MEETING OF THE TRUST BOARD IN PUBLIC

FRIDAY 26 JULY 2019

A meeting of the Trust Board in public will take place at 9.20am on Friday 26 July 2019 in the Boardroom of the Norfolk and Norwich University Hospital

The formal meeting will be preceded by clinical and departmental visits between 8.30am - 9.15am

---

AGENDA

	Item	Lead	Purpose	Page No
1	Apologies and Declarations of Interest			
2	Reflections on the visits	All		
3	Minutes of the Board meeting held in public on 31.05.19		Approval	**2**
4	Actions & Matters arising		Discussion	**11**
5	Chief Executive's Report	CEO	Discussion	**12**
6	Clinical focus: Infection Prevention & Control (Annual Report 2018/19) *Members of IP&C team to attend*	NF	Discussion	**33**
7	Reports from Board Committees: (a) Quality Programme Board (11.06.19 & 09.07.19)	MD	Information	**92**
	(b) Quality & Safety Committee (06.06.19 & 25.07.19)	GO	Information	**147**
8	Quality Strategy	ED/NF	Approval	**151**
9	Integrated Performance Report - Quality, Safety & Effectiveness - Caring & Patient Experience - Performance & Productivity - Workforce - Finance	Execs	Information	**163**
10	Feedback from Council of Governors (24.07.19 agenda)	Chair	Information	**197**
11	Any other business			

Date and Time of next Board meeting in public
The next Board meeting in public will be held at 9.20am on Friday 27 September 2019 in the Boardroom of the Norfolk and Norwich University Hospital

MINUTES OF TRUST BOARD MEETING IN PUBLIC

HELD ON FRIDAY 31 MAY 2019

Present:	Mr J Fry	- Chairman
	Mr C Cobb	- Chief Operating Officer
	Mr M Davies	- Chief Executive
	Prof E Denton	- Medical Director
	Prof 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
	Prof D Richardson	- Non-Executive Director
	Mrs A Robson	- Non-Executive Director
In attendance:	Ms F Devine	- Director of Communications
	Mr J P Garside	- Board Secretary
	Mr S Hackwell	- Director of Strategy
	Mr A Lundrigan	- Chief Information Officer
	Ms V Rant	- Assistant to Board Secretary

19/024 **APOLOGIES AND DECLARATIONS OF INTEREST**

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

19/025 **REFLECTIONS ON DEVELOPMENT AND ASSURANCE VISITS**

(a) Audiology Department

Mr Jeffries and Professor Fontaine visited the Audiology Department and met with Dr John Fitzgerald (Head of Audiology). The Department was in very good order and this had been achieved by employing a housekeeper who ensures that everything is as it should be. The Department has adopted LEAN methodology working practices. Dr Fitzgerald reported that the service had been awarded the highest accreditation rating in the region. Many procedures need to be undertaken at the hospital but the Department provides some services in the community and is thinking creatively about what it can offer Norfolk and GPs to improve audiology services.

(b) Main Theatres

Dr O'Sullivan, Mr Davies and Mr Hennessey visited Main Theatres and met with Michael Dicker (Matron) and Dr Michael Irvine (Service Director and Consultant Anaesthetist). The hospital has 26 theatres with 17 located on the third floor in Main Theatres and a number in DPU. The team provided an overview of how the department runs and reported how the Governance Lead for their area has made significant improvements to the way their service operates. Review of Never Events and compliance against required standards has also improved. An example of innovation was introduction of standardised equipment sets for anaesthetics in 'remote' clinical areas, such as MRI.

Mr Hennessey reported that the department expressed the desire to modernise theatre stock management systems which would generate efficiency savings. When asked why theatre throughput had slowed, the team had indicated that this had been due to an issue around beds and late cancellation of operations. Mr Davies indicated that there is a lack of confidence in the number of patients that can be added to operating lists which has been generated by the lack of beds for surgical patients and affecting overall productivity for the department.

(c) Histopathology and Cytopathology

Mrs Robson, Mr Garside and Mr Lundrigan visited the Histopathology and Cytopathology Departments at the Cotman Centre. Mrs Robson reported that the team are proud of winning the bid to provide regional HPV testing and work is underway to prepare for commencement of the service in July/August. This strengthens our position as a regional centre. Some estates work is needed to aid preparation for the new service and Mr Hackwell will follow this up.

There is a national shortage of qualified staff and the department has found it difficult to recruit pathologists. The Department is working on a digital histopathology project that will enable digital imaging and review of slides from remote locations. This provides a significant service transformation and cost saving opportunity, similar to Radiology.

Mr Davies noted that we need to keep working on connection with teams in the Cotman Centre and other buildings, to ensure that they feel integrated with the rest of the Trust.

(d) Rheumatology Day Unit

Mr Hackwell and Mr How visited the Rheumatology Department and met with Dr Tarnya Marshall and Sister Caroline Ferrari. The team were enthusiastic and the department was busy with patients at 8.30am. The Department provides patients with a range of treatments which is broader than just rheumatology. The department has limited space but is offering telly-clinics for those patients that live further away and may find it difficult to attend the hospital. There is the potential to be able to use skype but a greater WiFi speed would be needed to achieve this.

The department indicated that liaison with GPs in Norfolk in terms of provision of blood testing is good but there are some practices where this could be better.

(e) Elsing Ward

Professor Richardson and Mr Over visited Elsing Ward. The ward has capacity for up to 38 patients and typically has a number of patients who exhibit challenging behaviour due to dementia. There was a good 'team spirit' on the ward and the team reported that they receive good support from management and in development of their roles. The ward has experienced some issues with staffing in the past and there is more progress to be made to maintain sufficient levels.

There were issues in relation to furniture that appeared dated and in need of repair. The ward was satisfied with the level of support provided for cleaning and fridge temperature and resus trolley checks were compliant.

Professor Richardson reported that his discussion with a student on placement indicated that the Ward is a supportive environment offering a good student experience.

(f) Plastic Surgery Out-patient Department

Mr Fry, Mr Cobb and Professor Denton visited the Plastic Surgery Department and met with Julie Keeling (Senior Surgical Matron). The Department highlighted the adverse impact on surgical capacity caused by Escalation Policy accommodation of patients in the DPU area, which has meant that operations have had to be undertaken within the outpatient department. The department is operational from 8am to 6pm.

Mr Fry reflected that lack of capacity appears to be a theme in a number of areas and highlighted that this will be reviewed as part of the Estates Strategy at the next Board meeting. Mr Hackwell added that the Management Board will also be reviewing the Estates Strategy at its next Away Day.

The Board discussed mechanisms to feedback to the areas visited following Board visits and Mrs Devine offered to coordinate this.

19/026 **MINUTES OF PREVIOUS MEETING HELD ON FRIDAY 29 MARCH 2019**

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

19/027 **MATTERS ARISING**

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

19/005(iii) Mr Lundrigan updated the Board with regard to the business case for an e-obs system. The clinical and operational advantages are well understood – the issue is how we can make the finances work in the absence of approval of our capital application. We are exploring alternative systems and suppliers and the business case will be brought to F&I Committee to review once a proposal has been developed and the F&IC will be kept updated. Action closed.

Mr Hennessey reported that he and Mr Cobb had visited the Health Records Library on 30 May. The Records Library is vast and staff are working well within the current system. They are engaged in introduction of the EDMS and in the process of recruiting staff to undertake scanning. Progress will be difficult if the capital loan bid is not approved and we will need to consider another way of dealing with backlogs if funding is not made available soon.

19/020(c) Professor Fontaine reported that the CRR is reviewed regularly by the Risk Oversight Committee and this is due for review next week and the format will be revised to add a date each risk is likely to be further mitigated or resolved. Action closed.

19/028 **CHIEF EXECUTIVE REPORT**

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

(a) CQC Inspection Rating

Mr Davies informed the Board that the Trust's CQC rating had been upgraded from 'Inadequate' to 'Requires Improvement'. This is a rapid improvement and is a significant achievement and our staff have worked hard on improvements in order to achieve this. This gives us a platform from which to continue our journey to a rating of 'Outstanding' alongside the top 10% of Trusts in the country.

(b) Health Service Journal (HSJ) Award for NNUH Robotic Colorectal Surgery

The Board was informed that our Colorectal Surgery Team has won the national HSJ award for Innovative Practice in Surgical Services. This is a good example of the benefits that can be realised by targeting investment in key areas. NNUH was the first

hospital in East Anglia to perform robot assisted minimally invasive colorectal cancer surgery.

(c) North Norfolk Macmillan Centre at Cromer & District Hospital
The partnership between the Trust and Macmillan Cancer Support for refurbishment of the Davison Wing at Cromer Hospital has been announced publicly. Mrs Robson asked about the timeline for the refurbishment and Mr Hackwell confirmed that the unit is anticipated to be ready for opening in June 2020. We are applying for planning permission and a formal tendering process will commence shortly.

(d) Chief People Officer
Ms Prerana Issar has been appointed as the national NHSI/NHSE Chief People Officer. Our role of Director of Workforce has been changed to Chief People Officer accordingly and we will recruit to this post.

(e) Digital Collaboration and Transformation
Mr Lundrigan informed the Board that a commercial partner has been appointed to work with the three Acute Hospitals in this region to assist the EPR procurement process. Over the next 12-18 months, work will be undertaken to define the specification and business cases for procurement of the EPR. This is a key step for our Digital Strategy and will transform delivery of services for patients across the region.

19/029 **REPORTS FROM BOARD COMMITTEES**

(a) Quality Programme Board
Mr Davies informed the Board that the Quality Programme Board meetings continue to be effective and provides our regulators with assurance that actions within the Quality Improvement Plan are being addressed.

Ms Philippa Slinger will be moving post and we are waiting to hear who will be taking over her following her departure as NHSI Improvement Director.

Mrs Robson noted that some Evidence Review Group outcomes had reverted back to red in some areas, which is a good sign that our teams are applying scrutiny to ensure we are making sustainable and not just temporary changes. Internal Audit has reviewed the process which is considered to be robust. Professor Fontaine noted that the approach in the Trust is regarded as best practice which NHSI are proposing for use in other organisations. The frequency of the Oversight & Assurance Group has been reduced to bi-monthly.

(b) People and Culture Committee
Professor Richardson informed the Board that the People and Culture Committee had met on 14 May. This was the same day as the CQC announcement about the Trust's upgraded rating which inevitably impacted on attendance. The Committee is developing well and for this meeting encouraged the divisions to think about workforce planning.

Each Division provided an overview of their current and future workforce demand and supply. The future workforce requirements identified by these reviews will be used to inform discussion with the UEA and HEE. The value of producing these reports was recognised by the Divisions and this information will prove extremely useful in informing future discussions about how the Trust can respond to education/training needs.

Mr Over reported that the Chiefs of Division had described the process of producing their reports as being helpful in highlighting the longer term workforce plans for their Divisions. The Committee was informed that a dedicated team had been established to improve the Trust's recruitment function and a bespoke website for recruitment has been under development, focused on attracting people to come and work at the Trust.

