement Strategy **(BAF 1.1)**	NF/ED	Approval	**26**
6	Reports from Board Committees: (i) Quality Programme Board (08.01.19) (ii) Quality & Safety Committee (16.01.19)	MD GOS	Information	**31** **43**
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Date and Time of next Board meeting in public
The next Board meeting in public will be at 9am on Friday 29 March 2019 in the Boardroom of the Norfolk and Norwich University Hospital

Our Vision
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Norfolk and Norwich University Hospitals NHS Foundation Trust

MINUTES OF TRUST BOARD MEETING IN PUBLIC

HELD ON 30 NOVEMBER 2018

Present:	Mr J Fry	- Chairman
	Mr M Davies	- Chief Executive
	Professor E Denton	- Medical Director
	Professor N Fontaine	- Chief Nurse
	Mr T How	- Non-Executive Director
	Mr M Jeffries	- Non-Executive Director
	Mr J Hennessey	- Chief Finance Officer
	Mr J Over	- Director of Workforce
	Dr G O'Sullivan	- Non-Executive Director
	Mr R Parker	- Chief Operating Officer
	Mrs A Robson	- Non-Executive Director
	Miss S Smith QC	- Non-Executive Director
In attendance:	Mr C Cobb	- Divisional Operational Director – Medicine & Acting COO Designate
	Ms F Devine	- Director of Communications
	Mr J P Garside	- Board Secretary
	Mr S Hackwell	- Director of Strategy
	Mr A Lundrigan	- Chief Information Officer
	Ms V Rant	- Assistant to Board Secretary
	Ms P Slinger	- NHSI Improvement Director
	Members of the public	

18/044 **APOLOGIES AND DECLARATIONS OF INTEREST**

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

18/045 **MINUTES OF PREVIOUS MEETING HELD ON FRIDAY 28 SEPTEMBER 2018**

The minutes of the meeting held on 28 September 2018 were agreed as a true record and signed by the Chairman.

18/046 **MATTERS ARISING**

The Board reviewed the Action Points arising from its meeting held on 28 September 2018 as follows:

18/024 Carried forward. Mr How noted that around 20% of cancelled operations had been due to 'equipment failure/unavailability' (IPR Additional Slide 22b) and asked if these two issues could be reported separately to assist review of equipment failure in particular, given the constraints on our capital expenditure. Mr Parker explained that this is proving difficult to implement but should remain as an action until we find a solution. **Action: Mr Parker**

18/024 Carried forward. Mr Lundrigan reported that the format of the IPR is being revised and a revised draft should be ready for review in January.

Action: Mr Lundrigan

18/039(a) It was confirmed that the Duty of Candour compliance figure reported in the September IPR was an error and has been revised. Action closed.

18/039(a) Carried forward. Dr O'Sullivan referred to Core Slide 2 and highlighted that the number of patient moves had been raised as a concern by the CQC. The report should clearly report both clinical and non-clinical patient moves and Dr O'Sullivan highlighted that it is important that this is established urgently.

Action: Professor Denton/Professor Fontaine

18/039(c) A risk concerning special measures has been added to the Risk Register. Action closed.

18/039(c) The High Risk Tracker has been updated. Action closed.

Mrs Robson asked about the Internal Audit report concerning Theatre Productivity referenced at the last meeting and it was **agreed** that this should be added to the agenda for a future meeting in the New Year. **Action: Mr Cobb**

18/047 **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.

Mr Davies highlighted the letter from Dale Bywater (Executive Regional Managing Director – NHSI Midlands and East) emphasising the importance of focus on maintaining standards for infection prevention and control over the winter period and in light of increasing prevalence of antibiotic resistant organisms.

The Trust received an encouraging letter following the Winter Assurance visit by NHSI and NHSE on 14 November. Areas of good practice and strong performance were highlighted including recognition by staff that emergency department performance is a whole hospital issue, winter planning, triumvirate leadership structure; discharge facility, virtual ward, OPED and Children's ED. System-wide actions have been identified to further support readiness for winter.

Mr Davies informed the Board that the Trust's Haematology service has been awarded Accreditation from the Joint Accreditation Committee of the European Society of Blood and Marrow Transplantation. Dr Lawes (Chief of Service) and his team were thanked for their hard work in this significant achievement.

Mr Davies noted that every month he reports to the Board examples of our services that have been received both nationally and internationally. Mrs Devine is preparing a report for the Board meeting in January which will collate the overall picture where the Trust has been recognised for its services and accreditations so that the Board can see that overview. **Action: Mrs Devine**

Mr Davies informed the Board that Miss Sule (Consultant Obstetrician and Gynaecologist and Director of Postgraduate Medical Education) has been leading two projects which are key for progression of Strategic Objectives 3 and 4. The Trust has been asked by Health Education England East of England to be a Hub for provision of education and training for clinical and educational supervisors from QEHKL, JPUH and also GPs in Norfolk and Suffolk. Miss Sule has also led the creation of a Simulation Suite for clinical skills training which will be opening in December in the Centrum Building.

We are proud of our links and history of working with Veterans. The Veterans Covenant Hospital Alliance has accredited the Trust as a Veteran Aware Hospital in

recognition of our work identifying and sharing best practice for care of members of the armed forces. We have also received the Gold Award for our work in supporting Defence People under the Ministry of Defence Employer Recognition Scheme and invited to join the Gold Alumni Association.

The Norfolk Health and Wellbeing Board has agreed a Joint Health and Wellbeing Strategy for 2018-2022 and the NNUH Board has been asked to join other organisations in the County in confirming Board support for the draft Strategy and for collaborative work to deliver the objectives which are focused on making Norfolk a better place to live.

Mr Jeffries asked if there was potential for conflict between the STP Strategy and the Health and Wellbeing Strategy. Mr Davies explained that the Health and Wellbeing Strategy is high level and is not expected to cross over with the objectives of the STP Strategy. There is overlap between the constituent organisations, so there should be consistency of objectives. The Board **agreed** its support for the objectives of the Health and Wellbeing Strategy for 2018-2022.

Mr Davies informed the Board that we continue to implement actions to improve staff communication and culture and Chat with the Chief open sessions are now being held so that staff can attend to talk about any issues of concern. Staff attending have been from a mixture of staff groups and levels.

Mrs Robson asked if there had been any indication whether the staff attending had exhausted other ways of expressing their ideas or if they had been prompted by advertising. Mr Davies confirmed that there had been no indication that staff had attended as a last resort and staff had indicated that this was a very positive and additional way of enhancing engagement.

18/048 **WINTER PREPAREDNESS UPDATE (BAF 1.3)**

The Board received a report from Mr Parker concerning the Winter Plan. Mr Parker reminded the Board that our Winter Plan is based around 3 themes and 5 points of the plan relate to capacity. We are already seeing an extraordinary increase in non-elective activity this year, of up to 10% in some months.

Schemes to increase capacity are on track for completion as planned. The Aylsham Suite (Discharge Facility) is due to open around 17 December to provide a facility for patients to wait as they are prepared for discharge. A dedicated medical elective day unit will adjoin the discharge suite to release inpatient capacity and reduce the need for admission of elective patients to be cancelled.

Staff are in place ahead of opening to receive training and assist the process changes that will be needed ensure that patients can be transferred early in the day, thereby releasing capacity to accommodate patients arriving through the assessment units and Emergency Department. Additional resources have also been put in place to ensure rapid cleaning and turnaround of beds.

The winter triumvirate leadership team comprises the Winter Room Director, Winter Nurse Director and Winter Associate Medical Director and this team will be project managing the Winter Plan and creating a longer term sustainable transformation programme. The team will also be joined by a manager from the Ambulance Trust.

Mr Davies reported that the discharge facility modular building will be linked to the hospital via a corridor and will be clad with brick so that it will feel like part of the hospital. Professor Fontaine added that we have been focused on creating the right

feel and look for the facility so that our patients will feel they are in a clinical environment as they prepare for discharge.

Schemes to reduce length of stay and support improved flow earlier in the day are starting to take effect and the number of delayed transfers of care has been reduced from 40 patients to 20 or less. This additional capacity that we have created has been of significant benefit in light of growing non-elective activity.

Mr Hennessey asked about the anticipated impact from the reduction in bed capacity at QEHKL. Mr Parker explained that the main driver for growth in non-elective activity at this time is not due to closure of beds at QEHKL. It is anticipated that the number of non-elective patients who need to be diverted from the QEHKL is expected to be relatively low due to the associated logistical challenges. Mr Davies informed the Board that we are closely monitoring activity to identify any impact from QEHKL and the Board will be updated if there is any change in the position.

Mr Over informed the Board that the external target (75%) for the flu vaccination has been achieved a month ahead of schedule. This is a demonstration of the good work by our teams and a sign of staff engagement. The flu vaccine will continue to be available over the next few months.

Mr Garside highlighted the extracted page from the BAF (Strategic Threat 1.3) and reported that the Escalation Policy had been approved by the Management Board on 27 November, with an update to the Quality & Safety Committee on 29 November. The Quality & Safety Committee intends to frame its future agendas to undertake deep dives into the BAF and the Board will be updated on the outcomes of these reviews as they are completed. Although good progress has been made towards actions for improvement against this Strategic Threat, it was **agreed** that the score should remain as Red/Amber as we are approaching a historically challenging operational period over the winter.

18/049 **DIGITAL HEALTH STRATEGY**

The Board received a report from Mr Lundrigan concerning the Digital Health Strategy for 2018 to 2023. This is focussed on achieving improvements in quality and safety, operational efficiency and long-term financial sustainability. The level of digital maturity across all the hospitals in Norfolk is striking as being amongst the lowest in the NHS and is an exceptionally low base from which to build.

The Trust's budget for IT is currently £7.1m (1.18% of turnover). There are currently over 10,000 IT users with a small IT support team. The Trust has introduced some digital services such as Wi-Fi and self-check in service but the digital impact of these systems is low. Patients have indicated that they would like to find out more about how digital technology could support their care, particularly in scheduling appointments.

Staff have indicated that systems/equipment are old/slow and are not fit for purpose. More investment is needed to get the technology that our staff feel would help them do their jobs.

There is a need to enhance capture of data which can be used to improve management, quality and operational flow across the organisation. The technology to support joint working also needs updating so there are easy, intuitive ways to share information and manage care with our partners.

Our mission is to deliver the future of digital care to enable our future vision for the hospital. Six strategic objectives have been identified:

(i) Digitally empowered people;
(ii) Digitally enabled workforce;
(iii) Integrated and collaborative care;
(iv) Informatics;
(v) Innovation lab;
(vi) Digitally enabling infrastructure.

Key enablers for achievement of the strategic objectives are: team development; business relationships; governance/processes; and continuous improvement.

A Digital Health Team is being formed to identify opportunities for patients, staff and organisations to work together to maintain the wellbeing of people through self-management and support/care from healthcare organisations. The Digital Health Team will be looking to connect people to technology that is focused around patients.

A number of proposed actions have been identified under each of the six objectives as detailed in the papers.

Miss Smith asked what level of digital maturity we would hope to achieve through implementation of the Strategy. Mr Lundrigan confirmed that we would hope to be among the top category of Trusts being able to use digital technology to deliver acute care but this will require significant funding.

Dr O'Sullivan noted our digital ambitions at a time of significant financial pressure. Introduction of electronic patient record systems has been problematic in other trusts and we therefore need to look at what can be learnt from the experience in other organisations. Mr Lundrigan recognised that introduction of an EPR is complex and will require engagement of all staff in all areas. A robust plan for implementation and training of the new systems will be needed in order to mitigate risk and maximise benefit.

Mr How noted that the support contract for storage provision is due to end in December 2018 and expressed concern that a replacement arrangement is not ready to be put in place. Mr Lundrigan explained that this risk is recognised on the Risk Register. An investment of £2.7m is needed and approval of capital plans is awaited to support this replacement.

Mr How noted that our main datacentre had also been assessed as being not fit for purpose and indicated that this should also be a risk on the Risk Register. Mr Lundrigan indicated that the business case for the Electronic Data Management System is due to come to the Board in December, with an outline case for EPR coming to the Board in January.

Mr Davies indicated that he was aware of the organisational risks associated with IT system change from his experience in other Trusts. Mr Lundrigan was thanked for his work in development of the strategy. This will allow us to garner support and seek funding.

The next steps will be to identify timescales and to determine how this will fit in with the medium term financial plan. There will also be a lot of work to do around socialisation within the organisation. The plans arising out of the strategy will be key in engaging external partners and stakeholders in moving digitalisation projects forward.

Mr Fry asked if the Business Case would be brought to the Trust Board for review/approval and Mr Lundrigan explained that he would be able to provide the

Board with a further update on progress of this development at its meeting in December or January.

The Board **approved** the Digital Health Strategy 2018 to 2023.

18/050 **INFECTION PREVENTION AND CONTROL ANNUAL REPORT**

The Board received a report from Ms Sarah Morter (Lead Nurse for IP&C) and Dr Catherine Tremlett (Consultant in Microbiology) concerning the Infection Prevention and Control Annual Report for 2017/18.

Ms Morter highlighted that the Trust had received the highest quality rating for infection control following the external assessment by NHS Improvement in February 2018. Following a recommendation by NHSI at that time, the Annual Report has been reformatted to reflect the elements of the Hygiene Code.

A key part in infection prevention and control is increasing public awareness of infections and the Annual Report can also act as a learning and information tool for this purpose.

Two key national objectives for infection prevention were met in 2017/18: no cases of MRSA bacteraemias and the number of C Difficile infections was below the ceiling of 49 cases at 24 cases. Dr Tremlett reported that we are on track to achieve the MRSA and C Difficile targets this year.

We are recommissioning the ICNet system which will be key in helping to maintain high levels of infection control practice. Mr Lundrigan reported that he had recently attended a steering group to review proposals for introduction of the ICNet system. The group of system-wide partner organisations had agreed in principle the proposal but further work will need to be undertaken before it will be possible to introduce the system across the County.

There is a national requirement to reduce the number of E Coli blood stream infections by 50% by 2021 and we are closely monitoring levels of in-hospital infections. We perform very well by way of comparison to others and have one of the lowest rates nationally. A number of infections are brought into the hospital from the community and it is essential to work with our healthcare partners on a system-wide basis to try and address this risk.

Benchmark data and antibiotic prescribing audits indicate that we are performing well in comparison to other Trusts.

Mr Jeffries asked what would be the biggest threats to infection prevention and control. Ms Morter identified outside threats, such as Ebola and antimicrobial resistant organisms, and maintaining adequate staffing. Dr Tremlett added that we need robust processes in place in order to prepare staff to act quickly for those unknown issues that may come into the hospital.

Dr O'Sullivan praised the hard work by the infection prevention and control team. The CQC had raised a number of concerns over practices in the Trust relating to infection prevention and control, particularly in the Emergency Department and asked how this is being addressed. Ms Morter explained that significant work has been undertaken to address concerns in the Emergency Department and enhanced monitoring is undertaken regularly to ensure that standards are being maintained. Professor Denton confirmed that a new Matron is in place and many of the observations picked up by the CQC will now have been addressed. Professor Fontaine added that a number of

Quality Audit inspections have been undertaken and the CQC has acknowledged that there has been an improvement in this area.

Mr Fry thanked the infection prevention and control team for all their hard work and congratulated the team in achieving a reduction in the number of infections over the last 10 years. Ms Morter highlighted that reductions/low numbers of infections will be beneficial in generating financial savings for the Trust.

Mr Davies commented that in our drive to achieve excellence in quality and safety, achieving low rates of mortality and infection are key indicators and we perform notably well.

18/051 **REPORTS FROM BOARD COMMITTEES**

(a) Quality Programme Board
The Board received a report from Mr Davies as Chair of the Quality Programme Board concerning its meeting held on 6 November 2018.

Mr Davies reported that the Quality Programme Board continues to meet monthly and is proving an effective way of overseeing implementation of the Quality Improvement Plan and also acts as the mechanism for onward reporting of progress to the Trust Board.

Much work has been undertaken and we are now moving into the next phase where we will be undertaking audits to determine whether actions/behaviours are fully embedded to ensure performance can be sustained.

The Oversight Assurance Group continues to meet monthly. The Group consists of stakeholders and staff are invited to describe their work towards delivery of the actions under the Quality Improvement Plan to provide assurance that the rights steps are being taken.

The Oversight Assurance Group received two presentations at its last meeting, one concerning the Digital Strategy and one from the Emergency Department team about the significant cultural and physical changes in the department.

Professor Denton reported that there is daily focus on gathering evidence for reporting to the Quality Programme Board. The work that is being undertaken is focused on laying the foundations for the Quality Improvement Plan so that these changes become part of our 'business as usual'. The QIP Evidence Group has been introduced to add rigor to review of evidence supplied and is made up of Trust and external stakeholder representatives. In the event that evidence is considered insufficient, the group will request further work to be carried out.

The Internal Auditors have been commissioned to undertake a review underpinning the QIP processes and this will commence at the beginning of December. Work has commenced on the improvement plan for 2019/20 and beyond.

(b) Quality and Safety Committee (meeting 29.11.18)
Dr O'Sullivan reported that at its recent meeting the Quality and Safety Committee had discussed the changes in the Emergency Department and considered that there had been good progress towards the improvement actions.

The Committee also reviewed learning from Serious Incidents reporting during October 2018. One theme arising was the availability of out of hours emergency theatre capacity and it was agreed that this should be reviewed further. Professor Denton

highlighted that Dr Tim Leary (Consultant Anaesthetist and Chief of Division for Surgery) is developing proposals to implement additional emergency surgery capacity.

A discussion also took place around opportunities to increase the 'patient's voice' at Board meetings and it was agreed that this is an area that should be taken forward.

Committee members also attended an SI group meeting, which was well attended by a wide range of staff of various disciplines and there was good discussion about cases. Concern was raised at the SI Group about two CT scanners which were currently not operational and the impact this was having on patient care. A case of a patient at the End of Life was highlighted in particular. Professor Fontaine explained that concerns about patient safety had been looked into and the patient had been very unwell. The outcome for this particular patient was not affected by the scanner availability. The care of the patient was commended in terms of treatment and response.

Professor Fontaine reported that the number of whistle blowing issues raised with external stakeholders has reduced significantly which is a positive indication of the success of our new systems for speaking up.

Mr Over informed the Board that the Management Board will be receiving monthly updates on speak up issues in order to increase its oversight of issues. A fulltime Speak-Up Guardian was appointed this week and should be joining us in the New Year. This is an exciting appointment and the next step on our journey towards developing a value-based organisational culture more closely aligned with staff and public.

18/052 **ANNUAL MEDICAL APPRAISAL REPORT**

The Board received a report from Dr Caroline Kavanagh (Consultant Paediatrician and AMD for Medical Workforce) concerning the Medical Appraisal and Revalidation Annual Report for 2017/18. Dr Kavanagh is the Responsible Officer for Revalidation.

The Board was informed that the medical appraisal rate in 2017/18 was 96%. 86% of appraisals were considered to be excellent quality and the remainder were rated as good. 94% of appraisers were up to date with their training and all revalidation recommendations were made on time.

Professor Denton explained that Dr Kavanagh has successfully built on the work started by Peter Chapman and has established and embedded systems and processes to ensure delivery of this work, supported by the Medical Staffing Team.

Dr Kavanagh has now been appointed as the Winter Associate Medical Director and the post for Associate Medical Director for Medical Workforce has been advertised. Mr Fry emphasised the importance of maintaining focus during the transition period to ensure that there is no slippage in our performance.

18/053 **INTEGRATED PERFORMANCE REPORT**

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

(a) Quality, Safety and Effectiveness

Professor Denton highlighted that the national data for mortality is reported in arrears and there is no change to the data reported this month. We have met with representatives from the Dr Foster organisation to look at the reasons for a high SHMI figure which appears to be in contradiction to our falling HSMR. This pattern is also seen in some other organisations. It is anticipated that this is partly due to data and partly due to coding but this is being explored further.

Our crude mortality rate was 3.94% in October but it is anticipated that this will rise following increased non-elective activity in the last month.

The results of the latest 7-day services survey have been published, showing improvement in all priority clinical standards. We have one service that remains an outlier but we expect also to be operating a 7-day service by April. The Autumn 2018 survey is underway.

Mrs Robson referred to the figures for recognition and treatment of sepsis reported on Core Slide 2. Professor Denton explained that this data is collected through a review of paper based records and we think that the data collection process is flawed. Mrs Robson indicated that we want to be sure that this is the explanation for the sepsis figures and this will be confirmed. **Action: Professor Denton**

(b) Caring and Patient Experience

Professor Fontaine reported that the Friends and Family Test score remains high at 96% in October 2018. The number of medication errors reported has continued on an upward trend with the vast majority causing low or no harm which is a positive indication of our reporting and we continue to widely share learning outcomes from these incidents in order to prevent recurrence of errors in the future.

Professor Fontaine reported that the Trust's Pressure Ulcer Collaborative Team was awarded the peer nominated award for the most innovative pressure ulcer reduction initiative. The 'zero tolerance challenge' is showing signs of success and Earsham Ward are aiming to be the first ward to achieve 100 days without a patient developing a pressure ulcer.

The Trust has recently appointed a Patient Experience and Engagement Manager.

(c) Performance and Productivity

Mr Parker reported that our performance is indicative of a hospital under pressure and shows that we are treating more patients that in previous years.

The length of stay for our elective patients is showing an increase which reflects a change in the complexity of patients being treated. Cancer services continue to be an area of pressure with high demand for two week wait referrals. We are seeing more patients within the 4 hour target but this is alongside an increasing number of patients attending A&E and the increase between Q1 and Q2 2018/19 was 4.2%.

The number of patients admitted from A&E was an average of 149 per day between July and September last year compared 157 patients per day this year. Although we have worked hard to ensure that we have robust plans in place to ease pressure in the coming months, it is clear that there will be challenges.

The Board was informed that there has been a notable shift in surgical activity this year with 1,100 more patients requiring emergency treatment. Elective activity compared to the previous year has reduced by 161 patients due to the complexity of the surgery required.

(d) Workforce

Mr Over reported that appraisal and mandatory training compliance continue to be an area of focus for the Management Board. Two Divisions (Women & Children and Clinical Support) have achieved appraisal compliance which is above the target level and two other Divisions are close to the target. Mandatory training compliance has

also improved with two Divisions now compliant (Clinical Support and Corporate) and the remaining 3 Divisions continue to make good progress.

Performance for staff turnover and sickness is showing a slight increase but remains within acceptable levels and performance will be closely monitored to ensure that any areas for concern are identified.

(e) Finance

Mr Hennessey reported that the financial position at month 7 was a deficit of £32.4m which is £0.4m worse than plan. The profile for CIPs was £10m in the first half of the year and £20m for the second half of the year which creates significant pressure in the remaining part of the year.

Clinical income at month 7 is £3.6m worse than plan which has been offset by an underspend in operating expenditure. Income was behind plan in October due to the shift between emergency surgery and elective surgery activity. Specialist activity is funded by NHS England under a block contract arrangement and the Trust will only be paid for £2m of the £4m over performance.

Clinical income is the main driver for the financial underperformance in the Surgical Division, further evidencing the shift in emergency and elective activity. Financial performance in the Medicine Division is ahead of plan and remaining Divisions are close to achieving their plans.

£27.3m CIP schemes have been approved at end of October and it is hoped that this will have increased to £29m by the time of reporting in November. The national expectation for efficiency savings is 2% and we are aiming to achieve above this level at 5%.

The main risks to delivery of the financial plan are CIP delivery, under performance of clinical income, penalty fines from RTT and emergency performance and expenditure to address winter/CQC actions.

Mr How emphasised that there is a significant financial challenge ahead in trying to achieve increased activity during one of the busiest times of the year. If the Trust can deliver the levels of planned elective activity then this will be of significant benefit both to our patients and the financial position.

The actual deficit in the year to date is above plan but it is not considered necessary at this stage to adjust the forecast and we are continuing to project a deficit of £55m.

Mr Jeffries asked if the increase in emergency surgical theatre capacity would help to increase activity for elective patients. Professor Denton explained that the surgeons would be required to work during the night treating emergency patients, which will reduce their capacity to treat patients during the day. Mr Parker reported that once Turnstone Court becomes operational, this is expected to increase theatre capacity for elective patients.

Mr Davies informed the Board that the Executives have been working to develop a medium term financial plan. Mr How added that the plan will be reviewed by the Finance & Investments Committee prior to the next Board meeting.

18/054 **FEEDBACK FROM THE COUNCIL OF GOVERNORS**

The next meeting of the Council will take place on 23 January 2019.

18/055 **ANY OTHER BUSINESS**

There was no other business.

18/056 **DATE AND TIME OF NEXT MEETING**

The next meeting of the Trust Board in public will be at 9am on Friday 25 January 2019 in the Boardroom of the Norfolk and Norwich University Hospital.

Signed by the Chairman: …… Date: ……

Action Points Arising:

	Action
18/046	Carried forward. Mr How noted that around 20% of cancelled operations had been due to 'equipment failure/unavailability' (IPR Additional Slide 22b) and asked if these two issues could be reported separately to assist review of equipment failure in particular, given the constraints on our capital expenditure. Mr Parker explained that this is proving difficult to implement but should remain as an action until we find a solution. **Action: Mr Parker**
18/046	Carried forward. Mr Lundrigan reported that the format of the IPR is being revised and a revised draft should be ready for review in January. **Action: Mr Lundrigan**
18/046	Carried forward. Dr O'Sullivan referred to Core Slide 2 and highlighted that the number of patient moves had been raised as a concern by the CQC. The report should clearly report both clinical and non-clinical patient moves and Dr O'Sullivan highlighted that it is important that this is established urgently. **Action: Professor Denton/Professor Fontaine**
18/046	Mrs Robson asked about the Internal Audit report concerning Theatre Productivity referenced at the last meeting and it was agreed that this should be added to the agenda for a future meeting in the New Year. **Action: Mr Cobb**
18/047	Mrs Devine is preparing a report for the Board meeting in January which will collate the overall picture where the Trust has been recognised for its services and accreditations so that the Board can see that overview. **Action: Mrs Devine**
18/053(a)	Mrs Robson referred to the figures for recognition and treatment of sepsis reported on Core Slide 2. Professor Denton explained that this data is collected through a review of paper based records and we think that the data collection process is flawed. Mrs Robson indicated that we want to be sure that this is the explanation for the sepsis figures and this will be confirmed. **Action: Professor Denton**

REPORT TO THE TRUST BOARD (in public)

Date	**25 January 2019**
Title	**Chief Executive's Report**
Purpose	**To update the Board on matters relating to the Trust that are not covered elsewhere in the papers**

Summary:
The intention of this report is to cover key issues and matters not addressed elsewhere in the papers.

To avoid duplication, **attached** is a copy of the CEO report to the Public Council of Governors meeting on 23 January (with attachments) as previously circulated. This highlights issues consistent with the NHS Long Term Plan and in relation to:

- Improving quality and outcomes;
- New service models;
- Digital;
- Workforce;
- Finance;
- Winter and capacity;

Core issues will be covered through the IPR and reports on the Board Agenda. The Board will be updated at its meeting on the most current position in relation to other matters of note.

Also attached is a paper received by the STP Executive on 18 January 2019 with key messages from the work undertaken by the Boston Consulting Group who were commissioned to review demand and capacity across the STP. There are some clear conclusions that we will need to take into account in considering our own strategy and capacity requirements.

Recommendation
The Board is recommended to **note** recent matters relating to the Trust as highlighted.

REPORT TO THE COUNCIL OF GOVERNORS

Date	**23 January 2019**
Title	**Chief Executive's Report**
Exec Lead	**Mark Davies, Chief Executive**
Purpose	**To update the Council on key issues that are not covered elsewhere in the papers.**

Attached is a copy of the latest (December 2018) monthly Viewpoint letter to all Trust staff, which summarises a number of key and ongoing developments and themes in the Trust.

Also **attached** is a briefing note concerning the NHS Long Term Plan which was issued this month by NHS England. The Long Term Plan details an aim to improve health and care, through focus on the following areas:

- Improving quality and outcomes;
- Prevention;
- New service models;
- Digital;
- Workforce;
- Finance.

It is striking that core themes of the Plan mirror areas of particular focus in the Trust and these are reflected in the Council Agenda, as below:

(i) Improving quality and outcomes

A huge amount of work and effort is ongoing across the Trust to demonstrate improvement in relation to quality. We know that in many respects our clinical outcomes are extremely good, but there is a need for greater consistency and a more robust framework around this. The Council will be invited to comment on our draft Quality Strategy, as part of the meeting.

(iii) New service models

The Council will also receive an update from Mr Hackwell (Director of Strategy) on the ongoing work to promote consistent high quality acute hospital services across the County.

(iv) Digital

The Council has previously heard that the health system in Norfolk is the least digitally advanced of any in the country. At its meeting in November, the Board of Directors approved a Digital Strategy for the Trust. At its meeting in December, the Board then approved a major service initiative to implement an Electronic Data Management System (EDMS). We have now appointed our first substantive Chief Clinical Information Officer, Mr Ed Prosser Snelling (Consultant Obstetrician). The role will provide additional clinical leadership in improving our digital systems.

The next steps concern developing the business case for a full electronic patient record (EPR). We are also actively searching for the capital (c.£5m) to implement an electronic observation system during 2019/20.

(v) Workforce

As part of its agenda, the Council will receive an update from Mr Over on the actions we are taking to support our staff and develop our workforce so that we have the right number of suitably qualified, happy and well-motivated staff to meet the needs of our patients and develop our services.

(vi) Finance

It is well-reported that the NHS is facing significant financial constraints. We are no exception and our financial plan this year results in a large deficit. We are advanced in our planning for next year's budget and there will be a need for further savings.

We were understandably very disappointed that the Norfolk health system did not receive any central Government money in the latest capital allocation round. It is however worth noting that we continue to explore creative solutions and to invest where necessary and possible to safeguard patients and improve. Examples this year include:

- Creation of the Quadram Institute (opened December 2018);
- Expansion of the Interventional Radiology Unit (to open 2019);
- Aylsham Discharge facility (opened December 2018);
- New Cardiac procedure room (opened 2018);
- Replacement of CT Scanner in radiotherapy (enabling building work underway).

Winter Operational Pressures and Capacity

In addition to longer term planning, mention must be made of the immediate operational pressures facing the Trust. The Council will know that we made extensive plans for the anticipated increase in demand this winter. These plans were externally scrutinised and were seen as robust. An update on progress is **attached**.

We have seen a very substantial increase in the number of patients coming to hospital on a non-elective (emergency) basis – especially by ambulance and this has placed extreme pressure on the NNUH hospital and its staff, especially since the New Year. The response of our staff has been tremendous and we remain focussed on protecting the safety of our patients especially when particularly busy.

On a wider note, the STP has commissioned an extensive review of demand and capacity across the Norfolk health system and at its meeting, the Council will receive an update from Mr Hackwell on our capacity needs and plans.

Recommendations:

The Council is recommended to note the issues highlighted, for information.

From: Davies, Mark (NNUHFT)
Sent: 24 December 2018 13:42
To: NNUH Staff
Subject: Viewpoint - December

Dear Colleagues,

I am pleased to write to you today in the December Viewpoint summary letter where our topics include better connecting with staff, digital and celebrating success.

Connecting with Staff
We are looking for more ways to connect with staff and give everyone more opportunity to give feedback. For example you can see a video of my Viewpoint presentation **here** and I will do another video soon focusing on patient feedback letters. My drop-in staff surgeries 'Chat with the Chief' are going well – so far I have done three and they are becoming busier with each one which is great. The channels we offer to our staff for Speaking Up are also becoming more well used which is good news. Our Speak up Policy is **here** and our confidential Speak in Confidence online system is **here**.

Digital
We are working hard on how we can improve our digital maturity. Anthony Lundrigan, our Chief Information Officer presented the NNUH Digital Strategy to the Management Board and the Trust Board in November which was approved, and we are looking at how we can take this forward to improve digital systems for staff. We have all struggled at one time or another with digital technology here - whether it's problems with logging on or systems not talking to each other - we are determined to find a way to take it forward including finding external funding to help.

Finances
Everyone is working hard to make savings and achieve our £30million Cost Improvement Programme and this is all crucial to NNUH achieving its planned £55m deficit. We are also working on our Medium Term Financial Strategy looking five years ahead and exploring how we might be able to access help with our annual PFI costs from central Government.

STP progress
With our neighbouring hospitals, JPUH and QEH, we are working together more closely exploring the opportunities to join up their cardiology, vascular, urology, haematology, oncology, and ear, nose and throat services, and this is going well.

Celebrating Success
Staff this year have achieved more than ever and here you can see just a few examples of successful projects and well-deserved awards:

Joint award for Services to Disability Sport

won by Paediatric Orthopaedic Surgeon Rachael Hutchinson,

with former boxer and personal trainer Jon Thaxton.

Best Principal Investigator Award 2018 won by Professor Iain McNamara National Institute for Health Research (NIHR) Awards for Musculoskeletal Trauma Trials

Investing in Volunteers reaccreditation

celebrated by the Voluntary Services team. A national accreditation for the fifth time running – the first organisation providing acute care in the UK to achieve this.

UNICEF Baby Friendly Initiative (BFI) Award

re-accreditation for celebrated by NNUH maternity team.

International Award for Minimally Invasive Oesophagectomy (MIO) from the University of Pittsburgh Medical Centre (UPMC), awarded to Mr Ed Cheong, Consultant Oesophagogastric and Laparoscopic Surgeon.

National Oesophago-gastric Cancer Audit (NOGCA), named NNUH as one of the best centres in the UK for the eighth year running.

Gold Award from the Ministry of Defence

NNUH is one of 50 employers across the country to have received the Employer Recognition Scheme (ERS) Gold Award from the Ministry of Defence.

Simulation Centre

A new, state-of-the-art, training centre has been launched at NNUH enablin junior doctors and healthcare professionals to develop their skills in simulated medical scenari

Quadram Institute

The Gastroenterology department has now started to see patients in the Quadram Institute. The state-of-the-art multi-million pound facility is home to a range of endoscopy and bowel cancer screening.

The new discharge suite featured on BBC Look East on Friday (21st Dec)

New Rapid Treatment and Assessment Ser

Thank you to all staff who are continuing to work hard on our Quality Improvement Plan – this is making a real difference throughout wards and departments as you can see in our improvement newsletter Sharing the Learning helping us on our journey to achieve outstanding in five years.

Thank you to all staff for your hard work, kindness and dedication that you give to our patients and each other.

For more detail from Viewpoint you can see a video of the event **here**

Happy Christmas and New Year.

Best Wishes,

Mark Davies
Chief Executive

The NHS Long Term Plan
Snapshot view

W: www.carnallfarrar.com
E: admin@carnallfarrar.com
T: 020 3770 7535

Improving quality and outcomes

- Specific **waiting time targets** and **access standards** for emergency **mental health** services will be introduced from 2020, including children and young people's
- Greater emphasis will be placed by the CQC on **system-wide quality**
- New **Rapid Diagnostic Centres** for cancer from 2019

Prevention

- Funding for specific **new evidence-based prevention programmes**, including to cut smoking; reduce obesity and avoid Type 2 diabetes; limit alcohol-related A&E admissions; and lower air pollution
- Local health systems to **reduce inequalities** over the next decade

New service models

- Introduction of new primary care **network contracts** to extend the scope of primary and community services
- **2.5m people** will benefit from social prescribing, a personal health budget, and support for managing their own health
- A **Same Day Emergency Care** model across all acute hospitals, increasing the proportion of same day discharge from a fifth to a third
- A new **clinical assessment service** will be set up as the single point of access for patients, carers and health professionals
- Reforms to diagnostic services including investment in **CT and MRI** scanners

Digital care

- People will be able to switch from their existing GP to a **digital first provider**
- Everyone in England will have access to a **digital first primary care offer** e.g. online or video consultations by 2022/23
- Expansion of online consultations in secondary care to avoid **a third of all outpatient appointments** within five years
- All trusts must move to **full digitisation** by 2024
- By 2021/22, all ICSs to have a **chief clinical information officer** and a **CIO**
- Introduction of a new **digital front door**

Improving health and care

Building the foundation

Workforce

- Potential introduction of formal **regulation of senior NHS managers**
- Introduction of a **NHS leadership code** which will set out the cultural values and leadership behaviours of the NHS
- More doctors will be encouraged to train as **generalists**
- **Flexible rostering** will become **mandatory** across all trusts
- New **entry routes** supported: apprenticeships; nursing associates; online qualification; and 'earn and learn' support
- **£2.3m** investment to double volunteers

Finance

- **3.4%** funding growth over next **five years**
- Increasing funding for **primary and community care** by **£4.5b** and **mental health care** of **£2.3b** more a year
- Worst financially performing NHS trusts will be subject to a NHS Improvement-led **accelerated turnaround process**
- **Finance Recovery Fund** to be set up, accessible to trusts with identified financial risks
- NHS expected to save **£700m** from admin costs in the next **five years** – (£290m commissioners and £400m from providers)

Structure

- England covered by **integrated care systems (ICS)** in **two years** – involving a **single CCG** for **each ICS**
- ICSs supported by **legal shared duties** and ability to **create joint committees** between CCGs and providers
- **Legislative change requested** to free commissioners from procurement rules and remove the role of the Competition and Markets Authority in NHS merger and acquisitions
- Exploration of opportunities to fund **public health services** through the NHS budget
- NHS England and NHS Improvement empowered to establish **joint committees**

NNUH Winter Plan

Highlight Report
January 2019

Winter Planning 2018/19

- Based upon learning from prior year and National best practice guidance and developed in conjunction with the wider Norfolk system
- 3 themes overarching an '8-Point Plan'
- Delivery risks mitigated by assuming a 'belt and braces', planned over-provision set of solutions at this early planning stage

Capacity

- Additional beds – Modular Ward Facility plus all beds open and reconfigured
- Creating a discharge suite to free up ward space earlier in the day
- Additional ED cubicles to eliminate ambulance congestion and delay
- Open an 'NNUH @ Home' Virtual Ward for sub-acute patients
- Extend OPED Opening hours

Leadership

- Senior Nurse, Doctor and Manager to 'Project Manage' winter and seconded support / senior EEAST staff member to the NNUH Winter Team

Process

- Reduce the length of stay for 'Super Stranded' patients (over 21-days in hospital) in accordance with latest national guidance
- Focus clinical & operational processes relating to discharge earlier in the day

8 Point Plan

Sept 18 → March 19

The plan is 80% implemented with all bar the NNUH@Home aspects of capacity in operation. The primary focus is to ramp up the process work streams, embed the Aylsham Suite and RATs functions and to urgently address the outstanding issues to progress NNUH@Home.