Mr How informed the Board that Ms Frances Dawson (Lead Freedom to Speak-Up Guardian) is invited to future meetings to help to provide insight from staff feedback. It is useful having the Chiefs of Division involved but there is need for them to attend and this has been emphasised.

Dr O'Sullivan reported that the Quality and Safety Committee had been concerned to hear that the vacancy rate for senior doctors in ED was nearly 50% and asked about the arrangements to oversee recruitment to vacancies in vital areas such as the ED.

Mr Cobb explained that we currently have a 7.4 WTE gap in ED consultants against the full establishment of 20. Work is underway to review our recruitment processes for ED consultants. We have reviewed current advertising strategies and we will be using a rolling advert for every type of ED consultant in order to attract staff to work in the department. Progress on recruitment in the ED is monitored by the Urgent and Emergency Care Board.

Mr Garside suggested that the Board may find it helpful to reintroduce the report on vacancies/appointments via the Chief Executive Report and it was agreed that this should be reintroduced for future CEO reports. **Action: Mr Garside/Mr Jones**

19/030 **STAFF SURVEY RESULTS – NEXT STEPS**

Mr Over informed the Board that the 2018 Staff Survey results had been shared widely. A one page summary was developed to provide an overview of the work that has taken place so far on our journey to develop the culture within NNUH and in response to the Kings Fund recommendations.

The Staff Survey took place in October and November 2018 and our response rate was 46% against the national average of 44%. The methodology for reporting the results of the survey was changed this year and 32 key findings are now presented as 10 high level themes and benchmarked against other hospitals.

Our survey results were better than or equal to the benchmark average for four themes and worse than average for six themes. Our score for the question 'would you recommend NNUH as a place to work', improved by 1% and 'would you recommend NNUH as a place to receive care' remained at 76%.

There has been notable improvement in the results over the last four years relating to survey questions under the themes staff engagement; manager support; and appraisal. Areas requiring further improvement are Teamwork behaviours and Raising concerns.

A number of actions have been introduced to respond to the survey results:

- Leading with PRIDE values training programme;
- Communicating with PRIDE (dignity at work framework;
- Full-time Lead Freedom to Speak Up Guardian;
- Investment in Organisational Development for teams needing extra support;
- NHSI Culture Change Programme and staff change team;
- Health & Wellbeing – increased support for staff mental well-being;
- Post-shift debrief and support system.

We will be sharing actions we are taking with staff via ‘You said, We will’ postings across the Trust. Particular issues raised by staff relate to car-parking, staff rest areas and frustrations with IT.

Dr O’Sullivan noted that the score for the Safety Culture theme was low and suggested that further analysis would be helpful if we are to determine what actions need to be taken for improvement. Mr Over explained that workshop discussions highlighted that staff felt they were unable to treat patients at the level to which they aspire due to capacity constraints and this is relevant to the quality of care provided.

Professor Richardson highlighted that the People and Culture Committee had discussed methods for gathering feedback more regularly from staff as this may help to identify issues at an earlier stage as opposed to waiting for the annual staff survey review. If the Trust is aspiring to be within the top 10 of Trusts, then a clear plan of activity needs to be developed and owned across the entire organisation. It is important to identify which initiatives are having an impact and to ensure that our staff feel they are part of this journey towards improvement. Regular capture of data should help to provide oversight on whether our actions are making a positive difference.

Mr Fry noted that much progress has been made but there is still some way to go and highlighted the importance of team leaders continuing to make progress after Mr Over’s departure from the Trust. Mr Fry noted that some of the national average scores were low for example, health & wellbeing (5.9), morale (6.1) and quality of appraisals (5.4) and suggested that the Trust may need to look externally from the NHS to identify organisations who are performing better in these areas. Mr Over confirmed that the new Interim Director of Workforce will be commencing in post on 10 June and will continue to lead on projects with the teams but the support of the Management Board is also a key factor to ensure this work remains in sight.

Mr How suggested that it would be useful to look at best practice in other Trusts and this is something for review at a future People and Culture Committee meeting.

19/031 **INTEGRATED PERFORMANCE REPORT**

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

(a) Quality, Safety and Effectiveness

Professor Denton reported that the HSMR continues to reduce (91 in February 2019) and we are in the lowest quartile for acute hospitals according to HED data (December 2018 to February 2019). Dr Foster have revised and improved their reporting systems and it has been useful having both measures to report against. We are therefore trying to negotiate a reduction in Dr Foster’s service charge so that we can continue to report their data alongside HED data.

The SHMI has shown a small improvement and we are working closely with the teams at Addenbrookes to determine what we can learn in order to see further improvement against this metric.

(b) Caring and Patient Experience

Professor Fontaine reported that the Trust’s IP&C performance is the best in the Region. There were 3 hospital acquired C Difficile infections reported in April 2019 but we are expecting to remain within the target ceiling of 35 cases for 2019/20.

The rate of incident reporting is up, which is seen as a positive sign in the context of a reduction of harm. The rate of falls for March was 7.45 falls per 1,000 bed days and indicates a small increase in reporting of falls within the organisation. A Quality

Improvement Programme project has been initiated to reduce falls by 20% by March 2020. The project aims to ensure staff have the information, skills and tools to reduce falls and improve reporting/care across the Trust.

A ventilation duct cleaning programme is being established and Quality Impact Assessments are being undertaken. The start date for the works will be determined following assessment of the impact and identification of mitigation actions.

The Friends and Family Test Score remains high at 96 for April 2019. Professor Fontaine informed the Board that work continues on development of the Maternity Safety Dashboard. We continue to perform well in our Maternity Services. The Smoking Cessation programme is taking hold. We perform well in standards of care in labour with 1:1 care in labour and the midwife-birth ratios being above average.

Mr Jeffries expressed concern about the continuing spike in the number of Serious Incidents reported. Professor Fontaine explained that we encourage staff to report incidents and an increase in numbers reporting is not of itself a cause for concern. We are able to identify themes arising from incidents and failure to escalate deteriorating patients has been identified as an issue. It is anticipated that introduction of the E-Obs system will bring improvement in this area and we are reviewing options for the critical care outreach service.

(c) Performance and Productivity

Mr Cobb reported that 2 week wait (all cancers) performance was 94% in April 2019. This performance has been achieved ahead of schedule and we will need to continue to work to maintain this performance now.

Performance against the 62 day cancer target at 77% was the best in the last 12 months but is not yet at the 85% target level. Equipment failure (CT - 122 hrs downtime and MRI - 92 hrs downtime) has adversely impacted on performance. There is more work to be done and cancer MDTs are working to identify further actions/changes that can be put in place to improve our performance.

RTT 18 week performance has been adversely impacted by high numbers of cancelled operations, the Easter Bank Holiday and increase in cancer/urgent patients. The number of patients waiting over 52 weeks was reduced to zero in March and April 2019. There was a financial cost to achieve this but the number of long waiting patients has now been stabilised at a lower cost. There is more work to be undertaken to ensure effective processes are in place to manage routine patients so that the number of long waiting patients does not increase to unmanageable levels.

Stroke performance has reduced to a SSNAP rating of C in April. This decrease in performance was due to staff sickness, 13% increase in strokes and inconsistent ring-fencing of stroke beds and record keeping by therapists. A quality improvement plan and workforce business case for 2019/20 are being implemented to address performance issues.

Mr Cobb informed the Board that there has been a 5% reduction in the A&E 4 hour target across the country and there is now increased national focus on recovery of performance. Bed capacity has been challenging with the DPU and JPU being used as escalation areas throughout the month and this has also restricted elective surgery throughput, with medical boarder encroachment into surgical beds.

There were 112 breaches of ambulance handovers of >60 minutes in April. In order to address this, there has been increased monitoring to ensure that policies/operating

procedures are adhered to out of hours and that the escalation corridor is staffed every day. A number of other initiatives have also been introduced:

- RATS redesign;
- Trajectories for 30 and 15 minute performance;
- Audit of delay/harm;
- EEAST tripartite and breach validation process;
- Pilot streaming process, separating ambulatory 'minor' patients.

Performance in ambulance handover has improved significantly and there has been only I delay over an hour in the last week. The next area of focus is on waits greater than 30minutes. Mr Cobb explained the RATS redesign has started to evolve and appears to be working well. There has also been a notable change in atmosphere within ED with staff feeling proud of what they are doing and the support that they are now receiving. The Urgent and Emergency Care Board was established in March and is beginning to make a positive impact. Creation of the Winter Team has also been a positive intervention.

Professor Denton reflected on previous Board discussions regarding culture and leadership within the ED and since that time, many of the challenges appear to have improved with staff fully engaged in a collective endeavour towards good governance/safety, reporting and better leadership.

Mr Davies added that our Regulators have noted the positive changes that have been made in our ED but we will need to ensure we maintain our progress to demonstrate that we are making sustainable changes.

(d) Workforce

Mr Over referred to data in the new format IPR which provides greater detail on the current position on vacancies within the Trust.

(e) Finance

Mr Hennessey reported that the financial position at Month 1 was £6.2m deficit which is £0.65m worse than Plan. The main drivers for this adverse performance were clinical income behind plan and pay costs above plan.

Clinical income was behind Plan in April by £0.27m, due to underperformance in surgery (£0.7m) across both Elective and Non-Elective activity. There have been a significant number of surgical cancellations due to lack of bed availability resulting from medical 'boarders'. The income plan assumed some growth in activity but emergency demand is higher than commissioned and growth in activity necessitates increase in capacity.

Work continues to identify schemes to deliver the £26.6m CIP target. Schemes totalling £14.3m have been approved through Gateway 2 but work is continuing and we are pushing to formalise more schemes so that these can be progressed to the Gateway 2 threshold.

It is clear that rapid action needs to be taken to address the worsening financial position and particularly to address rising workforce costs. Although there has been an increase in the number of staff employed we haven't yet seen reduction in temporary staffing costs. Mr Fry asked what action is going to be taken and it was agreed that the Management Board would review the financial position at its next meeting and report to the Finance & Investments Committee on the corrective actions to be taken.

(f) Draft New Format IPR

The Board discussed the new format of the Integrated Performance Report.

Mr Fry noted that the 'Data Observations' and 'Comments and Action' fields were blank. Mr Lundrigan explained that the live IPR will display this information. There is however more work needed in order to complete some of the missing fields and this is expected to be ready for the next Board meeting.

Dr O'Sullivan emphasised the need for the Board to have sight of benchmarking data alongside NNUH reported performance and Mr Lundrigan confirmed that this is currently being reviewed to make this available where possible.

19/032 **DUTIES AS CRN HOST**

CRN (Eastern) Annual Report 2018/19 & Annual Plan 2019/20

Professor Denton presented the Annual Report and Plan of the CRN, which requires approval by the Board as Host organisation. We are one of 13 CRNs in the Country and our performance has improved in the last year – so we are now ranked 5th in the Country as opposed to 8th last year.

Professor Denton noted that Mrs Robertson is leaving the CRN this summer and the Board noted the significant contribution that she has made to setting up the team and structure for the CRN.

Mr Jeffries asked whether financial break-even is the best that the Trust can hope for. Professor Fontaine explained that we re-charge for administration, office space and overheads. The Board **approved** the CRN (Eastern) Annual Report 2018/19 & Annual Plan 2019/20.

19/033 **ANY OTHER BUSINESS**

Mr Fry noted that this was the last Board meeting for Mr Over and thanked him for his contribution to the Board and Trust.

Mr Davies highlighted that this would also be Mr Fry's last Board meeting and thanked him for his support personally, for the Executive and all he has done for the hospital and its patients.

19/034 **DATE AND TIME OF NEXT MEETING**

The next meeting of the Trust Board in public will be at 9am on Friday 26 July 2019 in the Boardroom of the Norfolk and Norwich University Hospital.

Signed by the Chairman: ………………………………………… Date: …………………………………

Action Points Arising:

	Action
19/029	Mr Garside suggested that the Board may find it helpful to reintroduce the report on vacancies/appointments via the Chief Executive Report and it was agreed that this should be reintroduced for future CEO reports. **Action: Mr Garside/Mr Jones**

Action Points Arising from Trust Board meeting (public) 31.05.19

Item	Action	Update - July 2019
19/029	The Board may find it helpful to reintroduce the report on vacancies/appointments via the Chief Executive Report and it was agreed that this should be reintroduced for future CEO reports.	Also on Agenda for Quality & Safety Committee meeting 25.07.19. Summary from Q&S papers added to CEO report.

JPG 19.07.19

REPORT TO THE TRUST BOARD (in public)

Date	**26 July 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.**

The intention of this report is to briefly update on matters that are not addressed elsewhere in the papers.

Each month, 'Viewpoint' letters are sent to all Trust staff and these provide an overview of our position and news of recent/ongoing developments and themes in the Trust. . **Attached** are the Viewpoint letters for May and June. Also **attached** are some slides from the monthly 'all staff' Viewpoint meeting held on 18 July, which will form the basis for the next Viewpoint letter.

It will be apparent that these Viewpoint documents highlight a number of key themes and issues:
- i) our commitment to and progress in improving **quality** as we continue our journey to 'outstanding';
- ii) our **financial** challenges and the need to make savings so that we can continue to invest in services for patients going forwards;
- iii) the significant **operational** pressures that the hospital continues to face – particularly with unplanned/emergency demand through the ED;
- iv) our investment in **digital** systems – to improve quality, efficiency and staff & patient experience;
- v) increasing **collaboration** with partner organisations;
- vi) creation of new **capacity** – in diagnostics (PET/CT), treatment (IRU & Cromer expansion) and inpatient care (new ward block & relocation of chronic dialysis).

In addition there are a few particular items of note:

- i) Royal College of Anaesthesia, Anaesthesia Clinical Services Accreditation (ACSA)
- ii) National leadership roles for Norwich clinicians
- iii) NNUH Cancer Lead
- iv) Strengthening collaboration with partners

Recommendation:
The Board is recommended to **receive** this report for information.

Our Values

Excellence

CHIEF EXECUTIVE'S REPORT TO TRUST BOARD 26 July 2019 (Public)

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

1 FOCUS ON QUALITY AND SAFETY

1.1 Anaesthesia Clinical Services Accreditation (ACSA)

It is very pleasing to report that we have received confirmation of Anaesthesia Clinical Services Accreditation (ACSA) from the Royal College of Anaesthetists. As part of this process we met over 160 quality standards and have been visited by an external team to review our processes.

The ACSA scheme is a voluntary scheme that offers quality improvement through peer review. The CQC recognises the scheme's value and reports that *'Participation in the scheme provides valuable assurance about anaesthetic services and we regard it as important evidence about the safety, effectiveness and responsiveness of services*.' Edward Baker (CQC CEO) has commented "*ACSA is a sign of a positive culture*".

This accreditation is therefore valuable not only in promoting high quality and safe services for patients but also demonstrating this to our regulators. Congratulations and thanks are due to all the staff involved, co-ordinated by Dr O'Hare as our ACSA lead and Dr Faulds as our trainee ACSA lead.

2 STAFF MATTERS

In addition to the appointments described in the Viewpoint documents there are a number of developments to highlight:

2.1 National leadership roles for Norwich clinicians

(a) Dr Edward Morris (NNUH Consultant Obstetrician and Gynaecologist) has been elected as President of the Royal College of Obstetricians and Gynaecologists and is due to commence this role in December. Dr Morris has been Vice President for Clinical Quality at the RCOG since 2016 and is a former chairman of the British Menopause Society.

Dr Morris' main clinical interests include menopause, minimally invasive gynaecological surgery and the advanced management of endometriosis Dr Morris is the co-editor of the Journal 'Post Reproductive Health' and has authored over 70 peer reviewed articles, book chapters and national documents. Dr Morris said he was "honoured and excited" to be elected as president of the college, which has more than 16,000 members worldwide. He said:

"Working at the Norfolk and Norwich University Hospital as a consultant has been a privilege. I work with the most amazing people and I am grateful to my colleagues, nursing and midwifery staff and the senior management team for all the support they have given me over my time here. Whilst President of the RCOG I plan to continue to not only deliver high quality care at home but also to support and promote the care of women and babies in my national work."

We encourage all our staff to take an active professional interest in the world outside Norfolk to bring back new ideas and Dr Morris is a great example to others.

(b) At the same time, Professor Amanda Howe (Professor of Primary Care at Norwich Medical School) has been elected as the next President of the Royal College of General Practitioners

(RCGP). In addition to her role in the Norwich Medical School, Amanda is a GP at Bowthorpe Surgery, Norwich.

2.2 NNUH Cancer Lead

We have appointed Consultant Haematologist, Dr Matt Lawes, as our NNUHFT Cancer Lead Clinician. Matt has been appointed for a fixed term 15 month post for 1 day a week, which is generously 50% funded by Macmillan.

Katie Cooper (Consultant Therapy Radiographer) was also appointed as Associate Clinical Lead for Cancer Pathway Transformation for 2 days a month working with Matt for the same 15 month period.

Matt will replace Mr Vivek Kumar (Consultant Urological Surgeon) who has been our Cancer Lead for a number of years. Together with Matt Keeling (former Cancer Manager), Vivek led initiation of our 5-year Cancer Strategy in 2017.

2.3 Medical Vacancies

The Board has indicated that it would like to receive regular status updates on vacancy 'hot spots' in the Trust. This provides background to consideration of performance, quality and financial issues and assurance that appropriate management and recruitment activity is underway. This issue is also on the agenda for the Quality and Safety Committee, not least with regard to our Emergency Department service, and **attached** is the report prepared for consideration by the Quality & Safety Committee.

3 SYSTEM AND PARTNERSHIP WORKING

3.1 Collaboration with UEA and NRP partners

Attached is a newspaper article from the EDP regarding a new prostate urine risk (PUR) test developed on the NRP through collaboration between clinicians and researchers from NNUH, Medical School and Earlham Institute. This is the latest example of the growing and deepening level of co-operation and collaboration between the institutions of the NRP

3.2 Three new clinical lecturer appointments have been made:

- Johannes Reinhold (Cardiology) - new treatment of myocardial infarction
- Kat Mattishent (Old Age Medicine) - the management of diabetes in dementia
- James Mackay (Radiology) - New radiological techniques for imaging osteoarthritis

All three are described as very talented young clinical researchers and clinicians and it is very encouraging to hear their excitement about coming to Norwich and working with UEA, NNUH and Quadram Institute. Alastair Watson, Consultant Gastroenterologist and Professor of Translational Medicine commented **"***This has been an excellent day for NNUH*".

3.3 Professor Sally Hardy has been appointed as the new Dean of the UEA School of Health Sciences. Sally will be joining us from London South Bank University, where she was Head of Advanced and Integrated Practice. Sally is a mental health nurse and Professor of Mental Health & Practice Innovation. Sally will succeed Professor Rosalyn Jowett.

4 RECOMMENDATION

The Board is asked to:

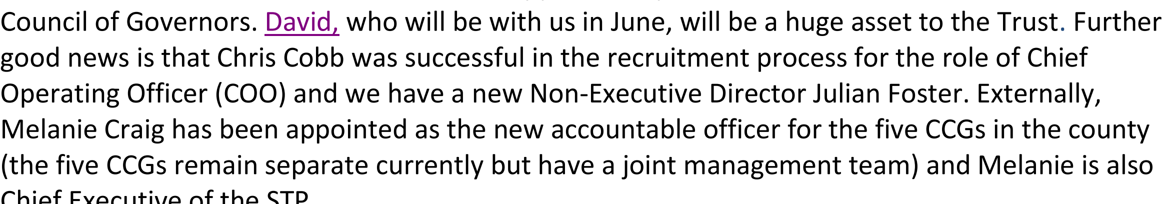
- **note** the contents of this report for information.

Viewpoint May 2019

Dear Colleagues,

I am pleased to write to you today in the May Viewpoint summary letter where our topics include senior appointments, development work, capacity and our CQC report.

Senior appointments – You will have seen the good news that our new Chairman, David White, has been appointed by our Council of Governors. David, who will be with us in June, will be a huge asset to the Trust. Further good news is that Chris Cobb was successful in the recruitment process for the role of Chief Operating Officer (COO) and we have a new Non-Executive Director Julian Foster. Externally, Melanie Craig has been appointed as the new accountable officer for the five CCGs in the county (the five CCGs remain separate currently but have a joint management team) and Melanie is also Chief Executive of the STP.



Development work – You will have seen that the new compound has been set up so that the Interventional Radiology Unit can be built as planned on top of the East wing of the hospital. The building work which has started now will continue until Christmas and the new service will be up and running for patients in April. We have been running a mobile PET CT for quite a while but work will start in a few weeks to build a permanent space for this which will be near Mulbarton Ward. We have also been in the process of upgrading our theatres, I have seen one of them and it is superb.

Capacity – We are planning for the Jack Pryor Unit to be relocated offsite before the end of the year. This frees up space for us creating capacity as part of our Winter plan, and patients like accessing the service in the community. We are creating our own space by moving services offsite and by leasing new buildings and equipment due to a lack of capital available nationally.

Regulators - Nationally and regionally NHS England and NHS Improvement have joined together rather than existing as separate organisations, and there is a new regional management team in place led by the East of England Regional Director Ann Radmore.

CQC report – Since the last Viewpoint event, our CQC report has been published. The report recognised the significant improvements we have made in many areas across the Trust and our rating was uplifted to Requires Improvement. I would like to thank every one of our amazing staff who are working so hard to deliver the Trust's comprehensive improvement programme. It is your dedication, commitment and hard work mainly through the winter months which has helped to improve our rating in such a short period of time. We are now well on our way on our five year journey to achieve outstanding. Thank you.