Additional support is being provided by NHSI via ECIST and the Improvement Directors/Urgent Care Regional Lead – this includes taking learning from other trusts. The intensity of system support has also been increased, which now includes daily Gold calls in addition to 2x daily silver ones

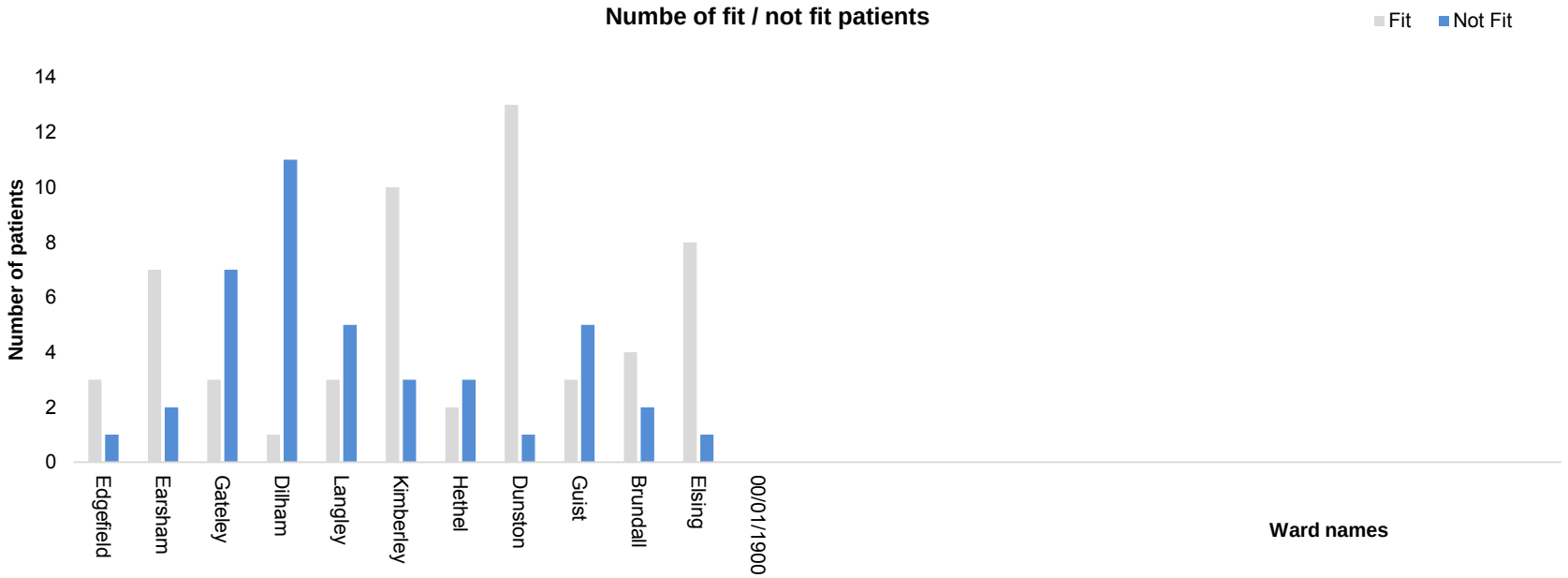
A

Theme	Progress	Risks	Mitigations	RAG
Capacity	The RATs cubicles and Aylsham Suite are both up and running. Daily evaluation is taking place to identify improvements and effectiveness but overall they are working as planned. All ward moves successfully completed. NNUH@Home – significant delays as due diligence needed to be completed. CQC registration now resolved and SOP signed off. Soft launch agreed, first 3 patients start on Wednesday 9th January. Recruitment issues remain – re advertising for coordinator post.	Discharge suite staffing – not all of the team have been released from the wards yet so there are some restrictions to opening hours and capacity. NNUH@Home – failed recruitment to the coordinator role restricting the volumes and start date	Discharge suite team will be fully operational by the end of the month Headhunting underway for the lead role – commencing a soft launch to test the processes	A
Leadership	Complete – full team in post, governance framework established and QIP launched on national portal	Nil	NA	C
Process	The escalation policy is still under monitoring but is being utilised with more frequent escalation and de-escalation during the course of the day. The new SOPs and processes e.g. for DPU and outlying are working effectively to better manage risk and flow. We have recently achieved 10 by 10 and improved flow to reduce exit block in ED and the assessment units. The weekly long stay reviews continue and the wards are starting to recognise the benefits as we are identifying a number of themes that are being followed up e.g. social services delays, funding issues and pathways like VAC dressings. The intensity of these reviews and improving red 2 Green/SAFER compliance is a key priority for the Winter Team as we failed to achieve the >21 day super stranded trajectory reduction to 88 patients (currently 106)	Delivery of the national 25% reduction of super stranded patients	Re-focus resources to support R2G and introduction of new discharge checklists	A

Complete / closed | On target | At risk | Missing target

Weekly Long Stay Review Summary (#TimelyTuesday)

Number	Reason	Number
1	F17 Waiting for external agency assessment – social care/MH/RH/NH	17
2	F16 Waiting for internal assessments/results before discharge agreed	15
3	NF5 Intravenous therapy – ask if it can be given elsewhere (ambulatory or in the community)	14
4	F11 Ready for home today – ask whether they are confident nothing will stop discharge	10
5	NF2 Active ongoing clinical treatment non-specific and not as sick as category NF4	9
6	F14 Discharge planned for tomorrow - what is stopping them going today?	6
7	NF7 Requiring clinical intervention that can only be provided in hospital	5
8	NF3 Waiting for internal test, specialist opinion or similar	4
9	F8 Waiting for patient/family choice or input to decision-making	3
10	F18 Waiting for start or restart of domiciliary care package – long-term packages	3



Subject:	Demand and Capacity – next steps following BCG report
Presented by:	Julie Cave, Interim Chief Operating Officer, Norfolk and Waveney STP
Prepared by:	Julie Cave, Interim Chief Operating Officer, Norfolk and Waveney STP
Submitted to:	STP Executive on 18th January 2019

Summary:

Background

1. The Boston Consulting Group review of demand and capacity reported to the STP Executive in December 2018. It concluded that the STP has key challenges, being:
   i. A growing and ageing population
   ii. Primary care working to capacity, with a shrinking GP workforce;
   iii. Acute inpatient bed capacity cannot meet demand;
   iv. Community services cannot meet demand from acutes;
   v. Social care DToCs are high and there is a lack of home care capacity;
   vi. The system has significant financial challenges.

2. The review highlighted that
   i. Demand and capacity is mismatched and could result in a 500 bed deficit by 2023 in a 'do nothing' scenario.
   ii. Current system issues cannot be addressed by any single provider. Collective interventions across the system could create a sustainable position.
   iii. Even given the potential solutions within the review it is estimated that there will be a shortfall of 140 beds so further capacity / new models of care will be required.

3. Representatives from the three acutes plus STP met on 16th January to propose next steps in taking forward the recommendations from the review.

Next Steps

4. The demand and capacity issues could potentially be covered by any one of three work streams, being Acute Transformation, Urgent & Emergency Care and Primary & Community Care. However the issues fall across the whole system and none of those work streams can cover the whole problem.

5. As such the group recommends that a new Demand & Capacity work stream is established with senior director level representation from across the acutes, community, social care and primary care. These representatives should also cover one of the three work streams, as above.

6. Whilst much work has been done in recent years to address the capacity shortfalls this has largely been fire-fighting with little strategic thinking on how we can address the issues in the longer term across the whole system. The Demand & Capacity work stream will establish a short, medium and long term plan with a significant part of its work to focus on the longer term strategy.

7. The links to the other work streams will mean that those work streams may undertake actions in relation to demand and capacity and report back to the Demand & Capacity programme as appropriate.

8. The Demand & Capacity Programme Board will be led by a programme director. It is the recommendation from the group that the Director of Strategy at JPUH undertakes this role.

9. Proposed membership should consist of:
   i. Acute representation: as a minimum, director of strategy & medical director.
   ii. A representative from NCHC & ECCH.
   iii. Clinical representation from GP Provider Organisations (GPPOs).
   iv. Social care representation.
   v. A commissioner.
   vi. Financial representation (CFO from West Norfolk CCG)
   vii. STP COO.

   Task and Finish groups will lead individual pieces of work as required and membership will be sought from appropriate organisations across the system.

10. The Programme Board will consider all the recommendations within the BCG review and report back on our response to each. The plans will build upon the new models of care that are currently being planned. The recommendations will drive the work plan and strategic direction.

Recommendation:
The STP Executive is asked to approve the approach to the next steps, including the establishment of a new work stream which will report to the STP Executive.

REPORT TO THE TRUST BOARD	
Date	**25/01/2019**
Title	**Draft Quality and Safety Improvement Strategy**
Author & Exec Lead	**Head of Patient Safety Improvement Barbara Hercliffe** **Chief Nurse Nancy Fontaine**
Purpose	**For Information/Discussion**

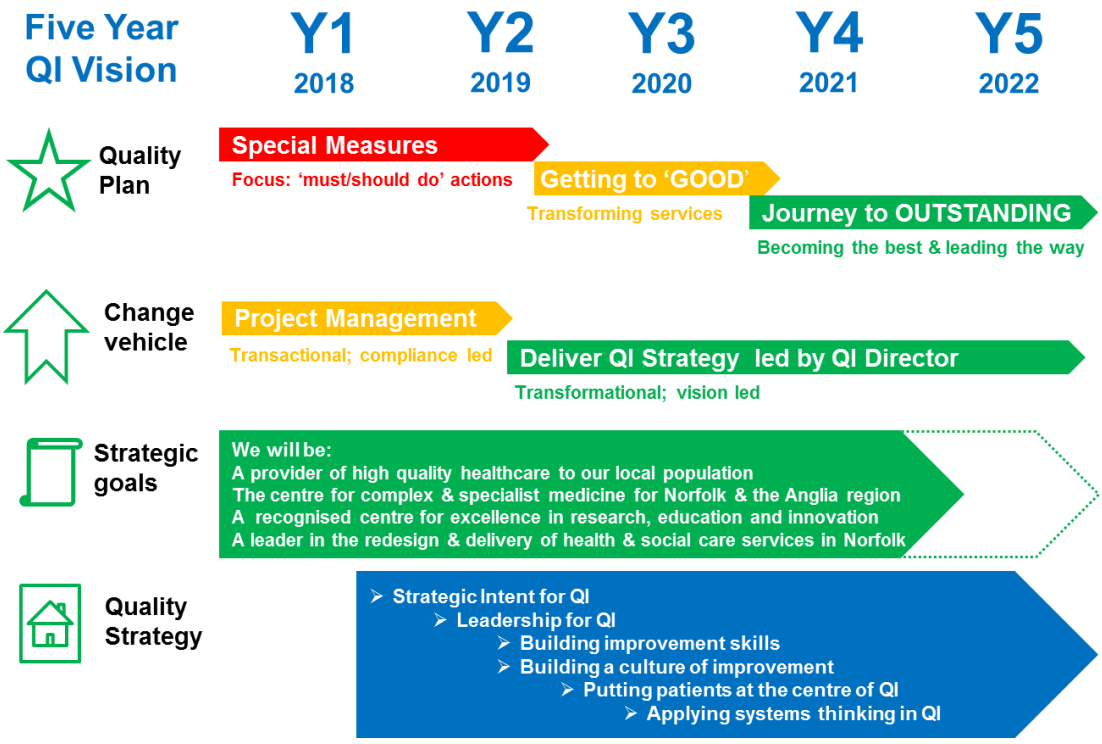
Background/Context

- Our Quality Improvement Plan is focused on the immediate priorities arising from the 2018 Care Quality Commission inspection and in setting the baseline from which to develop our longer-term objectives and priorities.

- Our Quality and Safety Improvement Strategy is just as explicit. It describes a five-year forward view of quality improvement and sets out how we will define, improve and assure the quality of our services and supports our 'journey to outstanding'.

- It aims to give our staff a clear focus and reflects the importance and commitment the Trust Board places on the quality of care and the requirement to continually learn and improve to meet the evolving demand and expectation of our patients and staff.

Fig 1.0 Quality Strategy Five year Vision

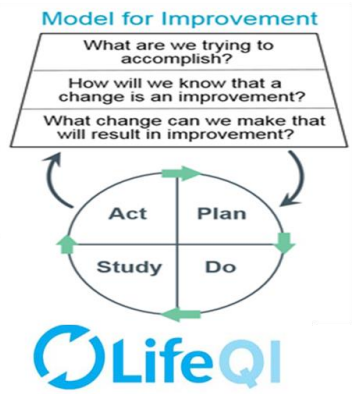


- This strategy describes the Trust's intent to embed a systematic and effective approach to Quality Improvement and create a culture of continuous improvement and learning which is both patient centred and safety focused.
- We will achieve this by addressing the following elements depicted in Fig 1.
  - Strategic intent for QI.
  - Putting patients at the centre of QI.
  - Leadership for QI.
  - Building improvement skills at all levels.
  - Building a culture of improvement.
  - Applying systems thinking in QI activity.

Fig 1.

Quality and Safety Improvement Strategy
"Supporting our Journey to Outstanding"

Our **Quality and Safety Improvement Strategy** describes our strategic intent for Quality Improvement (QI) and sets an ambition to build a culture of learning and continuous improvement at all levels



- Our **staff will feel empowered** to be creative and innovative, always looking for ways to improve their services and the care provided.
- Our **leaders create the conditions and commitment to QI** that is shared across the organisation
- The **focus on quality and safety first** will be a consistent part of our culture, **from ward to Board**

We will build the capacity and capability for improving quality and safety

- Using the **Model for Improvement** and **Life QI** platform to deliver improvement projects.
- Everyone from the Board to the frontline will have the ability to contribute.

Patient Safety will be underpinned by three principles:

- a just culture
- openness & transparency
- continuous improvement

We will design **safer systems** by:

- Learning from incidents
- Addressing Human Factors
- Risk management
- Enhancing what goes well

Our patients will be at the centre of QI and will be involved as true and equal partners.

- We will welcome **authentic patient partnership** – in their own care and in the processes of designing and delivering care.
- This will include participation in decision-making, goal-setting, care design, quality improvement, and the measuring and monitoring of patient safety.

Sharingthelearning

Updating you on the Trust's quality improvement projects

- It describes the approach to develop the capacity and capability for improvement so that QI becomes a frontline activity where staff listen to patients and implement changes that make a real difference to patient care.

Defining what Quality means to us.

- It is important that when we talk about quality there is a shared meaning which every one of the 7,500 people who work in the Trust can relate to in their day to day jobs supporting patients or supporting the teams who provide the care.
- Our definition of quality encompasses three equally important elements of care, safe, effective, and patient experience.
- Our quality improvement strategy uses these as a basis but takes this further by focussing on continual learning and improvement and supports the organisational vision ***'to provide every patient with the care we want for those we love the most'.***

Our Quality Priorities

- The strategic priorities within the strategy are aligned to those described in the Trust's Quality Report, Quality Improvement Plan and the Care Quality Commission's (CQC) domains of safe, effective, caring, responsive, and well-led.

- We are consulting on our key quality priorities for 2019–2020 and the final indicator set selected will include:
    - at least three indicators for patient safety
    - at least three indicators for clinical effectiveness and
    - at least three indicators for patient experience.
- Given the pace and breadth of change within the NHS, it is important to review strategy on a yearly basis to ensure it remains fit for purpose.

Next steps

- We want to hear from our staff , service users and stakeholders to gain feedback on the Quality Strategy
- Run engagement sessions to identify and propose Quality priorities for 2019- 2020.
- Carry out gap analysis and implement actions to evidence all elements of a mature quality improvement approach across the organisation as described in the CQC maturity model attached as appendix 1.

Recommendations:
The Board is recommended to: review and comment.

Appendix 1 Self assessment : CQC Well Led Domain: Quality, innovation and sustainability

Signs that a Quality improvement approach is not present	Y/N	Signs of a developing approach to quality improvement across the organisation.	Y/N	Signs of a mature Quality Improvement approach across the organisation	Y/N
Absence of quality strategy available on the Trust website and intranet		A quality strategy that mentions quality improvement		Quality Strategy available on website and intranet that explicitly mentions quality improvement and sets the organisation's quality improvement goals	
Board agenda and minutes demonstrate prioritisation of finance, performance and other issues over quality		Presence of a central team that leads the provider's quality improvement approach		Quality appears to be the priority at the Board, from agenda and minutes with a specific report on quality that is accessible publicly	
Absence of clinical leadership role focused on QI across the organisation		A small proportion of people across the organisation have been trained in quality improvement		The Board looks at data as time series analysis, and makes decisions based on an understanding of variation.	
People providing care state that the organisation is more focused on money or delivering externally imposed targets than quality of care		Minimal, distant or infrequent support available to teams using QI to solve quality issues		Clear and consistent improvement method for the organisation, and demonstrable across all areas/ operations of the organisation	
Poor level of staff engagement, satisfaction or confidence in their ability to improve care.		Evidence that a few teams or projects that have delivered sustainable improvements through the application of quality improvement, but these remain isolated hotspots		Presence of a central team dedicated to supporting quality improvement, with expertise in the improvement method and tools.	
		A small proportion of people across the organisation are able to describe the Trust's quality improvement approach, their involvement in it or the difference it has made		Plan for building improvement skills at all levels of the organisation, with a large proportion of the organisation (and at all levels) having developed improvement skills.	
		Lack of a single quality improvement method and language across the organisation.		Structures in place to oversee quality improvement work, with multiple executive directors involved in regular provider-level overview	
				Robust and regular and local support in place across all areas of the organisation to support teams using QI to solve complex quality issues	
				Quality improvement work across the organisation demonstrates alignment – projects at team level align with strategic objectives	
				Demonstrable use of measurement on a routine basis	

Signs that a Quality improvement approach is not present	Y/N	Signs of a developing approach to quality improvement across the organisation.	Y/N	Signs of a mature Quality Improvement approach across the organisation	Y/N
				to monitor progress of QI work against outcomes and ensure sustained improvement.	
				All executive team and clinical leaders are able to talk about their role in leading quality improvement, supporting teams in their quality improvement work	
				A majority of staff across multiple areas of the organisation and from a variety of backgrounds are able to talk about the provider's quality improvement approach, how they have been involved and the difference it has made.	

REPORT TO THE TRUST BOARD

Date	**25th January 2019**
Title	**Quality Programme Board update following 8th January meeting**
Author **Exec lead**	**Jane Robey, Head of Improvement** **Nancy Fontaine, Chief Nurse**
Purpose	**For Information**

1 Background/Context

The Quality Programme Board met on 8th January 2019.

The following documents are attached:

a) Agenda
b) Evidence Group Outcome Report
c) Risk Register

2 Key Issues/Risks/Actions

Items of note considered at the meeting included:

	Issues considered	Outcomes/decisions/actions
1	Highlight reports from exec and functional areas	In December, of the 82 Must do & Should do actions, we have : • 20 (29%) Blue • 10 (15%) Red • 13 (19%) Amber • 25 (37%) Green
2.	Change control	Ten new recommendations were added to the action plan in respect of the December review of the Section 29a notice. The Trust's response letter to the request for factual accuracy review was submitted to the CQC on Monday 7th January in accordance with the agreed deadline.
3.	Outcome of the Evidence Group	• The Evidence Group met on 27th December, to review the evidence in respect of twelve recommendations. At the meeting, ten of the twelve recommendations submitted were agreed as BLUE. • It was agreed at the meeting that the 10th January meeting will review all of the action plans put in place to address the Section 29a CQC requirements. A second meeting will also be held on 17th January.
4.	Risk register	One new risk (number 9) was added to the register in advance of the January QPB; it was agreed at the meeting that this risk should be removed.

3 Conclusions/Outcome/Next steps

The Quality Programme Board is scheduled to meet again at 9am on Tuesday 12th February 2019, at which meeting the Committee will review:

- Highlight reports from Trust-wide and functional areas for January.
- Recommendations assured as 'Complete and Evidenced' by the 10th and 17th January Evidence Groups

Recommendation:

The Board is recommended to note the work of its Quality Programme Board.

QUALITY PROGRAMME BOARD AGENDA

Tuesday 08th January 2019 Boardroom 0900-12:00 Hours

	Item	Lead	Purpose	Format
1.	Apologies and declarations of interest	CEO		Verbal
2.	Review of actions, minutes and matters arising	Exec Directors and CODs	To note and discuss	Document
3.	OAG Deep Dives	CEO	Discussion	Verbal
4.	Outcome of Evidence Group	Rosemary Raeburn Smith	Discussion	Document
5.	Highlight reports from Trust-wide and functional areas, focusing on: - Blue recommendations (complete and evidenced) - Red recommendations (Off track) Any successes or concerns that SROs wish to particularly highlight	Exec Directors and CODs	To note and discuss	Slide presentation
6.	Risks and issues	CEO	Discussion	Document
7.	AOB			

Date and Time of next meeting: Tuesday 12th February 2019, 09:00 hours, Boardroom

2019 dates: (all 09:00 until 12:00 in the Boardroom)
March 12th
April 9th
May 14th
June 14th
July 9th
August 13th
September 13th
October 8th
November 12th
December 10th

REPORT TO THE QUALITY PROGRAMME BOARD	
Date	**27th December 2018**
Title	**Outcome of Evidence Group**
Author & Lead	**Stacy Hartshorn** **Rosemary Raeburn Smith**
Purpose	**For Information**

1 Background/Context

The third QIP Evidence Group met on 27th December, to review the evidence in respect of twelve recommendations. The Agenda, Terms of Reference and Evidence Reports presented at the meeting are attached.

The group reviewed the evidence for suitability, relevance, and completeness, using an appreciative enquiry approach, assessing if the evidence supplied by the SRO and action leads provided sufficient assurance that the Recommendation and Outcome Statement has been met.

2 Outcome

For ten of the twelve recommendations, the group agreed that there was sufficient evidence to categorise the recommendation as BLUE (complete and evidenced). In respect of the remaining two recommendations, the group provided guidance as to the additional evidence required and offered suggestions how this could be achieved. These recommendations will be brought back to future meetings, when the supplementary evidence will be reviewed.

3 Conclusions/Outcome/Next steps

The Committee is scheduled to meet again at 8.30am on January 10th 2019, at which meeting the Committee is due to consider:

- New blue recommendations
- Bring back actions from previous evidence groups

Recommendation:

The Quality Programme Board is asked note the work of its Evidence Group.

1.1 Persons in attendance

The following people attended the meeting:

- Nancy Fontaine (NF), Chief Nurse NNUH
- Erika Denton (ED), Medical Director, NNUH
- Gemma Lynch (GL), Governance Compliance Manager, NNUH
- Jeremy Over (JO), Director of workforce, NNUH (For TW8.1 and TW10.1)
- Jane Robey (JR), Head of Improvement Team, NNUH
- Stacy Hartshorn (SH), Improvement Manager, NNUH
- Abbe Swain (AS), Improvement Manager, NNUH
- Jess Woodhouse (JW), Improvement Manager, NNUH
- Andree Glaysher, Governance Lead Medicine, NNUH

2.1 Review of minutes and actions

The Minutes were accepted as a true reflection of the previous meeting. Action updates below

Ref.	Action Updates in Red	Status	Owner

U1.1 & U8.1	• Ensure there is audited evidence of compliance with ED Floor co-ordinators checklists in respect of:
	  • Cleaning of clinical equipment
	  • Resus trolleys
	  • Cleaning of Toys
		Open	SH

	• Ensure that the mental health risk assessment is signed off at January medical Divisional Board	Open	SH
	• Evidence group to carry out a site inspection on November 29th and write a report to confirm that all works have been completed, and add to evidence repository. JF was nominated by the group to conduct this inspection. Complete JF Review U1.1 and U8.1 ED.docx	Closed	SH/JF
U3.1	• Ensure that the ChED SOP has a Trust Docs ID 14681 – uploaded – complete.	Closed	SH
U11.1	• Distribute this Audit Briefing to all governance leads and nurse leads, and to Stuart Williams and Amanda Williamson GL to ensure this has been distributed	Open	KK GL
	• Improve the documentation of audits reviewed in line with guidance which will be provided via KK.	Open	KK
DI1.1	• Glynis Wivell to provide get WHO compliance figures to Joel Fiddy Complete	Closed	GW
	• Audits to be completed weekly rather than monthly to provide a reasonable denominator. Need evidence to review next meeting	Open	JG
	• Noted that WHO debriefs could be improved within Radiology and to be reviewed Need evidence to review next meeting	Open	JG

	• Radiology has LOCSSIP checklists which are locally referred to as WHO checklists incorrectly. The forms need to be changed to reflect their true name and purpose. Suggested name is ambulatory WHO checklist. JW confirm with KK	Open	JW
	• To review which procedures should be WHO and which should be LOCSSIP and provide an SOP to identify which checklist should be used which each procedure wherever it takes place.	Open	JW/ Angela Adams
DI2.1	• Ensure the area of the CQC report is included in the evidence overview Complete	Closed	JW
	• Enquire into action plan to address training compliance gaps Complete	Closed	JW
DI6.1	• A robust plan is required for replacing capital equipment. NF and ED to discuss with Simon Hackwell. Complete	Closed	NF/ED
	• To review if the business continuity plans have been enacted during any instances of equipment failure.	Open	JW
	• Clarify how items are added to the 2018/19 capital programme, who is responsible for this and how the risk level is assessed Complete	Closed	KK
	• ToR for Capital Committee to be added to repository.	Open	JW
	• Review rolling capital programmes for other Trusts who have outstanding practice and what areas of best practice we could use. Complete	Closed	JW
TW28.1	• JF to provide evidence on better waste management in theatres Complete	Closed	JF
	• Sharp bin checks to be added to QAA Complete	Closed	KK
DI3.1	• Group requested that the works schedule for the permanent solution was added to the repository. Not complete, to bring back on 10th January	Open	JW
DI4.1	• Evidence of the 3 radiology support workers starting in January along with details of their extended HCA training to be added to the repository	Open	JW
TW6.1 & 6.2	• Reviewed "good when" statement. Agreed to remove original wording and replace with suggested revised wording. In addition the group agreed that the statement should include a requirement to evidence that we are following our policies correctly. Complete	Closed	SH
	• The group requested that the checklist for opening escalation areas and some completed examples should be added to the evidence repository.	Open	SH
	• The group requested evidence that staff feel the new	Open	AR via SH

	processes are safe and that staff feel supported. The Group asked Aiden Rice to review this. • The group requested evidence on the number of whistle blows for safety within escalation, as they would expect this number to decrease. • To change wording from mothballed to vacant. • To bring back in January 2019. Bought back 27th December	Open Open Closed	SH SH SH
TW29.1	• The internal target for complaints within 25 days must be increased from 50% to 100%. Complete – AS to add to ERep • NF to escalate the need to change the target and also the complaint timeline to the executive board for review. The group felt that complaints should be handled in a similar was to RCAs. Complete	Closed Closed	NF NF
TW25.1	• Committee minutes to be added to repository Complete	Closed	JW
General	• The group was satisfied that all recommendations bought were appropriate and that the level of scrutiny was a positive example of good governance. Complete	Closed	

3.1 Outcome of evidence reviews

Ref.	Recommendation	Outcome of Review
DI6.1	Ensure that Diagnostic Imaging equipment remains fit for use through the implementation of a capital replacement programme.	Blue – review in 2 months
TW 2.1	The trust must review the knowledge, competency and skills of staff in relation to the Mental Capacity Act and Deprivation of Liberty safeguards.	Blue – review 17th January
TW 6.1	The trust must review the bed management and site management processes within the organisation to increase capacity and flow and ensure effective formalised processes are in place to ensure patient safety in all escalation areas.	Blue review in January
TW 8.1	Review process for whistleblowing and take definitive steps to improve the culture, openness and transparency throughout the organisation.	Blue – review in 6 months
TW 10.1	Ensure consistent processes are in place for recruitment, fit and proper persons' regulation and line management at executive level.	Blue – review in 9 months
TW 14.1	The trust must ensure staff compliance improves for major incident training	Not complete
TW 15.1	The trust must ensure that oxygen cylinders are stored safely, that oxygen is readily available in all patient areas, and that this equipment is properly maintained.	Blue – review in February 2019

TW 25.1	The trust must ensure that equipment is maintained and fit for use	Blue – review in March 2019
TW 34.1	The trust should ensure that staff carrying out Root Cause Analysis (RCA) investigations for serious incidents receive appropriate RCA training	Blue – review in March 2019
TW 36.1	The trust should review its communication aids available to assist staff to communicate with patients living with a sensory loss, such as hearing loss	Blue – review in March 2019
TW 13.1	The trust must ensure that there are effective systems and processes in place to ensure assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are healthcare associated.	Blue – review in January 2019
TW 31.1	The trust should ensure that specialist personal protective equipment is checked on a regular basis and worn appropriately by staff	Not complete

4.1 OPEN Actions

Ref.	Action	Owner

U1.1 & U8.1	• Ensure there is audited evidence of compliance with ED Floor co-ordinators checklists in respect of:
	  • Cleaning of clinical equipment
	  • Resus trolleys
	  • Cleaning of Toys
	• Ensure that the mental health risk assessment is signed off at January medical Divisional Board
		SH
		
		SH

U11.1	• Distribute this Audit Briefing to all governance leads and nurse leads, and to Stuart Williams and Amanda Williamson GL to ensure this has been distributed • Improve the documentation of audits reviewed in line with guidance which will be provided via KK.	KK GL KK
DI1.1	• Audits to be completed weekly rather than monthly to provide a reasonable denominator. Need evidence to review next meeting • Noted that WHO debriefs could be improved within Radiology and to be reviewed Need evidence to review next meeting • Radiology has LOCSSIP checklists which are locally referred to as WHO checklists incorrectly. The forms need to be changed to reflect their true name and purpose. Suggested name is ambulatory WHO checklist. JW confirm with KK • To review which procedures should be WHO and which should be LOCSSIP and provide an SOP to identify which checklist should be used which each procedure wherever it takes place.	JG JG JW JW/ Angela Adams
DI6.1	• To review if the business continuity plans have been enacted during any instances of equipment failure. • ToR for Capital Committee to be added to repository.	JW JW
DI3.1	• Group requested that the works schedule for the permanent solution was added to the repository. Not complete, to bring back on 10th January	JW

DI4.1	• Evidence of the 3 radiology support workers starting in January along with details of their extended HCA training to be added to the repository	JW
TW6.1 & 6.2	• The group requested that the checklist for opening escalation areas and some completed examples should be added to the evidence repository. • The group requested evidence that staff feel the new processes are safe and that staff feel supported. The Group asked Aiden Rice to review this. • The group requested evidence on the number of whistle blows for safety within escalation, as they would expect this number to decrease. • To change wording from mothballed to vacant. • New action: Replace the escalation policy with final version	SH AR via SH SH SH SH
DI6.1	• New action: JW add in committee minutes discussing Capital replacement programme plan and risk assessment	JW
TW 2.1	• New action: First 2 documents need re-embedding. • New action: Future actions need to be added to Trust QIP plan	GW GW
TW 8.1	• New action: JO to review wording for "good when" statement three and replace all with a suitable target. • New action: JO to add in leading with PRIDE training • New action: JO to add in evidence for 2019 ongoing training. • New action: JO to add whistleblowing policy	JO JO JO JO
TW 14.1	• New action: Training records must be made available centrally rather than at departmental levels.	JW/SH/JR
TW 15.1	• New action: Copies of completed checklists to be added to the evidence repository.	JW
TW 25.1	• New action: Need to include an example of an area audit to ensure they have all their assets on eQuip	JW
TW 34.1	• New action: Include detail regarding joint investigations within Evidence	GL to discuss with KK
TW 36.1	• New action: Communication to staff of AbleAssist App	AS
TW 13.1	• New action: A compliance audit should be included as evidence to show that our policy and processes are effective.	AS
TW 31.1	• New action: FIT testing training needs to be prioritised in ED, Hethel, Mulbarton and Mattishall (now Gunthorpe).	JW

5.1 Date and Time of Next Meeting

Thursday 10th January 08:30 – 10:00 Board Room - Section 29a focus
Actions requested to bring back:-
U1.1 and 8.1
U3.1
U11.1

Thursday 17th January 08:30-10:00 Board room
Actions requested to bring back:-
TW27.1
TW13.1
TW6.1
TW2.1

Thursday 7th February 09.00 – 10:00 Holkham Room
Actions requested to bring back:-
TW15.1

March Evidence group
Actions requested to bring back:-
DI6.1
TW25.1
TW34.1
TW36.1

June Evidence group
Actions requested to bring back:-
TW8.1

September Evidence group
Actions requested to bring back:-
TW10.1

QIP Risk and Issues Log

								Unmitigated				Mitigated		
Risk No.	Risk	Project	Raised By	Date Raised	Owned By	Description	Status	Consequence (1-5)	Likelihood (1-5)	Score (1-25)	Measures currently in place to manage the risk	Consequence	Likelihood	Score
1	If there is insufficient executive capacity to drive improvement our improvement will not gain the necessary traction	Overall	CEO	07/08/2018	CEO	The Trust's strategic and operational agenda is challenging; therefore it is possible that executive directors and chiefs of division will find it difficult to release time to drive the improvements required to meet the CQC recommendations	Open	5	3	15	Discussion to be held at QIP Board about capacity and resources required to deliver, and consideration of the Trust's short and medium term priorities	5	2	10
2	If pressures within the hospital place competing priorities on staff it could lead to staff finding it difficult to engage with the quality improvement plan	Overall	CEO	07/08/2018	CEO	Staff are feeling under pressure and therefore may feel a little change fatigue and be concerned that their efforts may not make any difference	Open	4	4	16	Staff engagement plan needs to be developed	4	2	8
3	If there is insufficient capacity within individual roles within divisions, services and functions to undertake additional activity to drive the QIP, improvement may not proceed at pace	Overall	CEO	07/08/2018	CEO	Individual staff across the Trust will be required to undertake activity to drive forward the improvement work; it is likely that those staff do not have current capacity within their role	Open	4	4	16	Executive leads will need to consider the capacity required within the workforce to deliver the plan.	4	3	12
4	If the Trust's financial position remains challenged and the QIP requires more resources (recurrent and non recurrent) than the Trust has currently allocated, this will either add to the Trust's CIP or starve the QIP of needed resource	Overall	CEO	07/08/2018	CEO	It is possible that in order to provide the capacity and/or expertise required to deliver the plan the Trust will need to buy in additional people ; it is also possible that the sustainable solution to some of the quality challenges requires significant recurrent additional investment	Open	5	4	20	Significant financial involvement in the development of the plan and its delivery to ensure that costs in excess of provision can be mitigated	5	3	15
5	If the Trust's focus on quality and the operational challenges reduces the focus and attention on the systems of financial control and delivery of the CIP, this could lead to a worsening financial position	Overall	CEO	07/08/2018	CEO	The Trust's financial position is challenging and requires considerable attention to ensure the Trust delivers the financial plan. With the addition of significant quality pressures to address, there's a danger that the good work that has been achieved with finance starts to slip through lack of capacity to maintain the current level of focus	Open	5	4	20	The trust will need to consider the capacity it requires to deliver both financial and quality improvement	5	3	15

QIP Risk and Issues Log

								Unmitigated				Mitigated		
Risk No.	Risk	Project	Raised By	Date Raised	Owned By	Description	Status	Consequence (1-5)	Likelihood (1-5)	Score (1-25)	Measures currently in place to manage the risk	Consequence	Likelihood	Score
6	If the wrong actions and metrics have been selected the desired outcomes may not be achieved.	Overall	Head of Improvement	04/09/2018	Head of Improvement	The 60 'must do' and 22 'should do' recommendations are underpinned by supporting actions. Completion of these actions by the deadline could lead to false assurance that the aims of the recommendation have been addressed when, in reality, further work is required to ensure that the necessary changes have been embedded and could be articulated by staff.	Open	5	4	20	The Improvement Team is working with action owners and teams to amend actions and metrics to ensure that they are SMART and outcome focused. The revised actions/metrics should then provide greater assurance that the necessary changes will be properly embedded, fully understood by staff, and could be articulated by all members of the front line teams.	5	2	10
7	If action owners do not send their updates to Information Services in good time, or if the data source is inaccurate, incomplete or poor quality, IS will not be able to provide robust management reports, and monitoring of progress will be compromised	Overall	Chief Nurse	09/10/2018	Pete Best	Good quality, timely, relevant data is necessary to enable monitoring of progress towards achieving the recommendations. If this is not forthcoming, remedial action may be delayed and key milestones may be missed.	Open	4	4	16	Information Services is working with the Improvement Team to identify data providers for each of the agreed metrics. IS have a data collection proforma and a tried-and-tested process for requesting timely updates (which works well for the IPR). This process includes escalation triggers and named escalation routes if data submission dates are missed.	4	2	8
8	If the reporting interface is changed from slide pack format to live dashboard format in January, just prior to the CQC inspection, this could confuse members of the QPB and reduce confidence in the assurance process	Overall	Rosemary Raeburn-Smith	15/11/2018	Nancy Fontaine	Clear, understood, and familiar reporting processes are essential for gaining assurance. Changing the reporting interface in the immediate run-up to the CQC inspection has the potential to cause confusion and erode confidence among members of the QPB, especially if reporting & data/comment collection timescales result in the reported data being disseminated too close to the January QPB to enable members to thoroughly review the information in advance of the meeting.	Open	3	4	12	If the data collection template is ready in time, the Improvement Team will attempt to parallel run the two reporting interfaces for the December Board, by producing a full Slide Pack (original reporting interface) and also contributing fully to the live dashboard (new reporting interface). An agenda item on the December QPB will clearly outline the new reporting process that members can expect in January.	3	3	9

QIP Risk and Issues Log

								Unmitigated				Mitigated		
Risk No.	Risk	Project	Raised By	Date Raised	Owned By	Description	Status	Consequence (1-5)	Likelihood (1-5)	Score (1-25)	Measures currently in place to manage the risk	Consequence	Likelihood	Score
9	If the resouce supporting the Medical Director's actions is not replaced when the current post holder leaves in January, the areas of the action plan assigned to the Medical Director will lose traction and risks, issues or loss of momentum may be overlooked.	Medical Director areas	Jane Robey	12/12/2018	Medical Director	Dedicated support for each of the SROs is essential to ensure traction on the actions and to provide assurance that risks, issues etc. are being highlighted in a timely manner and brought to the attention of the QPB. The person supporting the Medical Director is leaving in January, and no replacement has yet been appointed. The Improvement Team is at full capacity and cannot support this workstream	Open	5	4	20	No resource has yet been identified to support this workload	5	4	20

REPORT TO THE TRUST BOARD

Date	**25 January 2019**
Title	**Quality and Safety Committee Meeting on 16.01.19**
Author & Exec lead	**John Paul Garside (Board Secretary) on behalf of Dr Geraldine O'Sullivan (Chair of Committee)**
Purpose	**For Information**

1 Background/Context

The Quality and Safety Committee met on 16 January 2019 and discussed matters in accordance with its Terms of Reference. The Agenda for the meeting is **attached**. Papers for the meeting have been circulated to all Board members for information in the usual way.

2 Key Issues/Risks/Actions

In addition to reviewing standard items in accordance with the Committee's Terms of Reference, items of note considered at the meeting included:

	Issues considered	Outcomes/decisions/actions
1	Focus on Winter Plan implementation and escalation (inc Ambulance Handover)	The meeting commenced with Committee members attending the daily 11.30 hours meeting in the Operations Centre, followed by a meeting with the COO & Winter Team. Committee members noted: • broad attendance by multi-disciplinary staff from across the Trust; • the meeting was conducted in an inclusive and respectful way, with opportunities for all staff to input; • there was a concise overview of the operational position across the hospital, with care taken to consider safety and staffing; • actions at the previous meeting were identified and followed up. Following the operational meeting there was designated time to review staffing across the hospital.
2	Movement of patients	The Committee discussed the availability of data to enable oversight of patient moves in the hospital – to safeguard against inappropriate decisions regarding movement of patients for non-clinical reasons. The Committee was informed that this is overseen by the Caring and Patient Experience Governance Sub-Board. Operational decisions are made at a very senior level with safeguards in place to ensure that the safety of patients is not compromised. Providing readily accessible reports so that the Board can gain assurance this remains a 'work in progress' and must remain as an action point.
3	Q&S extracts from BAF	The Committee discussed the Strategic Threats in the BAF relating to Strategic Objectives 1 and 2. The Committee considered whether these are effectively resolved or mitigated and could be removed as no longer requiring Board focus. It was **agreed** that they are all 'live' and should remain. They will be subject to ongoing review at the next Board Strategy Day (February 2019).
4	High Risk Tracker	Progress is being made in developing the High Risk Tracker. There are notable high risks relating particularly to equipment failure, but not to

		staffing numbers. The next Committee meeting will include focus on risk associated with equipment.
5	Safe Staffing	This Committee received an update on safe staffing to supplement the direct observation of the meeting held in the Operations Centre.
6	CQIA Update	Update from PMO, including details of schemes where approval was not granted – pending further information on risk mitigation or monitoring.
7	Sepsis update - Dr Mike Irvine (Consultant Anaesthetist)	Update received. The need for improvement in documentation is recognised but in practice the best rates are achieved by organisations who have an e-Obs System and this is a priority for investment.
8	Clinical audit	The Committee received an update on the Clinical Audit plan. For future reports the Committee has asked for increased focus on actions taken in response to any areas of shortfall identified by Audit.
9	Committee planning 2019	The Committee **agreed** to establish a cycle of divisional reports (similar to the F&I Committee) and commencing in February with the Division of Surgery.