Please join us at the **next Viewpoint at 1pm on 4 June** which will feature the launch of our new recruitment website. All staff are very welcome.

Best Wishes,
Mark Davies
Chief Executive

June 2019

Dear Colleagues

I am pleased to write to you today in the June Viewpoint summary letter where our topics are quality, capacity and collaboration.

Quality – I would like to share with you some important statistics as examples of the great quality of care that we provide to our patients: we are maintaining our low infection rates with zero cases of MRSA, our renal unit has the lowest infection rates in the country, Denton Ward has had 300 days without a pressure ulcer, and our Hospital Standardised Mortality Ratio is at 88.7. Plus the team who perform robotic-assisted colorectal surgery here at the NNUH has scooped a national HSJ award for improving care for some patients with colon and rectal cancer and won the Surgical Services Initiative of the Year category at the HSJ Value Awards, which is amazing. These annual awards recognise healthcare providers for excellent use of resources, whilst improving outcomes for patients and I am so delighted for the team. We are now planning to invest in additional robots to build on this track record so the NNUH will go from strength to strength providing the best care and treatment for our patients using the most up-to-date technology. These are just a few of the examples of the superb care you provide here for our patients. Thank you.

Capacity – As you know we announced the expansion at Cromer Hospital in April, and now I am delighted to announce that the Trust Board has approved the construction of a new ward block at the N&N to provide an additional 70 + beds. It's going to happen really quickly and will be a modular build with brick walls so it will look and feel like the rest of the hospital and is a permanent building. This is a very exciting project. It will be a three storey build, two storeys to be fully used initially and then the third will come into service. This is going to be a great support to our capacity needs for our patients and staff and will be part of our Winter plan, and will focus on short stay medicine to help flow through the hospital. Of course recruiting the staff with the right skill mix for this new facility will be crucial.

Collaboration - Thinking about our role as a regional university hospital and one of our four strategic objectives to be the centre for complex and specialist medicine for Norfolk and the Anglia region, we have made very significant progress on this. Our roles in running the NIHR Clinical Research Network, the Radiology Academy and the Eastern Pathology Alliance have been in place for a few years, and more recently we have been successful in our bids to run the East of England Radiotherapy Network and the East of England Cervical Screening Service. These projects and services represent a huge body of work and are a testament to your commitment and dedication, and to the achievement of excellent standards for our patients.

Here is the amazing video celebrating our nurses and midwives which we played at Viewpoint. Please join us at the **next Viewpoint at 1pm on 18 July** which will feature a presentation from our mental health team. All staff are very welcome.

Best Wishes,
Mark Davies
Chief Executive

Viewpoint
18th July 2019

Mark Davies - CEO Update

Our Values People focused Respect Integrity Dedication Excellence

Mark Davies
CEO Update

- Operational Performance, Financial Performance and Quality and Safety – ‘Achieving a Balance’
- People
- Building more capacity
- STP
- Patients’ Letters

Our Values People focused

Achieving a balance
Operational Performance

- Still under huge pressure – Thank You
- National priorities – A&E, 52 weeks
- c. 11% increase in footfall in Emergency Dept
- Plan for 399/day – max 480/day (av. 438)
- ALOS 3.9 days
- Keep it up – keep going – Well Done

Achieving a balance Financial Performance

- Big cost improvement programme 4.1% (£26m) - £6m behind plan at month 3
- Pressure on budgets – expenditure and income
- Drive to reduce locum/agency spend
- £34m at risk if we do not hit plan
- Quarter one – achieved but by non-recurrent fixes – so a lot of work to do

Achieving a balance
Quality and Safety

- Signed contract for Electronic Document Management System (EDMS)
- NHSI/E Infection Prevention & Control (IPC) visit 16th July – we are **GREEN** - Well done everyone
- Replacing all PCs over 2 years
- Developing a Quality Improvement Academy (QIA)
- 200 staff trained in Root Cause Analysis (RCA)
- Daily SIG meetings working well

People

- Professor Kris Bowles – Associate Medical Director (AMD) Research
- Dr Linda Hunter – AMD Primary Care and System Transformation
- International recruitment for nurses to India in August (100)
- Mr E Morris (Consultant Gynaecologist) elected as President of the Royal College of Obstetricians and Gynaecologists (RCOG)
- Emergency and Urgent Care appointments:
  - Rachael Cocker – Nurse Director
  - Paul Walker – Operations Director

(Interviews for Emergency and Urgent Care Associate Medical Director scheduled for 31st July)

Visit by Ambassador Torbjörn Sohlström, (Swedish Ambassador) to the Jenny Lind Children's Hospital

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

Our Values

Building more capacity

Interventional Radiology Unit

PET-CT

STP
Acute Services Integration (ASI)

- Progress – 3 Trust Boards agreed:
  - **From 31/12/19**:
    - Combined Urology service (NNUH/JPUH/QEH)
    - Combined ENT service (NNUH/JPUH)
  - **From 30/3/20**:
    - Combined Haematology/Oncology service (NNUH/JPUH)

NB – what this means?

- One (senior) clinical team (TUPE c. 50 staff)
- One waiting list
- One budget
- One commissioner contract

Patients' Letters

Thank you - Questions

Urine test could provide better diagnoses for prostate cancer

Researchers in Norwich are bringing a less invasive test for prostate cancer on stream.

BETHANY WHYMARK
Bethany.Whymark@archant.co.uk

The prostate urine risk (PUR) test can differentiate between men with prostate cancer which will require treatment, those with a low-risk disease which is unlikely to need clinical intervention, and those without prostate cancer – something not possible with current diagnostic tests.

It is hoped the breakthrough test – developed by researchers at the University of East Anglia (UEA) and Norfolk and Norwich University Hospital (NNUH) – could help large numbers of men avoid an unnecessary initial biopsy and repeated invasive follow-ups for "low-risk" patients.

Prostate cancer, the most common cancer in men in the UK, usually develops slowly and the majority of cancers will not require treatment in a man's lifetime – but it is hard for doctors to predict which tumours will become aggressive and therefore decide on appropriate treatment.

The most common tests include blood tests, a physical examination known as a digital rectal examination (DRE), an MRI scan or a biopsy.

Lead author Shea Connell from UEA's Norwich Medical School said the uncertainty of diagnostic tests for prostate cancer meant a policy of "active surveillance" was developed, which results in some men electing for unnecessary treatment.

"Unfortunately, we currently lack the ability to tell which men diagnosed with prostate cancer will need radical treatment and which men will not," he said.

"It's clear that there is a considerable need for additional, more accurate, tests."

Fellow researcher Dr Jeremy Clark, also from the medical school, added: "If this test was to be used in the clinic, large numbers of men could avoid an unnecessary initial biopsy and the repeated, invasive follow-up of men with low-risk disease could be drastically reduced."

Dr Mark Buzza, global director of biomedical research programs at the Movember Foundation, one of the organisations which funded the study, said: "The PUR test has enormous potential to transform the diagnosis and treatment of prostate cancer."

The research was carried out in collaboration with organisations including the Earlham Institute, Norwich and the Institute of Cancer Research, London, as well as partners in the US, the Netherlands, Norway and Northern Ireland.

Love Norfolk Hate Litter

Nigel Ford, who is behind the Love Norfolk Hate Litter campaign being launched at the Royal Norfolk Show Picture: ARCHANT

People in Norfolk are being called to the front line in a new war on litter.

The Love Norfolk Hate Litter campaign calls on everyone to do their bit to keep the county cleaner.

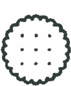
Supported by Norfolk Waste Partnership and the Lord Lieutenant of Norfolk, Sir Richard Jewson, the campaign will be launched at the Royal Norfolk Show today. There are many ways people can get involved, from joining a community litter pick or setting up a new group to taking two minutes to clean up the beach on their next trip to the seaside.

Norfolk's councils are supporting the campaign and providing materials, equipment and downloadable resources, as well as a schools pack to help teach children about the harm litter can cause.

Love Norfolk Hate Litter is the brainchild of Norfolk resident Nigel Ford, who has worked hard to keep the county clean. Other groups doing the same locally include Pure Clean Earth and Surfers against Sewage.

skyessentials
Broadband | Calls | Sky+ box

Unlimited broadband. Free UK calls.
Sky+ box. 3-year price guarantee.
All for only £26 a month.
Includes line rental, but not tea and biscuits
18-month contract and £25 upfront set-up fee



Call 0800 759 1463 or see us at any Sky retail store

REPORT TO QUALITY AND SAFETY COMMITTEE	
Date	**25 July 2019**
Title	**'Hard Truths' – Medical Staffing Report**
Author & Exec Lead	**Author: Rees Millbourne, Executive Lead: Professor Erika Denton**
Purpose	**For Information**
Relevant Strategic Objective and BAF Ref	**SO: 1: We will be a provider of high quality health and care services to our local population** **BAF Ref:1.7 Staff vacancies and/or demand outstripping supply has potential quality impact and may result in premium pay costs**

1. **Background/Context**
   - To inform the Quality and Safety Committee that medical staffing levels are not recorded in the same manner as other staff groups within the Trust such as Nursing & Midwifery colleagues, therefore it is not currently possible to compare the impact of unfilled medical staffing shifts using the same metrics.
   - To provide information on the vacancy rates for the Trust in relation to medical staffing.
   - To provide context on the action taken to mitigate any associated patient safety risks due to medical staffing levels.

2. **Key issues, risks and actions**
   - The vacancy rates for medical staffing overall continues to fluctuate.
   - There are a number of areas which meet the 'Hard to Fill' criteria set by workforce for a number of reasons. The Emergency Department is one of these areas and the number of vacancies in this department challenges delivery of patient care and national standards.
   - Incidents are reported by Medical staff concerning patient safety and staffing levels, however a report needs to be developed to allow this data to be extracted from the reporting system.

3. **Conclusions/Outcome/Next steps**
   - To review current medical staffing reports to support development of this paper.
   - To continue development of digital recruitment for Medical Staffing
   - To develop the content of this report in order to be able to triangulate patient safety incidences against medical staffing data.

Recommendations:

The Committee is recommended to:

- note this report for information purposes.

Planned (budgeted) versus Actual (contracted)

The April position from workforce reports a 76.7 WTE vacancy rate for Consultants and 68 WTE for other grades of medical staffing across the organisation. This is a shortfall of 12% or 144.7 WTE from planned level of 1178.5 WTE medical staff required to deliver patient care.

The overall vacancy figures reported fluctuate month on month.

The divisional position for medical staffing is shown in table one below, with full departmental detail provided in Appendix A.

Table One

Division	Consultant			Non-Consultant			Total		
	Budget	Contracted	Vacancy	Budget	Contracted	Vacancy	Budget	Contracted	Vacancy
Total	**522.5**	**445.9**	**76.7**	**656.0**	**587.9**	**68.0**	**1178.5**	**1033.8**	**144.7**
Medicine Division	169.6	140.6	29.0	277.1	226.0	51.1	446.7	366.6	80.1
Surgery Division	212.7	183.4	29.3	213.8	203.6	10.2	426.5	387.1	39.5
Women & Children Division	59.0	56.2	2.9	79.8	72.1	7.6	138.8	128.3	10.5
Clinical Support Division	79.6	64.1	15.5	68.3	64.3	4.0	147.9	128.4	19.5
Corporate	1.6	1.6	0.0	17.0	21.9	-4.9	18.6	23.5	-4.9

Recruitment initiatives are being utilised such as advertising in the British Medical Journal (BMJ) and a consultant open day planned for the autumn. However the focus is moving towards improving digital recruitment and engagement with potential candidates through social media platforms (twitter, Facebook, etc.) and expansion of the newly launched recruitment website, which was initially developed with nursing & midwifery to now include medical staffing.

Included in these figures are a number of medical staff who have been appointed and are due to start in the organisation over the next three months.

Hard to Fill

22.7 WTE vacancies not successfully filled in a six month period are classed as hard to fill by workforce.

The areas listed below have consultant vacancies. For each of these areas, the department will have reorganised operational duties to provide cover in the short term.

- Acute Medical Unit
- Dermatology
- Emergency Department
- Gastroenterology
- Histopathology
- Paediatric Medicine Oncology
- Paediatric Emergency Department
- Restorative Dentistry

Emergency Department Medical Staffing

Medical staffing levels within the Emergency Department are being monitored, escalated and reported both internally and externally (NHS Improvements (NHSI) and Care Quality Commission (CQC)). Key staff within the department are devoting time to the recruitment process for substantive

staff and locums. Agency locums have to be used to cover the shortfall in bank doctors. The department have recently signed up to a recruitment and retention programme.

Locum Usage

The Trust will look to optimise the use of internal locums or bank doctors initially to cover shortfalls in medical staffing, however for longer term absences or vacancies or due to the specialist clinical requirements of the department, agency locums are required.

Agency cap rates are applied to medical staffing with a process in place and overseen by the Medical Director for enhanced rates (when appropriate)

Mitigating risk associated with patient Safety due medical staffing

Operational issues, such as short term absence are escalated through the triumvirate and clinical leads chain of command as identified. These will be resolved if possible or escalated to the next level up to and including the Medical Director.

For longer term issues these are reviewed at various meetings and committees where actions will be agreed.

Incident Reporting

Incident reporting for the Trust has improved, medical staff will raise incident forms and attend the daily Serious Incident Group (SIG) as appropriate to discuss their incidents. A report needs to be developed to be able to extract data to be able to provide a meaningful analysis of incidents related to patient safety and medical staffing levels.

Appendix A - Medical Budget v Contracted WTE – 30-Apr-2019

Division	Consultant			Non-Consultant			Total		
	Budget	Contracted	Vacancy	Budget	Contracted	Vacancy	Budget	Contracted	Vacancy
Total	**522.5**	**445.9**	**76.7**	**656.0**	**587.9**	**68.0**	**1178.5**	**1033.8**	**144.7**
Medicine Division	169.6	140.6	29.0	277.1	226.0	51.1	446.7	366.6	80.1
Surgery Division	212.7	183.4	29.3	213.8	203.6	10.2	426.5	387.1	39.5
Women & Children Division	59.0	56.2	2.9	79.8	72.1	7.6	138.8	128.3	10.5
Clinical Support Division	79.6	64.1	15.5	68.3	64.3	4.0	147.9	128.4	19.5
Corporate	1.6	1.6	0.0	17.0	21.9	-4.9	18.6	23.5	-4.9
Medicine Division	**169.6**	**140.6**	**29.0**	**277.1**	**226.0**	**51.1**	**446.7**	**366.6**	**80.1**
Cardiology	16.7	15.3	1.4	19.0	16.8	2.2	35.7	32.1	3.6
Emergency	30.8	20.7	10.1	89.7	63.8	25.8	120.4	84.5	35.9
Endocrinology	9.1	8.5	0.7	15.1	15.0	0.1	24.2	23.4	0.7
Gastroenterology	21.6	14.5	7.1	19.2	16.0	3.2	40.8	30.5	10.3
Medicine Mgt	1.4	0.7	0.7	0.0	0.0	0.0	1.4	0.7	0.7
Neurology	17.0	15.0	2.0	15.1	10.2	4.9	32.1	25.2	6.9
Older Peoples Medicine	16.3	17.3	-1.0	45.6	43.0	2.5	61.9	60.3	1.5
Oncology	28.7	23.6	5.1	27.2	18.6	8.6	55.9	42.2	13.7
Palliative Care	3.1	3.2	-0.1	7.8	6.4	1.4	10.9	9.6	1.3
Renal	7.5	6.5	1.1	13.0	11.0	2.0	20.5	17.5	3.1
Respiratory Medicine	11.0	9.8	1.3	18.0	16.6	1.4	29.0	26.4	2.7
Rheumatology	6.4	5.7	0.7	7.6	8.6	-1.0	14.0	14.3	-0.3
Surgery Division	**212.7**	**183.4**	**29.3**	**213.8**	**203.6**	**10.2**	**426.5**	**387.1**	**39.5**
Dermatology	12.3	9.8	2.6	17.4	14.0	3.4	29.7	23.8	6.0
Ear Nose And Throat	9.0	7.0	2.0	17.7	13.2	4.5	26.7	20.2	6.5
General Surgery	27.9	23.0	4.9	47.9	39.4	8.5	75.8	62.4	13.4
Ophthalmology	14.7	13.8	1.0	17.2	14.0	3.2	31.9	27.8	4.2
Oral Surgery	8.4	5.9	2.5	13.4	12.6	0.8	21.8	18.5	3.3
Plastic Surgery	16.2	13.8	2.4	17.4	12.5	4.9	33.6	26.3	7.3
Surgical Mgt	0.3	0.2	0.1	0.0	0.0	0.0	0.3	0.2	0.1
Surgical Support	66.7	62.1	4.7	17.7	46.2	-28.5	84.4	108.2	-23.8
Trauma And Orthopaedics	33.1	29.2	3.9	27.0	26.2	0.8	60.1	55.4	4.7
Urology	14.8	11.8	3.0	20.6	13.6	7.0	35.4	25.4	10.0
Vascular Surgery	9.3	7.0	2.3	17.6	12.0	5.6	26.9	19.0	7.9
Women & Children Division	**59.0**	**56.2**	**2.8**	**79.8**	**72.1**	**7.7**	**138.8**	**128.3**	**10.5**
Obs And Gynae	26.5	26.2	0.2	34.1	33.3	0.8	60.6	59.5	1.1
Paediatrics	32.6	30.0	2.6	45.7	38.8	6.9	78.2	68.8	9.4
Clinical Support Division	**79.6**	**64.1**	**15.5**	**68.3**	**64.3**	**4.0**	**147.9**	**128.4**	**19.5**
Cellular Pathology	22.8	19.5	3.3	9.0	6.0	3.0	31.8	25.5	6.3
CSD Mgt	0.6	0.5	0.1	0.0	0.0	0.0	0.6	0.5	0.1
Laboratory Medicine	13.7	12.4	1.3	7.5	5.9	1.6	21.2	18.3	2.9
Imaging	40.5	29.7	10.8	51.8	52.4	-0.6	92.3	82.1	10.2
Radiology Academy	2.0	2.0	0.0	0.0	0.0	0.0	2.0	2.0	0.0
Corporate inc. R&D	**1.6**	**1.6**	**0.0**	**17.0**	**21.9**	**-4.9**	**18.6**	**23.5**	**-4.9**

REPORT TO THE TRUST BOARD OF DIRECTORS	
Date	26 July 2019
Title	Infection Prevention and Control [IP&C] Annual Report 2018-19
Author & Exec lead	Professor Nancy Fontaine, DIPC and Chief Nurse Sarah Morter, Senior Nurse for IP&C [author]
Purpose	For Approval (report attached)

1. **Background/Context**
   - Annual report provided by IP&C on behalf of the DIPC as a requirement of the Trust Board and as outlined in Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance, updated July 2015 (Hygiene Code). This is to provide assurance on IP&C activity for the Financial Year 2018-19.
   - From April until August 2018 there was an interim DIPC who was also the interim Director of Nursing and then from August 2018 the new Chief Nurse was appointed who is also the DIPC.

2. **Risks and actions**
   - The Trust received a red-rating following an external IP&C NHSI inspection in February 2019. A rapid improvement plan was immediately instigated and continues whilst we await a follow-up inspection. NB follow up inspection on 16/07/19 was verbally rated as green however we await written confirmation.
   - During this year the Trust was compliant with PHE HCAI *Clostridium difficile* objective. The Meticillin resistant *Staphylococcus aureus* blood stream infection objective of zero was breached due to a case in July 2018.

3. **Next steps**
   - Trust recommissioning of the ICNet or similar system during 2019 is crucial to maintenance of this high level of Infection Control Practice.
   - Maintaining adequate levels of IP&C staffing and resource are also key to ongoing delivery of essential Trust Infection Control targets and ability to support additional requirements such as Winter pressures, education and mandatory training, building work and other new initiatives.

Recommendations:
The Board is recommended to:
- Approve this report as an assurance of IP&C practice within the Trust
- Support necessary ongoing resource for IP&C to maintain this level of performance

Our Values

Infection Prevention & Control Annual Report for April 2018 – March 2019 and Annual IP&C Plan for April 2019 – March 2020

Director of Infection Prevention & Control: Professor Nancy Fontaine/ Frances Bolger

Written & Compiled by: Infection Prevention & Control Team

April 2019

Infection Prevention and Control Annual Report 2018-2019

Contents	Page Number
Executive Summary for 2018-19	3
Abbreviations	4
Hygiene code Criteria 1	5-23
Hygiene code Criteria 2	24-27
Hygiene code Criteria 3	28-32
Hygiene code Criteria 4	33
Hygiene code Criteria 5	34-43
Hygiene code Criteria 6	44
Hygiene code Criteria 7	44-45
Hygiene code Criteria 8	45
Hygiene code Criteria 9	46
Hygiene code Criteria 10	47
References	48
IP&C Annual Programme April 2019–March 2020	49-58

DRAFT

Infection Prevention and Control Annual Report 2018-2019

Executive Summary

This annual report provides a summary of Infection Prevention and Control (IP&C) work undertaken within the Norfolk and Norwich University Hospital NHS Foundation Trust (NNUH).

NNUH annual IP&C report summarises the work undertaken within the organisation from 1st April 2018 until 31st March 2019. As in last year's report it is set out to follow the 10 criteria under the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance, updated July 2015 in order to provide assurance.