3 Conclusions/Outcome/Next steps

The Committee is scheduled to meet again at 10am on 27 February 2019, at which meeting the Committee is due to focus particularly on:

- Specialty Focus – Surgical Division;
- Quality risks associated with equipment failure and replacement – as indicated by the High Risk Tracker;
- Terms of Reference, membership and Work Programme for the Committee.

Recommendation:

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

MEETING OF THE QUALITY AND SAFETY COMMITTEE

16 January 2019

A meeting of the Quality and Safety Committee will take place from 12.00 to 14.30 on 16 January 2019 in the Chief Executive's Office of the Norfolk and Norwich University Hospital

The meeting will be preceded by attending the Hospital Operational Meeting at 11.30 -12.00

AGENDA

	Item	Lead	Purpose	Page
1	Apologies and Declarations of Interest			
2	Minutes of meeting held on 29 November 2018 & matters arising		Approval & Discussion	1
3	Focus on Winter Plan implementation and escalation (inc Ambulance Handover Plan) - *Meeting with COO & Winter Team*	CC	Discussion	8
4	Q&S extracts from BAF (sections 1 & 2)	JPG	Discussion	23
5	High Risk Tracker	KK	Discussion	40
6	Matters referred from Quality Programme Board & update on Quality Improvement Plan	NF/ED	Discussion	47
7	Serious Incidents & Organisation-wide Learning (inc Selected SI RCA Report – subdural haematoma following fall – W132032)	KK	Discussion	59
8	Safe Staffing	NF	Discussion	95
9	CQIA Update	PMO	Information	109
10	Update on sepsis – Dr Mike Irvine (Consultant Anaesthetist) to attend at 13:15hrs	ED	Discussion	To follow
11	Clinical audit	KK	Information	116
12	Draft of Quality Strategy with 5 year QI plan	ED/NF	Discussion	To follow
13	Committee membership & 2019 planning	NF/ED		
14	Date and Draft Agenda for next meeting	Chair	Agreement	120
15	Reflections on the meeting	Chair	Discussion	verbal
16	Any other business			

Date and Time of next meeting:
The next meeting will be from 10am to 1pm on 27 February 2019 at the Norfolk and Norwich University Hospital

Integrated Performance Report

January 2019 (December 2018 data)

Core Slide 1 Quality and Safety Summary - Lead Directors Nancy Fontaine / Erika Denton

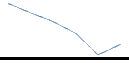
Quality & Safety		Target	July 2017 to June 2018	July 2016 to June 2017
Mortality	Core Slide 3			
1 SHMI*		N/A	107.64	106.52

Quality & Safety		Outturn 2017/18	Monthly Target	Dec-18	6 month trend	YTD 2017/18	YTD 2018/19
Mortality	Core Slide 3-4						
1 HSMR**			100	95.6			
2 Crude Mortality Rate***		5.07	n/a	3.04		5.07	3.73
Incidents	Core Slide 5-7						
3 Serious Incidents		138	n/a	16		95	131
4 Incident Reporting		17171	n/a	1813		12431	15544
5 Insulin errors causing NPSA category moderate harm or above		1	0	0		1	1
6 Medication Errors		1204	n/a	111		915	1116
7 Patient Falls causing moderate harm or above		33	n/a	4		28	18
8 Never Events****		7	0	0		5	4
Pressure Ulcers	Core Slide 8						
9 Grade 2 hospital acquired pressure ulcers		217	n/a	15		146	168
10 Grade 3 hospital acquired pressure ulcers		56	n/a	5		37	45
11 Grade 4 hospital acquired pressure ulcers		2	0	0		1	0
Infection Control	Core Slide 9						
12 HAI C. difficile Cases (excluding non-trajectory and pending cases)		11	0	0		9	7
13 Hospital Acquired MRSA bacteraemia		0	0	0		0	1
14 CPE screens taken		554	n/a	32		458	476
15 CPE positive screens		4	n/a	1		4	2
16 CPE screens of patients positive from other hospitals		0	n/a	0		0	1
17 E.coli trust apportioned		57	n/a	1		48	44
18 E. Coli community apportioned		311	n/a	25		249	231
19 Klebsiella trust apportioned		21	n/a	1		16	10
20 Klebsiella community apportioned		64	n/a	9		53	46
21 Pseudomonas trust apportioned		11	n/a	0		7	14
22 Pseudomonas community apportioned		32	n/a	2		25	24
Other							
23 EDL to be completed within 24 hours in 95% of discharges		76.72%	95.00%	77.40%		76.70%	77.00%
24 Harm Free Care		90.95%	n/a	96.50%		92.48%	88.46%
25 Patients 'extremely likely' or 'likely' to recommend our service to friends and family		96.73%	100.00%	96.59%		96.75%	96.38%
26 Complaints		890	n/a	62		636	775

* SHMI data is updated quarterly by NHS Digital
** HSMR data is the latest available and reported three months in arrears
*** Crude Mortality Rate is reported one month in arrears, in order to include deaths within 30 days of discharge from hospital
****Please note that (8)Never events are also included in the total for (3)Serious Incidents

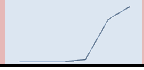
Core Slide 2

Quality Priorities – Patient Safety

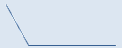
	Quality Priorities - Patient Safety	Measure	Lead	Outturn 2017/18	Monthly Target	Dec-18	6 month trend	YTD 2017/18	YTD 2018/19
1	Reduction in medication errors	Insulin errors causing NPSA category moderate harm or above	Erika Denton	1	0	0		1	1
2	Prompt recognition and treatment of sepsis*	% of Sepsis patients screened	Erika Denton	86.17%	90.00%	72.00%		87.11%	80.00%
		% of Sepsis patients treated	Erika Denton	92.61%	90.00%	92.21%		92.67%	92.53%
3	Keeping patients safe from hospital acquired thrombosis	95% compliance with TRA assessment as evidenced on EPMA. (and audit of appropriate actions)	Erika Denton	98.93%	95.00%	98.80%		98.94%	98.88%
4	Incident reporting and management	NNUH duty of candour compliance	Erika Denton	99.48%	100.00%	80.00%		99.31%	88.74%

*Reported in arrears – current value is for September 2018

Quality Priorities – Patient Experience

	Quality Priorities - Patient Experience	Measure	Lead	Outturn 2017/18	Monthly Target	Dec-18	6 month trend	YTD 2017/18	YTD 2018/19
1	Treat Patients with privacy and dignity	Patients 'extremely likely' or 'likely' to recommend our service to friends and family	Nancy Fontaine	96.73%	100.00%	96.59%		96.75%	96.38%
2	Improved continuity of care and experience through reduced ward moves and reduced numbers of outliers	No more than 20 patients recorded as boarders. Monthly average	Chris Cobb	42.65	20.00	41.00		42.65	24.40
3	Improved discharge processes	EDL to be completed within 24 hours in 95% of discharges	Chris Cobb	76.72%	95.00%	77.40%		76.70%	77.00%

Quality Priorities – Clinical Effectiveness

	Quality Priorities - Clinical Effectiveness	Measure	Lead	Outturn 2017/18	Monthly Target	Dec-18	6 month trend	YTD 2017/18	YTD 2018/19
1	Keeping patients safe from infection	HAI C. difficile Cases (excluding non-trajectory and pending cases)	Nancy Fontaine	11	0	0		9	7
2	Keeping patients safe from infection	Hospital Acquired MRSA bacteraemia	Nancy Fontaine	0	0	0		0	1
3	Improve quality of care through research	Year on year increase in patients recruited into research studies. Aim to recruit 5000 into research studies in 2016-17.	Erika Denton	3500	417	156		2709	3828
4	Timely medical review of all patients	Average number of patients with LoS >14 days	Chris Cobb	196.6	200	176		196.6	185.4

Core Slide 3

Mortality Dashboard - Inpatient Monitoring

Crude Mortality	
Month	Rate
Jul-18	3.80%
Aug-18	3.28%
Sep-18	3.34%
Oct-18	4.01%
Nov-18	3.49%
Dec-18	3.04%

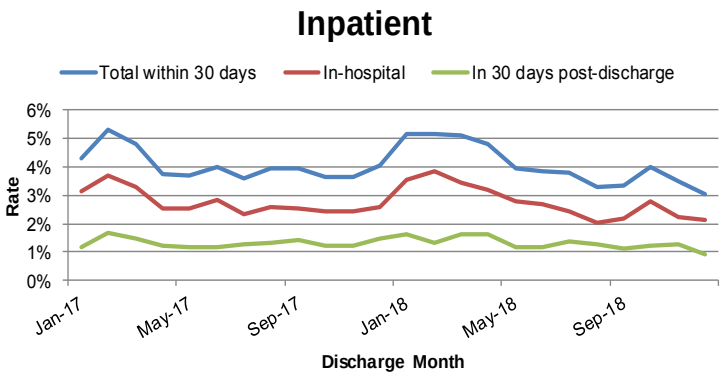
(Crude Mortality is reported one month in arrears)

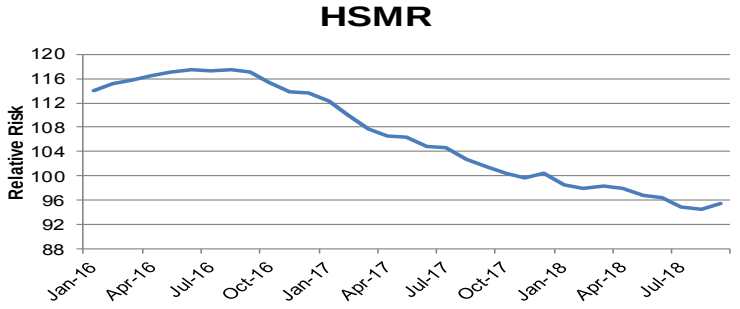
HSMR	
Jul-18	94.92
Aug-18	94.51
Sep-18	95.58

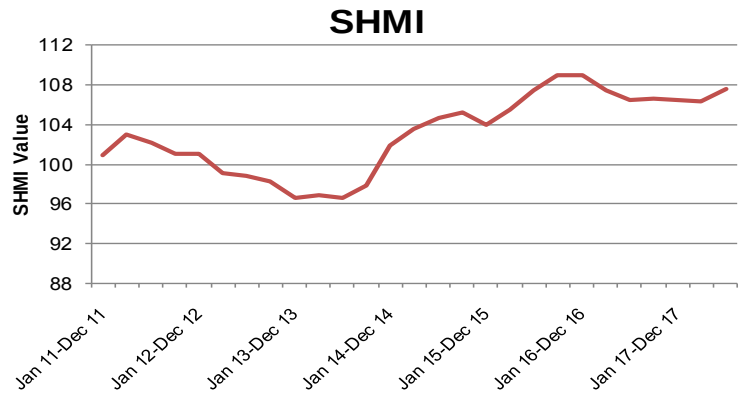
(HSMR and SHMI reported on Slide 2 are the latest available data)

SHMI	
Jul 17-Jun 18	107.64

(New reporting period of July 17 – June 18 being published on 22nd November 2018)

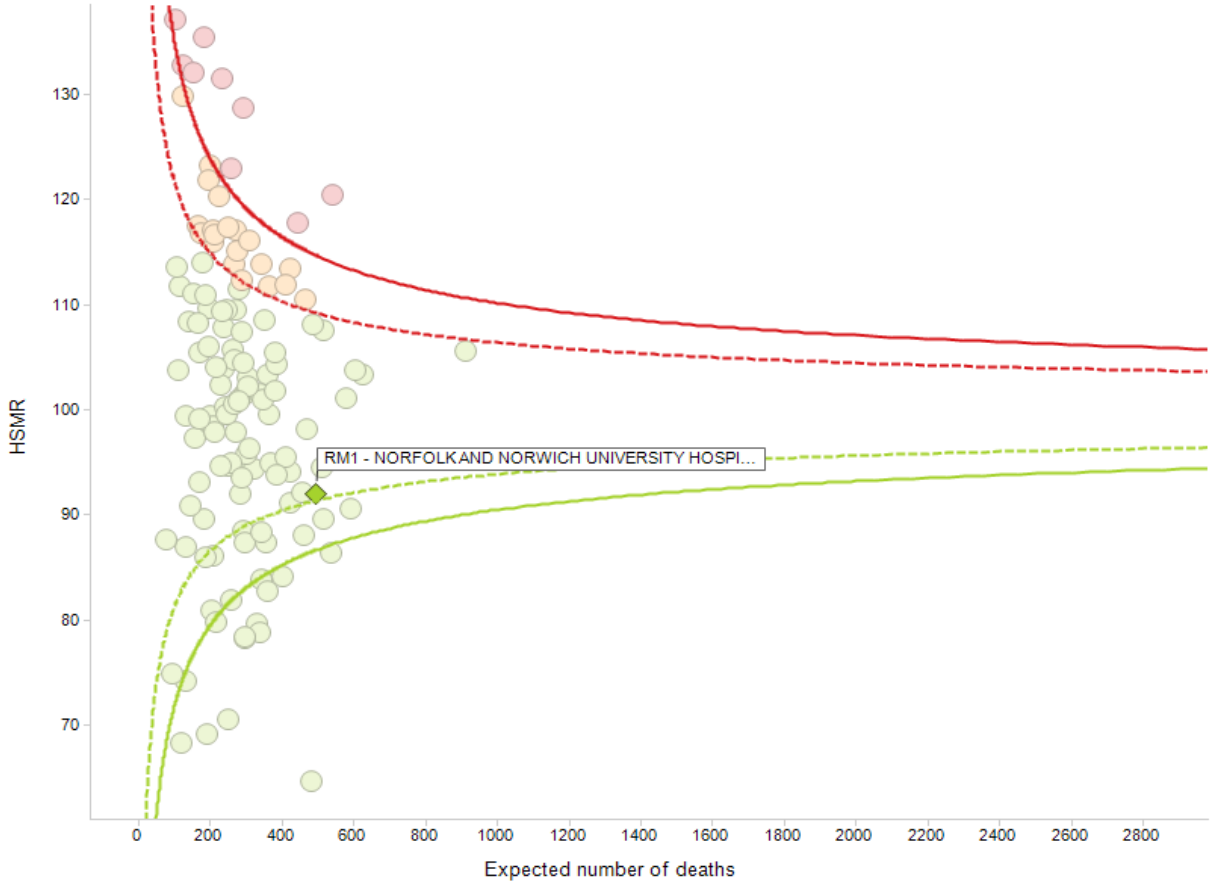






	2017/18	2018/19		
	Q4	Q1	Q2	Q3
Total deaths excluding ED	1084	872	793	776
Total deaths for ED	62	28	45	30
Number of in-hospital deaths	752	591	520	539
Number of deaths within 30 days of discharge	332	281	273	237
Number of reviews completed	429	397	380	152
Number of deaths on review considered potentially preventable	2	4	2	1
Percentage of deaths considered as potentially preventable	0.47%	1.01%	0.53%	0.66%
Numbers of deaths considered under SI process	3	6	6	8
Maternity deaths reviewed	0	0	0	0
Deaths in Learning disability reviewed (LeDeR)	4	4	2	0
Paediatric deaths reviewed	0	0	0	0
Mental Health deaths reviewed	0	0	0	0
Themes identified from mortality reviews and investigations	A need has been identified for strengthened mortality surveillance processes for improved accuracy of information form all sources so we can identify themes and trends in a consistent way.			
Actions taken	Work with Karen Kemp, Berenice Lopez and Angela Adams to establish assurance processes.			

Core Slide 4 HED - HSMR Overview – July 2018 to September 2018



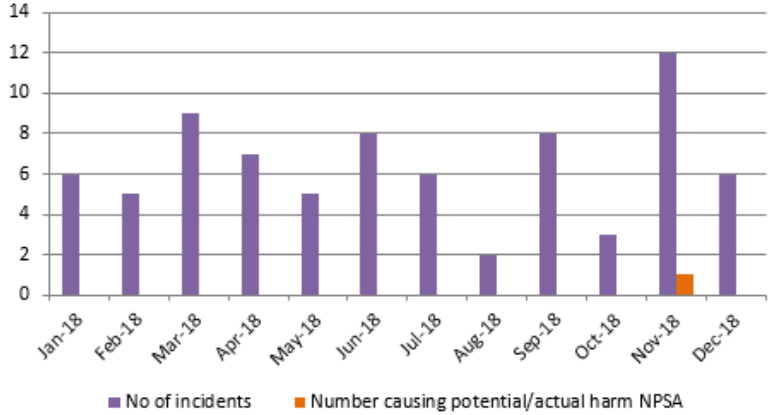
Organisation (provider): RM1 - NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
Trust Group: 1. My Trust
Alert Level: Green
HSMR: 92.06
HSMR 95% CI: (83.79,100.92)
Number of super-spells: 17853.00
Number of observed deaths: 455.00
Expected number of deaths: 494.25

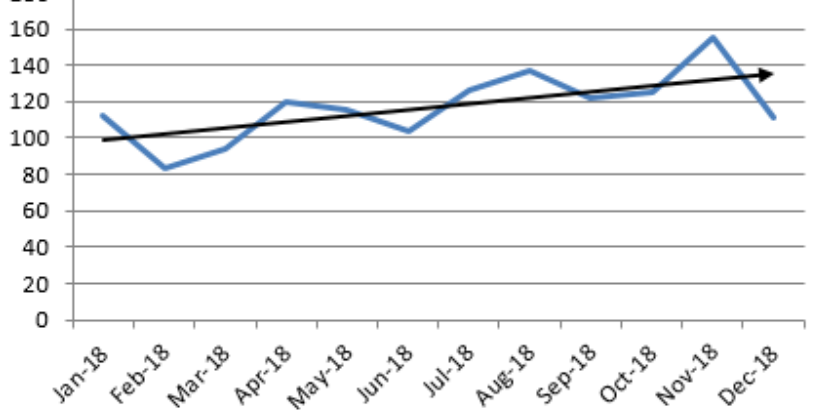
Core Slide 5 Safety and effectiveness - Lead Directors Nancy Fontaine / Erika Denton

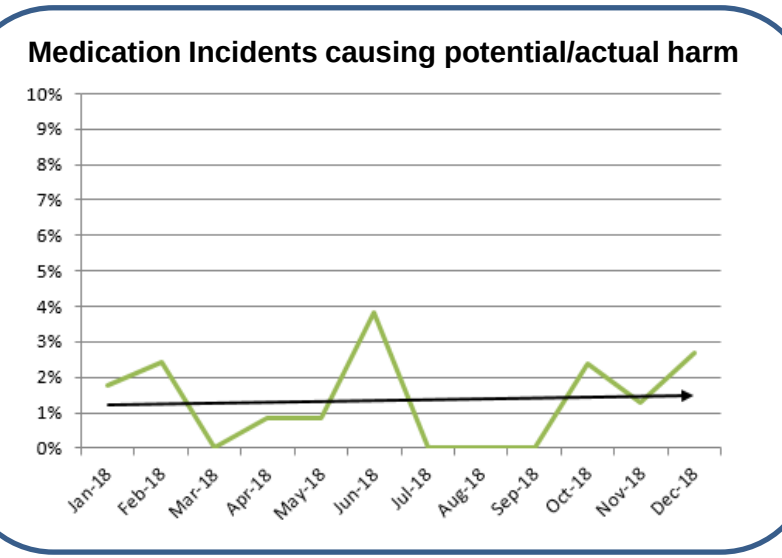
Key Issues

- Ageing IT infrastructure and paper based systems with the associated risks
- Supply of medicines – concerns surrounding supply and stockpiling because of Brexit remain
- Ownership of Never Event Action Plans now sits with the Divisions and they report to Clinical Safety and Effectiveness Board
- Capital equipment plans currently being developed to prioritise capital expenditure to patient need and clinical risk
- We have 50% more SI's being reported than last year. Most are low or no harm. The Trust is not an outlier and this is a marker of high quality care

Core Slide 6 Quality & Safety (Incidents) – Lead Directors Nancy Fontaine / Erika Denton





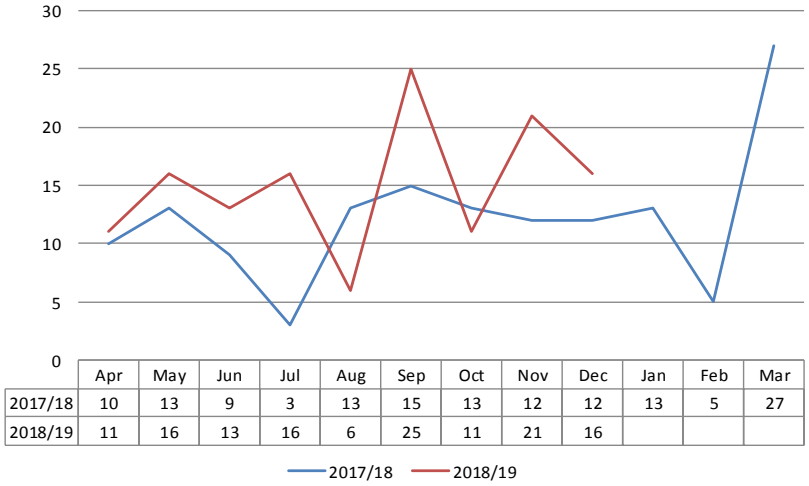


- 111 medication incidents were reported in Dec 18
- 1 incident resulted in death of the patient and is currently awaiting outcome of investigation for clarification of severity category
- 2 were classified as temporary harm requiring intervention
- The remainder were classified as no or low harm incidents
- There were 6 insulin incidents in December – all classified as no harm

Core Slide 7

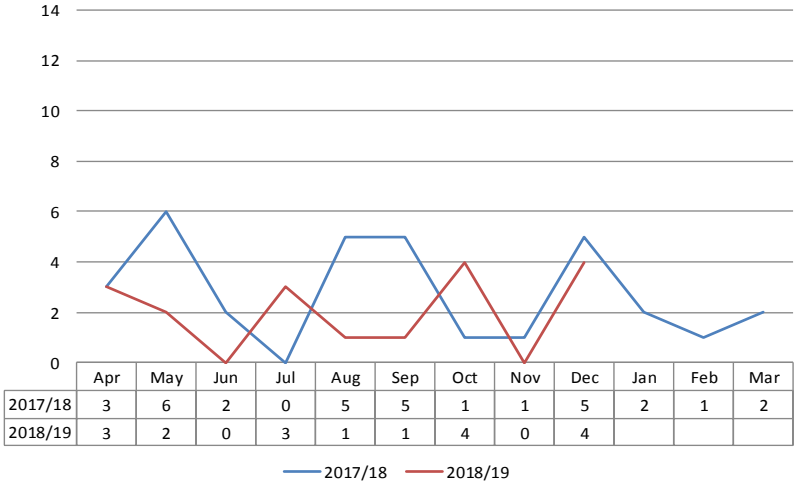
Quality & Safety (Incidents) – Lead Directors Nancy Fontaine / Erika Denton

Serious Incidents and Never Events (reported onto STEIS)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	10	13	9	3	13	15	13	12	12	13	5	27
2018/19	11	16	13	16	6	25	11	21	16			

Patient Falls causing moderate harm or above (reported onto DATIX)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	3	6	2	0	5	5	1	1	5	2	1	2
2018/19	3	2	0	3	1	1	4	0	4			

Individual Serious Incidents
(These are serious incidents reported onto STEIS which impact patients directly)

- **5 patients with Cat 3 PU**
- **1 Medication incident**
- **1 Adult Safeguarding**
- **2 Patient fall- #NOF**
- **3 Delay in diagnosis**
- **1 Hospital Acquired Thrombosis**
- **1 MH patient under section/ self-harm**

Organisational Serious Incidents
(These are serious incidents reported onto STEIS that may indirectly affect patient safety**)**

- **1 retrospective report relating to 60 minute ambulance delays reported for the month of November 2018.**
- **1 HCAI incidents involving wards closed for Norovirus outbreak.**

Compliance with the Duty of Candour has breached in 3/15 cases

In December2018 there were 182 patient falls reported. The trend over the past three years is reducing with almost 650 less patient falls reported compared to the same 12 month period in 2015/2016.

Falls per Occupied Bed Day (OBD)

The data for December bed day data indicates that the NNUH inpatient falls rate was **7.05 falls** per 1000 patient bed days. This is an increase in reporting of patient falls in the organisation.

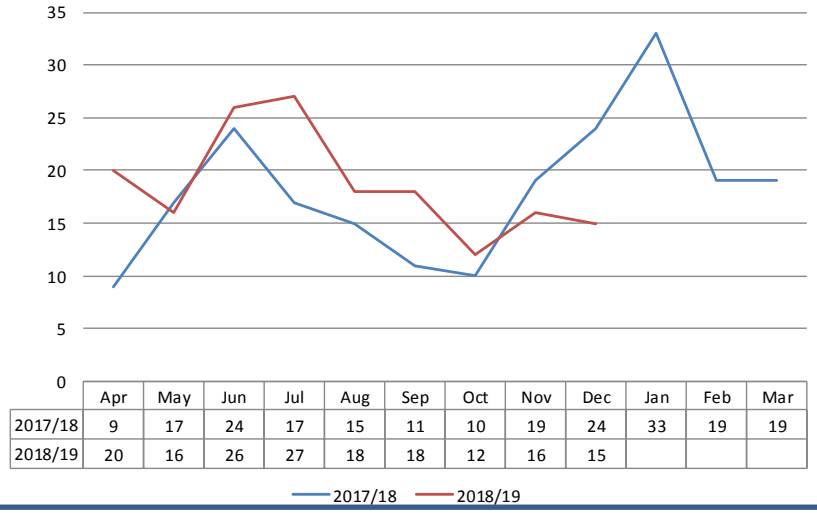
For falls that resulted in moderate harm or greater, the Trust's rate for December 2018 is **0..232** falls per 1000 patient bed days which is again an increase in the severity of harm sustained when patients have fallen.

The Essential Care Scrutiny Panel continue to review all falls RCA's to identify and share learning to improve this patient safety outcome measure.

Core Slide 8

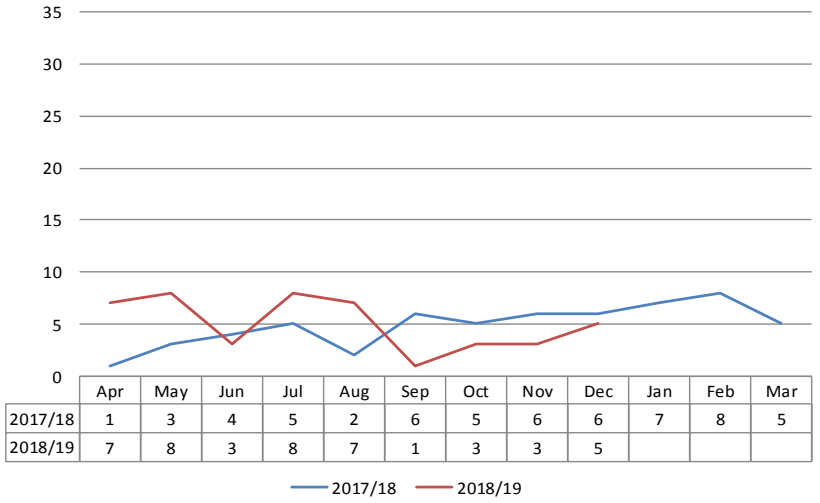
Quality & Safety (Pressure Ulcers) – Lead Director Nancy Fontaine

Grade 2 hospital acquired pressure ulcers



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	9	17	24	17	15	11	10	19	24	33	19	19
2018/19	20	16	26	27	18	18	12	16	15			

Grade 3/4 hospital acquired pressure ulcers



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	1	3	4	5	2	6	5	6	6	7	8	5
2018/19	7	8	3	8	7	1	3	3	5			

Category 2 PU

- A total of 15 patients developed a Grade 2 HAPU whilst in our care in December 2018.

Category 3 & 4 HAPU

- A total of 6 patients developed a Grade 3 hospital acquired pressure ulcer whilst in our care in December 2018. 5 of these have been reported as SI's – the 6th will be reported with January SI's. No patients developed a Grade 4 pressure ulcer in our care.

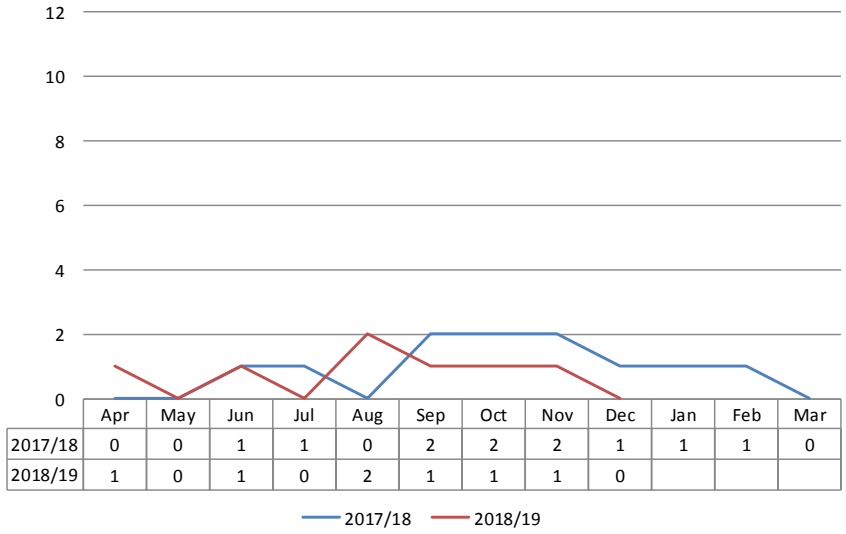
Learning from recently completed RCA's

The learning from the RCA's is reviewed by the TVN's: Ongoing actions include the following

- Earsham Ward have taken up the chief Nurse's challenge to be the first ward to 100 days without a patient developing a pressure ulcer At the time of this report they have reached **Day 81**.
- A number of RCA's have been reviewed where all practise was identified as being good - often this is in patients at the end of life, where skin is much more susceptible to damage as nutrition and oxygenation reduces. In all of these cases a detailed review is always undertaken to identify any potential learning.

Core Slide 9 Quality & Safety (Infection Control) – Lead Director Nancy Fontaine

HAI C. difficile Cases (excluding non-trajectory and pending cases)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	0	0	1	1	0	2	2	2	1	1	1	0
2018/19	1	0	1	0	2	1	1	1	0			

MRSA Hospital Attributable Bacteraemia 2018/19 Objective zero
- Year to date 1

MSSA Hospital Attributable Bacteraemia 2018/19 No objective
- Year to date 10

Gram Negative Hospital Attributable Bacteraemia 2018/19 (YTD)
- E. coli 43
  Pseudomonas aeruginosa 14
- Klebsiella sp. 10

Ward Closures as below:

Ward	Reason for closure	Closed	Opened	SI meeting date
Loddon	Norovirus	05/11/2018	10/11/2018	23/11/2018
Kimberley	Norovirus	10/11/2018	20/11/2018	29/11/2018
Guist	Norovirus	30/11/2018	08/12/2018	07/01/2019

Following the post infection review [PIR] meeting with Trust and CCG's representatives each hospital acquired case of C. difficile is:-

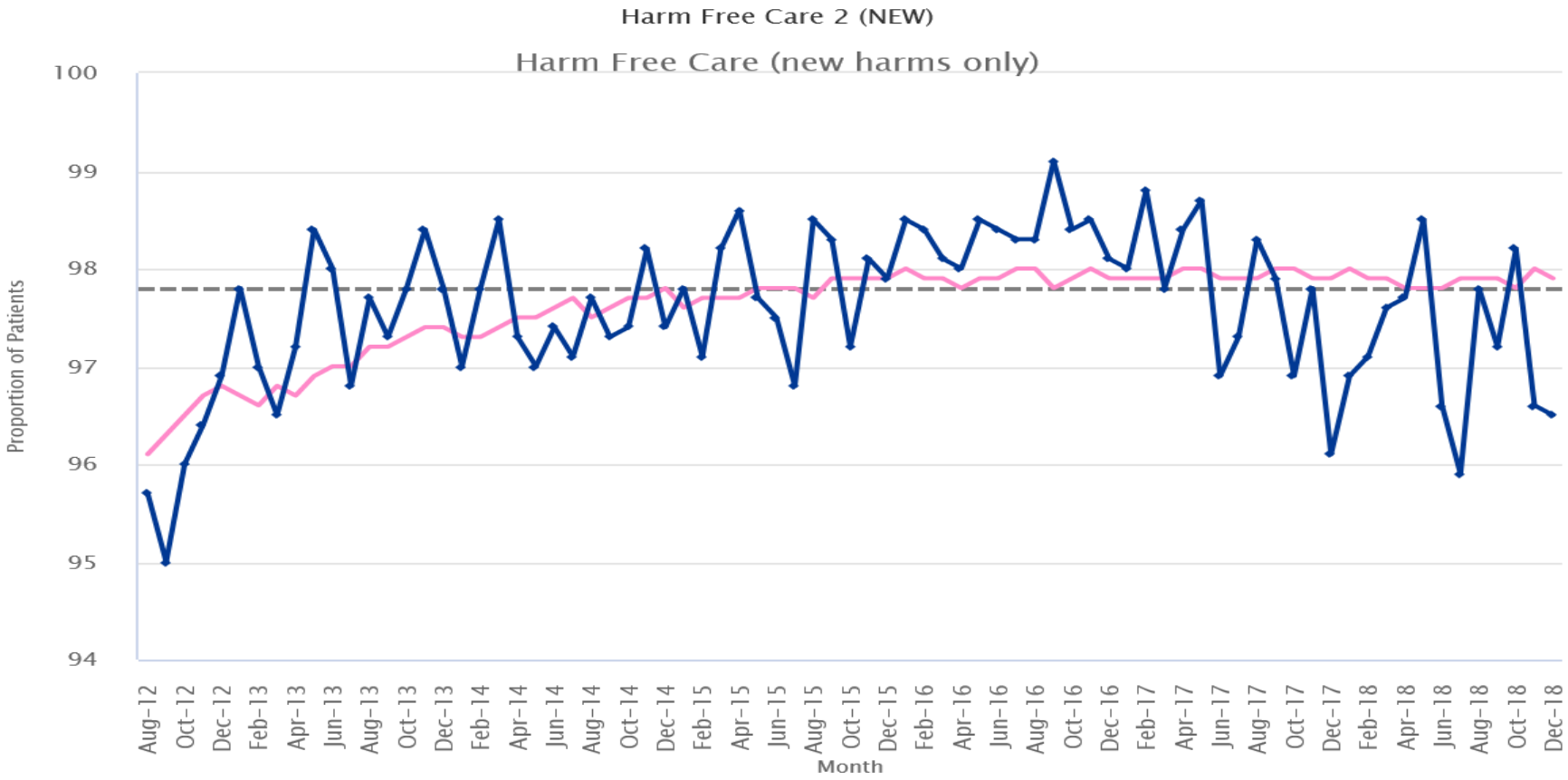
Trajectory	deemed to have lapses in care
Non-Trajectory	Deemed to have no lapses in care

Pending cases are either awaiting the PIR meeting or the CCG's have requested further information

Summary Table		Non-Trajectory	Trajectory	Pending	Total
Quarter	4				
	3	1	2	1	4
	2	8	3	0	11
	1	6	2	0	8
Year to date 18/19		15	7	1	23
Previous year 2017/18 Total		*24*	*11*	*0*	*35* 55

Core Slide 10

Safety Thermometer – Lead Director Nancy Fontaine



The Patient Safety Thermometer Data published on the website contains information that relates to all data collection until December 2018. The above data compares “Harm Free Care – New Harms” since data collection began. The graph has been taken from the PST website and demonstrates NNUH NHSFT Harm Free Care (All new harms) of 96.5% for December 2018 against a national average reported of 97.9%. The graph provides data since Safety Thermometer collection commenced in 2012.