The infection prevention and control committee reports to the Board via the clinical safety and effectiveness sub board and the DIPC takes the integrated performance report to the monthly trust board

The code states that the Director of Infection, Prevention and Control (DIPC) produces an annual report and releases it publicly. From April until August 2018 there was an interim DIPC who was also the interim Director of Nursing and then from August the new Chief Nurse was appointed who is also the DIPC.

- There were 31 total cases of *Clostridium difficile* infection (CDI) of which after review 14 counted towards the government set objective of 48

- There was 1 case of Meticillin Resistant *Staphylococcus aureus* (MRSA) blood stream infection which breached the government objective of zero cases. This case was a likely contaminant and learning was shared widely

The IP&C audit and surgical site surveillance programme has continued and more detail can be found later in this report.

The CQC acknowledged the positive impact on IP&C of the environmental changes in ED but still had concerns around the process for isolation of suspected/known infectious patients.

This was followed up by an inspection of ED and a ward by NHSI in February 2019, this inspection resulted in a red rating. A rapid improvement plan was immediately instigated and continues whilst we await a follow-up inspection.

The IP&C team wish to recognise the hard work and commitment of many staff across the healthcare community which collaboratively continue to strive for the highest quality IP&C standards and patient safety for those they care for.

The authors would like to acknowledge the contribution of other teams and colleagues in compiling this report.

DRAFT

Infection Prevention and Control Annual Report 2018-2019

Abbreviations

AMR	Antimicrobial Resistance
C4C	Cleaning for Credits
CCG	Clinical Commissioning Group
CDI	*Clostridium difficile* Infection
CEO	Chief Executive Officer
COO	Chief Operating Officer
CPD	Continuing Professional Development
CPE	Carbapenemase-producing Enterobacteriaceae
CQC	Care Quality Commission
CQUIN	Commissioning for Quality and Innovation
CVC	Central Venous Catheter
DH	Department of Health
DIPC	Director of Infection Prevention & Control
DTMM	Drugs, Therapeutics and Medicines Management Committee
E. coli	*Escherichia coli*
EPA	Eastern Pathology Alliance
EPMA	E-prescribing & Medicines Administration
ESBL	Extended Spectrum Beta Lactamase
FM	Facilities Management
GRE	Glycopeptide Resistant Enterococcus
HCAI	Health Care Associated Infection
HICC	Hospital Infection Control Committee
ICD	Infection Control Doctor
ICN	Infection Control Nurse
ICON	Infection Control on NICU
IP&C	Infection Prevention & Control
HICC	Hospital Infection Prevention & Control Committee
MGNB	Multi Resistant Gram Negative bacilli
MHRA	Medicines and Healthcare Products Regulatory Agency
MRSA	Meticillin Resistant *Staphylococcus aureus*
MSSA	Meticillin Susceptible S*taphylococcus aureus*
NHSI	National Health Service Improvements
NICU	Neonatal Intensive Care Unit
NNUH	Norfolk and Norwich University Hospital Foundation Trust
OWL	Organisation Wide Learning
PCR	Polymerase Chain Reaction
PICC	Peripherally Inserted Central Catheter
PHE	Public Health England
PIR	Post Infection Review
PLACE	Patient-led assessments of the care environment
PPE	Personal Protective Equipment
RAG	Red, Amber, Green
RCA	Root Cause Analysis
SSI	Surgical Site Infection
VRE	Vancomycin Resistant Enterococcus
WHWB	Workplace Health and Well-Being

DRAFT

Hygiene Code Compliance Criteria 1:
Systems to manage and monitor the prevention and control of infection

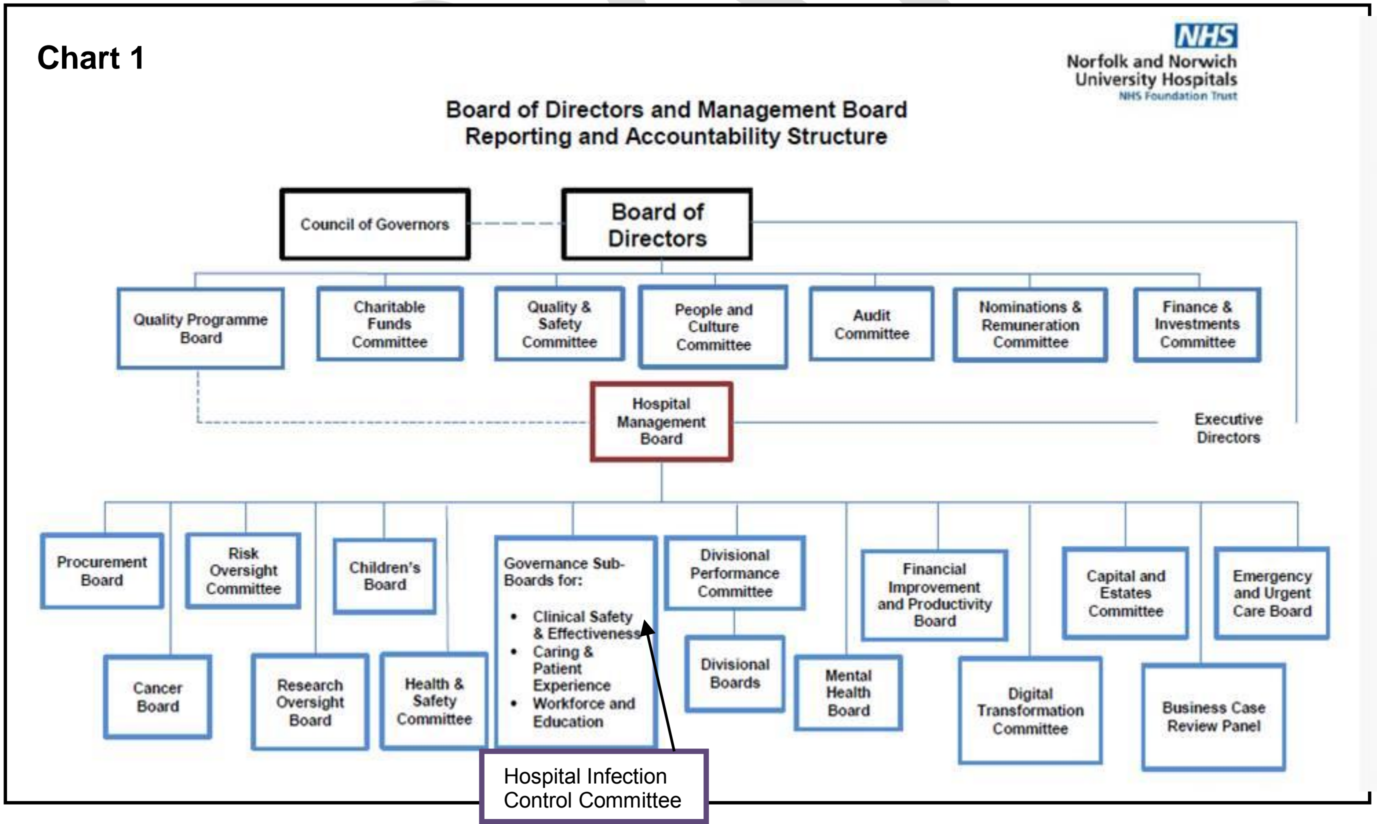
These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.

Governance and Monitoring

The Board of Directors collectively work within the NNUH Healthcare Governance Framework to ensure that high quality and safe services are in place for patients, visitors and staff to minimise the risk of infection. Overall responsibility for IP&C is held by the Chief Executive Officer (CEO).

The DIPC role is undertaken by the Chief Nurse with the support of the IP&C team. The DIPC provides strategic direction and leadership to the Trust on all IP&C matters.

The Hospital Infection Control Committee (HICC) reports to the Clinical Safety and Effectiveness Board, see chart 1. HICC has a key role in ensuring that there are effective systems and processes in place to reduce the risk of hospital acquired infections and provide assurance of such to the board. HICC will be responsible for the strategic planning and monitoring of the Trusts IP&C programme. In October 2018 the meeting frequency changed from 3 monthly to monthly.



IP&C Reporting Processes

- The Chief Nurse, who is DIPC and executive lead for IP&C reports key performance indicators monthly to the Trust board.
- The DIPC/deputy reports to the clinical safety sub-board monthly.
- The IP&C team provides a comprehensive monthly IP&C report which is widely distributed to senior managers, Divisional leads, Governance leads, Matrons, Ward managers, CCG and CCG IP&C nurse. This report contains the current position of IP&C in the Trust and highlights any risks.
- The IP&C team report on all key aspects of IP&C at the HICC meetings with reports from internal and external representatives, see chart 2.

Chart 2

NHS
Norfolk and Norwich
University Hospitals
NHS Foundation Trust

Infection Prevention & Control Governance Structure

Trust Board

Management Board

Clinical Safety & Effectiveness Sub-Board

HICC
Hospital Infection Control Committee Chaired by the DIPC

NCHC Infection Control Team

Antimicrobial subcommittee (report)

Trust Facilities & Estates (report)

Health & Safety (Joint report)

Workplace Health & Wellbeing (Joint report)

Divisional Representatives (report)

CCG Infection Prevention & Control

Cleaning Services (SERCO & Trust) (report)

Public Health England

Water Safety Group (report)

Decontamination committee (report)

Microbiology/ Virology Department

Clinical Commissioning Groups (CCG)

The commissioning IP&C team monitor IP&C at NNUH. The CCG team contribute to environmental inspections, attend HICC and the post infection reviews for all patients who develop an MRSA bacteraemia or CDI in line with national guidance and participate in incident management meetings.

Decontamination and Water Safety Groups

During 2018-19, the Water Safety and Decontamination Groups have been restructured to address the requirements of current guidelines and the clinical service.

Decontamination Group

There was a change in decontamination lead in February 2019 when a new Chief Operating Officer (COO) came in to post. This has resulted in the group agreeing to meet bi-monthly.

Water Safety Group

The Water Safety Group follows and implements the standards and guidance set out in Health Technical Memorandum 04-01, Safe Water in Healthcare Premises. Accordingly Water Safety Group meetings have been re-scheduled and now are programmed bi-monthly to align more closely with Trust HICC meetings to which it report. The Group has been further reformed over the reporting year to provide more clinical emphasis and is chaired by the Clinical Support Services Divisional Director and the Group is additionally supported by senior Divisional representatives with technical expertise provided by FM colleagues.

ICNet

The IP&C team use a commercial software system, called ICNet which allows the team access to 13 years of historical data and advice. In addition the system permits the IP&C team to:-

- Continually analyse data and identify events which may cause a patient harm or risk associated with infection and ensure that the infection prevention and control teams and ward teams are 'sighted' on these risks. This allows for earlier intervention and risk reduction e.g. recognising periods of increased incidence (PII) with early commencement of IP&C supportive measures. This also allows us to run custom made reports.

- The prompt reporting of patients with an alert organism or known or suspected infection. Also the use of alerts which give the team the ability to identify patients with previous infections thereby ensuring that patients are cared for in the most appropriate environment, reducing risk of transmission to other patients and staff.