Core Slide 11

Maternity Safety Dashboard – Lead Director Nancy Fontaine

		NNUH Maternity 2018/19	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Total
Activity	Mothers Delivered	Mothers delivered	438	479	460	475	470	475	486	419	427	4129
	Babies Delivered	Total Births	443	488	466	479	479	482	496	426	431	4190
		Live Births	439	483	463	478	477	479	494	425	430	4168
		Stillbirths	4	4	3	1	1	3	2	1	1	20
		Adjusted Stillbirths Total SB less TOP ≥24wks & SB with severe anomalies	*4*	*0*	*3*	*1*	*0*	*3*	*1*	*0*	*0*	*16*
	Early NND	NNUH born alive & die ≤ 7days	0	1	0	0	1	0	1	0	2	5
	Bookings	Total number of Bookings	488	518	495	489	456	475	525	503	452	4401
		% Bookings ≤12+6 Weeks	93.0%	92.1%	90.7%	92.6%	91.4%	93.3%	90.5%	91.1%	87.6%	91.4%
	Inductions of labour	% Total IOLs	37.0%	35.3%	36.7%	35.2%	30.6%	30.7%	31.5%	39.1%	33.7%	34.3%
	Normal Vaginal Deliveries	% Total Cephalic & Other Cephalic & Breech	61.4%	65.8%	60.7%	57.7%	59.4%	62.3%	61.1%	60.4%	57.8%	60.8%
	Instrumental Deliveries	% Total Ventouse / Forceps	9.8%	10.0%	12.0%	11.4%	11.7%	10.9%	10.1%	10.7%	12.6%	11.0%
		% Forceps	7.5%	6.3%	8.3%	8.2%	7.2%	7.8%	6.0%	7.9%	10.1%	7.7%
		% Ventouse	2.3%	3.8%	3.7%	3.2%	4.5%	3.2%	4.1%	2.9%	2.6%	3.4%
	Caesarean Sections	% Total CS (Elective & Emergency)	29.2%	26.5%	28.5%	31.8%	30.9%	27.6%	30.9%	30.5%	29.5%	29.5%
		% Emergency (CS1, CS2, CS3)	16.9%	12.3%	15.9%	17.1%	13.2%	14.9%	18.1%	16.7%	14.8%	15.5%
		% Elective (CS4)	12.3%	14.2%	12.6%	14.7%	17.7%	12.6%	12.8%	13.8%	14.8%	14.0%
		% Robson 1: Primip single cephalic ≥37 wks spont. onset	1.6%	2.5%	2.4%	1.5%	2.3%	3.2%	4.1%	3.1%	1.6%	2.5%
		% Robson 2: Primip single cephalic ≥ 37 wks IOL / ELCS	9.8%	8.8%	12.4%	14.7%	10.6%	9.3%	10.9%	11.7%	10.8%	11.0%
		% Robson 5: Multip Prev CS, single cephalic ≥37 wks	8.0%	5.0%	5.7%	5.9%	5.1%	5.5%	4.5%	7.2%	5.2%	5.7%
Place	MLBU Births	MLBU Births	18.9%	18.4%	16.7%	18.1%	17.4%	18.7%	16.9%	20.0%	15.9%	17.9%
	Homebirths	Home births (Planned & Unplanned & Intransit)	2.1%	2.5%	2.0%	1.7%	1.7%	0.8%	3.1%	1.7%	3.3%	2.2%
Professionals	Care in Labour	Number BBA's (No MW or Obstetrician in attendance)	5	8	3	2	2	0	11	4	6	41
		% 1:1 Care in Labour	91.9%	92.2%	92.5%	93.1%	93.8%	91.6%	88.4%	93.4%	89.3%	91.8%
	Lead professional	% MW Led at birth	41.6%	39.9%	34.8%	38.5%	34.0%	26.7%	27.0%	22.7%	24.1%	32.3%
		% Cons Led at birth	58.7%	60.3%	65.2%	61.5%	66.2%	73.3%	73.0%	77.6%	75.9%	67.8%
	Cons Hrs	Wkly dedicated Cons hrs on Labour ward	60	60	60	60	60	60	98	98	98	60
	MW Hrs	Midwife : Birth Ratio excl. band 3 MCA	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:29	1:28	1:30
		Midwife : Birth Ratio inc. band 3 MCA's	1:28	1:28	1:28	1:28	1:28	1:28	1:28	1:28	1:27	1:28
Wellbeing	Smoking status	% Mothers smoking at Booking	10.5%	11.5%	12.8%	11.4%	10.0%	12.0%	9.9%	12.4%	11.9%	11.4%
		% Mothers smoking at Delivery	10.7%	10.6%	10.2%	9.9%	8.7%	9.5%	8.6%	11.2%	9.8%	9.9%
	Breastfeeding	% Initiation: Breast milk < 48hrs	83.1%	80.4%	79.3%	78.5%	79.1%	78.3%	80.0%	79.5%	86.2%	80.4%
		% Exclusive BF @ transfer to community	62.3%	63.7%	62.2%	61.3%	64.0%	64.0%	63.2%	61.1%	64.6%	62.9%
		% Breast + Mixed feeding @ transfer to community	72.6%	71.6%	70.9%	69.5%	72.3%	72.8%	70.6%	69.7%	74.0%	71.5%
Risk Management	Maternal	% 3rd & 4th degree tears (per vaginal births)	2.2%	3.9%	4.2%	3.7%	4.2%	2.6%	1.7%	2.7%	2.0%	3.0%
		% PPH ≥1500mls	3.7%	2.9%	3.3%	3.8%	2.3%	5.1%	3.3%	4.1%	3.7%	3.6%
		Number Unplanned Admission To Critical Care Complex	0	0	0	0	1	1	0	0	0	2
		Number Emerg readmissions ≤30 days of delivery	6	10	4	12	4	6	5	8	4	59
		Number Maternal Death	0	0	0	0	0	0	0	0	0	0
	Neonatal	Number of Hypoxic Encephalopathy (Grades 2 & 3)	0	0	0	0	0	0	0	2	1	3
		Number Unplanned NICU ≥37wk Admissions (E3)	19	19	13	19	27	23	19	21	20	180
		Number Apgar score <7 @5, ≥37wk	3	7	5	0	8	2	4	6	11	46
	Serious Incidents	Number Number of SI's	0	0	0	1	1	2	0	1	0	5
	Closures & Diverts	Number Unit closures	0	0	0	0	0	1	0	0	0	1
		Number Mothers transferred out of unit	2	0	0	0	3	5	2	0	2	14

HoM Comments: Saving Babies Lives dashboard being created with clinical maternity network

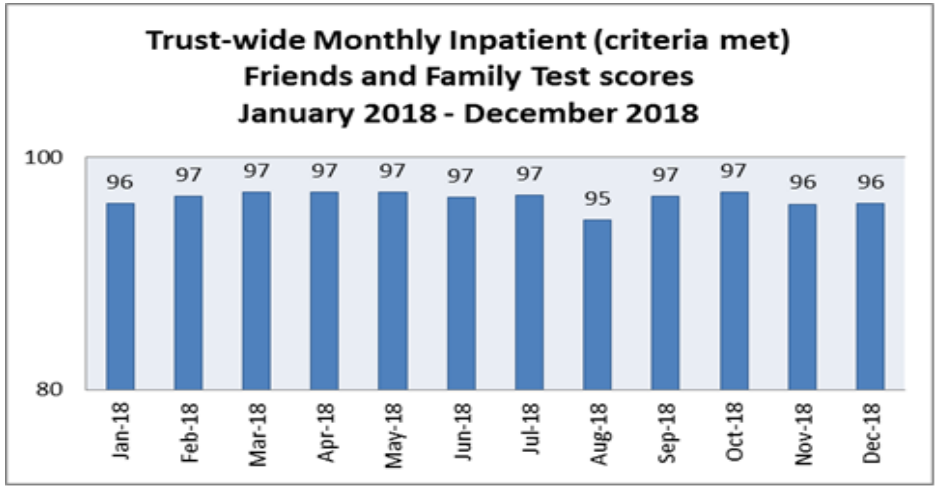
Core Slide 12

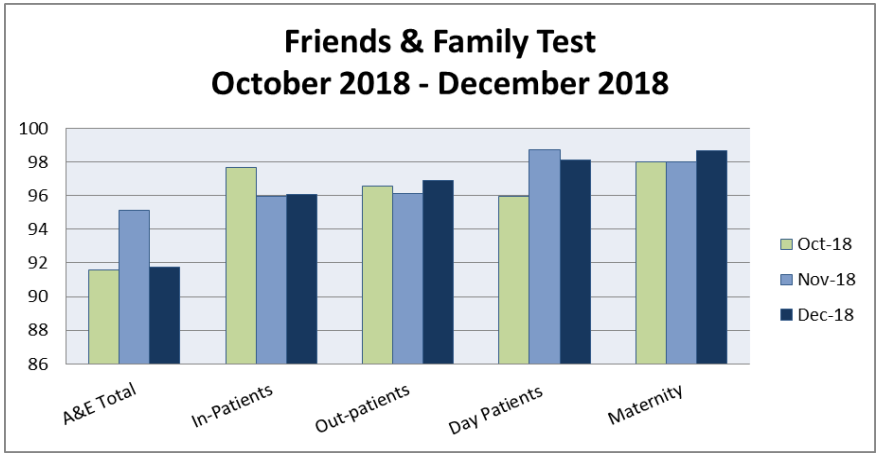
Quality and Safety Dashboard – Lead Director Nancy Fontaine

		Outrun 2017/18	Monthly Target	Dec-18	6 Month Trend	YTD 2017/18*	YTD 2018/19
Caring and Patient Experience							
1	Same Sex Breach	62	0	0		18	34
Infection Prevention and Control							
2	C Diff cases (hospital acquired)	35	N/A	1		28	23
3	MRSA bacteraemias (hospital acquired)	0	0	0		0	1
4	Norovirus (confirmed cases)	88	N/A	21		61	95
5	Elective MRSA Screening compliance	93.7%	>=95.0%	94.3%		93.4%	96.0%
6	Emergency MRSA Screening compliance	96.4%	>=95.0%	95.7%		96.8%	96.3%
7	Hand Hygiene Compliance	94.8%	>98.0%	97.6%		95.5%	96.7%
8	Dress Code Compliance	98.1%	>98.0%	99.1%		98.1%	98.8%
9	Commode Audits	95.3%	>98.0%	92.2%		95.7%	94.2%
Health & Safety							
10	Needlestick Incidents	114	N/A	8		87	68
Incident Reporting							
11	Total Number of Datix Incidents in month	12368	N/A	1335		9007	10635
12	Datix Incidents (reported in month) Finally Approved	6089	N/A	633		4635	5329
13	Number of Datix Incidents reported in month not closed	6270	0	0		4363	4605
Cleaning							
14	Cleaning Audit Results	96.1%	>=95.0%	96.3%		96.0%	96.1%
15	Cleaning Audit Results if Re-Audited	96.3%	>=95.0%	97.0%		96.1%	96.7%
Call Bell Waits							
16	Day Call Bell: Patient Call	02 min 07 sec	02 min 30 sec	02 min 16 sec		02 min 03 sec	02 min 05 sec
17	Day Call Bell: Bathroom Call	01 min 23 sec	02 min 00 sec	01 min 29 sec		01 min 21 sec	01 min 23 sec
18	Night Call Bell: Patient Call	01 min 20 sec	02 min 30 sec	01 min 15 sec		01 min 19 sec	01 min 17 sec
19	Night Call Bell: Bathroom Call	01 min 02 sec	02 min 00 sec	00 min 54 sec		01 min 02 sec	00 min 53 sec
Staffing							
20	Number of red flags for the month	12342	N/A	498		9929	4582

**YTD 2017/18 refers to the YTD figure at this point last year*

Core Slide 13 Caring and Patient Experience – Lead Director Nancy Fontaine





Overall Trust wide performance of FFT is 96% for December 2018. The other table identifies performance within individual areas.

Cinema Evenings In the Gooch
A proposal for consideration has been made by the Volunteer team, to introduce a Movie Evening for patients. This will involve turning The Gooch Hall Lecture Theatre into a cinema.

The aim is to encourage patients and their loved ones to watch a movie together and at the same time to support 'Get up, Get dressed, Get moving' and mental wellbeing.

New Roles supporting improvements in patient experience, as well as quality and safety.

Dementia Care Strategy and Performance
Jenny Woolgrove has been appointed into the role of Dementia Care Clinical Specialist and started in post on the 24th September 2018.

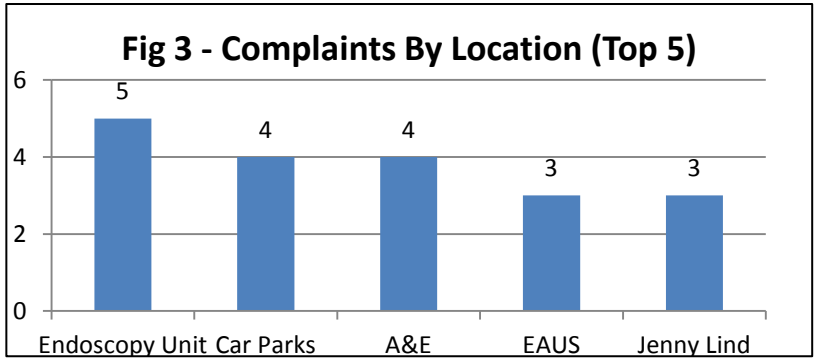
Learning Disabilities & Autism:
Fiona Springall has been appointed and commenced in post as the LD Liaison Nurse for Children and Young Persons.

EOL/SPCT
Butterfly Volunteers - The Anne Robson Trust are a team of volunteers who work to ensure that "nobody dies alone" the interviews have taken place for a Butterfly co-ordinator who will work with the SPCT to support patients at EOL

Core Slide 14 Caring and Patient Experience – Lead Director Nancy Fontaine

Complaints Summary

62 formal complaints were received in December 2019. This compares to an average monthly figure of 81 complaints (average over the past 5 years)



For the first time since October 2017, A&E is not the area with the largest number of complaints. The Endoscopy unit (formally known as the Gastro Unit) had the largest number of complaints. This is a high volume area and the number of complaints is similar to that of previous months (November n=6 and December n=4). There were no obvious themes identified within these complaints.

Complaints about communication remains the single largest theme (n=23 in January compared to n=18 in December). The other reasons for complaints featuring in the top 5 relate to Patient Care (n=8), Clinical Treatment – Surgical (n=7), Clinical Treatment – Medicine (n=6) and Admissions and Discharges(n=6).

A review in to the number of complaints relating to Hygiene, and Nutrition / Hydration was carried out this month. The review concluded that the number of complaints received regarding these areas of care were comparable to those received in the previous year.

Trust wide performance against the standard of completing complaint responses within 25 days in November was achieved for 63 out of 102 complaints raised. This equates to 62% compliance.

The details below identify Divisional performance:

Medicine – 26 of 50 completed within 25 working days = 52%
Surgery – 18 of 31 completed within 25 working days = 58%
W&C – 6 of 11 completed within 25 working days = 55%
CSS – 4 of 9 completed within 25 working days = 44%

The below table provides some additional oversight of the current timeframes taken to taken to complete complaints responses

2018	Number of complaints	25 days	40 days	60 days
June	82	54%	87%	98%
July	100	42%	73%	92%
August	90	53%	74%	94%
September	77	57%	87%	96%
October	96	50%	79%	Ongoing
November	102	62%	Ongoing	Ongoing

Work with the Divisions is taking place to improve compliance against this Trust standard.

Core Slide 15 High Risk Tracker (page 1 of 3) Lead Director Nancy Fontaine

Risk Register HIGH RISK Tracker 15+ Risks **Date of Update** **03/01/2019**

This high risk tracker highlights all current risks on the Risk Register that have a Residual Risk Rating of 15+. Each risk is summarised below together with its current score and direction of travel over the last 3 months. The final column details the anticipated date for the reduction or resolution of the risk.

Ref	Risk Name	Current Risk score			3 month risk trend			Date Risk added	Executive Lead	Date of Last review	Latest Status report
		Cons.	Freq.	Risk Score	1mth ago	2mth ago	3mth ago				
ID 604	Sustainability of Cardiology catheterisation laboratory services due to equipment failure	4	4	16	16	16	16	03/05/2018	COO	28/12/2018	Once Quadram opens in Q3 2018/19 then additional capacity will be created to assist in the management of patients waiting for Cath labs until new IRU opens. The procedure room refurb has been signed off and should be available for more complex cases in August 2019. Cardiology are hoping to move into some of the Gastro theatre space in December 2018 (utilising hired/purchased new equipment) and an MES is part way through a tendering process with contracts due to be signed in January 2019.
ID 572	Financial sustainabilty	4	5	20	20	20	20	13/10/2015	CFO	01/10/2018	Risk of financial penalties both from 16/17 not resolved and 18/19 penalties due to the Trust not accepting its control total
ID 576	Nuclear Medicine - loss/disruption of service and regulatory compliance due to equipment failure, design of facilites and access to medical physics resource.	4	4	16	16	16	16	18/01/2018	Director of Strategy	28/12/2018	Business case progressing.Ageing and failing equipment. Nuclear Medicine visited by F&I sub board. SRO changed from COO to Director of Strategy
ID 571	Failure to achieve key local and national operational performance targets	4	4	16	16	16	16	13/10/2015	COO	28/12/2018	New RATS facility and Discharge suite opened in late December. Need to review impact. Cancer deep dive presented at Board in November. No change to current score.
ID 387	IRU capacity	4	4	16	16	16	16	03/06/2014	COO	28/12/2018	Once Quadram opens in Q3 this will create some capacity in Cath lab to help manage the waiting list until new IRU building work is completed.
ID 404	Cardiology pacing waiting lists	4	4	16	16	16	16	10/11/2017	COO	28/12/2018	Quadram now open which should stop the Radial Lounge being inappropriately moved and therefore cancellations should be reduced. Need to review impact. The procedure room refurb has been signed off and should be available for more complex cases in August 2019. Cardiology are hoping to move into some of the Gastro theatre space in December 2018 (utilising hired/purchased new equipment) and an MES is part way through a tendering process with contracts due to be signed in January 2019. If the cath lab recovery area can be used as a recovery area again turnaround times will improve and increase efficiency through increased flow.
ID 568	Non -compliance with mandatory training	3	5	15	15	15	15	02/09/2015	HRD	28/12/2018	Progress is showing - current overall % is above 85% for the first time, however the target is 90% so score remains unchanged.
ID 610	Ageing IT infrastructure	5	4	20	20	20	20	02/08/2018	CIO	05/11/2018	No change to score
ID 611	Ageing Sterile Services Equipment	4	5	20	20	16	16	14/08/2018	Director of Strategy	28/12/2018	New replacement equipment ordered. Risk remains the same until equipment arrives and is commissioned.

Core Slide 15a High Risk Tracker (page 2 of 3) Lead Director Nancy Fontaine

Risk Register HIGH RISK Tracker 15+ Risks **Date of Update** **03/01/2019**

This high risk tracker highlights all current risks on the Risk Register that have a Residual Risk Rating of 15+. Each risk is summarised below together with its current score and direction of travel over the last 3 months. The final column details the anticipated date for the reduction or resolution of the risk.

Ref	Risk Name	Current Risk score			3 month risk trend			Date Risk added	Executive Lead	Date of Last review	Latest Status report
		Cons.	Freq.	Risk Score	1mth ago	2mth ago	3mth ago				
ID 619	CQC Rating	4	5	20	20	20	20	02/10/2018	Chief Nurse	28/12/2018	QIP in place and being actively monitored via Quality Programme Board and Oversight and Assurance Group. NHSi have conducted a practice well led inspection and Enable East invited in to do an unannounced practice inspection.
ID 363	Opthalmology capacity for follow up appointments	4	4	16	16	16	12	20/03/2013	COO	28/12/2018	HII action plan being worked through. Processes have been improved which will assist with prospective management of the waiting list. However the backlog of patients is still being worked through and a failsafe office needs to be appointed. Until these have occurred no change to score.
ID 623	Non delivery of financial plan 2018/19	4	4	16	16	16	16	31/10/2018	CFO	31/10/2018	Financial plan in place Regular financial forecasting reported through Trust Governance structure to the Board Accountability meetings with Divisional Triumvirates
ID 624	Medium term financial strategy	4	5	20	20	20	20	31/10/2018	CFO	31/10/2018	Plan being worked up by end Q3. This will include reasonable assumptions about structural and national funding. Plan will be stress tested
ID 625	Equipment replacement programme	5	3	15	15	15	15	31/10/2018	Director of Strategy	31/10/2018	Divisions asked for list of urgent equipment replacement risk rated for both clinical risk and business risk impact. This went through Divisional Governance processes and was approved via Divisional boards.All those scoring >12 were included on the Capital loan application to NHSi. NHSi asked for Trust to rationalise the value of the application therefore risks scoring >16 have been put forward. Still awaiting NHSi decision on loan application.
325	Delays in handover of patients from ambulance crews	4	4	16	16	12	12	09/02/2012	COO	28/12/2018	New RATS facility opened mid December. New ways of working need to embed
524	GIOTTO detector failure	4	5	20	20	10	10	07/07/2017	Director of Strategy	05/11/2018	The stereotactic GIOTTO Mammography unit is used for breast biopsies to diagnose cancer and image guided minimally invasive excision of breast lesions as alternative to open breast surgery. The unit is now approaching 9 years old. On Trust list of current capital equipment. Public Health, England, have said this must be replaced so there is a risk of funding being withdrawn, and hence losing the service. Scoring reviewed and increased to 20.
632	IRU on call rota - nursing shortage	5	3	15	15	New	New	22/11/2018	Chief Nurse	22/11/2018	Currently 8 nurses short for on call service due to vacancies, new /untrained staff, sickness and restrictions to practice adversely impacting on patient treatment through delay a lack of Interventional On call service
642	Impact of no deal Brexit on pharmacy stock holding / stock availability.	5	4	20	20	New	New	22/11/2018	Medical Director	22/11/2018	The outcome of Brexit may affect the supply of medicines and the newly formed DHSC Medicines Supply Contingency Planning Programme are putting in place plans considering how they may support suppliers in making stockpiling arrangements. Due to the storage and space issues within Pharmacy we have a particularly low stock holding. This may result the Trust having stock outs at a much earlier stage than other Trusts across the country

Core Slide 15b High Risk Tracker (page 3 of 3) Lead Director Nancy Fontaine

Risk Register HIGH RISK Tracker 15+ Risks **Date of Update** **03/01/2019**

This high risk tracker highlights all current risks on the Risk Register that have a Residual Risk Rating of 15+. Each risk is summarised below together with its current score and direction of travel over the last 3 months. The final column details the anticipated date for the reduction or resolution of the risk.

Ref	Risk Name	Current Risk score			3 month risk trend			Date Risk added	Executive Lead	Date of Last review	Latest Status report
		Cons.	Freq.	Risk Score	1mth ago	2mth ago	3mth ago				
646	Ultrasound drop probe	4	5	20	New	New	New	14/12/2018	Director of Strategy	**14/12/2018**	Broken robot ultrasound drop probe in urology theatres this will prevent the treatment of some patients on the cancer pathway. Rep/Company aware and have quoted for replacement.Supplier has offered a loan device as soon as they receive a purchase order number.Dept planning to purchase a replacement robotic ultrasound drop probe from either BK Medical or Hitachi (quote being sought from second supplier)
651	Non compliance with Network and Information Systems Regulations 2019	4	5	20	New	New	New	28/12/2018	CIO	**28/12/2018**	Inability to comply with the UK's NIS Regulations as a defined operator of essential services, due to a lack of people, technology, training, appropriate processes and pockets of shadow IT as identified by the NIS Gap Analysis report submitted to Trust Board. Business case submitted.
654	IM&T staffing	4	4	16	New	New	New	28/12/2018	CIO	**28/12/2018**	IM&T department are unable to meet the demands for its services across the organisation. The current requests from the divisions and organisation as a whole outweighs the number of resources available. This is now having an impact on key projects being requested and hindering their ability to deliver. Department are utilising contract/agency staff to maintain 'business as usual' but this additional capacity doesn't help support these new initiatives and projects
655	Inappropriate use of POCT equipment	4	4	16	New	New	New	28/12/2018	Medical Director	**28/12/2018**	Inappropriate use of POCT equipment could lead to harm to patients. Need to follow MHRA guidance on POCT testing, as defined in Management and use of IVD point of care test devices. POCT committee with appropriate clinical input from outside of pathology. Lines of accountability for POCT management need to be clear. Assessment of the service by an external accreditation body is required e.g. ISO 22870:2016. Clear, comprehensive record keeping and documentation of POCT; Competency, reagents, results. Transfer of POCT results to Web ICE
671	Medisa Camera - poor quality images	3	5	15	New	New	New	02/01/2019	Director of Strategy	**02/01/2019**	Poor quality images limits the sensitivity and specificity in making a clinical diagnosis. Limited investigations are scheduled for this equipment. This does not reduce the risk for those patients scheduled on the Mediso camera. Replace camera with modern SPECT CT camera required to maintain service provision.
677	Ageing defibrillators	4	5	20	New	New	New	03/01/2019	Director of Strategy	**03/01/2019**	The hospital has over 80 defibrillators which are at the end of their lives as spare parts will not be available after December 2018. We get at least 60 arrest calls per month. Replacement equipment required.
678	Ageing Cobra counting equipment - Nuclear Medicine	4	4	16	New	New	New	03/01/2019	Director of Strategy	**03/01/2019**	Risk of service failure in Nuclear Medicine for undertaking Glomerular Filtration Rate investigation. The Packard Cobra II Auto-gamma counting equipment and Epson dot matrix printer LQ-590 are more than 20 years old. The Cobra fails to count every sample leading to necessity of repeat counting.The Cobra needs to be supported by a dot matrix printer which is also old and fails on occasions. Replacement equipment required.
679	Lack of patient voice and engagement	3	5	15	New	New	New	03/01/2019	Chief Nurse	**03/01/2019**	We do not actively engage with patients/carers to obtain their views to inform how services are delivered or work with them in partnership to shape and design services. Services will not be reflective of patient need and this will lead to criticism from our patients and regulators and adversely affect Trust reputation as a provider of responsive quality services which meet best practise

Core Slide 16

Performance – Monitor KPI's - Lead Director Chris Cobb

Performance		Outturn 2017/18	Monthly Target	Dec-18	6 month trend	YTD 2017/18	YTD 2018/19
Cancer	Core Slide 18-20						
1 Cancer 62 day target for referral to treatment - GP Referral *		81.52%	85.00%	71.68%		82.62%	71.71%
2 Reallocated Cancer 62 day target for referral to treatment (Previous Month) - GP Referral * +		83.04%	85.00%	74.55%		83.44%	74.23%
3 Cancer 2 week wait - all cancers *		94.29%	93.00%	88.10%		93.82%	79.24%
4 Cancer - 62 day screening *		87.41%	90.00%	81.03%		86.35%	81.52%
6 Cancer 31 day target compliance		98.59%	96.00%	96.45%		98.83%	95.97%
7 Cancer 31 day target for subsequent treatments - Surgery *		95.33%	94.00%	82.61%		97.07%	84.84%
8 Cancer 31 day target for subsequent treatments - Anti Cancer Drugs *		99.77%	98.00%	97.67%		100.00%	99.12%
9 Cancer 31 day target for subsequent treatments - Radiotherapy *		98.32%	94.00%	98.50%		98.44%	97.60%
A&E	Core Slide 21						
10 A&E 4 hour target compliance		80.67%	90.00%	74.40%		85.53%	81.59%
11 A&E 4 hour target compliance combined (inc WiC)***		n/a	90.00%	82.50%			87.29%
12 Number of 30 minute handover breaches		6196	0	863		3835	6103
13 Number of 60 minute handover breaches		3698	0	673		2071	2805
14 Arrival to Handover time (>15 minutes)		48.9%		70.5%		39.5%	63.2%
RTT	Core Slide 22						
15 18 week RTT target - Patients on an incomplete pathway		83.91%	92.00%	81.83%		84.22%	83.92%
16 Admitted Backlog		3995.0	n/a	4218		3995	3921
17 Incomplete Non Admitted Backlog		2423	n/a	3348		2423	2721
Stroke	Core Slide 23						
18 Stroke internal overall SSNAP rating		B	B	B	ABBAAB	B	B
Patient Flow							
19 Diagnostics		99.14%	99.00%	97.58%		99.19%	98.99%
20 Cancelled Operations		1354	n/a	118		785	871
21 Number of 28 day breaches		231	0	23		130	135
22 Average Delayed Transfers of Care		36	n/a	40		36	36
23 30 Day Readmission Rates**		12.43%	n/a	13.12%		12.39%	13.00%
24 Length of Stay (Elective)		3.10	n/a	3.45		3.10	3.29
25 Length of Stay (Non-Elective)		4.23	n/a	4.13		4.23	4.04
26 Average number of patients with LoS >14 days		197	200	176		197	185
*Please note these figures are provisional							
** Reporting one months in arrears							

+ This metric has been calculated in accordance to NHSI and East of England Cancer Alliance Reallocation policy, which displays the Trust's reallocated position. Please note that this policy came in to affect for August 2017's data. Therefore, all data predating August 2017 should be considered as the Trust's pre-reallocated position. December's 2018's data is subject to final validation and agreement from tertiary provider trusts.

*** Please note that the A&E combined performance for April 2018 has been calculated using the provisional daily figures for the Walk in Centre

Core Slide 17

Performance Summary - Lead Director Chris Cobb

Performance – key issues

1. **Cancer** – January 62 Day forecast downgraded against trajectory to 67.5% from 80% whilst final backlog clearance takes place to maximise opportunity to achieve 85% in February. Delayed diagnostic phases of pathways present key risk with targeted actions needed to mitigate impact.

2. **ED** – System performance below recovery trajectory at 82.5%. ED demand increased by 5.1% on December 2017 with ambulance arrivals up by 7% on December 17. Bed pressures, were the main contributory factor in the under delivery of this trajectory. Additional Winter capacity introduced late December.

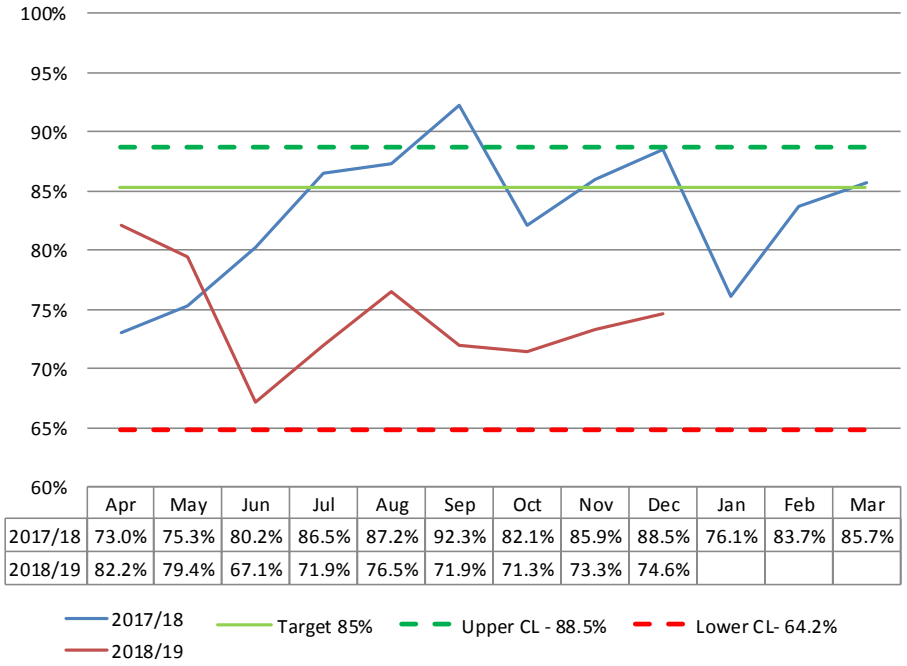
3. **RTT** – A continued increase in 2ww referral impacting on RTT. Reduction schemes continue to be explored with commissioners as part of mitigating actions within and additional to the RAP. Known issues of an ageing waiting list remain. Long waits continue to be clinically reviewed and the PTL manages prospective risk. 52 week breach risk remains with greater clinical urgency displacing long routine waits.

4. **Stroke** – Overall SSNAP rating of 'B' for December. "A" rating missed by 2%. The main factors for reduced rating were reduced performance in OT and SALT interventions due to a combination of increased demand and sickness.

Core Slide 18

Performance (Cancer) - Lead Director Chris Cobb

Reallocated Cancer 62 day target for referral to treatment (Previous Month) - GP Referral *



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	73.0%	75.3%	80.2%	86.5%	87.2%	92.3%	82.1%	85.9%	88.5%	76.1%	83.7%	85.7%
2018/19	82.2%	79.4%	67.1%	71.9%	76.5%	71.9%	71.3%	73.3%	74.6%			

Issues

- High numbers of 2ww referrals impacting on capacity and recovery. Backlog reduction still a priority to reduce breaches and regain performance with progress demonstrated in December however increase seen in January due to reduction in activity.
- Capacity constraints in template biopsies and imaging leading to increased waits and decreased overall urology performance.
- Complex pathways in Breast cancer and spikes in referral leading to increased breaches.
- Large PTL in Colorectal and delayed investigative pathway

Actions

- Micromanagement of cancer PTL continues with second weekly escalation PTL meetings in place for challenged specialties as required.
- Additional 2WW clinics to respond to demand in Breast
- Increased diagnostic/treatment capacity in Urology in place via weekend working and change in weekday list allocation.
- STP focus on lung and urology pathways with additional posts for both pathways approved.
- Cancer transformation funding allocated for projects to commence and recruitment now underway. Capital funding allocation agreed which will ease pressure on Urology pathway.

**This metric has been calculated in accordance to NHSI and East of England Cancer Alliance Reallocation policy, which displays the Trust's reallocated position. Please note that this policy came in to affect for August 2017's data. Therefore, all data predating August 2017 should be considered as the Trust's pre-reallocated position.* December's 2018's data is subject to final validation and agreement from tertiary provider trusts. Final position will be confirmed in February 2019.

Core Slide 18a

Performance (Cancer) - Lead Director Chris Cobb

62 Day GP Breaches – November (Open)

	Breast	Gynaecology	Haematology	Head and Neck	Lower GI	Lung	Other	Sarcoma	Skin	Upper GI	Urology	Grand Total
Administrative delay (e.g. failed to be rebooked after Did Not Attend, lost referral)				1	2.5	0.5	0.5		1	1.5	4	11
Complex diagnostic pathway (many or complex diagnostic tests required)						1				1		2
Elective cancellation (for non-medical reasons)		1								0.5		1.5
Elective capacity inadequate (Patient unable to be scheduled for treatment within standard time)				0.5	2	1		0.5	2		5	11
Health care provider initiated delay to diagnostic test or treatment planning	1	2	2	2		3				2	2.5	14.5
Out-patient capacity inadequate (i.e. no cancelled clinic, but not enough slots for this patient)	1				1	1			7		1	11
Patient did not attend treatment appointment					0.5							0.5
Grand Total	**2**	**3**	**2**	**3.5**	**6**	**6.5**	**0.5**	**0.5**	**10**	**5**	**14.5**	**53.5**

	Cancer Waiting Times	East of England Reallocation
Activity	187.5	176.5
Breaches	53.5	50
Performance	71.47%	71.67%

Urology breach share decreasing – anomalous levels of Skin breaches forecast to be resolved by February. Targeted actions in Breast, Colorectal and Lung to reduce marginal breaches to trajectory

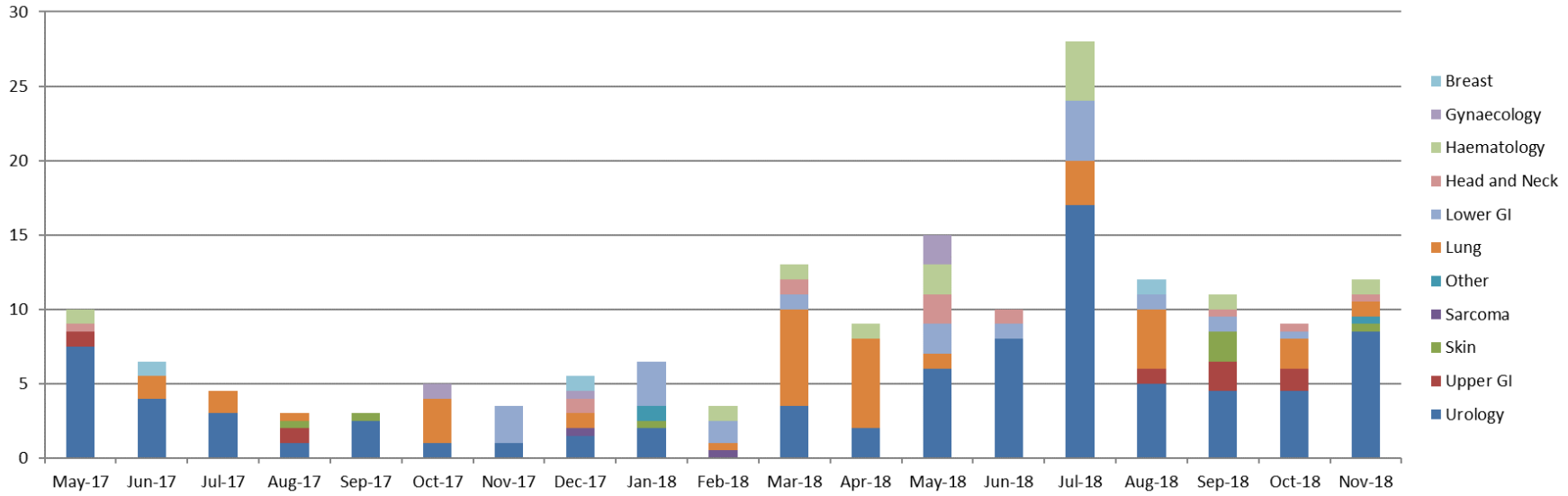
Core Slide 18b

Performance (Cancer) - Lead Director Chris Cobb

62 Day GP Breaches waiting over 104 Days – November (Open)

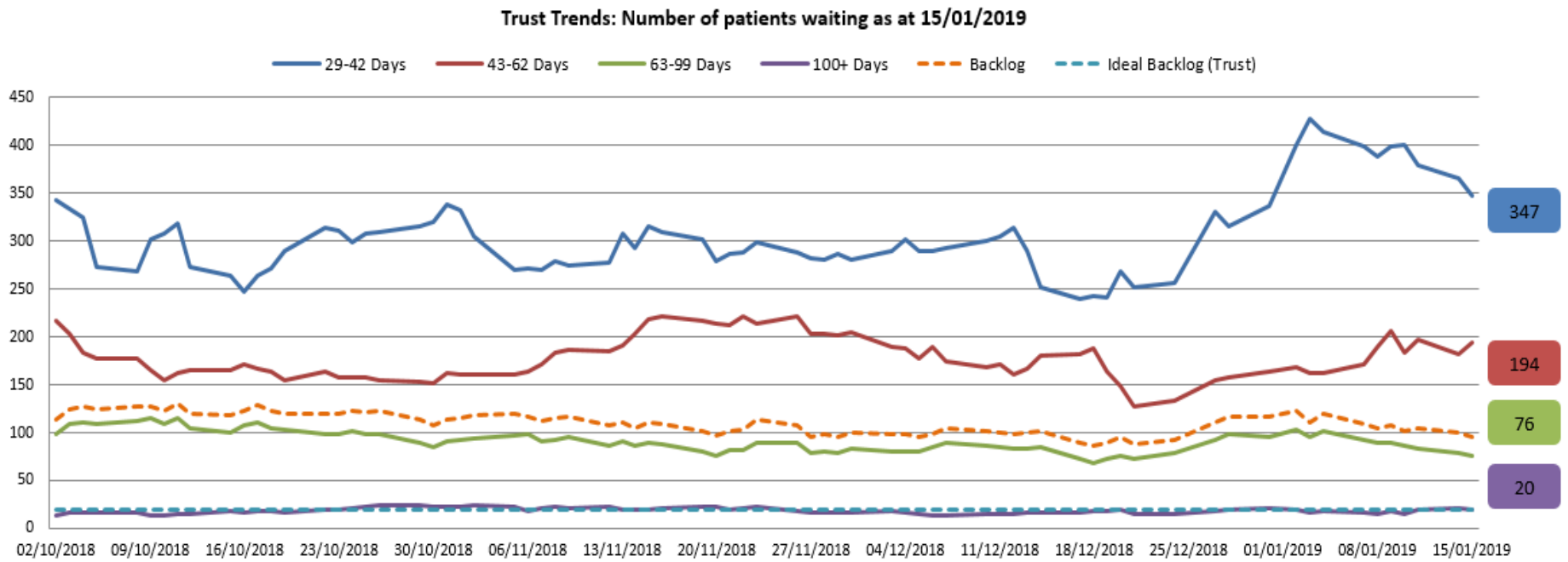
	Haematology	Head and Neck	Lung	Other	Skin	Urology	Grand Total
Administrative delay (e.g. failed to be rebooked after Did Not Attend, lost referral)		0.5		0.5	0.5	3	4.5
Elective capacity inadequate (Patient unable to be scheduled for treatment within standard time)						2	2
Health care provider initiated delay to diagnostic test or treatment planning	1		1			2.5	4.5
Patient initiated (choice) delay to diagnostic test or treatment planning, advance notice given						1	1
Grand Total	**1**	**0.5**	**1**	**0.5**	**0.5**	**8.5**	**12**

Urology represents most long waiters consisting primarily of Prostate patients. All harm reviews have shown no harm caused.



Core Slide 19

Performance (Cancer) - Lead Director Chris Cobb



TOTAL	0-14 Days	15-28 Days	29-42 Days	43-62 Days	63-99 Days	100+ Days	Backlog	Rollovers*
2,058	987	434	347	194	76	20	96	32

Backlog increased due to Dermatology pathology reporting delays, these patients have been treated and are waiting for histology results. Waiting times for Dermatology reducing and will have significant improvement on backlog numbers. Urology backlog increased in January having been significantly reduced. Large growth in 29-42 day cohort in Colorectal.

Core Slide 20

Performance (Cancer) – Lead Director Chris Cobb

Cancer 31 day target for subsequent treatments - Surgery *

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	96.4%	94.0%	98.3%	98.0%	97.9%	100.0%	96.5%	98.0%	94.5%	93.3%	90.3%	86.7%
2018/19	94.1%	86.0%	87.4%	91.4%	82.4%	73.6%	80.6%	85.4%	82.6%			

Please note data for November 2018 data is provisional

Issues

- Competing targets and pressures in Urology and Plastic Surgery continue to depress performance.
- Actions in place to increase capacity in plastics (from December 18) and Urology.

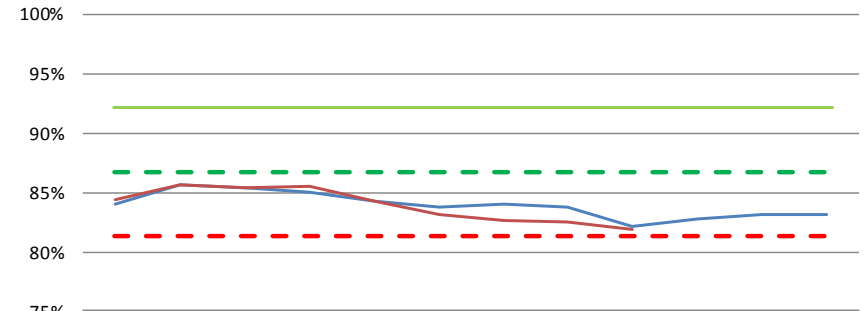
Actions

- Urology cancer priorities for additional lists
- Additional weekend lists throughout November and December
- Weekly surgical planning meeting (separate to PTL meeting) now in place to guide prioritisation of patients
- Plastic Surgery activity review undertaken with changes being implemented to balance demand and capacity.