- Allows the coming together of data thereby reducing the teams' activity time by having relevant information in one place, rather than needing to access multiple software packages Telepath, ICE, PAS etc. It forms the basis of data used in IP&C e.g. for surveillance, board reports etc.

ICNet will no longer supported by the company from July 2019 due to the age of the system. A business case will be written to support the recommissioning of an electronic IP&C system.

Infection Prevention and Control Annual Report 2018-2019

The IP&C Team Structure

Chart 3

IP&C Team Structure 2018-19

Director of Nursing
Exec lead for IP&C
Director of Infection, Prevention & Control
Interim Post
April – August 2018

Chief Nurse
Exec lead for IP&C
Director of Infection, Prevention & Control
August 2018- March 2019

Senior Nurse Specialist
(1 WTE)

Infection Control Doctor
(3 sessions)
Interim Post

IP&C Nurses

- IP&C Specialist Nurses (1 WTE) (Job Share)
- IP&C Specialist Nurse (1 WTE) (Maternity Leave until January 19 then Annual Leave until March 19)
- IP&C Nurse (1 WTE)
- IP&C Nurse (0.8 WTE) (Vacancy from December 18, filled 0.6 WTE February 19)
- IP&C Nurse (0.8 WTE) (Vacancy from December 18)

Support Workers

- Support Worker (1 WTE)
- Support Worker (0.8 WTE)
- Support Worker (0.6 WTE)

Administration

- IP&C Coordinator (1 WTE) (Fixed term contract to cover maternity leave)
- Admin Assistant (0.6 WTE) (Maternity leave until June 2018)
- Apprentice Admin Assistant (1.0 WTE)

Audit & Surveillance

- IP&C Nurse Specialist (1 WTE)
- IP&C Nurse (0.8 WTE)
- IP&C Nurse (0.6 WTE)
- Information Officer (1.0 WTE)

NNUH has 24hour IP&C support and advice provided by the on-call out of hours service for any urgent issues. IP&C registered nurses cover evenings, weekends and bank holidays and are supported by the Consultant Microbiologists on call (ICD is a named Consultant person/role). Virology and Microbiology cover is provided by a team of Consultant Microbiologists/Virologists see Chart 3.

CQC and NHSI inspections

The CQC have made a number of visits this year and have raised concerns about IP&C in the emergency department (ED), particularly around the process for isolation of suspected/known infectious patients. This was followed up by an inspection of ED and a ward by NHSI in February 2019 which resulted in a red rating. A rapid improvement plan was immediately instigated and we await a follow-up inspection.

The most recent CQC report following visits in January and February 2019 and published in May said that *"the service controlled infection risk well. Equipment and premises were clean. Staff used control measures to prevent the spread of infection. This was an improvement on our last inspection."*

Infection Prevention and Control Annual Report 2018-2019

Mandatory Surveillance of Healthcare Associated Infection to Public Health England *Clostridium difficile* infection (CDI)

All cases of CDI that occur on or after the 4th day of admission in hospital are reported to PHE as hospital acquired (HAI). In 2018-19 the government set objective was to remain below 48 cases with NNUH ending the year with 31 cases in total, see tables 1 & 2.

Table 1

NNUH performance for CDI – number of cases				
Financial Year	**Community Origin** (sampled before day 4)	**NNUH Objective**	**Hospital Origin** (sampled on or after day 4)	**Total**
2018-19	**114**	**48**	**Total 31 cases** of which 17 with no lapses deducted from final total leaving **14** with lapses in care **counting towards the objective**	**145**
2017-18	139	49	Total 35 cases of which 24 with no lapses deducted from final total leaving 11 with lapses in care counting towards the objective	174
2016-17	128	49	Total 42 cases of which 22 with no lapses deducted from final total leaving 20 with lapses in care counting towards the objective	170

https://www.gov.uk/government/statistics/clostridium-difficile-infection-monthly-data-by-nhs-acute-trust

Table 2

Public Health England

Clostridium difficile

Count of acute trust apportioned cases per month

Trust Code	Acute Trust Name	Trajectory	2018 April	May	June	July	August	September	October	November	December	2019 January	February	March	Total
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	30	6	0	4	3	2	1	1	3	2	4	2	4	**32**
RC1	Bedford Hospitals NHS Trust	10	1	1	0	0	4	0	0	0	0	1	0	2	**9**
RGT	Cambridge University Hospitals NHS Foundation Trust	48	4	10	1	9	9	8	6	2	2	4	8	3	**66**
RWH	East & North Hertfordshire NHS Trust	10	5	1	0	3	5	1	4	1	2	3	2	0	**27**
RDE	East Suffolk & North Essex NHS Foundation Trust	34*	2	4	8	5	7	4	4	4	6	6	1	5	**56**
RGP	James Paget University Hospitals NHS Foundation Trust	16	3	3	1	0	1	1	1	0	0	3	2	0	**15**
RC9	Luton & Dunstable Hospital NHS Foundation Trust	6	0	1	0	0	0	0	1	0	1	0	0	1	**4**
RQ8	Mid Essex Hospital Services NHS Trust	12	5	3	5	1	8	2	2	4	7	1	2	0	**40**
RD8	Milton Keynes Hospital NHS Foundation Trust	38	1	0	2	1	3	3	1	0	1	3	0	0	**15**
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	48	3	4	1	4	5	2	2	1	1	2	0	6	**31**
RGN	North West Anglia NHS Foundation Trust	39	6	2	2	3	6	1	6	4	4	8	3	3	**48**
RGM	Royal Papworth NHS Foundation Trust	5	1	1	0	1	3	1	1	0	1	0	0	0	**9**
RQW	Princess Alexandra Hospital NHS Trust	10	2	2	1	1	1	0	1	0	1	3	0	1	**13**
RAJ	Southend University Hospital NHS Foundation Trust	29	0	6	3	3	1	2	1	3	1	2	1	3	**26**
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	52	3	1	0	4	6	1	1	3	2	0	1	0	**22**
RWG	West Hertfordshire Hospitals NHS Trust	22	3	1	0	3	2	0	0	2	0	0	3	1	**15**
RGR	West Suffolk Hospitals NHS Trust	15	1	0	0	1	1	1	1	2	0	0	4	1	**12**
	East of England Total	**390**	**46**	**40**	**28**	**42**	**64**	**28**	**33**	**29**	**31**	**40**	**29**	**30**	**440**
	England Total	**4503**	**401**	**346**	**335**	**428**	**437**	**362**	**350**	**301**	**290**	**327**	**309**	**313**	**4199**

*The official trajectory for East Suffolk & North Essex has not yet been published since the creation of this Trust in July 2018. The trajectory presented has been calculated by adding together the trajectories for the previous Ipswich Hospital and Colchester Hospital NHS Trusts

There is a thorough investigation of each hospital attributable CDI case using a standardised post infection review tool with any learning or good practice shared via the governance meetings. Participants Attendees include the clinical team responsible for the patient, Antibiotic Pharmacist, Microbiologist and IP&C team. The CCG IP&C team also attend and make the final decision as to whether there have been any lapses in care and ensure any learning for community partners within the CCG is also shared accordingly.

Following post infection review with the CCG IP&C team 14 cases were reviewed as being trajectory (lapse in care) against an objective of 48 cases and 17 deemed non-trajectory (no lapses in care), see table 3.

NNUH has consistently met its national CDI objectives since 2011.

Table 3

NNUH lapses in care identified from 14 trajectory cases of *C. difficile 2018- 2019*

Lapses	Number of times lapse occurred
Delay in sampling	4
Delay in isolation (placing in single room)	8
Hand hygiene score below 95%	1
Poor documentation	3
Low cleaning score	1
Stool chart not completed daily	4
Inappropriate isolation	1
Inappropriate prescribing	1
Some trajectory cases had > one lapse. Lapses are included in the learning outcomes	

A weekly multidisciplinary team ward round of CDI patients is led by a consultant microbiologist.

Clostridium difficile can be carried asymptomatically and may be present prior to admission becoming apparent when the toxin production is triggered by administration of antibiotics after admission. Possible sources are asymptomatic colonisation prior to admission or via cross infection in a healthcare setting e.g. from contaminated equipment or hands of staff. It is notable that some patients who are colonised with *Clostridium difficile* may excrete the spores without showing symptoms.

Recognised risk factors for CDI include antibiotic use, proton pump inhibitors, use of laxatives, medication and bowel procedures along with age >65, presence of co-morbidities such as malignancy, diabetes, kidney and liver disease and immunosuppression from treatment or cancer.

Despite thorough investigations using timelines, tracking patients' movements in the preceding 3 months and molecular typing, it is often difficult to prove conclusively where a patient acquired the *Clostridium difficile* organism.

DRAFT

Glycopeptide-resistant Enterococcus (GRE) Blood Stream Infection

The Trust continues to record very low rates of GRE blood stream infection. These have remained stable in single figures annually since 2013-14. Patient identified as having a GRE are nursed in a single room with enhanced IP&C precautions. Antibiotics are prescribed based on the sensitivity of the particular strain.

Enterococci are organisms that reside in the gastrointestinal tract, GRE are multi-drug resistant Enterococci which are resistant to the Glycopeptide antibiotics Vancomycin and sometimes Teicoplanin.

There were 3 cases of GRE/VRE blood stream infection in 2018-19; none of which were due to transmission within the hospital.

Carbapenemase-producing Enterobacteriaceae (CPE)

In the UK, over the last seven or so years there has been a rapid rise in the incidence of infection and colonisation by multi-drug resistant carbapenemase-producing organisms with an increase in the number of clusters and outbreaks reported in England. The north west of England continues to see ongoing and persistent problems with CPE but generally England has not reached the numbers of cases as seen in some other countries.

NNUH invested in highly sensitive and specific molecular screening method (PCR) test for the detection of CPE in 2016. This testing method can rapidly identify presence or absence of carbapenemase genes in a faecal specimen which aids decisions on patient management and infection control measures, see table 4.

Table 4

Carbapenemase-producing Enterobacteriaceae - Cases identified
4 new CPE cases tested on admission to NNUH Patients from United Arab Emirates, Greece, Egypt & University College Hospital London
3 known CPE positive patients Found to be CPE negative when tested on admission to NNUH
4 identified 2018-19 - No cases of hospital origin CPE attributed to NNUH

Gram Negative Bacteraemia/ Blood Stream Infections

The ambition set by NHSI in 2017 is that the number of Gram negative blood stream infections (BSI) will be reduced by 50% across the whole healthcare economy by March 2021.

This is the second year of PHE reporting for *Klebsiella species and Pseudomonas aeruginosa* and therefore we now have comparative figures. See tables 7, 8, 9 & 10. Gram negative BSI includes the following:-

- *Escherichia coli (E. coli)*
- *Klebsiella species*
- *Pseudomonas aeruginosa*

Escherichia coli

Often referred to as *E. coli*, this is part of the normal gut flora and can commonly cause urinary, biliary or gastrointestinal tract related infection leading to blood stream infection (E. coli blood stream infection). Some *E. coli* are enzyme producers known as extended spectrum beta lactamase (ESBL) which increase the resistance to multiple antibiotics.