Core Slide 21

Performance (RTT and A&E) – Lead Director Chris Cobb

18 week RTT target - Patients on an incomplete pathway

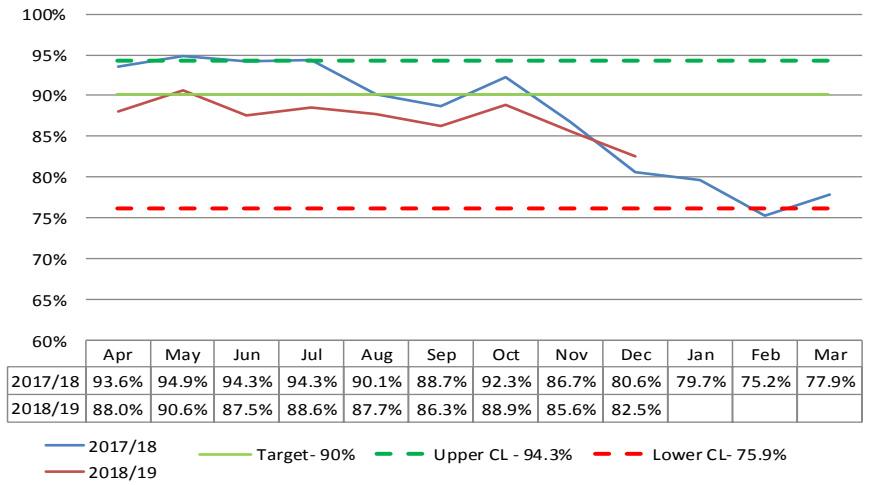


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	84.0%	85.6%	85.4%	85.0%	84.3%	83.8%	84.1%	83.7%	82.2%	82.7%	83.2%	83.1%
2018/19	84.3%	85.7%	85.4%	85.5%	84.3%	83.1%	82.6%	82.5%	81.8%			

Issues
- Waiting list holding steady due to slight reduction in referrals in Dec 18, increasing backlog over 18 weeks.
- Corresponding increase in 40+weeks and associated 52 weeks
- 52 week waits increasing due to IRU and theatre capacity issues

Actions
- New RTT RAP in production with Ops Teams to revisit schemes for delivery of business plan
- Commissioner demand management scheme exploration to inform RTT RAP underway
- IRU deep dive underway into booking processes,
- Initiatives planned to reduce 52 week breaches to zero for end March 19

System Performance



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	93.6%	94.9%	94.3%	94.3%	90.1%	88.7%	92.3%	86.7%	80.6%	79.7%	75.2%	77.9%
2018/19	88.0%	90.6%	87.5%	88.6%	87.7%	86.3%	88.9%	85.6%	82.5%			

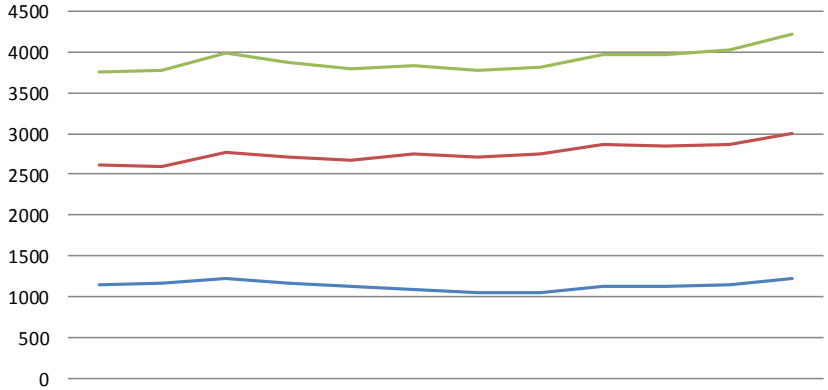
Issues
- NNUH performance 74.4% compared to 69% last December
- System wide performance 82.5% compared to 80.6% last December.
- Attendances up by 5.1% with ambulance arrivals up by 7% compared to last December

Actions
- Winter Plan introduced late December.
- Winter Room triumvirate appointed

Core Slide 22

Performance (RTT) – Lead Director Chris Cobb

Admitted Backlog

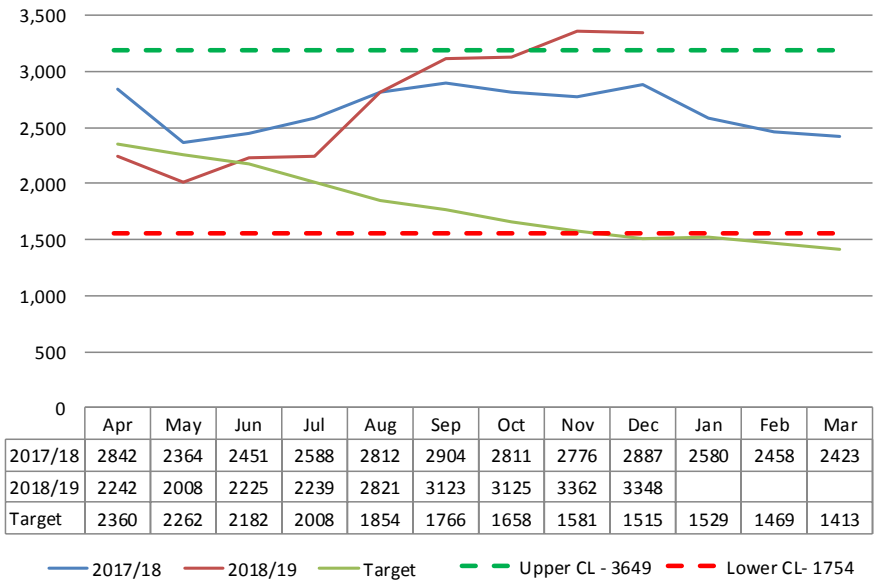


	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Admitted IP Backlog	1139	1174	1224	1172	1126	1095	1059	1055	1119	1129	1145	1223
Admitted DC Backlog	2608	2596	2771	2707	2667	2744	2720	2751	2858	2853	2874	2995
Admitted Backlog	3748	3770	3995	3879	3793	3839	3779	3806	3978	3977	4019	4218

Issues
- Backlog increasing and increased cancer demand and Urgent case mix impacting on delivery of routine work.
- Increasing 52 week breaches and likelihood of further breaches
- Cancellations due to bed pressures impacting performance

Actions
- Theatre efficiency programme in place, week on week improvements seen up to Christmas week
- Initiatives under development to minimise 52 week breaches at end March 19
- Case to utilise Turnstone court theatres in development

Incomplete Non Admitted Backlog



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	2842	2364	2451	2588	2812	2904	2811	2776	2887	2580	2458	2423
2018/19	2242	2008	2225	2239	2821	3123	3125	3362	3348			
Target	2360	2262	2182	2008	1854	1766	1658	1581	1515	1529	1469	1413

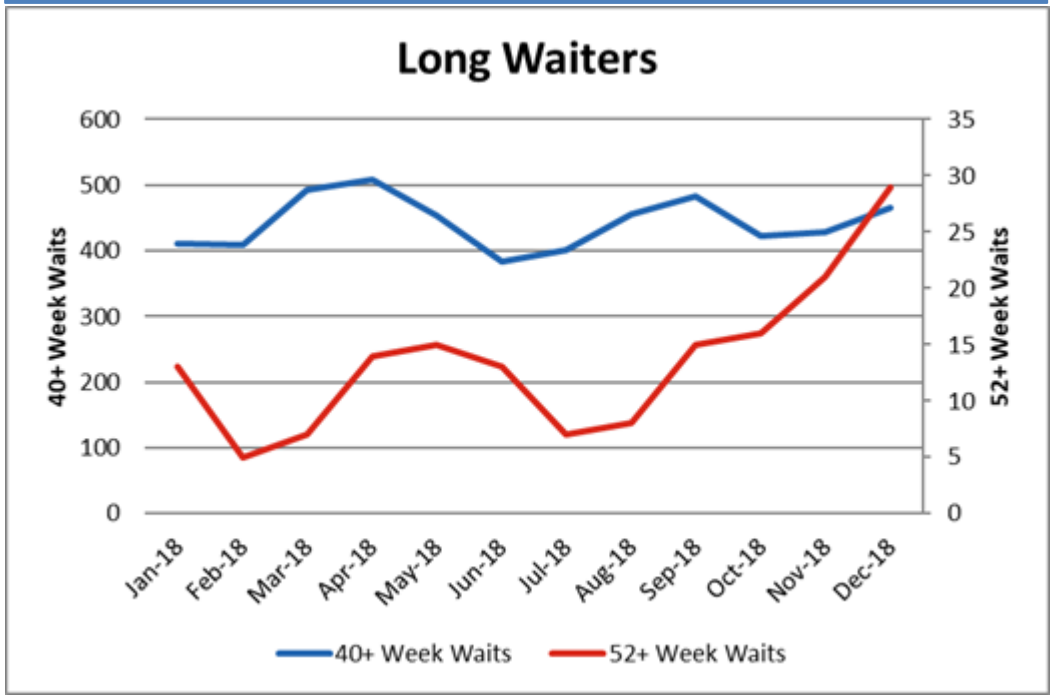
Issues
- Increase in non admitted waiting list continues, driven by increase demand and 2ww referrals
- Increase in 2ww referrals impacting on overall waiting list size and will continue to impact on backlog in future months
- Dec steady due to reduced referrals over Xmas period

Actions
- Additional OP capacity across all specialities in progress
- Targeted validation of waiting lists in place
- Working with clinical teams to ensure correct application of RTT
- Working with commissioners on demand management

Additional Slide 22a

Performance (RTT) – Lead Director Chris Cobb

Long Waiters – Over 40 and 52 Weeks*



Please note the figures for December 2018 are provisional

Comments

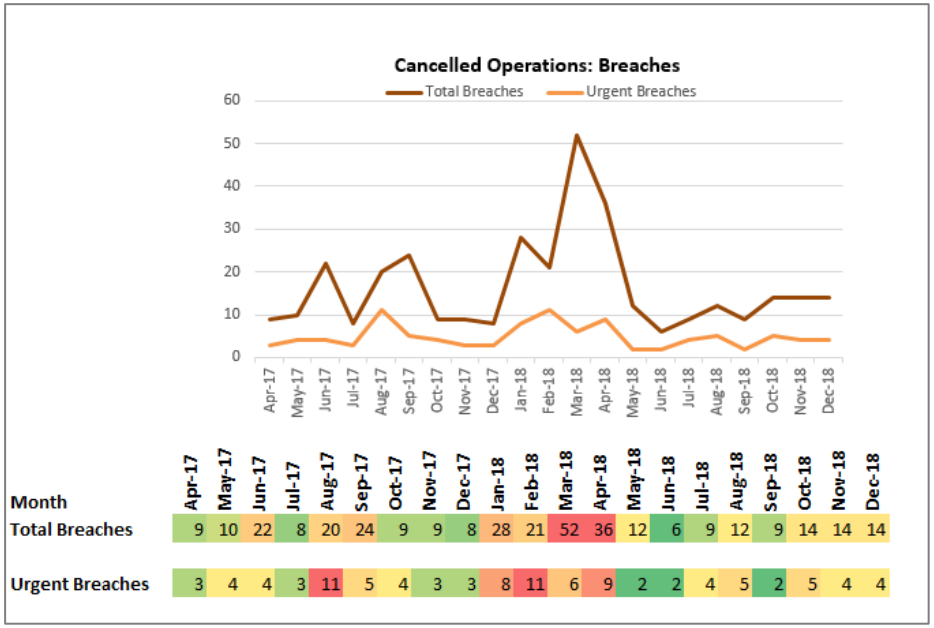
- increase in 52wk patient numbers due to IRU capacity and limited Theatre capacity, with cancellations for bed pressures impacting on 40 weeks. Interim plans being developed to increase IRU capacity and reduce number of 40 week waits,
- Rigorous monitoring of clinical harm in place
- Proactive management of long-waiting patients continues but with an increasing spread across several specialities.

Additional Slide 22b

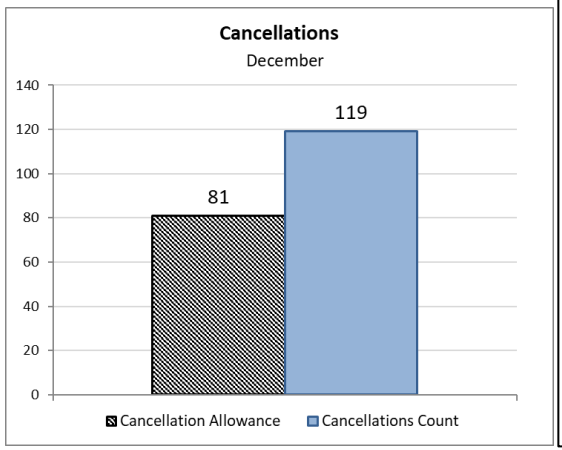
Performance (RTT) – Lead Director Chris Cobb

Cancelled Operations

Targets based on the previous four quarters of the QMCO aim for NNUH to reflect NHS England's trajectory for last minute cancelled operations, as well as breaches of the 28 day target. *N.B. QMCO data has now been updated to include 2018/19 Q1 data.*

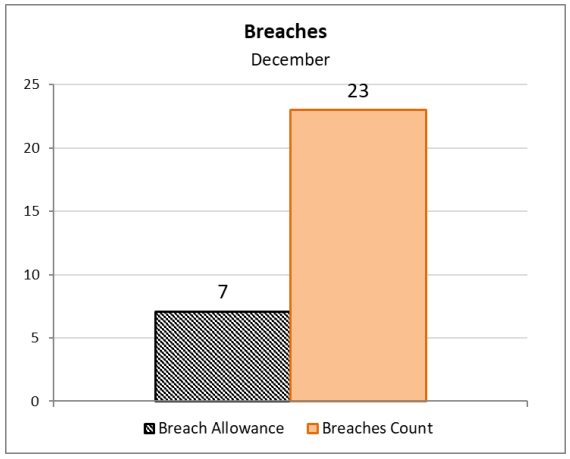


Month	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Total Breaches	9	10	22	8	20	24	9	9	8	28	21	52	36	12	6	9	12	9	14	14	14
Urgent Breaches	3	4	4	3	11	5	4	3	3	8	11	6	9	2	2	4	5	2	5	4	4



Target: NHS England's last minute cancelled operations rate is c. **1.07%** of all elective activity.

- Based on December's elective activity this would equate to **81** cancellations.
- NNUH saw **119** cancellations.
- This represented **1.58%** of elective activity.



Target: NHS England's breach percentage is c. **8.78%** of last minute cancelled operations.

- Based on December's last minute cancellations this would equate to **7** breaches.
- NNUH saw **23** breaches.
- This represented **19.33%** of cancellations.

Core Slide 23
Internal Sentinel Stroke Audit Programme (SSNAP) Dashboard

PERIOD	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
OVERALL SSNAP SCORE	74.5	72.0	66.0	84.0	74.0	72.0	74.0	82.0	76.0	80.0	82.0	82.0	80.0
OVERALL SSNAP RATING	B	B	C	A	B	B	B	A	B	B	A	A	B
POTENTIAL STROKES	309	297	296	310	310	311	283	281	299	287	279	295	295
DIAGNOSED STROKES	97	98	107	112	106	93	80	103	91	91	104	96	107
DOMAIN 1 score	CT Scanning	85.3	84.0	73.5	96.7	87.7	93.3	82.5	96.7	93	82.59	92.4	89	90.2
DOMAIN 1 rating		B	C	C	A	B	B	C	A	A	C	B	B	B
DOMAIN 2 score	Stroke Unit	60.9	55.9	49.7	60.8	69.5	69	67	74.5	74.9	73.6	83.2	75.7	77.4
DOMAIN 2 rating		D	E	E	D	D	D	D	C	C	C	B	C	C
DOMAIN 3 score	Thrombolysis	70.6	69.6	63.4	71	55.3	66.4	65.7	75.8	75.4	72.4	77.4	65.9	70.7
DOMAIN 3 rating		B	C	D	B	D	C	C	B	B	B	B	C	B
DOMAIN 4 Score	Specialist Assessments	90.5	91	83.3	89.3	86.7	88	85.1	88	91	88.7	92.2	91.3	92.8
DOMAIN 4 Rating		A	A	B	B	B	B	B	B	A	B	A	A	A
DOMAIN 5 Score	Occupational Therapy	77.1	80.4	74.5	82.5	76.2	67	75.9	77.2	74.7	83.62	76.6	85.5	76.2
DOMAIN 5 Rating		B	A	C	A	B	C	B	B	C	A	B	A	B
DOMAIN 6 Score	Physiotherapy	74.7	69.8	76.3	80.2	78.6	73.2	75	76	75.1	80.21	78.5	75.2	76
DOMAIN 6 Rating		C	C	B	B	B	C	B	B	C	B	B	B	B
DOMAIN 7 Score	SALT	58.8	57.3	63.6	70.5	65.7	62.8	62.5	59.5	53.6	56.59	63.6	66.2	57
DOMAIN 7 Rating		C	C	C	B	B	C	C	C	D	C	C	B	C
DOMAIN 8 Score	MDT Working	78.8	77.6	78.2	82	79.5	75.8	80.9	81.9	79.2	81.0	81.0	84.7	82.6
DOMAIN 8 Rating		C	C	C	B	C	C	B	B	C	B	B	B	B
DOMAIN 9 Score	Standards by Discharge	95.8	98.0	97.7	97.9	98.7	95.7	97.9	98.3	92.0	98.5	91.0	88.1	81.5
DOMAIN 9 Rating		A	A	A	A	A	A	A	A	B	A	B	B	B
DOMAIN 10 Score	Discharge Process	99.5	100.0	100	100	100	100	100	100	98.3	100	100	96.2	100
DOMAIN 10 Rating		A	A	A	A	A	A	A	A	A	A	A	A	A

Internal overall SSNAP Rating for December 2018

B 80%

Overall Summary:

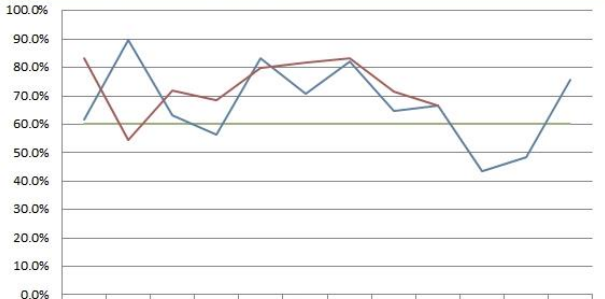
- Achieved a C in Stroke unit with ongoing winter pressures
- 6% improvement with Thrombolysis
- The SSNAP QUIP team are focusing on Stroke unit, Therapies and Standards by Discharge

Action:

- Ongoing education & awareness planning inside and outside of the Trust
- Workforce plan being developed for 2019/20
- Neurosciences unit escalation policy review in progress

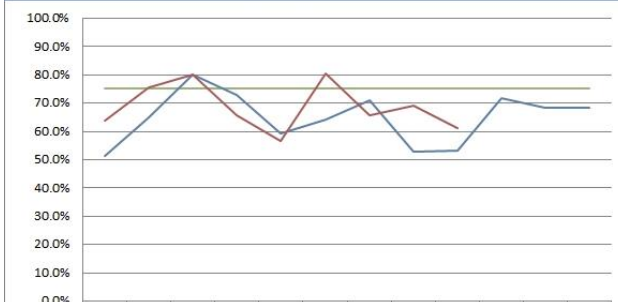
Core Slide 24 Performance (Cardiology) - Lead Director Christopher Cobb

% NSTEMI Time to Procedure < 72 Hours



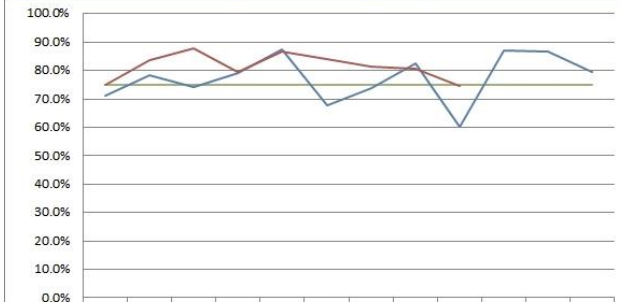
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%
2017-18	61.5%	89.7%	63.3%	56.5%	83.3%	70.6%	82.1%	64.9%	66.7%	43.5%	48.5%	75.8%
2018-19	83.3%	54.5%	71.8%	68.4%	80.0%	81.8%	83.3%	71.4%	66.7%			

% PPCI Call to Balloon < 150 Minutes



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%
2017-18	51.4%	64.9%	80.0%	73.0%	59.4%	64.3%	71.1%	52.9%	53.3%	71.8%	68.4%	68.4%
2018-19	63.9%	75.7%	80.0%	65.8%	56.8%	80.6%	65.6%	69.2%	61.1%			

% PPCI Door to Balloon < 60 Minutes



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%
2017-18	71.1%	78.4%	74.3%	78.9%	87.5%	67.9%	73.7%	82.4%	60.0%	87.2%	86.8%	79.5%
2018-19	75.0%	83.8%	87.8%	79.5%	86.5%	83.9%	81.3%	80.8%	74.5%			

NSTEMI

Standard Delivered

Call To Balloon Breach Reasons:

- 13 - Delayed/ Long journey time
- 2 - Another Patient on table, STEMI noted on subsequent ECG
- Cath lab access delayed
- ECG non diagnostic, Delay in A&E (NNUH)Initial ECG not exactly diagnostic, LVH, it was thought to be NSTEMI.
- Procedure delayed due to repeated failure of x ray equipment to boot up
- Initial ECG non diagnostic
- Emergency treatment required, pre PPCI Patient was agitated and needed to be sedated and intubated.
- Further medical assessment required pre PPCI, Delay in A&E (NNUH)ECG was not interpreted initially as STEMI and the ambulance ECG not available initially

Door to Balloon Breach Reasons:

- 4 - Delay in A&E (NNUH)
- 4 - Another Pt already on the table
- 2 - Short activation time
- Further medical assessment required pre PPCI
- Cath lab access delayed
- Emergency treatment required pre PPCI
- Technically difficult procedure

Core Slide 25 Performance (Productivity) Summary – Lead Director Chris Cobb

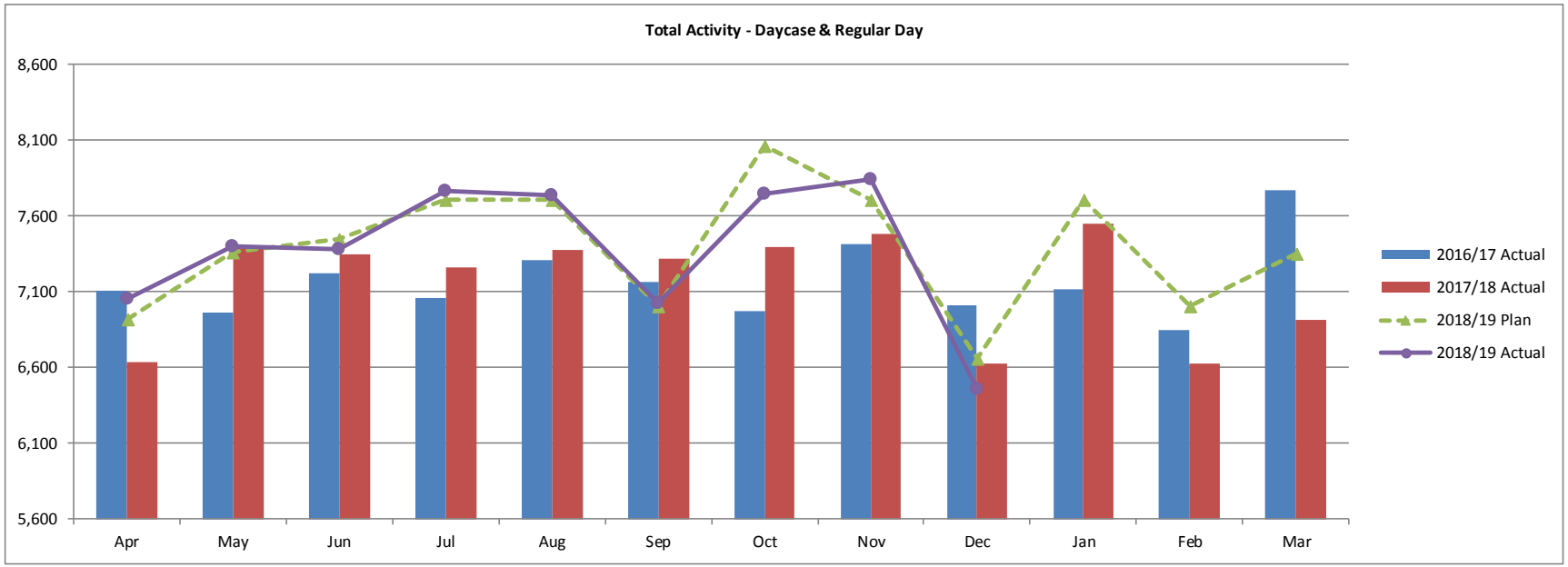
Productivity		Outturn 2017/18	Monthly Target	Dec-18	6 month trend	YTD 2017/18	YTD 2018/19
A&E Activity (attendances)		131235	11534	11454		100277	106720
Elective Activity - Day case spells	Core Slide 26	85923	6656	6456		64843	66417
Elective Activity - Elective inpatient spells	Core Slide 26a	13330	1033	950		10141	9618
Emergency Admissions	Core Slide 26b	56018	4763	5020		42083	43903
Outpatient Activity (consultant led & non-consultant led)	Core slide 26c	725710	53084	53861		541906	573523

Core Slide 26

Performance (Productivity) – Lead Director Chris Cobb

Activity & Income
2016/17 vs 2017/18 vs 2018/19 YTD
Daycase and Regular Day Attenders

Activity	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Full Year
2016/17 Actual	7,111	6,959	7,219	7,063	7,311	7,161	6,970	7,419	7,013	7,113	6,846	7,774	**64,226**	**85,959**
2017/18 Actual	6,636	7,402	7,346	7,263	7,372	7,316	7,400	7,481	6,627	7,546	6,623	6,912	**64,843**	**85,924**
2018/19 Plan	6,920	7,360	7,449	7,709	7,709	7,006	8,064	7,707	6,656	7,708	7,010	7,356	**66,580**	**88,654**
2018/19 Actual	7,053	7,398	7,385	7,770	7,738	7,029	7,744	7,844	6,456				**66,417**	**66,417**
Variance to 2017/18	417	(4)	39	507	366	(287)	344	363	(171)				**1,574**	**1,574**
Variance to 2017/18 %	6.3%	-0.1%	0.5%	7.0%	5.0%	-3.9%	4.6%	4.9%	-2.6%				**2.43%**	
Variance to Plan	133	38	(64)	61	29	23	(320)	137	(200)				**(163)**	**(163)**
Variance to Plan %	1.9%	0.5%	-0.9%	0.8%	0.4%	0.3%	-4.0%	1.8%	-3.0%				**-0.25%**	



Issues and Comment

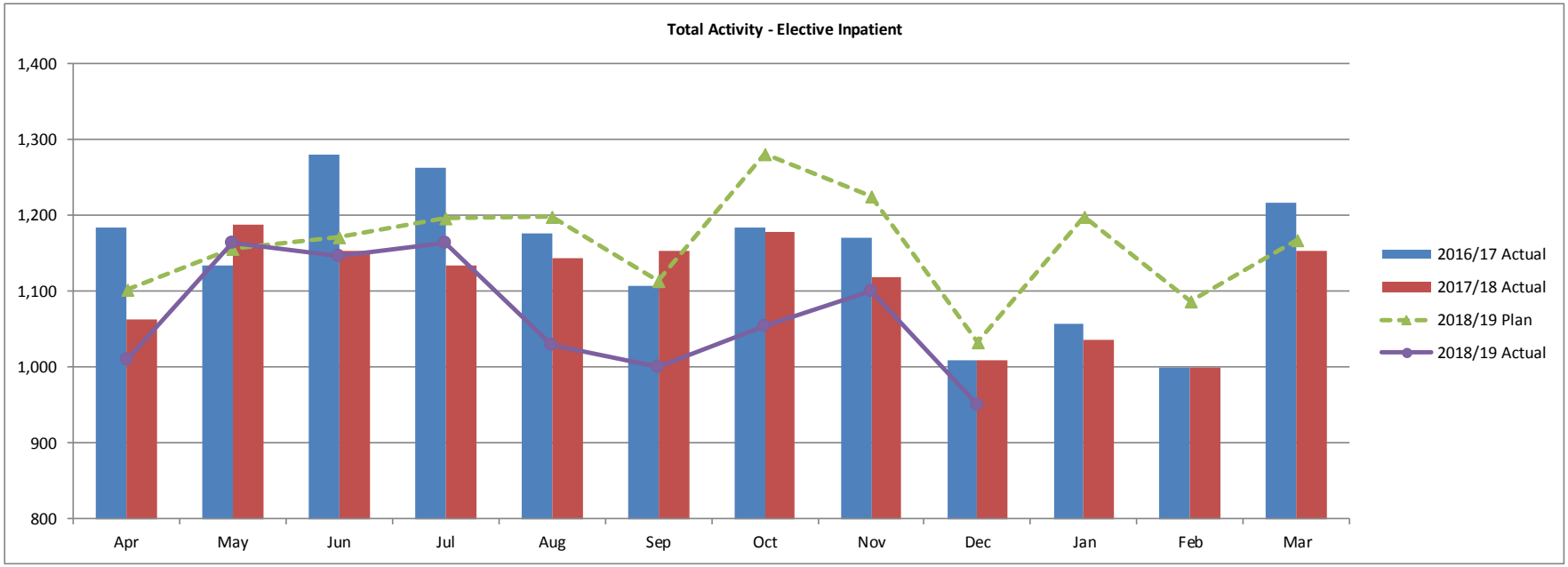
- Overall daycase performance was under plan by 200 cases (-3.0%) and 171 behind December 2017 levels (-2.6%)
- This performance was again a mixed picture with medicine over performing by 34 cases (mainly clinical haematology) and surgery 247 cases down compared to plan (Ophthalmology, Pain Management and Dermatology). Dermatology have an ongoing challenge with capacity and demand, new outpatients prioritised to manage 2ww referrals, full compliment of Junior doctors from September will see an improving picture. Dermatology accounted for 104 cases behind the plan.
- Case mix shift in Surgery work with a high level of non-elective activity particularly in general surgery, plastics and ENT, limiting over performance in day cases and electives as a result of theatre productivity programme

Additional Slide 26a

Performance (Productivity) – Lead Director Chris Cobb

Activity & Income
2016/17 vs 2017/18 vs 2018/19 YTD
Elective Inpatient

Activity	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Full Year
2016/17 Actual	1,184	1,134	1,280	1,263	1,177	1,107	1,184	1,171	1,009	1,057	999	1,217	**10,509**	**13,782**
2017/18 Actual	1,063	1,188	1,153	1,134	1,143	1,154	1,179	1,118	1,009	1,036	1,000	1,153	**10,141**	**13,330**
2018/19 Plan	1,101	1,156	1,172	1,197	1,198	1,114	1,282	1,225	1,033	1,199	1,087	1,167	**10,479**	**13,933**
2018/19 Actual	1,010	1,163	1,147	1,163	1,029	1,000	1,055	1,101	950				**9,618**	**9,618**
Variance to 2017/18	(53)	(25)	(6)	29	(114)	(154)	(124)	(17)	(59)				**(523)**	**(523)**
Variance to 2017/18 %	-5.0%	-2.1%	-0.5%	2.6%	-10.0%	-13.3%	-10.5%	-1.5%	-5.8%				**-5.16%**	
Variance to Plan	(91)	7	(25)	(34)	(169)	(114)	(227)	(124)	(83)				**(861)**	**(861)**
Variance to Plan %	-8.3%	0.6%	-2.2%	-2.8%	-14.1%	-10.2%	-17.7%	-10.1%	-8.1%				**-8.22%**	



Issues and Comment

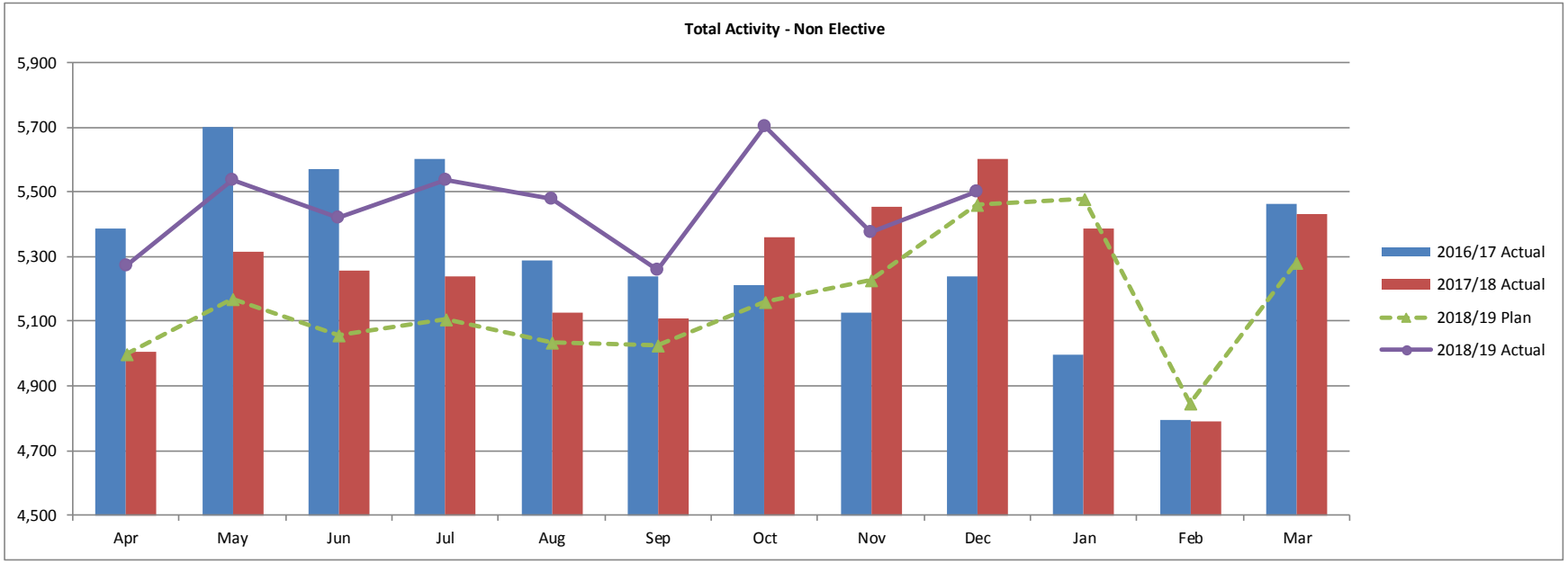
- Elective activity was 83 cases behind plan (-8.1%) and 59 cases (-5.8%) behind December 2017 levels.
- Surgery were 8 cases ahead of plan in month (due to T&O/spinal). Cardiology were 78 cases behind plan. High levels of non-elective activity within the hospital and surgical specialities has had a knock on impact on electives. Gynaecology activity was also 19 less than plan.
- Theatre productivity programme focusses on d/c electives. This is not reflected in current reporting therefore the plan will be corrected for future months i.e. the elective plan reduces and the day-case plan increases

Additional Slide 26b

Performance (Productivity) – Lead Director Chris Cobb

Activity & Income
2016/17 vs 2017/18 vs 2018/19 YTD
Non Elective (exlcuding Marginal Rate)

Activity	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Full Year
2016/17 Actual	5,385	5,703	5,572	5,602	5,289	5,240	5,212	5,128	5,240	4,998	4,794	5,464	**48,371**	**63,627**
2017/18 Actual	5,006	5,314	5,255	5,239	5,127	5,111	5,359	5,453	5,601	5,388	4,788	5,432	**47,465**	**63,073**
2018/19 Plan	5,000	5,169	5,057	5,107	5,034	5,025	5,162	5,229	5,460	5,478	4,845	5,280	**46,244**	**61,847**
2018/19 Actual	5,274	5,539	5,421	5,539	5,478	5,260	5,702	5,376	5,501				**49,090**	**49,090**
Variance to 2017/18	268	225	166	300	351	149	343	(77)	(100)				**1,625**	**1,625**
Variance to 2017/18 %	5.4%	4.2%	3.2%	5.7%	6.8%	2.9%	6.4%	-1.4%	-1.8%				**3.42%**	
Variance to Plan	274	370	364	432	444	235	540	147	41				**2,846**	**2,846**
Variance to Plan %	5.5%	7.2%	7.2%	8.5%	8.8%	4.7%	10.5%	2.8%	0.7%				**6.15%**	



Issues and Comment

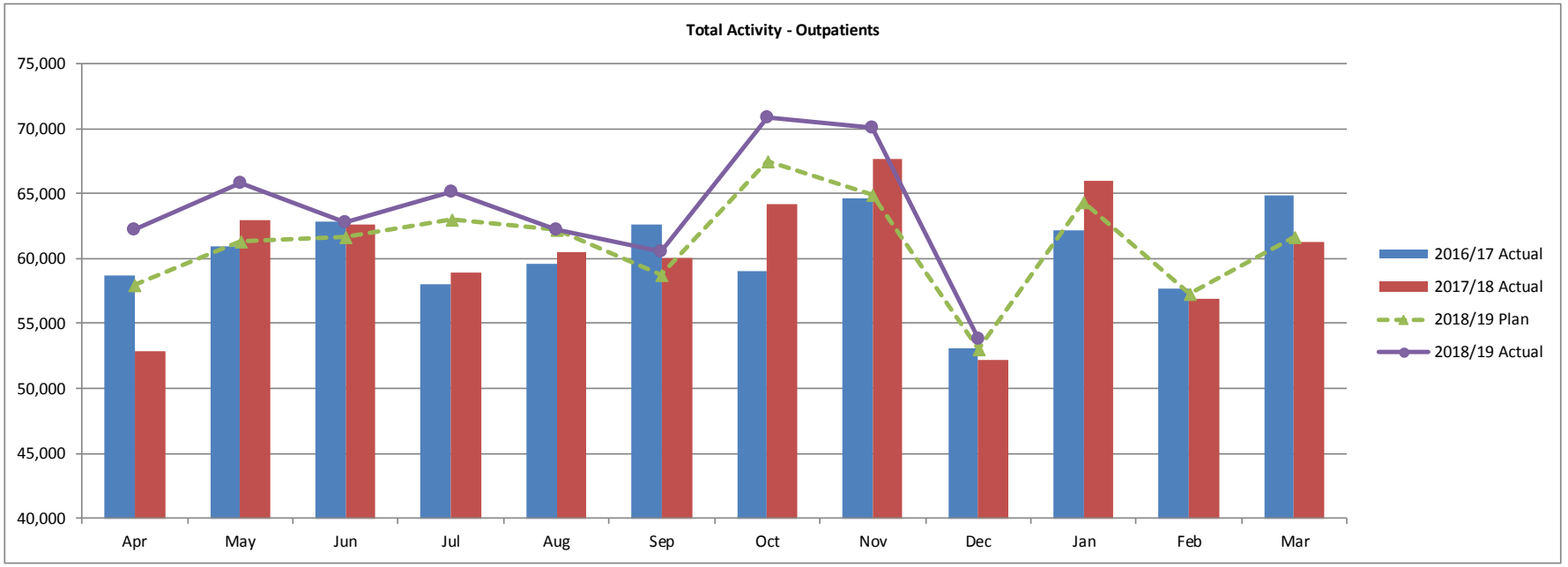
- Non-electives were 0.7% (41 cases) above business plan but 1.8% (-100 cases) behind prior year levels. The levels of non-elective admissions remain a cause for concern re the impact on elective capacity.
- An early warning contract notice has been issued to commissioners to highlight concern around growing levels of non-elective demand.
- The main areas of over performance were across medicine (+51 cases) as well as women & children (+23 cases)– with the worst hit specialities being OPM /Stroke (+170) , Cardiology (+61) and Paediatrics (+122).

Additional Slide 26c

Performance (Productivity) – Lead Director Chris Cobb

Activity & Income
2016/17 vs 2017/18 vs 2018/19 YTD
Outpatient - All (Consultant & Non Consultant Led, New & Follow Up)

Activity	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Full Year
2016/17 Actual	58,647	60,971	62,885	58,054	59,595	62,622	59,078	64,679	53,131	62,166	57,652	64,853	**539,662**	**724,333**
2017/18 Actual	52,854	63,012	62,641	58,913	60,491	60,005	64,170	67,685	52,135	65,980	56,915	61,313	**541,906**	**726,114**
2018/19 Plan	58,005	61,327	61,643	63,068	62,229	58,746	67,457	64,977	53,084	64,342	57,259	61,639	**550,537**	**733,777**
2018/19 Actual	62,223	65,871	62,750	65,151	62,216	60,550	70,858	70,043	53,861				**573,523**	**573,523**
Variance to 2017/18	9,369	2,859	109	6,238	1,725	545	6,688	2,358	1,726				**31,617**	**31,617**
Variance to 2017/18 %	17.7%	4.5%	0.2%	10.6%	2.9%	0.9%	10.4%	3.5%	3.3%				**5.83%**	
Variance to Plan	4,218	4,544	1,107	2,083	(13)	1,804	3,401	5,066	777				**22,986**	**22,986**
Variance to Plan %	7.3%	7.4%	1.8%	3.3%	0.0%	3.1%	5.0%	7.8%	1.5%				**4.18%**	

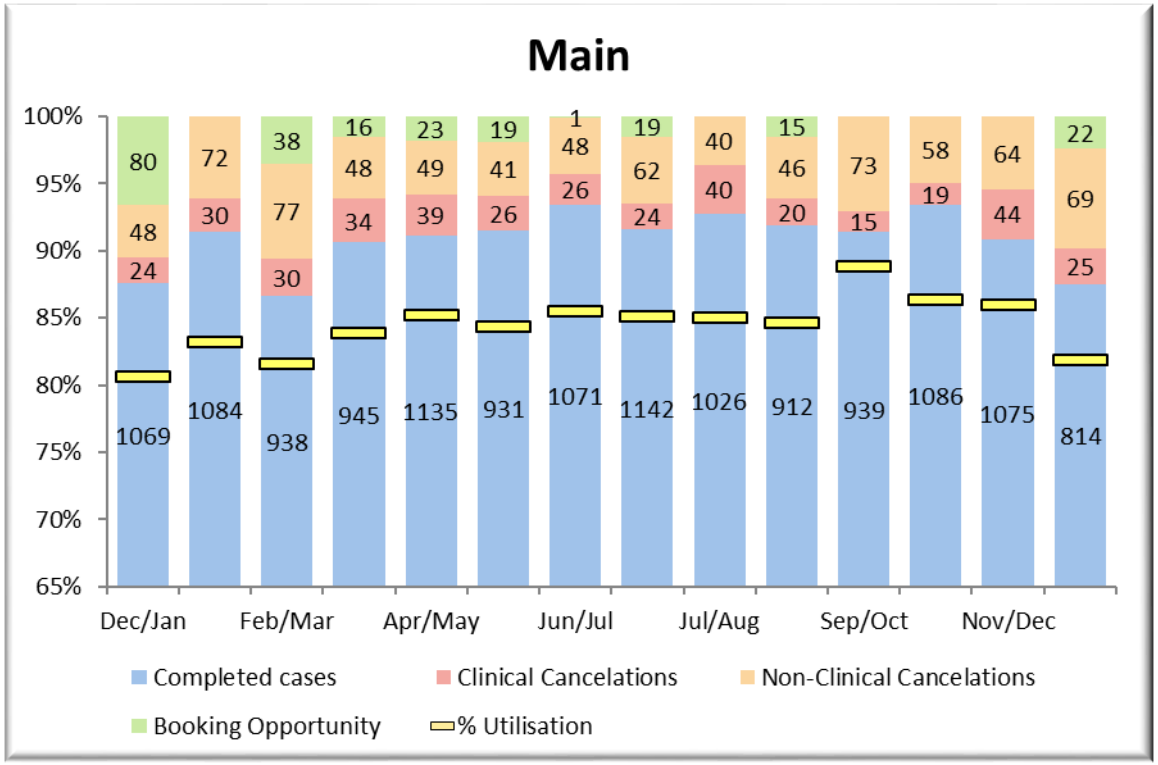


Issues and Comment

- OP activity performance for December was 1.5% ahead of plan and 3.3% ahead of December 2018 levels
- Overall consultant OP news were ahead of plan by 190 driven by increases in medicine (particularly Gastro and Neurology) and Paediatrics (+201 cases).
- Overall consultant follow-ups were over plan (+2,057) with gains in medicine (+1,170) and surgery (+994). The biggest areas of over performance was cardiology (+848)

Additional Slide 26d

Theatre Productivity (Main) – Lead Director Chris Cobb



Issues

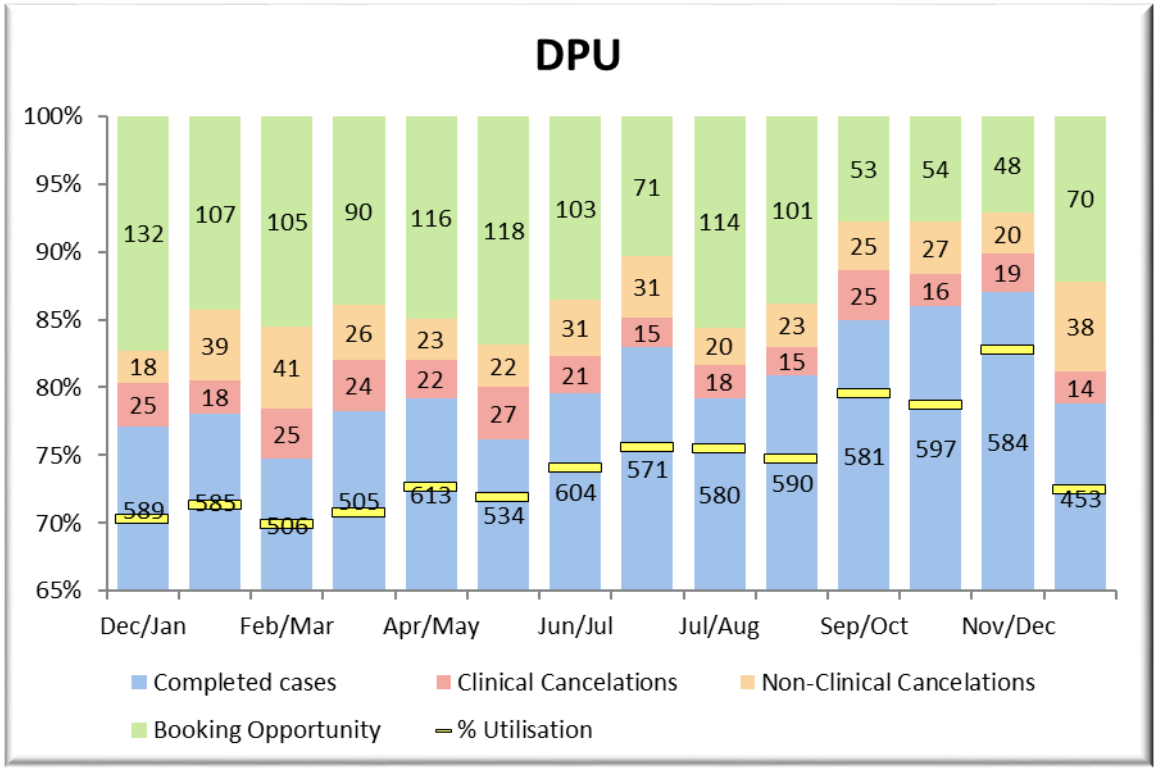
- Lower booking and utilisation typical over late December period.
- Non elective demand impacting on elective work
- Bed pressure s impacting electives in late December and first two weeks of January (last four week cycle shown here runs 17/12 to 13/01)

Actions

- New theatre timetable in place with fewer half day sessions.
- Prioritise lock down of lists at 4 weeks and patients booked by 2 weeks

Additional Slide 26e

Theatre Productivity (DPU) – Lead Director Chris Cobb



Issues
- Escalation into DPU and bed pressures impacting electives in late December and first two weeks of January (last four week cycle shown here runs 17/12 to 13/01)

Actions
- Theatre reconfiguration review completed for implementation in January
- Prioritise lock down of lists at 4 weeks and patients booked by 2 weeks

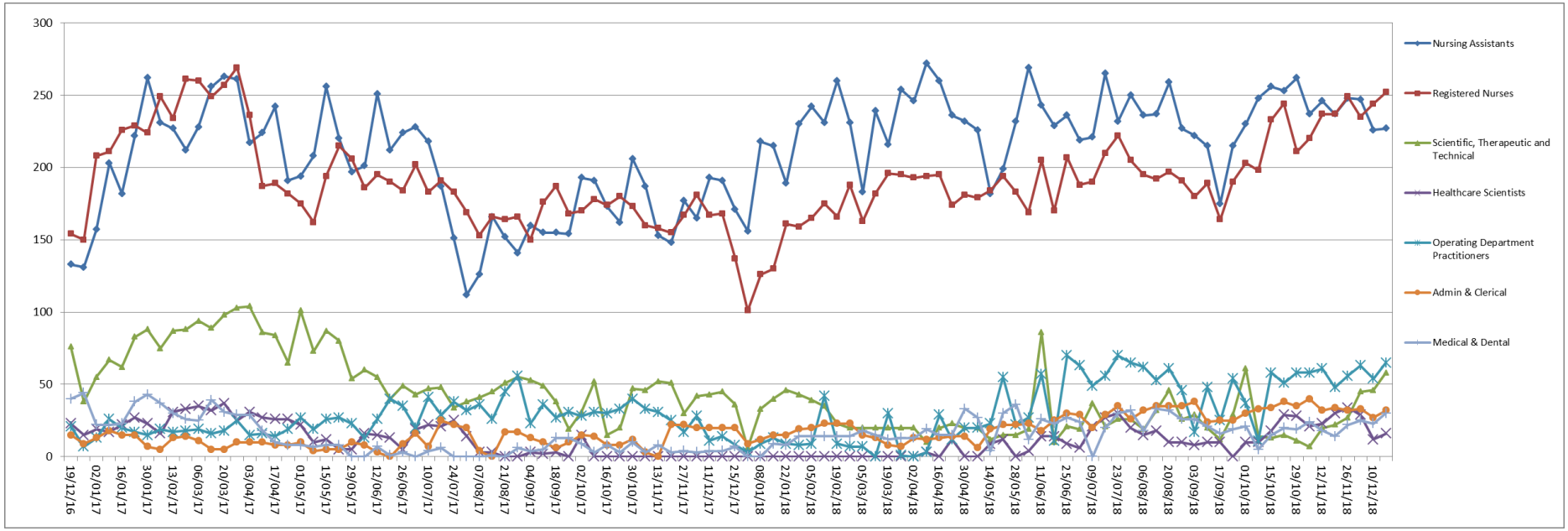
Core Slide 27

Workforce Summary – Lead Director Jeremy Over

Workforce		Outturn 2017/18	Monthly Target	Dec-18	6 month trend	YTD 2017/18
Payroll						
1 Budgeted WTE*		7360	n/a	TBC		7360
2 Actual WTE*		6830	n/a	TBC		6830
3 Vacancy maximum (%)		7.20%	10.00%	TBC		7.20%
Pay Spend						
4 Pay spend - % employed (%)*		90.13%	n/a	89.20%		90.24%
5 Pay spend - % bank (%)*		3.29%	n/a	4.47%		3.29%
6 Pay spend - % agency (%)*		2.56%	n/a	2.70%		2.48%
7 Pay Spend - % Medical Locum (%)*		2.38%	n/a	1.90%		2.32%
Staffing Numbers	Core Slide 36					
8 % of registered nurse day hours filled as planned		92.30%	n/a	87.79%		92.79%
9 % of unregistered care staff day hours filled as planned		123.24%	n/a	100.56%		127.09%
10 % of registered nurse night hours filled as planned		93.85%	n/a	91.06%		93.92%
11 % of unregistered care staff night hours filled as planned		138.08%	n/a	123.41%		138.45%
12 RGN % Actual to planned		92.96%	n/a	89.16%		93.27%
13 HCA % Actual to planned		129.30%	n/a	109.37%		131.82%
14 Care hours per patient day (registered)		3.9	n/a	4.2		3.9
15 Care hours per patient day (Non-registered)		3.3	n/a	3.5		3.3
16 Care hours per patient day (Total)		7.3	n/a	7.7		7.3
Other						
17 Appraisals completed	Core Slide 32	65.80%	80.00%	80.81%		66.11%
18 Staff Turnover rate	Core Slide 33	10.43%	10.00%	10.66%		10.52%
16 Mandatory Training	Core Slide 34	83.13%	90.00%	86.43%		82.85%
17 Sickness levels**	Core Slide 35	4.02%	3.50%	4.61%		3.82%
18 Time to Hire (All)		68.5	n/a	73.0		68.5
Staff Survey						
19 Staff FFT – recommendation of NNUH as a place to receive care		72%	n/a	76%		TBC
20 Staff FFT – recommendation of NNUH as a place to work		56%	n/a	61%		TBC
* Please note these figures are provisional						
** Reported one month in arrears						

Core Slide 28 — Workforce - Lead Director Jeremy Over

Agency and Locum Shifts Booked

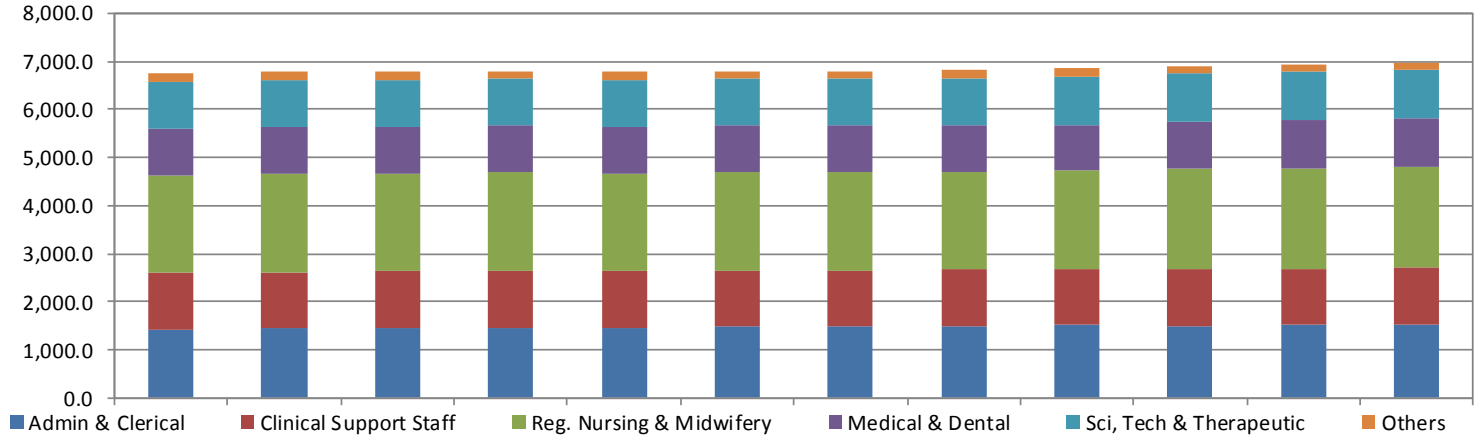


Commentary

- The latest monthly agency expenditure is detailed in the Finance IPR section
- Controls continue to be effective and responsive to situations where temporary workers are absolutely required based on clinical need and safety grounds.
- The Finance section of the IPR details the expenditure for the month.
- Break glass arrangements only for exceptional safety grounds (with executive level sign off).
- Pre-authorisation checklist and daily scrutiny by Medical Director for all locum requests has been very effective.
- Recruitment Oversight Group is in operation and applies controls to avoid cost pressures and assists with speedy recruitment.
- Bank incentives have had a positive impact on RN 'bank hours worked'.
- Overall workforce utilisation (WTE) is within agreed workforce plans (see finance section of IPR).

Core Slide 29 Workforce - Lead Director Jeremy Over

Workforce Staff in Post - WTE



Staff Group	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Difference	*% change*
Admin & Clerical	1,429.8	1,444.1	1,452.0	1,458.5	1,461.7	1,478.8	1,481.3	1,490.1	1,505.8	1,503.7	1,505.3	1,522.0	1,537.4	107.6	*7.5*
Clinical Support Staff	1,160.7	1,168.7	1,170.4	1,171.0	1,167.3	1,169.3	1,171.8	1,173.5	1,171.9	1,175.0	1,184.1	1,196.5	1,208.8	48.2	*4.2*
Reg. Nursing & Midwifery	2,021.3	2,055.1	2,043.7	2,048.1	2,045.0	2,035.7	2,031.2	2,040.1	2,036.6	2,079.3	2,088.1	2,096.7	2,097.3	76.0	*3.8*
Medical & Dental	975.9	967.5	966.1	973.5	965.3	970.7	968.8	955.3	971.2	985.9	988.0	991.4	999.0	23.2	*2.4*
Sci, Tech & Therapeutic	980.9	984.8	983.3	978.9	973.8	977.3	978.1	983.9	997.6	1,003.1	1,011.9	1,018.4	1,019.6	38.7	*3.9*
Others	168.3	166.8	164.9	164.9	161.0	161.6	163.4	162.0	160.0	158.0	156.8	158.6	159.4	-8.8	*-5.3*
Grand Total	**6,736.9**	**6,787.0**	**6,780.4**	**6,794.9**	**6,774.0**	**6,793.4**	**6,794.5**	**6,804.9**	**6,843.2**	**6,905.0**	**6,934.2**	**6,983.6**	**7,021.6**	**284.7**	***4.2***

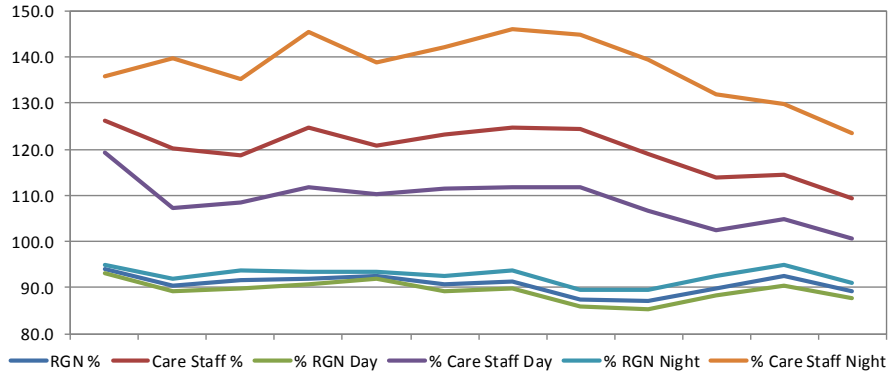
Commentary

- This slide / graph details the numbers of staff in post (WTE) at month end.
- The graph stacks the staff in post by staff group.
- Overall, in the last twelve months, there are 284.7 additional staff, an increase of 4.2% across NNUH as a result of service developments and capacity and quality investments.

Core Slide 30

Workforce - Lead Director Jeremy Over

Ward Nursing fill-rate Analysis



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
RGN %	94.0	90.5	91.6	91.9	92.7	90.7	91.4	87.4	87.1	90.0	92.4	89.2
Care Staff %	126.2	120.1	118.8	124.7	120.8	123.3	124.8	124.4	119.1	113.8	114.5	109.4
% RGN Day	93.3	89.3	89.9	90.6	92.1	89.3	89.7	85.8	85.4	88.2	90.6	87.8
% Care Staff Day	119.3	107.4	108.4	111.9	110.2	111.5	111.7	111.7	106.6	102.6	104.8	100.6
% RGN Night	95.0	92.1	93.9	93.6	93.5	92.7	93.7	89.7	89.5	92.5	95.0	91.1
% Care Staff Night	135.9	139.9	135.1	145.3	138.9	142.2	146.1	145.0	139.4	131.9	129.9	123.4

Care Hours per Patient Day - CHPPD

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Registered	4.0	3.8	3.9	4.1	4.1	4.1	4.2	4.0	3.9	4.2	4.2	4.2
Care Staff	3.0	3.3	3.3	3.5	3.6	3.5	3.6	3.6	3.5	3.5	3.6	3.5
Total	7.0	7.2	7.3	7.6	7.7	7.7	7.8	7.7	7.4	7.7	7.8	7.7

Escalations

<80% RN fill rate for December:

Ward	RN Fill Rate %
GMDU	68.5

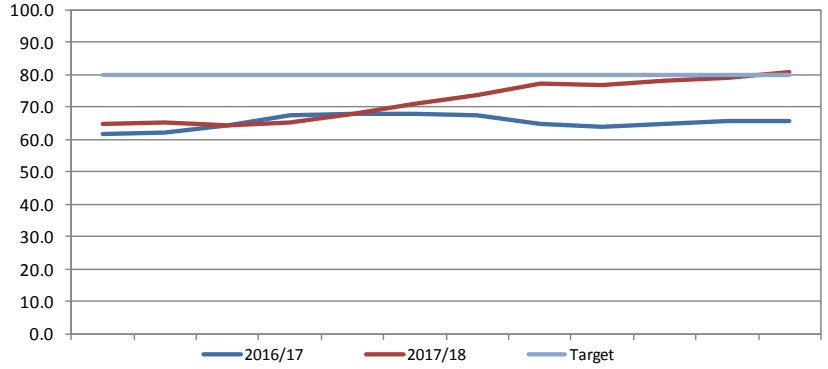
Commentary

- The first graph (Ward nursing fill rate) shows our planned nursing versus actual staffing levels in percentage terms.
- 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 (e.g. a third nursing assistant, compared with a staffing plan of 2 for the shift will result in a fill-rate of 150%).
- The fill rate for unregistered staff in day time hours remains above 100%.
- Care hours per patient day is calculated as: The total number of patient days in the month (Using the actual number of patients on the ward at 23:59 each day) / Total hours worked in the month (Total combined number of hours worked for both registered staff and care staff)

Core Slide 31

Workforce - Lead Director Jeremy Over

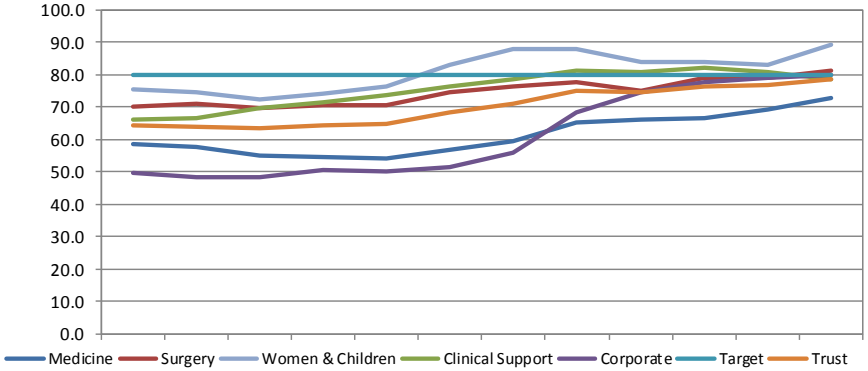
Appraisals completed* - Trust



Division	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2016/17	61.8	62.1	64.4	67.3	67.8	67.8	67.5	64.9	64.0	64.6	65.6	65.5
2017/18	65.0	65.1	64.5	65.3	68.0	71.2	73.6	77.0	76.6	78.3	79.2	80.8
Target	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0

*2016/2017 Trust figures based on Non-medical appraisals & 2017/18 based on all appraisals

Appraisals completed - Divisions



Division	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Medicine	58.7	57.6	55.0	54.5	54.3	56.9	59.5	65.1	65.9	66.4	69.4	72.6
Surgery	70.0	70.9	69.9	70.6	70.8	74.7	76.5	77.6	74.8	79.2	78.8	81.3
Women & Children	75.5	74.5	72.5	74.1	76.5	83.1	88.0	88.0	83.7	83.7	82.9	89.2
Clinical Support	66.3	66.7	69.7	71.6	73.6	76.6	78.4	81.3	80.9	82.2	80.8	78.5
Corporate	49.8	48.2	48.2	50.5	50.3	51.5	55.7	68.2	74.6	77.6	79.0	79.8
Trust	64.4	64.1	63.5	64.3	65.0	68.4	71.1	74.9	74.5	76.4	76.9	78.8
Target	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0

Commentary

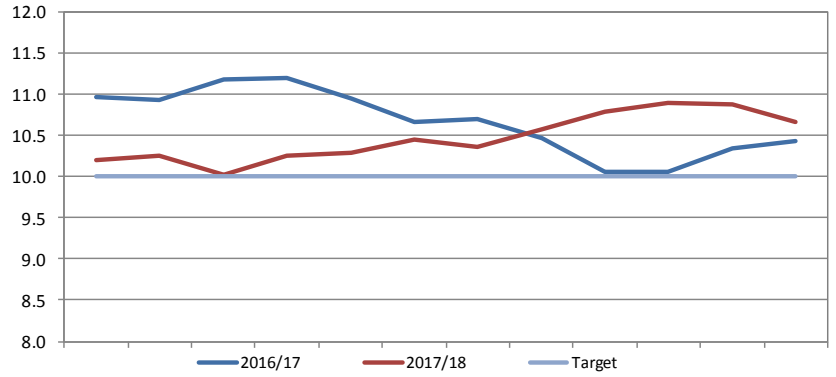
- Improvement of the annual appraisal completion rate is a must do from the CQC inspection. The target level was achieved in December.
- 80.8% of eligible staff (Non-Medical and Medical Staff) have had an appraisal during the last 12 months.
- Furthermore the rate of Non-Medical only appraisals has increased from 65% to 78.8% in the past 7 months
- Both Surgery and Women and Children Divisions are above 80%.
- Medicine Division has improved significantly in the past two months but, remains an outlier at 72.6%
- The NHS Staff Survey results suggest that 83% of our staff have responded that they have been appraised in the last 12 months (up from 82% in 2016). Also, the survey reports an increase in the quality of appraisals from 2016 to 2017 (the 'rating' increasing from 2.90 to 3.03 of a scale of 1-5).

Corporate Breakdown	Eligible	Current	%
Communications	3	3	100.0%
Clinical Effectiveness & Audit	11	11	100.0%
Safeguarding	8	8	100.0%
Commisioning, Data Quality, Coding	52	50	96.2%
Practice Development	17	16	94.1%
Complaints & Legal	13	12	92.3%
Infection Control	13	12	92.3%
Integrated Discharge	38	34	89.5%
Estates & Facilities	18	16	88.9%
Human Resources	62	55	88.7%
Finance	32	28	87.5%
Improvement Team	7	6	85.7%
Workplace Health & Wellbeing	33	28	84.8%
Ops Centre	25	21	84.0%
Training, Learning & Development	28	22	78.6%
Information Technology	79	58	73.4%
PMO	3	2	66.7%
Risk Mgt & Incident Reporting	8	5	62.5%
Research*	89	54	60.7%
Other**	46	26	56.5%
Corporate	**585**	**467**	**79.8%**

Core Slide 32

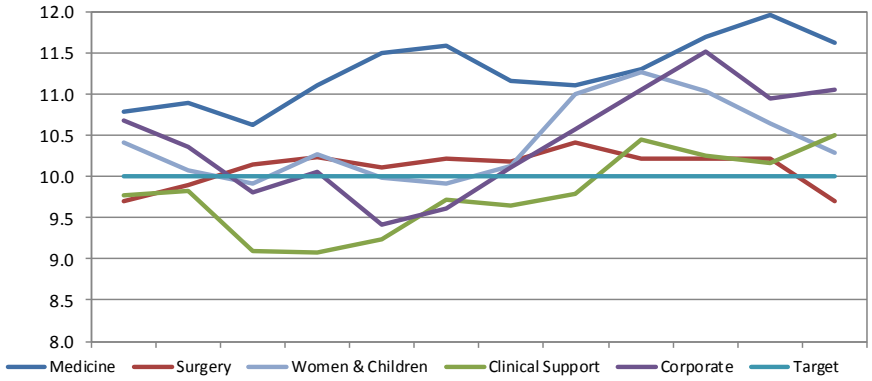
Workforce - Lead Director Jeremy Over

Annualised Staff Turnover rate - Trust



Division	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2016/17	11.0	10.9	11.2	11.2	11.0	10.7	10.7	10.5	10.0	10.0	10.3	10.4
2017/18	10.2	10.2	10.0	10.2	10.3	10.5	10.4	10.6	10.8	10.9	10.9	10.7
Target	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0

Annualised Staff Turnover rate - Divisions



Division	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Medicine	10.79	10.89	10.63	11.11	11.50	11.58	11.16	11.10	11.30	11.69	11.96	11.62
Surgery	9.70	9.90	10.14	10.23	10.10	10.21	10.18	10.42	10.22	10.21	10.22	9.69
Women & Children	10.42	10.08	9.91	10.27	9.99	9.91	10.13	11.01	11.27	11.04	10.65	10.28
Clinical Support	9.77	9.82	9.10	9.07	9.24	9.72	9.65	9.80	10.45	10.24	10.17	10.51
Corporate	10.68	10.35	9.81	10.05	9.42	9.61	10.11	10.57	11.06	11.52	10.94	11.06
Target	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00

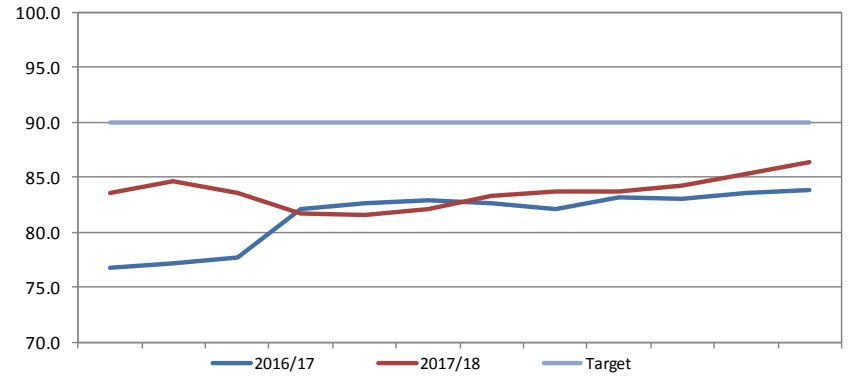
Commentary

- The Turnover rate is the percentage of the workforce that has left NNUH over the past twelve months. It is a 12-month rolling figure.
- The calculation excludes fixed-term contracts, (for instance junior doctors on rotational training programmes).
- The turnover rate for the four months to December 2018 has remained at 10.8% (+/- 0.1%)
- Positively, the numbers of Registered Nursing and Midwifery leavers in December was below the 12-month average level.
- Reduced turnover means greater retention of knowledge and skill in our teams, and reduced volume of replacement recruitment activity and induction / on-boarding.

Core Slide 33

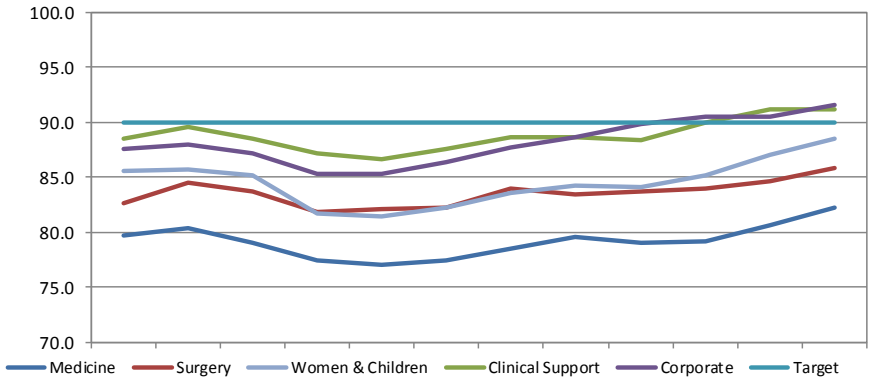
Workforce - Lead Director Jeremy Over

Mandatory Training - Trust



Division	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2016/17	76.8	77.1	77.6	82.0	82.6	82.9	82.6	82.1	83.2	83.0	83.5	83.8
2017/18	83.6	84.6	83.6	81.7	81.6	82.1	83.3	83.7	83.6	84.2	85.3	86.4
Target	90.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0	90.0

Mandatory Training - Divisions



Division	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Medicine	79.67	80.38	79.00	77.46	77.06	77.45	78.50	79.60	79.09	79.15	80.60	82.22
Surgery	82.67	84.54	83.72	81.81	82.15	82.21	83.90	83.40	83.73	83.91	84.69	85.79
Women & Children	85.55	85.73	85.20	81.71	81.40	82.20	83.60	84.27	84.07	85.13	87.08	88.50
Clinical Support	88.50	89.57	88.52	87.12	86.66	87.56	88.57	88.68	88.42	90.00	91.13	91.21
Corporate	87.61	88.02	87.17	85.27	85.27	86.41	87.69	88.70	89.83	90.48	90.56	91.51
Target	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00

Commentary

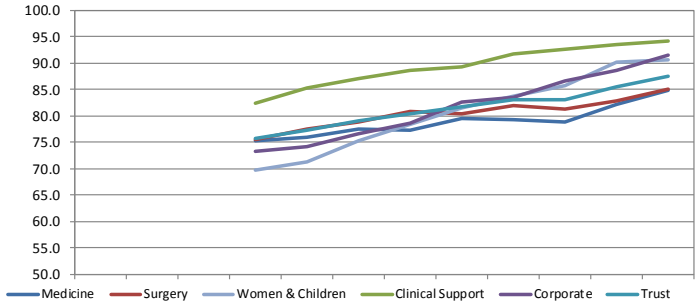
- Improvement of mandatory training attendance is a must do from the CQC inspection.
- Positively, this is the first time the compliance rate has been above 86%.
- All Divisions and Corporate areas have compliance rates above 80% with two areas (CSS and Corporate) above the target rate of 90%.
- A series of improvements and interventions are in place to support enhanced compliance. These include training days/events where support is available to maximise mandatory training and a range of support options for staff accessing eLearning.
- Divisional level mandatory training rates are discussed at divisional performance committee.
- The Head of OD & Learning is leading on a project to address the capacity and system constraints that need to be overcome in order to enable greater take-up of mandatory training which is resulting in ongoing improvements.
- Recent interventions to target non-compliant staff to raise their awareness of non-compliance and sign post them to all the support available is having a direct impact in improving compliance rates.

Additional Slide 33a

Workforce - Lead Director Jeremy Over

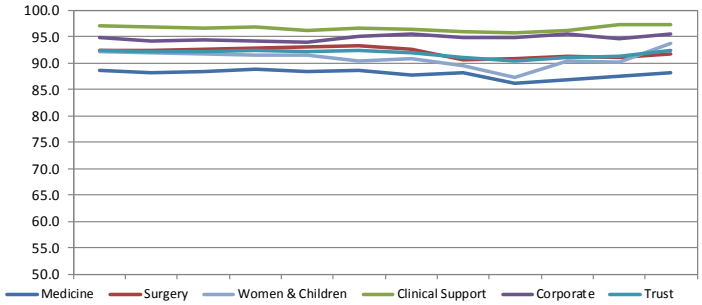
Mandatory Training – CQC 'must do'

MCA/DoLS Training - Divisions



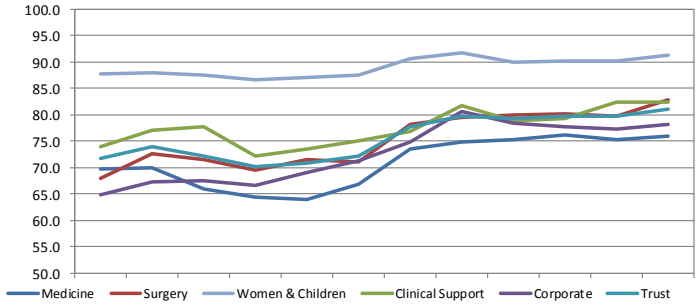
Division	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Medicine				75.37	76.01	77.45	77.36	79.56	79.26	78.78	82.27	84.77
Surgery				75.44	77.50	78.84	80.87	80.44	82.02	81.21	82.79	85.13
Women & Children				69.81	71.33	75.17	78.29	81.41	83.80	85.71	90.09	90.53
Clinical Support				82.46	85.29	86.97	88.53	89.27	91.80	92.59	93.63	94.15
Corporate				73.33	74.07	76.69	78.68	82.61	83.58	86.67	88.72	91.60
Trust				75.72	77.29	79.12	80.49	81.83	82.95	83.04	85.58	87.47

Safeguarding Children Training - Divisions



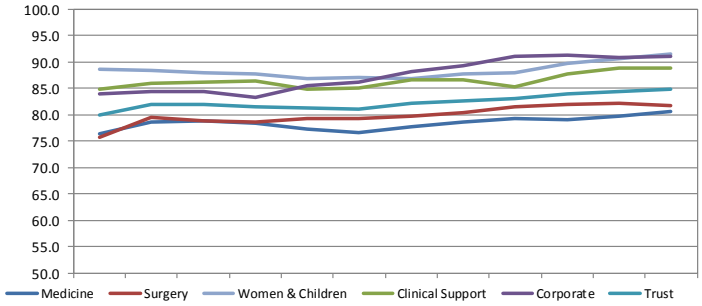
Division	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Medicine	88.56	88.17	88.38	88.91	88.50	88.55	87.72	88.13	86.17	86.83	87.41	88.28
Surgery	92.38	92.39	92.57	92.79	93.08	93.22	92.67	90.55	90.95	91.27	90.96	91.71
Women & Children	92.22	92.04	91.66	91.60	91.53	90.41	90.92	89.44	87.19	90.37	90.19	93.78
Clinical Support	97.09	96.96	96.73	96.89	96.11	96.71	96.50	95.88	95.83	96.15	97.24	97.25
Corporate	94.92	94.22	94.45	94.15	94.04	95.02	95.56	94.89	94.95	95.56	94.63	95.54
Trust	92.38	92.15	92.19	92.42	92.19	92.33	91.96	91.16	90.36	91.12	91.33	92.31

Resus (Adult) Training - Divisions



Division	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Medicine	69.60	69.97	66.00	64.43	63.97	66.90	73.53	74.85	75.36	76.27	75.35	75.88
Surgery	67.93	72.55	71.53	69.45	71.44	70.98	78.16	79.39	79.88	80.23	79.74	82.74
Women & Children	87.69	88.00	87.60	86.72	87.17	87.52	90.65	91.71	89.94	90.19	90.09	91.32
Clinical Support	74.01	77.02	77.71	72.22	73.40	75.04	76.89	81.83	78.83	79.20	82.40	82.37
Corporate	64.92	67.37	67.57	66.49	68.95	71.28	74.87	80.61	78.31	77.78	77.35	78.09
Trust	71.82	74.02	72.26	70.09	70.87	72.16	77.72	79.64	79.23	79.73	79.63	80.98

Infection Control Training - Divisions



Division	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Medicine	76.47	78.71	78.76	78.31	77.24	76.52	77.81	78.70	79.23	79.07	79.76	80.63
Surgery	75.71	79.57	78.94	78.66	79.27	79.34	79.74	80.37	81.44	82.02	82.10	81.79
Women & Children	88.67	88.37	88.06	87.73	86.88	87.12	86.81	87.70	87.95	89.84	90.63	91.59
Clinical Support	84.88	85.98	86.13	86.34	84.81	84.98	86.57	86.52	85.21	87.79	88.94	88.92
Corporate	83.93	84.50	84.44	83.23	85.60	86.25	88.13	89.18	91.07	91.39	90.91	91.07
Trust	80.00	82.04	81.86	81.55	81.19	81.11	82.07	82.72	83.07	83.93	84.44	84.76

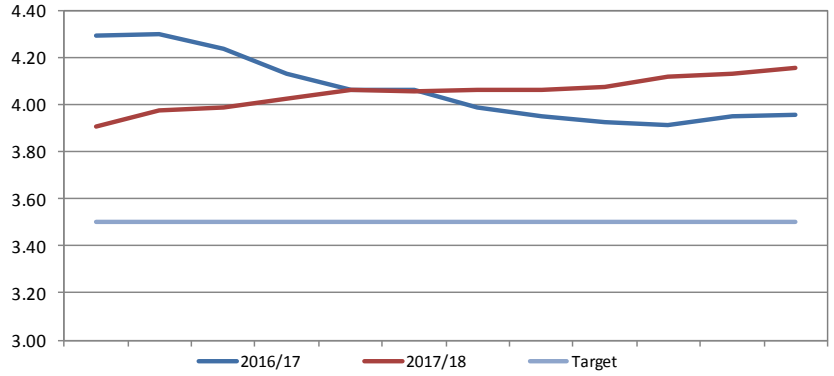
Commentary

- These tables are a sub-set of all mandatory training compliance and reflect some of the mandatory training compliance issues highlighted in the recent CQC inspection.

Core Slide 34

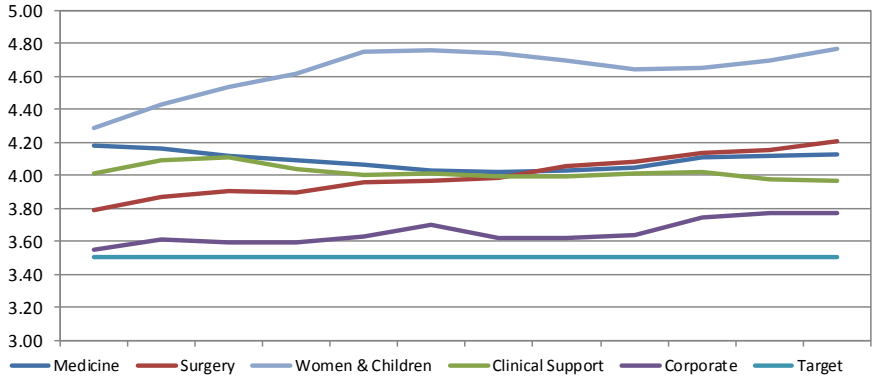
Workforce - Lead Director Jeremy Over

Sickness levels (12 month rolling average)



Division	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
2016/17	4.30	4.30	4.23	4.13	4.06	4.06	3.99	3.95	3.93	3.92	3.95	3.95
2017/18	3.91	3.97	3.99	4.02	4.06	4.05	4.06	4.06	4.08	4.12	4.13	4.15
Target	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50

Sickness levels (12 month rolling average)



Division	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Medicine	4.18	4.16	4.12	4.09	4.06	4.03	4.02	4.03	4.05	4.11	4.12	4.13
Surgery	3.79	3.87	3.90	3.90	3.96	3.97	3.98	4.05	4.08	4.13	4.15	4.21
Women & Children	4.29	4.43	4.54	4.62	4.75	4.76	4.74	4.70	4.64	4.65	4.70	4.77
Clinical Support	4.01	4.09	4.11	4.03	4.00	4.01	4.00	3.99	4.01	4.02	3.98	3.97
Corporate	3.55	3.61	3.60	3.60	3.63	3.70	3.62	3.62	3.64	3.74	3.77	3.77
Target	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50

** Reported one month in arrears

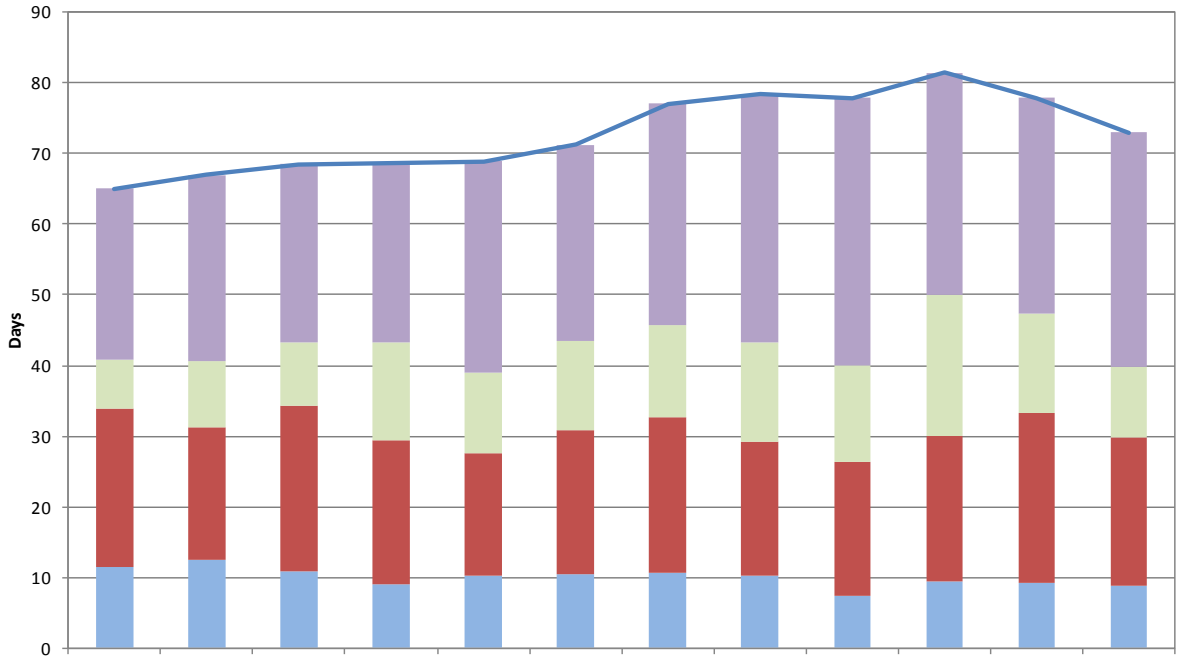
Commentary

- The most significant indicator is the rolling 12-month average sickness rate.
- As at 30 November 2018, the rate is 4.15%.
- This still represents a significant reduction in excess of 6% on the peak from August 2016 and equates to the equivalent of approximately 20 additional staff (headcount) being available every day.
- Based on provisional data, the expectation is that the 12-month average sickness rate will reduce in December.
- Analysis confirms the vast majority of sickness absence is longer term and HRBP's are supporting divisional colleagues to intervene to support returns to work.
- Data recently published by the Department of Health for the calendar year of 2017 indicates that on average there were 9.1 lost working days per staff member.
- This 'ranks' NNUH as 83rd out of 224 Trusts. For comparison, QEH has 11.2 days, NCHC has 10.9 days, JPH has 9.3 days and Cambridge 7.3 days.
- NB. For data accuracy and reliability purposes, sickness figures are reported one-month in arrears.

Core Slide 35

Workforce - Lead Director Jeremy Over

Recruitment Time to Hire



Recruitment Stage	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18
Total Time to Hire	65.1	67.0	68.5	68.6	68.9	71.2	77.0	78.4	77.9	81.4	77.8	73.0
Checks Complete	24.2	26.4	25.2	25.3	29.9	27.8	31.3	35.0	37.9	31.4	30.4	33.1
Time to Offer	6.8	9.2	9.1	13.9	11.4	12.5	13.0	14.1	13.7	20.0	14.2	10.0
Time with Manager	22.5	18.8	23.3	20.3	17.4	20.5	22.2	19.0	18.8	20.6	23.9	21.1
Time to advert close	11.5	12.6	10.9	9.1	10.3	10.5	10.6	10.2	7.5	9.4	9.3	8.8
Number at checks complete	134	112	109	105	130	140	122	111	123	185	166	157

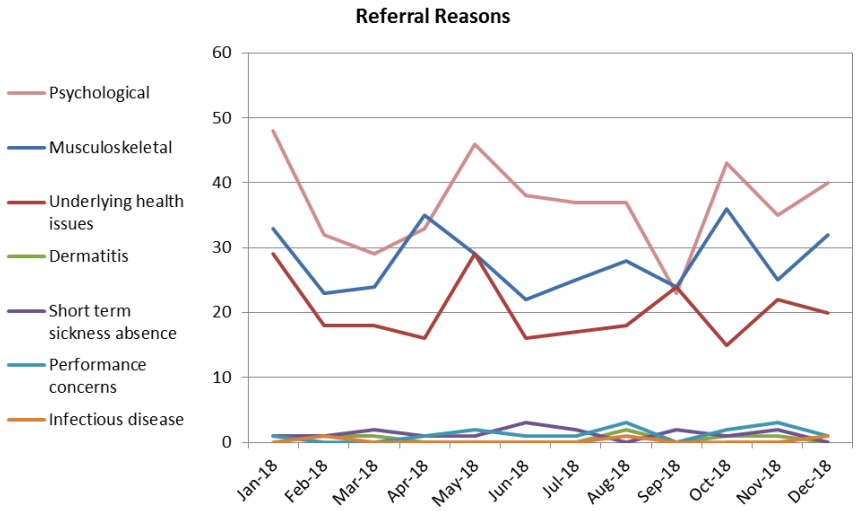
Commentary

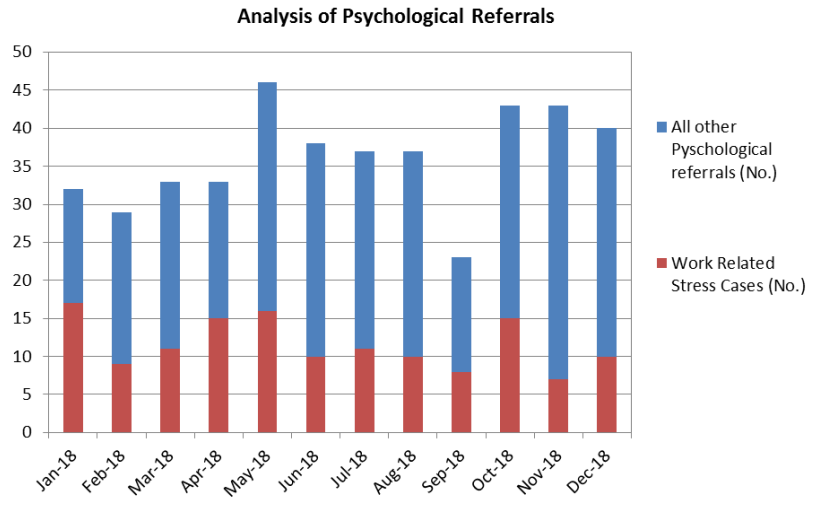
- This data reflects all substantive recruitment through our Trac system.
- The Time to Hire measure has reduce to 73.0 days, a reduction of 8.4 days since October.
- The Time to Hire measure includes a Time to Offer measure which has halved from 20.0 to 10.0 in the same period.

Core Slide 36

Workforce - Lead Director Jeremy Over

Staff Health, Safety and Wellbeing





Commentary

- The first graph reflects the trend in respect of all referrals (by managers, or self-referral) to Workplace, Health and Wellbeing.
- There were 94 referrals assessments undertaken in December 2018 which is an increase from the previous month (+6).
- The second graph reflects the trend for psychological referrals (by managers, or self-referral) received by Workplace, Health and Wellbeing.
- The total number of psychological referrals in December was similar to that for the preceding two months.

Additional Slide 36a

Workforce - Lead Director Jeremy Over

Consultant Job Plans

Stage	Trust	Medicine	Surgery	Women & Children	Clinical Support	Other
Total Consultants	484	161	190	59	72	2
Job plans signed off	231	74	109	6	41	1
	47.7%	46.0%	57.4%	10.2%	56.9%	50.0%
In discussion stage/ draft stage	121	48	30	23	19	1
	25.0%	29.8%	15.8%	39.0%	26.4%	50.0%
Awaiting sign off	132	39	51	30	12	0
	27.3%	24.2%	26.8%	50.8%	16.7%	0.0%

Commentary

- The above chart reflects progress in respect of the introduction of Electronic Job Planning for Consultants as at 13 January 2019
- E-job planning was introduced from April 2017 with extensive engagement and consultation with Consultants.
- Oversight of e-job planning sits with an E-job Planning Advisory Panel which reports into the Medical Workforce Group, chaired by the Director of Workforce, and attended by senior clinicians from each Division.
- There is a need to accelerate the sign off of the first round of e-job plans.

Core Slide 37 – Workforce – supplementary briefing

Promoting NNUH & Norfolk as a place to work and live

A new recruitment video, promoting NNUH as a place to work, Norfolk as a place to live – representing a diverse and passionate workforce – has been produced and is now live. The film has been positively received and is being promoted internally and externally.

Workplace Health and Wellbeing

The 'flu vaccination uptake has attained its highest ever level, now at 83%.

The staff physiotherapy service is delivering a programme of preventative inputs within clinical teams to prevent injury and look after staff Musculo-skeletal wellbeing.

Lead Freedom to Speak Up Guardian

Following an extensive search for quality candidates, the Trust has been successful in recruiting its Lead Freedom to Speak Up Guardian. Fran Dawson, who is a specialist Physiotherapist at Norfolk Community Health & Care was the unanimous choice and is planned to commence on 18 March 2019

Developing our organisational culture

The last twelve months have seen a strong focus on the development of our organisational culture, as we have delved deeper into our staff survey results to learn more from staff experience, and further developed the role of our PRIDE values in leadership and communication in the workplace. We did this in partnership with the King's Fund in April/May, and then, working with staff, launched Leading with PRIDE and Communicating with PRIDE in the Autumn.

In December, the Board endorsed the next step on this journey, participating in a national programme of work led by NHSI which supports culture change. Already adopted by around 50 trusts, and built on the research evidence base of Prof Michael West, the programme centres on the creation of a 'change team' of around 20-25 staff who guide the development of the diagnostic and project work. This particular feature, of a bottom-up rather than top-down approach, is particularly compelling as it further helps build staff-led change and ensures the work is credibly based on their everyday experiences of working at NNUH.

The Change Team has now been recruited and comprises around 25 staff from a diverse mix of roles and levels within the organisation. The group took part in a training day on 21 January and is now planning next steps.

Core Slide 38

Finance - Lead Director John Hennessey

Executive Summary

- The reported deficit for the year to date is £46.7m, being £4.5m worse than budget.
- The in-month position, before mitigation is £3.2m worse than budget, mainly due to clinical income being £1.9m worse (Surgery down £1.1m) and Pay costs being £1m worse than budget. Mitigated in part by £0.24m, from an opening balance sheet review and £0.25m review of in year accruals, resulting in a reported position of £2.7m down in month.
- Year to date, we have mitigated the reported adverse variance by £0.64m in total, from a review of the opening balance sheet. Without this we would be £5.14m behind budget at M9.
- Clinical Income at end M9 is £6.5m worse then budget (1.9%). Opex at end M9, net of drugs income is £1.4m worse than budget (0.3% small variance) comprising: Pay of £1.7m (0.7%) adv, Drugs- net £0.6m fav, Clinical Supplies of £0.5m adv (1.1%) and Non Clinical Supplies of £0.5m fav (0.8%), PFI £0.2m adv.
- The CIP target is £30m. The YTD CIP budget is £18.7m with actual YTD being £18.9m. The profile of CIPs is £18.7m in the first 9 months and £11.3m (37%) in the last quarter - creating significant pressure in Q4.

Key Risks

- Delivering the £30m CIP and identifying the remaining £1.4m yet to reach Gateway 2.
- Income – delivery of plan - surgery is underperforming. The M10 plan is @ £40.1m, biggest in the year.
- Successful negotiation of an £11m block income contract.
- Operating expenditure – containing to forecast budget M10-12

Forecast - NHSI protocol dictates that a formal reforecast can be made at a quarter end, thus at M9. Based on the current run rate and assuming a successful negotiation of an £11m for over-performance the Trust is forecasting a deficit (excluding donated additions) of £58.8m.

FINANCIAL SUMMARY

I&E Performance YTD	(£46.7m)	Deficit
I&E Variance against budget YTD	(£4.5m)	Adverse
In month variance to in month budget	(£2.7m)	Adverse
Cash at Bank - actual	£5.9m	£3.6m Fav
Borrowings - actual	£93.5m	£14.3m Fav
CIP Variance against budget YTD	£0.1m	Favourable
Full Year CIP Target of £30m identified	£28.6m	£1.4m remaining

SUMMARY INCOME AND EXPENDITURE ACCOUNT	In Month			Year to Date			Full Year Forecast		
	Actual £m	Budget £m	Variance (adv)/fav £m	Actual £m	Budget £m	Variance (adv)/fav £m	Forecast £m	Budget £m	Variance (adv)/fav £m
Clinical Income excluding NT Drugs	34.4	36.3	(1.9)	333.3	339.9	(6.6)	449.8	454.9	(5.1)
NT Drugs	4.8	5.8	(1.0)	50.3	51.9	(1.6)	66.9	69.2	(2.3)
Other Income	6.4	6.1	0.3	60.2	58.0	2.2	83.5	76.3	7.2
TOTAL OPERATING INCOME	45.6	48.2	(2.6)	443.8	449.8	(6.0)	600.2	600.4	(0.2)
Pay Costs	(30.5)	(29.4)	(1.1)	(265.7)	(264.0)	(1.7)	(355.0)	(351.0)	(4.0)
Drugs	(5.6)	(6.8)	1.2	(59.5)	(61.8)	2.3	(79.2)	(82.3)	3.1
Other Non Pay Costs	(15.5)	(15.0)	(0.5)	(133.6)	(133.4)	(0.2)	(182.0)	(177.7)	(4.3)
TOTAL OPERATING EXPENSES	(51.6)	(51.2)	(0.4)	(458.8)	(459.2)	0.4	(616.2)	(611.0)	(5.2)
EBITDA	(6.0)	(3.0)	(3.0)	(15.0)	(9.4)	(5.6)	(16.0)	(10.6)	(5.4)
Depreciation	(0.8)	(0.9)	0.1	(7.8)	(8.1)	0.3	(10.6)	(11.0)	0.4
Finance Costs	(2.7)	(2.9)	0.2	(24.0)	(24.7)	0.7	(32.4)	(33.4)	1.0
Other - PDC, Disposals & Interest Income	0.0	0.0	0.0	0.1	0.0	0.1	0.2	0.0	0.2
(Deficit)/surplus after tax excluding Donated Additions	(9.5)	(6.8)	(2.7)	(46.7)	(42.2)	(4.5)	(58.8)	(55.0)	(3.8)

Core Slide 39

Finance - Lead Director John Hennessey

Income and Expenditure Summary as at December 2018

The reported I&E position for M9 is a deficit of £9.5m, against a planned deficit of £6.8m. This results in a £2.7m adverse variance in month (adverse variance of £4.5m YTD). The M9 reported position is after recognising £0.24m from an opening balance sheet review and a review of in year accruals of £0.25m. Without this, the in-month position would have been £3.2m worse than budget.

Clinical Income, is £1.9m worse than budget in month, and pay and supplies are £1.6m worse than budget in month – Pay being £1.1m worse (4%), Clin Supplies £0.6m worse (11%) and Non clin supplies £0.1m better (1%).

The mitigation of £0.49m is reported within other non clinical income.

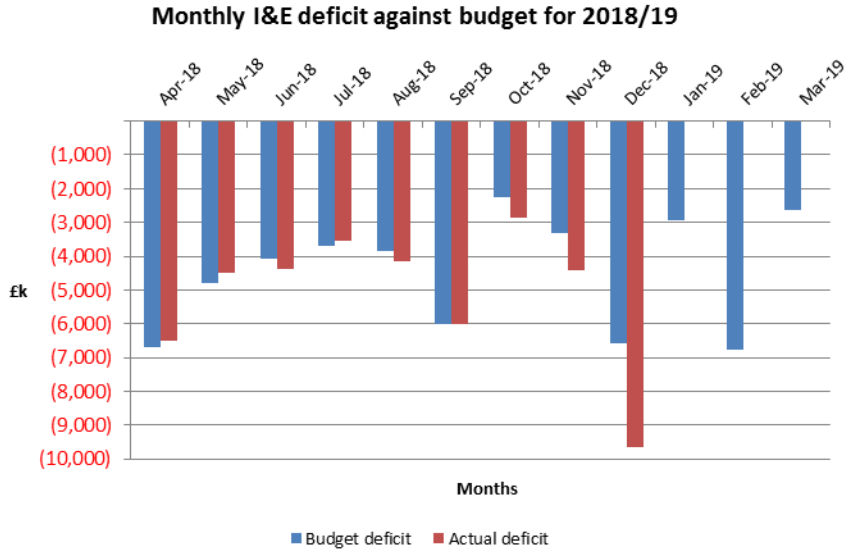
Summary of I&E Indicators

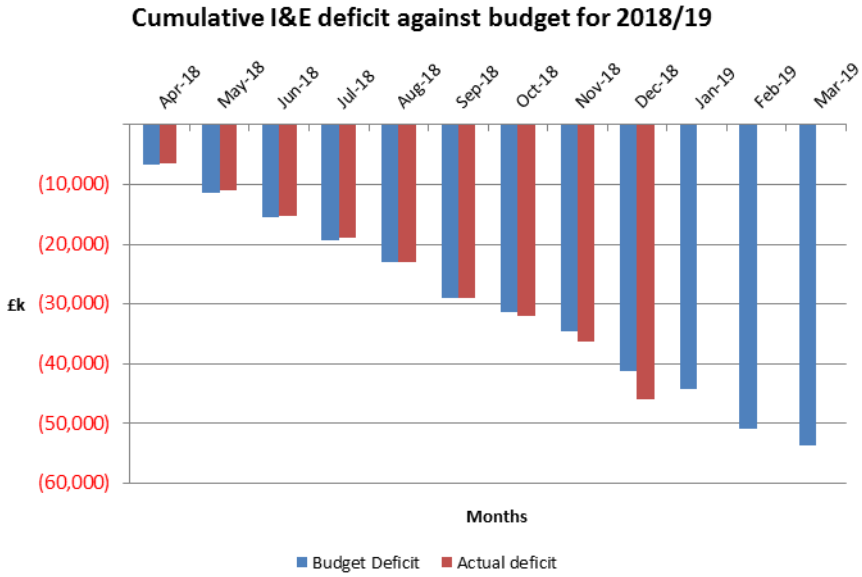
Income and Expenditure	Actual / Forecast £'000	Budget / Target £'000	Variance to Budget (adv) / fav £'000	Direction of travel (variance)	RAG
In month (deficit) / surplus	(9,499)	(6,754)	(2,745)	↓	Red
YTD (deficit) / surplus	(46,666)	(42,187)	(4,479)	↓	Red
Forecast (deficit) / surplus	(58,800)	(55,000)	(3,800)	↓	Red

NHS Clinical Income (exc Drugs) YTD	333,349	339,871	(6,522)	↓	Red
Non Clinical Income YTD	57,921	55,598	2,323	↑	Green
Pay YTD	(265,745)	(264,004)	(1,741)	↓	Red
Non Pay YTD	(193,143)	(195,143)	2,000	↑	Green
Non Opex YTD	(31,807)	(32,832)	1,025	↑	Green
CIP Target YTD	18,922	18,803	119	↓	Green

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

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

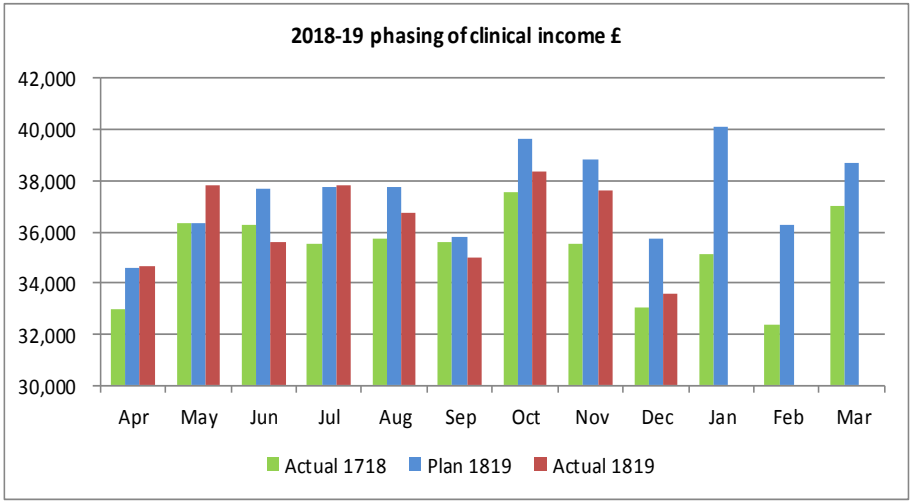




Core Slide 40 Finance - Lead Director John Hennessey

Income Analysis

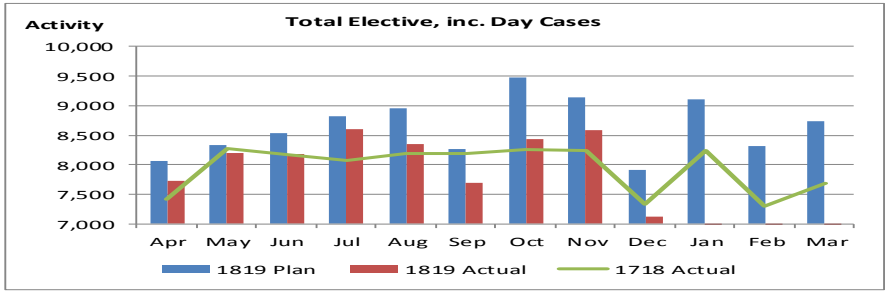
The chart below sets out the monthly phasing of the clinical income plan (exc. Spire to aid prior year comparison) for 2018/19. This phasing is in line with activity phasing which is how the income is recognised. The phasing is responsive to actual days and working days, hence the monthly variation.

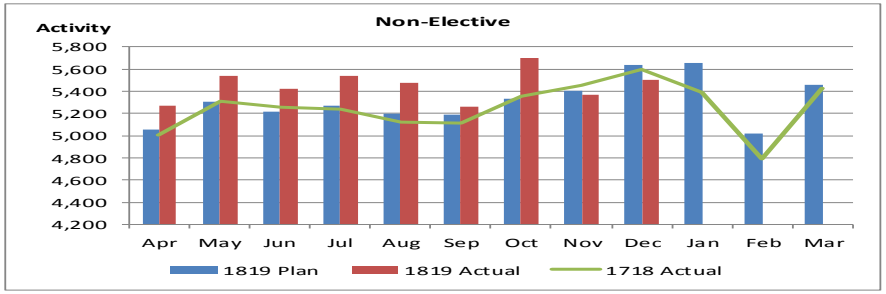


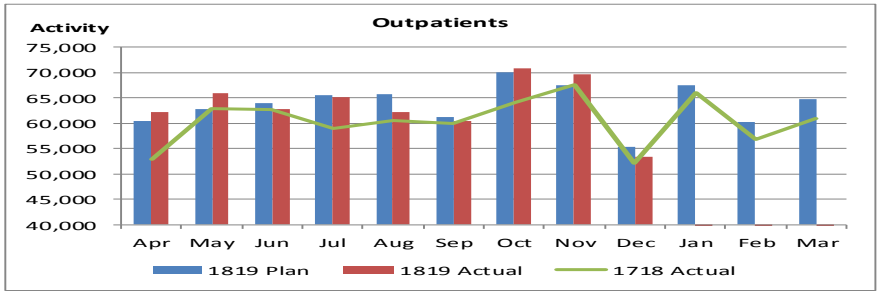
The income position was behind plan for December by £1.9m, with the under-performance within; Surgery (£1.1m) , Centralised (£0.4m) & Women & Children (£0.3m). Mainly: Electives £0.1m, DC by £0.4m. Non-Electives (inc. marginal rate) £0.3m and unidentified CIPs of £0.6m – all underperformed.

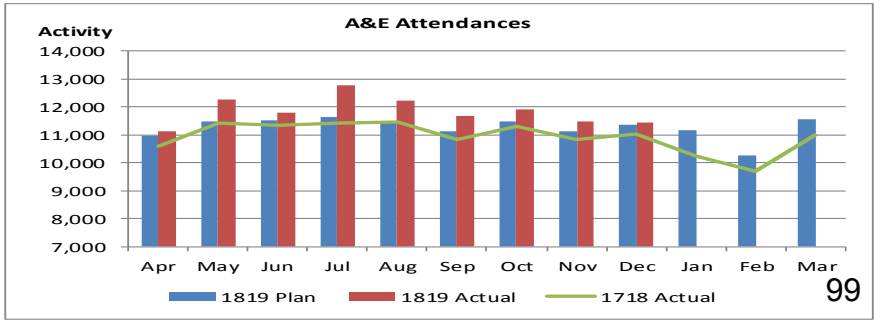
	Current month			Year to date		
Income (£'000s)	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Daycase (inc. Reg Day Attd)	4,091	3,690	-401	39,198	37,847	-1,351
Elective	3,496	3,308	-189	35,637	33,183	-2,453
Non Elective	12,303	12,344	41	105,110	109,652	4,542
Marginal Rate Reduction	-728	-964	-235	-6,371	-7,903	-1,532
Accident & Emergency	1,415	1,461	46	12,738	13,280	541
Outpatients	5,683	5,541	-142	58,963	58,561	-402
CQUIN	760	758	-2	7,238	7,393	156
C&V	5,519	5,392	-126	53,236	53,142	-94
Other*	3,815	2,896	-919	34,121	28,194	-5,927
Total	**36,345**	**34,426**	**-1,919**	**339,870**	**333,349**	**-6,521**

* includes M9 YTD adverse variance on block (£1.1m) & a non finalised clinical income CIP target YTD (£2.4m)









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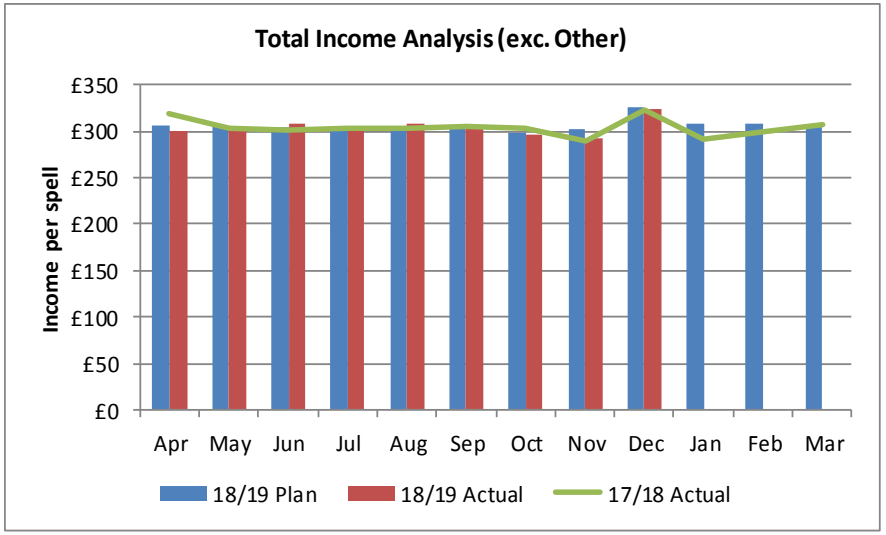
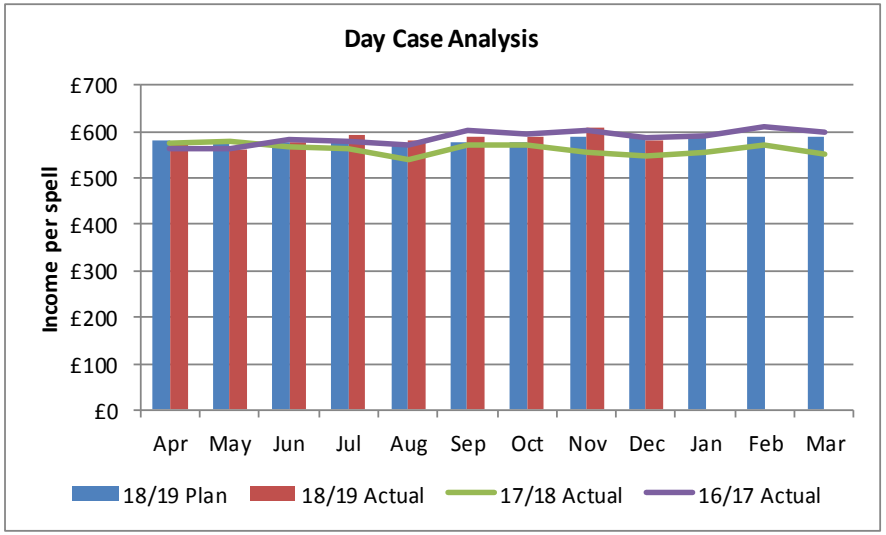
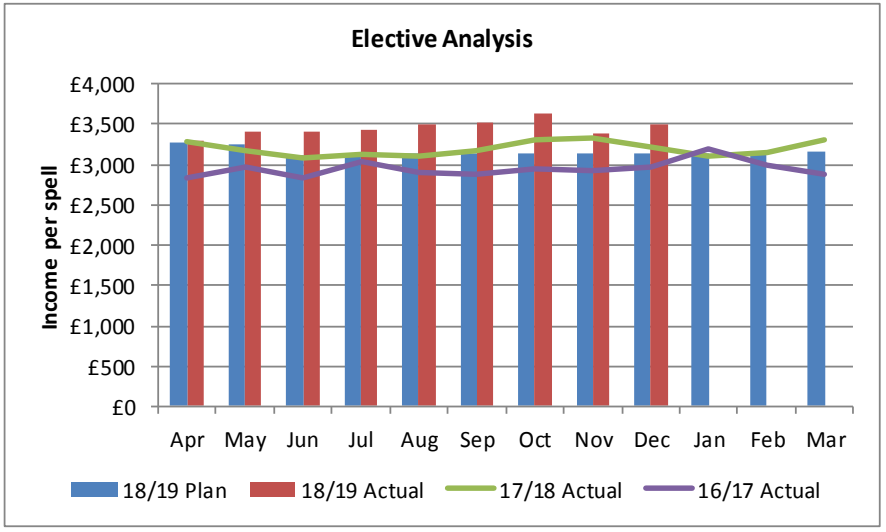
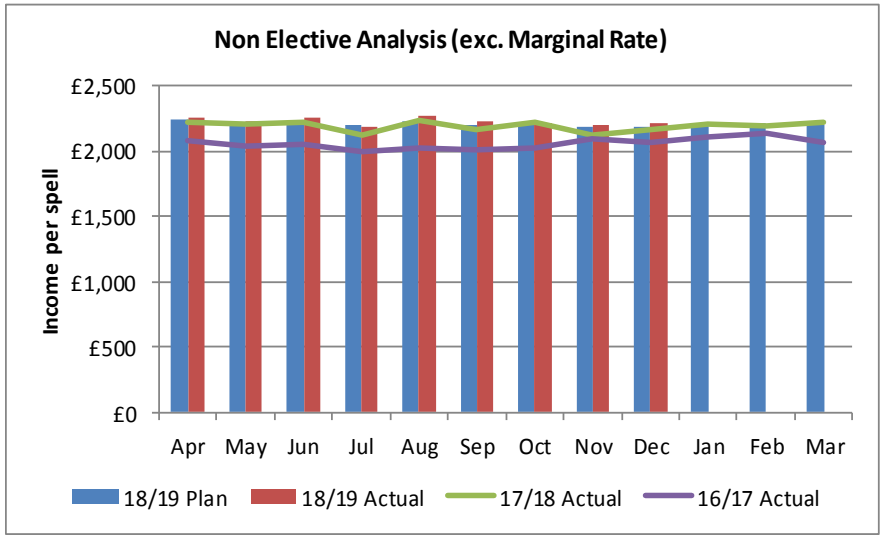
Finance - Lead Director John Hennessey









Core Slide 42

Finance - Lead Director John Hennessey

Pay cost by 'type'

Monthly Expenditure (£)				
As at December 2018	Dec-18	Nov-18	Dec-17	YTD 2018-19
	£'000	£'000	£'000	£'000
Budgeted costs in month	**29,378**	**29,281**	**28,281**	**264,004**
Actuals:				
Substantive staff	**26,420**	**25,988**	**25,095**	**231,385**
Medical External Locum Staff*	188	191	98	1,816
Medical Internal Locum Staff	462	526	542	5,012
Additional Medical Sessions	455	434	418	4,039
Nursing Agency Staff*	616	648	467	5,181
Nursing Bank Staff	1,201	964	857	8,684
Other Agency Staff (AHPs/A&C)*	208	234	249	1,834
Other Bank Staff (AHPs/A&C)	161	156	137	**1,343**
Overtime	550	534	505	**4,694**
On Call	214	199	193	**1,755**
Total temporary expenditure	**4,057**	**3,886**	**3,467**	**34,360**
Total Pay costs	**30,476**	**29,875**	**28,562**	**265,745**
Variance Fav / (Adv)	(1,098)	(594)	(281)	(1,741)
Temp Staff costs % of Total Pay	**13%**	**13%**	**12%**	**13%**
Memo: Total agency spend in month*	**1,013**	**1,074**	**814**	**8,832**

Headcount

Monthly Whole Time Equivalents (WTE)			
As at December 2018	Dec-18	Nov-18	Dec-17
	WTE	WTE	WTE
Budgeted WTE in month	**8,019**	**7,994**	**7,307**
Employed substantive WTE in month	**7,083**	**7,016**	**6,749**
Medical External Locum Staff*	11	10	4
Medical Internal Locum Staff	70	75	75
Additional Sessions	-	-	13
Nursing Agency*	97	103	63
Nursing Bank	60	70	62
Other Agency (AHPs/A&C)*	99	111	107
Other Bank (AHPs/A&C)	329	368	368
Overtime	-	-	153
On Call Worked	43	40	38
Total equivalent temporary WTE	**709**	**777**	**883**
Total equivalent WTE	**7,791**	**7,792**	**7,632**
Variance Fav / (Adv)	227	202	(325)
Temp Staff WTE % of Total WTE	**9%**	**10%**	**12%**
Memo: Total agency WTE in month*	**207.34**	**224.00**	**174.52**
Sickness Rates	**4.61%**	**4.21%**	**4.62%**
Mat Leave	**2.58%**	**2.55%**	**2.21%**

Data taken from the workforce return as agreed with deputy workforce director each month. Sickness and Mat leave calculations provided by data workforce analyst.

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

Employed substantive provided by payroll. Medical Agency/locum WTE generated via an average cost per grade applied to the total spend.

Additional sessions, overtime & on call sourced from payroll.

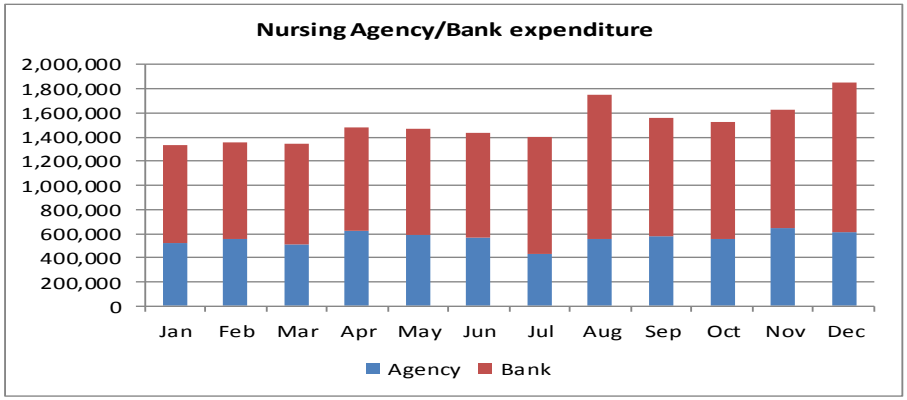
Agency & Bank are generated via hours worked from our E-Roster system. This is then converted into WTE.

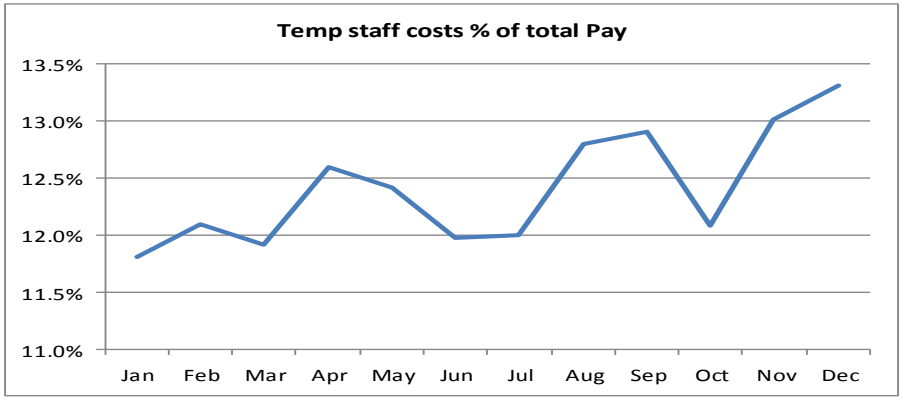
Core Slide 43

Finance - Lead Director John Hennessey

Pay Trends & Analysis

Medical staff premium Pay YTD (source: budget statements)	WLI	Internal Locum	External Locum & NAG	Total
Emergency	2,252	2,021,967	464,782	**2,489,000**
Surgical Support	718,836	97,205	643,587	**1,459,629**
General Surgery	331,464	234,064	168,725	**734,253**
Older Peoples Medicine	49,972	545,152	20,335	**615,459**
Imaging	535,487	7,093	0	**542,580**
Oral Surgery	20,930	294,990	143,373	**459,292**
Ophthalmology	295,982	123,208	0	**419,190**
Urology	367,947	40,575	9,372	**417,894**
Plastic Surgery	142,297	211,375	21,321	**374,992**
Paediatrics	78,457	258,012	28,627	**365,096**
Gastroenterology	279,163	39,602	0	**318,765**
Cellular Pathology	103,866	24,447	176,673	**304,986**
Dermatology	239,692	62,039	0	**301,731**
Obstetrics And Gynaecology	131,680	144,378	5,840	**281,898**
Cardiology Summary	150,358	39,715	74,823	**264,896**
Neurosciences	118,103	139,224	652	**257,979**
Respiratory Medicine	138,029	114,239	0	**252,268**
Trauma And Orthopaedics	180,979	73,995	-8,286	**246,688**
Ear Nose And Throat	133,026	66,411	15,291	**214,729**
Services	523	180,174	17,885	**198,581**
Oncology & Haematology	14,363	151,476	4,028	**169,867**
Laboratory Medicine	0	39,307	23,758	**63,065**
Palliative Care	0	55,190	0	**55,190**
Endocrinology	4,843	27,710	5,332	**37,885**
Therapies & Support Services	0	16,616	0	**16,616**
Renal	0	3,489	0	**3,489**
Rheumatology	1,174	620	0	**1,794**
Total	**4,039,423**	**5,012,271**	**1,816,118**	**10,867,812**





- The Pay budget YTD is £264m v £265.7m actual cost delivering an overspend of £1,741k.
- Emergency has overspent in the YTD by £2,099k through additional Locum spend, additional floor coordinators & doctor cover in the evening of circa two doctors. The locum overspend is being reviewed within the division.
- Premium pay (all temp costs exc. on-call) is currently running at circa £3.6m per month (£3.8m in M9), & totals £32.6m YTD. Key areas of focus is control on overtime payments (£4.7m YTD, £0.55m M09), Agency (£7.0m YTD; £0.82m M09) & Locum incl. NAG spend (£6.8m YTD; £0.65m M09).

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CIP Performance

CIP Plan Development

- To date £28.5m of cost improvement initiatives have been approved through Gateway 2 and into delivery against the £30.0m CIP target with further schemes continuing to be developed through the governance process, with £1.4m through 'Gateway 1'.
- A concerted effort is required to convert further initiatives into approved schemes as soon as practical to provide assurance over the deliverability of the £30.0m CIP target.
- The Trust should consider 'hard stop' actions to reduce discretionary spend where clinically safe to do so to deliver further initiatives to reduce the risk adjusted delivery gap.

CIP Performance

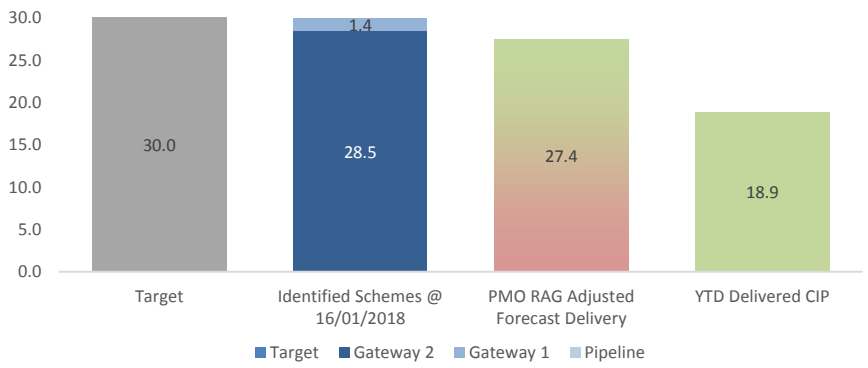
- YTD the Trust has delivered £18.9m of CIPs against a FIP Board approved YTD plan of £18.2m (YTD plan per annual plan is £18.7m), an over-performance of £0.7m arising due to additional delivery in day case and outpatient productivity schemes within Medicine and over-performance of non-recurrent schemes within surgery offsetting clinical income underperformance.
- The risk adjusted forecast delivery for Gateway 2 schemes is currently £27.4m based on the YTD financial performance of 'in delivery' CIPs, progress against milestone delivery and performance against quality and performance indicators. This presents a significant risk to achievement of the £30.0m target.

FY18/19 Performance by Division

Division	Number of schemes 'In Delivery'	CIP Delivery		
		YTD FIP Board Approved Plan £'000	YTD Actual £'000	YTD Variance £'000
Medicine	35	6,048.1	6,988.0	939.9
Surgery	30	5,650.2	5,873.4	223.2
Women & Children's	16	1,949.3	1,930.0	(19.3)
Clinical Support Services	19	2,941.9	2,834.7	(107.1)
Corporate	14	1,636.6	1,295.5	(341.1)
Cross-Divisional*	2	-	-	-
	116	**18,226.1**	**18,921.7**	**695.6**
YTD per Annual Plan		18,743.0		
Variance to Annual Plan		**(516.9)**		

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

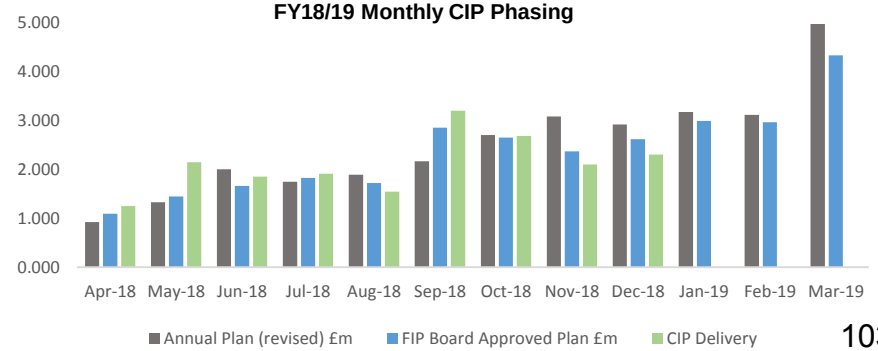
FY18/19 CIP Identified Position



Category	Annual Plan £'000	FIP Approved Plan YTD £'000	Actual YTD £'000	Variance £'000
Clinical Income	17,580.3	11,648.8	12,407.8	758.9
Pay*	8,530.8	5,222.9	5,269.7	46.8
Non-pay*	2,191.3	688.1	949.4	261.3
Other Income*	1,000.2	459.0	87.5	(371.5)
Non-Opex	697.4	207.3	207.3	-
	30,000.0	**18,226.1**	**18,921.7**	**695.6**

*Information is shown as the savings identified net of any costs associated with the delivery of clinical income initiatives, which is £2.1m across the categories.

FY18/19 Monthly CIP Phasing



Core Slide 45

Finance - Lead Director John Hennessey

Summary by Division

DIRECTORATES INCOME & EXPENDITURE	Dec-18 Budget £k	Dec-18 Actual £k	Dec-18 Variance F/(A) £k	Year to date Budget £k	Year to date Actual £k	Year to date Variance F/(A) £k
MEDICINE & EMERGENCY						
Total Income	19,110	18,354	-756	173,640	178,302	4,662
Pay Costs	-9,412	-10,039	-627	-84,704	-87,262	-2,558
Non-Pay Costs	-7,521	-6,733	788	-65,108	-67,004	-1,896
Total Expenditure	-16,932	-16,772	161	-149,812	-154,267	-4,454
SURPLUS/(DEFICIT)	**2,178**	**1,582**	**-595**	**23,828**	**24,035**	**208**
SURGERY						
Total Income	14,153	12,583	-1,570	133,350	126,385	-6,965
Pay Costs	-8,777	-8,949	-172	-78,307	-78,384	-78
Non-Pay Costs	-4,234	-4,079	155	-37,925	-36,538	1,387
Total Expenditure	-13,011	-13,028	-17	-116,231	-114,922	1,309
SURPLUS/(DEFICIT)	**1,142**	**-445**	**-1,587**	**17,119**	**11,463**	**-5,656**
WOMENS & CHILDREN						
Total Income	5,306	5,078	-228	48,661	47,836	-825
Pay Costs	-3,172	-3,395	-223	-29,003	-29,263	-261
Non-Pay Costs	-560	-624	-64	-5,290	-5,338	-47
Total Expenditure	-3,732	-4,018	-287	-34,293	-34,601	-308
SURPLUS/(DEFICIT)	**1,574**	**1,060**	**-515**	**14,368**	**13,235**	**-1,133**
CLINICAL SUPPORT						
Total Income	3,938	3,799	-139	36,622	37,187	565
Pay Costs	-5,285	-5,280	5	-47,579	-46,976	603
Non-Pay Costs	-2,415	-2,973	-558	-21,833	-24,371	-2,537
Total Expenditure	-7,700	-8,254	-553	-69,413	-71,347	-1,934
SURPLUS/(DEFICIT)	**-3,763**	**-4,455**	**-692**	**-32,791**	**-34,159**	**-1,369**
SERVICES						
Total Income	605	686	81	5,884	6,224	340
Pay Costs	-2,403	-2,450	-47	-21,022	-20,564	458
Non-Pay Costs	-5,329	-5,440	-111	-46,113	-46,811	-698
Total Expenditure	-7,731	-7,890	-158	-67,135	-67,376	-240
SURPLUS/(DEFICIT)	**-7,126**	**-7,203**	**-77**	**-61,251**	**-61,152**	**99**
OTHER						
Total Income	4,894	5,214	320	48,350	48,095	-255
Pay Costs	-331	-365	-34	-3,389	-3,295	94
Non-Pay Costs	-5,323	-4,887	435	-48,421	-44,888	3,533
Total Expenditure	-5,654	-5,252	402	-51,810	-48,183	3,627
SURPLUS/(DEFICIT)	**-759**	**-38**	**722**	**-3,459**	**-87**	**3,372**
TOTAL						
Total Income	48,251	45,714	-2,537	449,792	444,029	-5,763
Pay Costs	-29,379	-30,477	-1,098	-264,004	-265,745	-1,741
Non-Pay Costs	-25,627	-24,736	890	-227,975	-224,950	3,025
Total Expenditure	-55,006	-55,213	-208	-491,978	-490,695	1,284
SURPLUS/(DEFICIT)	**-6,754**	**-9,499**	**-2,745**	**-42,186**	**-46,666**	**-4,479**

Medicine

Although performance YTD the Medicine and Emergency division remains ahead of plan, in month performance is behind plan for the third consecutive month. Costs have increased slightly but the shortfall is being mainly driven by a ramp up of the Clinical Income target, due to back ended FIPs.

Pay remains a concern in the Emergency & OPM sub-division with overspend YTD of £2.1m. Increased activity has driven spend, and a subset of this is an additional two junior doctors to ensure the trust meets the NHSI targets. The on boarding of Doctors from the overseas recruitment is gathering pace which has helped reduce the reliance on Locums going forward, however nursing costs, particularly HCA's, increased significantly through December due to Staff Leave and high levels of 1:1 care required.. Further adverse variance are due to increased activity; Sleep Apnoea £180k, Cardiology Devices £200k, 18Week Support Gastro weekend delivery £250k.

Surgery

Performance YTD for the Surgical Division is behind plan by £5.656m, a deterioration of £1.587m in the month. Total Income is £6.965m behind the YTD plan. Clinical Income drives this variance, currently c.£6.2m behind plan.

The trend relating to General Surgery has continued in the period with increased non- elective income through the increase A&E activity, impacting on the elective activity which is a higher income generating area. Vacancies, long term sickness, aggressive CIP plans & cancellations from winter pressures in Plastics, Dermatology and T&O is still impacting the performance against plan. Typing backlogs & the new pensions taxation continues to limit the willingness of consultants to perform WLI sessions.

Pay costs YTD are overspent against plan by £78k, due to increased spend against vacancies. Non-Pay is £1.4m underspent resulting from the delay in opening the additional Critical Care beds and a general reduction in spend due to reduced activity relative to Clinical Income CIPs.

Core Slide 46

Finance - Lead Director John Hennessey

Summary by Directorate (cont.)

Women's and Children's

Performance YTD is now behind plan by £1.1m. The driver behind this is clinical income being behind plan by £1.0m with Outpatients being the significant driver of the deterioration.

Pay is overspent YTD by £261k, the vacancies in Paeds nursing and Student Midwives YTD has now been offset by the commencement of the unidentified pay CIP from M07 of £90k per month. Non pay expenditure is underspent YTD but £302k behind due to no spend on SHS and Medinet being lower than plan, this underspend is reduced by the increase in drugs spend which mainly flows through into income as well as the unidentified CIP plan of £21k per month from M07

Clinical Support

Divisional performance for CSSC has deteriorated from M08, with an under performance against plan in M09 of £1.4m YTD.

Total Income is ahead of plan by £565k, with increased direct access radiology and pathology work, and an increased EPA recharge due to overspends in Non-Pay.

Pay remains underspent YTD by £603k, with underspends across the directorates.

Non-Pay remains a concern, the YTD overspend against budget is now £2,537k. £450k variance relating to the Abbotts contract CIP (this as now been resolved moving forward). Other significant variances relate to additional expenditure on HODs and other sendaway testing (£200k) & maintenance contracts. Other adverse variances include £816k YTD of consumables/MSC's in EPA (including overspends on Genmed contracts), £403k YTD of SHS expenditure in Cell Path, £195k YTD in CT Radiology, £180k on IRU consumables and £241k unidentified non-pay CIPs, & £97k on Air pressure mattress hire.

Services

YTD Services are ahead by £100k. A large driver of this has been driven through additional income received though CNST savings in Maternity,

Pay is £458k underspent against budget YTD, but was £47k overspent in month. Pay is anticipated to carry on in line with budget due to savings at the start of the year being non-recurrent.

Non-Pay however is overspent YTD against budget by £698k. This includes an adjustment to the procurement contract agreement which was not budgeted.

Other - YTD

The income variance of £0.4m adverse is a net of an adverse clinical income variance of £2.6m and a favourable 'other income' variance of £2.2m.

Note that the drugs inflation income budget of £3m to date has been netted off the inflation cost budget for drugs in this presentation, and reversed back for the overall Trust position on slide 45.

Clinical Income is where contract risks and issues are posted - away from the divisional performance. It is worse than plan by £2.6m being; Specialised Block where we have done more work than the block contract will pay - £1.1m, Readmissions costs £0.3m worse than plan, Cancelled Operations £0.3m, Cancer 62 day target penalties £0.6m and other risks provided.

Income is a net £2.2m fav variance, with key items being £0.64m release of opening balance sheet review, £0.4m re Education and training, adverse R&D income variance of £0.4m (offset to nil through cost variances), accrual for income risk / winter reserve of £1.0m and other net variances.

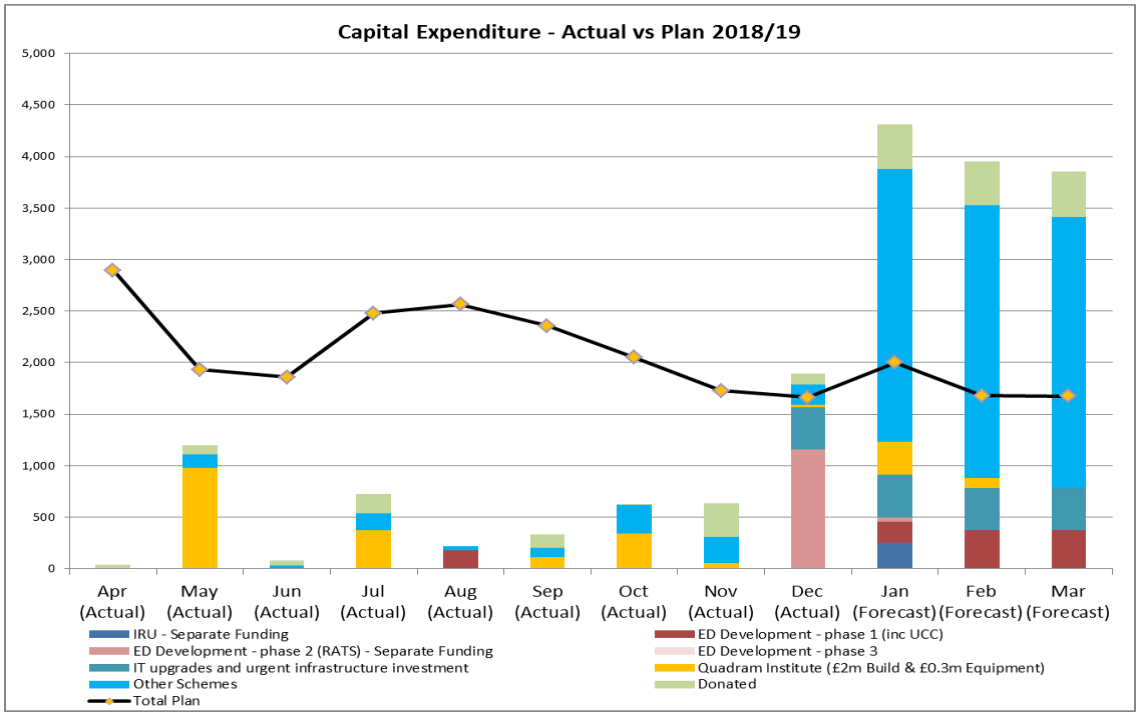
Non-Pay is £3.5m better than budget being: £1.5m general inflation cost pressure not allocated to specific costs, £0.5m under spent on R&D – matches under on related income, £1.0m fav on non opex – see below and other slippage.

Non-Opex is £1.0m better than budget: Depreciation £0.3m from slippage in spend, Interest on borrowings £0.55m from interest rate and borrowing variances and Contingent Rent £0.15m from RPI being less than assumed and £0.1m on interest receivable and asset disposals.

Core Slide 47

Finance - Lead Director John Hennessey

Capital Progress Report



The original plan for the year was expenditure of £25.8m.

The current forecast for the year is £17.9m and its monthly phasing is shown in the graph to the left.

Of this £5.7m has been spent to date, leaving £12.2m for the final quarter. This is largely dependent upon receiving a capital loan from NHSI – which has been re evaluated downwards having regard to likely timing of spend in 2019/20 to £5.4m.

Internally generated funding for capital is £7.0m, comprising, depreciation net of balance sheet cash items of £1.0m, STF of £4.5m, and capital assets disposals of £1.5m as part of the move to a managed service relating to QI. Of this £3.6m has been spent to date, leaving £3.4m funding attached to the Q4 expenditure forecast.

	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Actual £'000	Aug Actual £'000	Sep Actual £'000	Oct Actual £'000	Nov Actual £'000	Dec Actual £'000	Jan Forecast £'000	Feb Forecast £'000	Mar Forecast £'000	TOTAL Forecast £'000
IRU - Separate Funding	0	0	0	0	0	0	0	6	0	252	0	0	**258**
ED Development - phase 1 (inc UCC)	0	0	0	0	175	0	0	0	0	206	370	370	**1,121**
ED Development - phase 2 (RATS) - Separate Fundin	0	0	0	0	0	0	0	0	1,159	41	0	0	**1,200**
ED Development - phase 3	0	0	0	0	0	0	0	0	0	0	0	0	**0**
IT upgrades and urgent infrastructure investment	0	0	0	0	0	0	0	0	411	410	410	410	**1,641**
Quadram Institute (£2m Build & £0.3m Equipment)	0	975	0	375	0	116	343	49	17	325	100	0	**2,301**
Other Schemes	0	133	30	158	44	85	272	254	203	2,645	2,645	2,632	**9,102**
Donated	42	86	50	188	0	135	14	323	106	432	428	440	**2,245**
Total Actual to Date / Forecast	42	1,194	80	721	220	335	629	632	1,896	4,312	3,953	3,852	17,867
Cumulative Actual to Date	42	1,236	1,317	2,038	2,258	2,593	3,222	3,854	5,750				
Total Plan	2,896	1,933	1,858	2,479	2,566	2,356	2,050	1,726	1,664	2,001	1,677	1,674	24,880

Core Slide 48

Finance - Lead Director John Hennessey

Statement of Financial Position at 31st December 2018

	Opening Balance as at 1 April 2018 £'000	Plan 31 March 2019 £'000	Plan YTD 31 December 18 £'000	Actual YTD 31 December 18 £'000	Variance YTD 31 December 18 £'000
Property, plant and equipment	234,749	249,516	246,558	233,834	(12,724)
Trade and other receivables	71,245	77,940	76,256	76,595	339
Other financial assets	0	0	0	0	0
Total non-current assets	**305,994**	**327,456**	**322,814**	**310,429**	**(12,385)**
Inventories	9,369	9,369	9,369	10,574	1,205
Trade and other receivables	28,621	24,040	27,038	31,759	4,721
Non-current assets for sale	0	0	0	0	0
cash and cash equivalents	5,733	1,681	2,244	5,867	3,623
Total Current assets	**43,723**	**35,090**	**38,651**	**48,200**	**9,549**
Trade and other payables	(61,085)	(61,256)	(61,011)	(70,550)	(9,539)
Borrowing repayable within 1 year	0	0	0	0	0
Current provisions	(308)	(307)	(307)	(308)	(1)
Deferred Income	(5,138)	(4,764)	(4,764)	(10,375)	(5,611)
Total current liabilities	**(66,531)**	**(66,327)**	**(66,082)**	**(81,233)**	**(15,151)**
Total assets less current liabilities	**283,186**	**296,219**	**295,383**	**277,396**	**(17,987)**
Borrowings - PFI & Finance Lease	(193,856)	(190,761)	(191,733)	(191,735)	(2)
Borrowings - Revenue Support	(52,393)	(103,493)	(93,419)	(93,534)	(115)
Borrowings - Capital Support	0	(18,601)	(14,445)	0	14,445
Provisions	(2,159)	(1,892)	(1,959)	(2,096)	(137)
Deferred Income	(4,606)	(4,875)	(4,901)	(4,381)	520
Total non-current liabilities	**(253,014)**	**(319,622)**	**(306,457)**	**(291,746)**	**14,711**
Total assets employed	**30,172**	**(23,403)**	**(11,074)**	**(14,350)**	**(3,276)**
Financed by					
Public dividend capital	28,408	28,408	28,408	29,608	1,200
Retained Earnings (Accumulated Losses)	(13,239)	(66,814)	(54,485)	(58,945)	(4,460)
Revaluation reserve	15,003	15,003	15,003	14,987	(16)
Total Taxpayers' and others' equity	**30,172**	**(23,403)**	**(11,074)**	**(14,350)**	**(3,276)**

Non-Current Assets

There is some slippage on the capital programme primarily due to a delay in receiving capital support from DHSC of £14.4m YTD.

Trade and Other Receivables

This balance is £4.7m higher than plan YTD. Various - key driver is timing.

Cash

Cash is £3.6m higher than plan at the end of December due to short term timing differences and operational performance. Loan drawdowns continue to be delayed as long as possible.

Trade and other payables

This is £9.5m higher than plan YTD.

£1.1m relates to a capital accrual for the discharge suite works and will convert to spend in month 10.

£0.5m is YTD accrual of £2m contingency reserve.

£1.5m increase in levels of goods received not invoiced.

Increased levels of general trade payables – timing difference.

Increase in N.I. and tax liability following AfC pay increase.

Deferred Income

This balance is £5.1m higher than plan YTD. £1.5m relates to the sale of endoscopy equipment and is a short term timing difference. £0.6m relates to risk on assumed VAT recovery relating to the QI. The remainder are small timing differences.

Borrowings

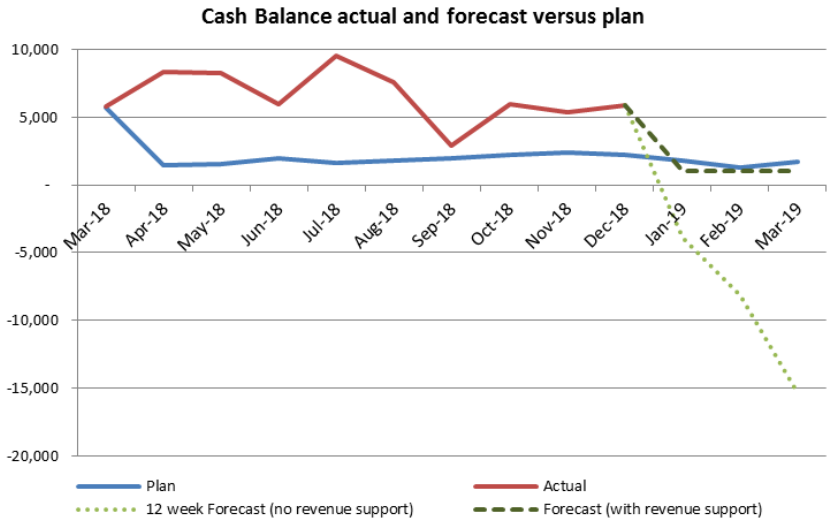
Total overall borrowings are £14.3m lower than plan.

In year revenue borrowings are £41.1m against a YTD plan of £41.0m. Being £0.1m higher than plan.

In year capital borrowings are £0m against a YTD plan of £14.4m. Being £14.4m lower than plan. This is primarily due to the lengthy DHSC process of approving the revised capital loan applications of £5.7m and the funding being released.

Core Slide 49

Finance - Lead Director John Hennessey



	Opening	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
Cum. Rev. Borrowings-Plan	52,393	55,393	57,393	63,531	67,019	72,142	78,234	81,853	86,150	93,419	97,011	102,257	103,493
Cum. Rev. Borrowings-Actual	52,393	57,671	61,450	65,142	73,369	74,906	76,425	82,544	88,296	93,534			
Variance - (Adverse) / Favourable	0	(2,278)	(4,057)	(1,611)	(6,350)	(2,764)	1,809	(691)	(2,146)	(115)			

- The graph shows the cash levels since the end of March 2018. Short term timing differences drive the difference between actual and plan.
- The Trust is required to keep a minimum balance of £1 million, hence the closing cash plan every month is circa £1m.
- The future cash loan requirements on current projections are: £4.9m in January (received), £4.4m in February and estimated £7.143m in March
- The borrowings of £93.5m at the end of M09 comprise: £16m in 2016/17, £36.4m in 2017/18 & £41.1m in 2018/19.
- The interest rates are: 3.5% on £53.3m. 1.5% on the remainder of £40.2m.

NOTE:

- The plan for 2018/19 assumed additional borrowings of £51.1m for revenue. It is expected to be £57.6m, bringing total revenue borrowings to £110m.
- The Trust Board approved borrowing 'limit' is £100m revenue and £25m capital. A request for an increase in revenue borrowings limit to £160m forms part of the board papers.
- The need for the funds is driven by our operational performance.

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

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	33,621	35,713	33,035	(2,092)	(6%)	586	2%
Clinical Income - Spire Contract	805	632		173	27%	805	
NT Drugs	4,772	5,771	5,114	(999)	(17%)	(342)	(7%)
Total NHS clinical income	**39,198**	**42,116**	**38,149**	**(2,918)**	**(7%)**	**34,084**	**89%**
Non NHS clinical income							
Private patients	112	158	110	(46)	(29%)	2	2%
Other - RTA	106	109	19	(3)	(3%)	87	458%
Total Non NHS clinical income	**218**	**267**	**129**	**(49)**	**(18%)**	**89**	**69%**
Other Income							
R&D	1,785	1,810	1,931	(25)	(1%)	(146)	(8%)
Education & Training	2,080	1,929	1,831	151	8%	249	14%
STF Income			(797)			797	(100%)
Other non patient care income	2,418	2,129	3,534	289	14%	(1,116)	(32%)
Total other Income	**6,283**	**5,868**	**6,499**	**415**	**7%**	**(216)**	**(3%)**
TOTAL OPERATING INCOME	**45,699**	**48,251**	**44,777**	**(2,552)**	**(5%)**	**33,957**	**76%**
EXPENDITURE							
Employee benefit expenses	(30,477)	(29,379)	(28,057)	(1,098)	(4%)	(2,420)	(9%)
Drugs	(5,554)	(6,834)	(6,214)	1,280	19%	660	11%
Clinical supplies	(6,189)	(5,578)	(5,282)	(611)	(11%)	(907)	(17%)
Non clinical supplies	(7,484)	(7,594)	(6,947)	110	1%	(537)	(8%)
- Fixed	*(1,784)*	*(1,784)*	*(1,341)*		*0%*	*(443)*	*(33%)*
- Capacity	*(333)*	*(553)*	*(529)*	*220*	*40%*	*196*	*37%*
- Income Backed including Spire	*(2,653)*	*(2,477)*	*(2,103)*	*(176)*	*(7%)*	*(550)*	*(26%)*
- £2m Contingency Reserve	*(180)*	*(180)*			*0%*	*(180)*	
- Variable	*(2,534)*	*(2,600)*	*(2,974)*	*66*	*3%*	*440*	*15%*
PFI operating expenses	(1,828)	(1,813)	(1,772)	(15)	(1%)	(56)	(3%)
TOTAL OPERATING EXPENSES	**(51,532)**	**(51,198)**	**(48,272)**	**(334)**	**(1%)**	**(3,260)**	**(7%)**
Profit/(loss) from operations	**(5,833)**	**(2,947)**	**(3,495)**	**(2,886)**	**98%**	**30,697**	**(878%)**
Non-operating income							
Interest	14	3	7	11	(367%)	7	100%
Profit/(loss) on asset disposals	1	(3)	2	4	133%	(1)	(50%)
Total non-operating income	**15**		**9**	**15**		**6**	**67%**
Non-operating expenses							
Interest on PFI and Finance leases	(1,419)	(1,419)	(1,438)		0%	19	(1%)
Interest on Non Commercial Borrowing	(196)	(292)	(83)	96	33%	(113)	136%
Depreciation	(926)	(945)	(948)	19	2%	22	(2%)
PDC			(25)			25	(100%)
Other - Contingent Rent	(1,140)	(1,151)	(1,047)	11	1%	(93)	9%
Total non operating expenses	**(3,681)**	**(3,807)**	**(3,541)**	**126**	**3%**	**(140)**	4%
Surplus (deficit) after tax from continuing operations	**(9,499)**	**(6,754)**	**(7,027)**	**(2,745)**	**(41%)**	**30,563**	**435%**
Memo:							
Donated Asset Additions	106	159	3	(53)	(33%)	103	3433%
Surplus (deficit) after tax and Donated Asset Additions	**(9,393)**	**(6,595)**	**(7,024)**	**(2,798)**	**(42%)**	**30,666**	**437%**

Notes:

Calendar Days	31	31	31
Working Days	19	19	19

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

Income Statement Comparison - Year to 31 December 2018

	FULL YEAR BUDGET	Year to date			Variances Fav / (Adv)			
		Actual	Budget	Prior year	To Budget		To prior year	
	£'000	£'000	£'000	£'000	£'000	%	£'000	%
INCOME								
NHS clinical income								
Clinical Income	447,320	327,255	334,186	318,628	(6,931)	(2%)	8,627	3%
Clinical Income - Spire Contract	7,578	6,094	5,684		410	7%	6,094	
NT Drugs	69,230	50,296	51,917	47,725	(1,621)	(3%)	2,571	5%
Total NHS clinical income	**524,128**	**383,645**	**391,787**	**366,353**	**(8,142)**	**(2%)**	**17,292**	**5%**
Non NHS clinical income								
Private patients	1,899	1,167	1,424	1,339	(257)	(18%)	(172)	(13%)
Other - RTA	1,318	1,169	988	832	181	18%	337	41%
Total Non NHS clinical income	**3,217**	**2,336**	**2,412**	**2,171**	**(76)**	**(3%)**	**165**	**8%**
Other Income								
R&D	21,644	15,692	16,215	16,100	(523)	(3%)	(408)	(3%)
Education & Training	23,267	17,886	17,482	17,165	404	2%	721	4%
STF Income				3,853			(3,853)	(100%)
Other non patient care income	28,176	24,343	21,902	34,260	2,441	11%	(9,917)	(29%)
Total other Income	**73,087**	**57,921**	**55,599**	**71,378**	**2,322**	**4%**	**(13,457)**	**(19%)**
TOTAL OPERATING INCOME	**600,432**	**443,902**	**449,798**	**439,902**	**(5,896)**	**(1%)**	**4,000**	**1%**
EXPENDITURE								
Employee benefit expenses	(351,045)	(265,745)	(264,004)	(246,140)	(1,741)	(0.7%)	(19,605)	(8%)
Drugs	(82,270)	(59,549)	(61,766)	(57,079)	2,217	3.6%	(2,470)	(4%)
Clinical supplies	(65,909)	(49,822)	(49,288)	(49,287)	(534)	(1.1%)	(535)	(1%)
Non clinical supplies	(90,707)	(67,412)	(67,930)	(56,198)	518	0.8%	(11,214)	(20%)
- Fixed	(21,366)	(16,012)	(16,012)	(13,154)		0%	(2,858)	(22%)
- Capacity	(6,213)	(4,753)	(4,703)	(4,556)	(50)	(1%)	(197)	(4%)
- Income Backed including Spire	(29,720)	(22,050)	(22,291)	(16,392)	241	1%	(5,658)	(35%)
- £2m Contingency Reserve	(2,000)	(1,360)	(1,360)				(1,360)	
- Variable	(31,408)	(23,237)	(23,564)	(22,096)	327	1%	(1,141)	(5%)
PFI operating expenses	(21,091)	(16,360)	(16,159)	(15,606)	(201)	(1.2%)	(754)	(5%)
TOTAL OPERATING EXPENSES	**(611,022)**	**(458,888)**	**(459,147)**		**259**	**0%**	**(34,578)**	**#DIV/0!**
Profit/(loss) from operations	**(10,590)**	**(14,986)**	**(9,349)**	**15,592**	**(5,637)**	**60%**	**(30,578)**	**(196%)**
Non-operating income								
Interest	32	113	24	32	89	(371%)	81	253%
Profit/(loss) on asset disposals	(40)	14	(30)	9	44	147%	5	56%
Total non-operating income	**(8)**	**127**	**(6)**	**41**	**133**	**(2217%)**	**86**	**210%**
Non-operating expenses								
Interest on PFI and Finance leases	(17,085)	(12,828)	(12,829)	(13,034)	1	0%	206	(2%)
Interest on Non Commercial Borrowing	(2,799)	(1,284)	(1,835)	(608)	551	30%	(676)	111%
Depreciation	(11,021)	(7,805)	(8,126)	(7,948)	321	4%	143	(2%)
PDC				(222)			222	(100%)
Other - Contingent Rent	(13,497)	(9,890)	(10,042)	(9,054)	152	2%	(836)	9%
Total non operating expenses	**(44,402)**	**(31,807)**	**(32,832)**	**(30,866)**	**1,025**	**3%**	**(941)**	3%
Surplus (deficit) after tax from continuing operations	**(55,000)**	**(46,666)**	**(42,187)**	**(15,233)**	**(4,479)**	**(11%)**	**(31,433)**	**(206%)**
Memo:								
Donated Asset Additions	1,425	944	941	1,397	3	0%	(453)	(32%)
Surplus (deficit) after tax and Donated Asset Additions	**(53,575)**	**(45,722)**	**(41,246)**	**(13,836)**	**(4,476)**	**(11%)**	**(31,886)**	**(230%)**

The table below shows the position on a control total basis. Although the control total has not been accepted, the Trust is obliged to report against this on a monthly basis to NHSI.

Deficit on a control total basis - reportable to NHSI:								
Surplus (deficit) after tax and Donated Asset Additions	(53,575)	(45,722)	(41,246)	(13,836)	(4,476)	(11%)	(31,886)	230%
Remove: Donated Asset Additions	(1,425)	(944)	(941)	(1,397)	(3)	0%	453	(32%)
Add back: Donated Depreciation	807	646	610	498	36	6%	148	30%
Adjusted financial performance surplus/(deficit)	**(54,193)**	**(46,020)**	**(41,577)**	**(14,735)**	**(4,443)**	**(11%)**	**(31,285)**	**212%**
CONTROL TOTAL	**10,683**	**7,069**	**7,069**	**2,205**		**0%**	**4,864**	**221%**
Performance against control total	**(64,876)**	**(53,089)**	**(48,646)**	**(16,940)**	**(4,443)**	**(9%)**	**(36,149)**	**213%**

Notes:

Calendar Days	275	275	275
Working Days	190	190	188

REPORT TO THE TRUST BOARD IN ITS CAPACITY AS CORPORATE TRUSTEE	
Date	**25 January 2019**
Title	**Charitable Funds Expenditure Requests**
Author & Exec lead	**Julie Cooper, Charitable Funds Accountant** **John Paul Garside, Board Secretary – Executive Lead for N&N Charity**
Purpose	**For Approval**

1. Background/Context

1.1 In accordance with agreed delegated authority, expenditure of charitable funds in excess of £10,000 requires the approval of the Board in its capacity as Corporate Trustee.

1.2 The **attached** paper sets out the charitable funding requests for January 2019, for approval.

2. Key issues and considerations

2.1 There are two new requests set out in the accompanying schedule to a total of £95,837.

i) Refurbishment of the control room for Linac 2 (linear accelerator – for radiotherapy treatment of patients with cancer)

This will improve use of the current control space and will facilitate radiographers treating patients to be able to focus on treatment without distraction.

ii) Extension of the post of CCT Rheumatology Fellow until 31st December.

Dr Lim's work involves the design, development and running of two research studies sponsored by the Trust investigating undiagnosed axial spondyloarthritis (a severe but treatable inflammatory spinal condition) among patients who attend the Gastroenterology Department with inflammatory bowel disease.

Preliminary findings have already been published in medical journals and the research is aimed at reducing the delay in diagnosis of axial spondyloarthritis.

2.2 It is confirmed that the proposed expenditure is:

i) within the objects of the N&N Hospitals Charity;
ii) consistent with any restrictions on use of relevant funds;
iii) within the agreed budget and spending proposals for the Charity;
iv) supported by relevant fund advisers as being appropriate expenditure of charitable funds.

2.3 One item of expenditure over £10k has been given 'exceptional' approval by the CEO and the Board Secretary, in accordance with the agreed procedure for exceptional funding. This was to support installation of a second CT scanner, improving patient access to Radiotherapy. A funding decision was required in advance of January's Board meeting, to allow the installation to proceed at the same time as other building work, resulting in a saving of £20k.

Recommendation:
The Board is recommended to **approve** the expenditure as set out in the attached schedule.

Norfolk & Norwich Hospitals Charity

Funds requests over £10,000

January 2019

Fund	Balance available before request £	Request Details	Amount requested £
Oncology Fund Designated	**619,233**	To refurbish the control room for Linac 2 and create a quiet office space for clinical staff. This will improve use of the current control space, and will allow those treating patients to be able to focus on treatment, with fewer distractions from radiographers carrying out 'outside tasks' and vice versa.	**35,691**
Rheumatology Bone Fund Designated	**63,231**	To extend the post of CCT Rheumatology Fellow (Dr Edwin Lim) until 31st December 2019.	**60,146**
			95,837

Approved by the Trust Board in its capacity as Corporate Trustee

Signed: _____
Mr John Fry (Chairman) - Norfolk and Norwich University Hospitals NHS Foundation Trust

Date: _____

Items given 'Exceptional' approval by the Board Secretary and the CEO on behalf of the Corporate Trustee:

Fund	Balance available before request £	Request Details	Amount requested £
Scanner Fund Designated	**78,792**	To enable installation of a second CT scanner, improving patient access to Radiotherapy *Exceptional approval given 10/01/2019 due to the need for funding of this project to be agreed to take advantage of shared costs with other building work already underway resulting ina saving of £20k.*	**60,000**