Attention to insertion and care of urinary catheters, audits, education and reporting of catheter associated urinary tract infection are directed to further reduce HAI E. coli BSI.

The NHS healthcare providers in Norfolk have been working collaboratively to find ways of reducing urinary tract infections (UTI's) are the commonest source of E. coli BSI. Work has included reviewing the guidance on when and how to sample urine and a review of patient information so that there is continuity within the healthcare providers. This is a priority for the forthcoming year. See tables 5 & 6.

DRAFT

Healthmatters **Most common source of E. coli BSI**

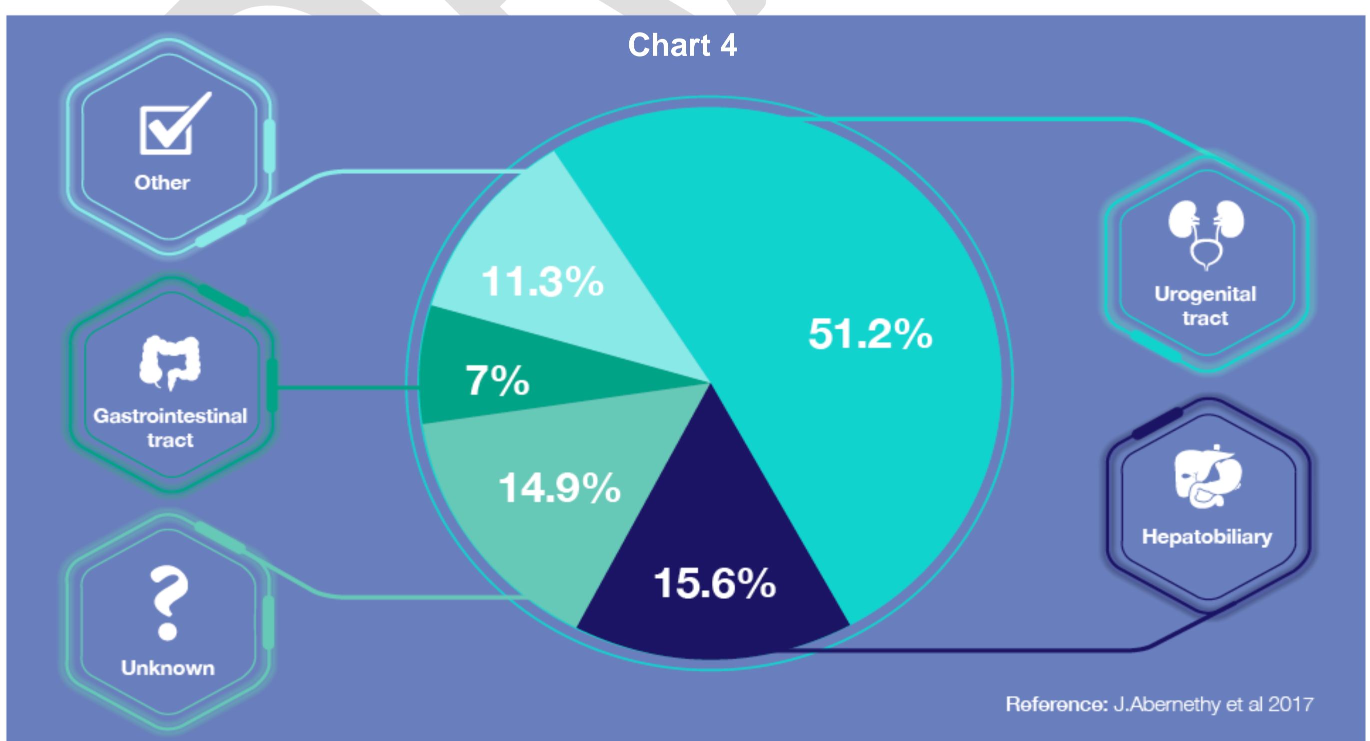


Table 5			
NNUH performance for *Escherichia coli* BSI – number of cases			
Financial Year	Community Origin	Hospital Origin (on or after day 3)	Total
2018-19	**295 (83%)**	**57 (17%)**	**352**
2017-18	314 (85%)	56 (15%)	370
2016-17	321 (87%)	49 (13%)	370

Public Health England

Table 6

Escherichia coli

Count of hospital onset cases per month

Trust Code	Acute Trust Name	Trajectory	2018 April	May	June	July	August	September	October	November	December	2019 January	February	March	Total
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	3	1	5	3	3	6	4	4	2	2	3	3	**39**
RC1	Bedford Hospitals NHS Trust	N/A	2	2	1	1	1	4	1	0	1	1	1	0	**15**
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	4	8	10	11	9	10	7	11	6	13	9	5	**103**
RWH	East & North Hertfordshire NHS Trust	N/A	4	4	3	4	1	3	2	2	2	3	6	1	**35**
RDE	East Suffolk & North Essex NHS Foundation Trust	N/A	7	2	9	9	7	4	6	2	4	6	5	6	**67**
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	4	3	6	2	6	1	4	5	1	7	4	5	**48**
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	3	4	3	2	6	2	2	4	1	4	1	5	**37**
RQ8	Mid Essex Hospital Services NHS Trust	N/A	1	6	0	4	4	1	4	0	3	7	1	2	**33**
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	5	1	4	4	3	1	1	4	1	4	1	2	**31**
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	4	4	7	4	2	8	5	8	1	5	4	5	**57**
RGN	North West Anglia NHS Foundation Trust	N/A	2	0	3	4	3	4	6	3	2	4	4	3	**38**
RGM	Royal Papworth NHS Foundation Trust	N/A	0	0	1	0	1	0	0	3	1	0	0	0	**6**
RQW	Princess Alexandra Hospital NHS Trust	N/A	3	0	1	2	1	0	1	1	1	1	2	1	**14**
RAJ	Southend University Hospital NHS Foundation Trust	N/A	4	4	4	5	1	3	3	4	2	4	4	6	**44**
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	2	1	3	5	2	3	1	2	1	1	2	1	**24**
RWG	West Hertfordshire Hospitals NHS Trust	N/A	3	1	2	3	5	2	3	3	1	6	6	5	**40**
RGR	West Suffolk Hospitals NHS Trust	N/A	1	2	2	1	1	1	2	0	1	2	0	2	**15**
	East of England Total	**N/A**	**53**	**45**	**66**	**65**	**57**	**54**	**54**	**56**	**31**	**70**	**53**	**52**	**656**
	England Total	**N/A**	**626**	**642**	**644**	**651**	**669**	**666**	**651**	**630**	**600**	**618**	**576**	**658**	**7631**

*The official trajectory for East Suffolk & North Essex has not yet been published since the creation of this Trust in July 2018. The trajectory presented has been calculated by adding together the trajectories for the previous Ipswich Hospital and Colchester Hospital NHS Trusts

Public Health England

Healthmatters **Rates of E. coli BSI**

Infection Prevention and Control Annual Report 2018-2019

Table 7			
NNUH performance for *Klebsiella* BSI – number of cases			
Financial Year	**Community Origin**	**Hospital Origin (on or after day 3)**	**Total**
2018-19	**55 (80%)**	**14 (20%)**	**69**
2017-18	**64 (75%)**	**21 (25%)**	**85**

Public Health England

Table 8

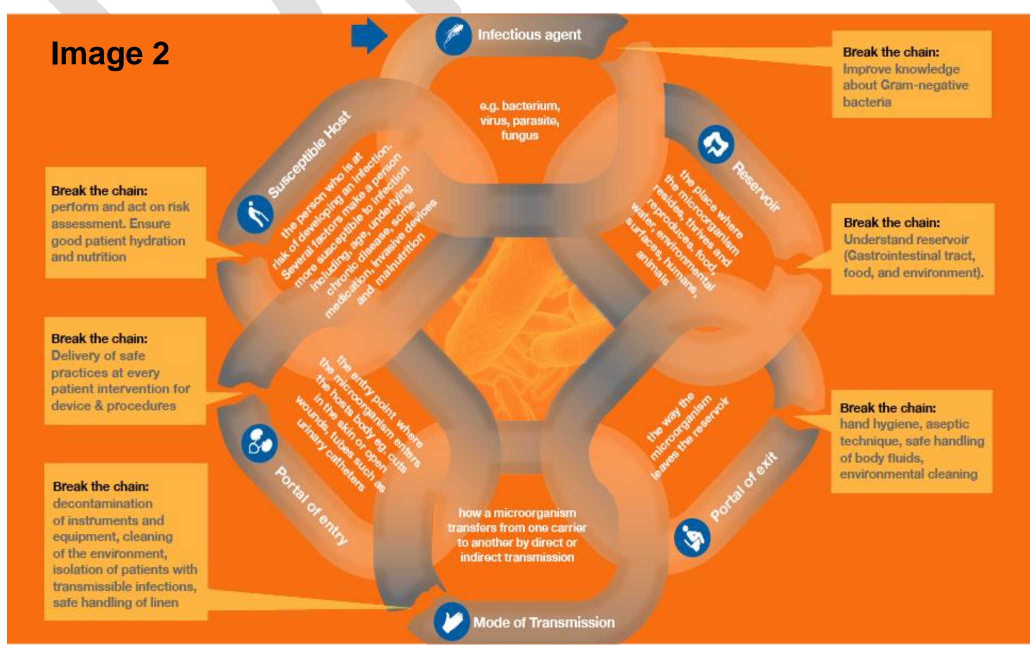
Klebsiella spp.

Count of hospital onset cases per month

Trust Code	Acute Trust Name	Trajectory	2018 April	May	June	July	August	September	October	November	December	2019 January	February	March	Total
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	0	3	1	2	1	3	0	3	2	3	2	2	**22**
RC1	Bedford Hospitals NHS Trust	N/A	0	0	1	1	1	1	0	0	0	0	0	1	**5**
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	1	4	1	4	2	2	4	7	1	1	2	3	**32**
RWH	East & North Hertfordshire NHS Trust	N/A	2	1	0	0	3	1	0	0	0	2	0	1	**10**
RDE	East Suffolk & North Essex NHS Foundation Trust	N/A	2	2	2	9	1	1	4	2	1	3	1	1	**29**
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	1	1	0	0	0	0	2	2	1	0	2	1	**10**
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0	2	1	2	1	1	0	0	1	1	2	0	**11**
RQ8	Mid Essex Hospital Services NHS Trust	N/A	0	1	2	3	3	0	0	2	0	2	0	0	**13**
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	0	1	3	0	4	1	1	1	1	0	0	1	**13**
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	0	0	2	0	2	4	0	1	1	2	1	1	**14**
RGN	North West Anglia NHS Foundation Trust	N/A	0	2	1	2	0	2	3	1	2	2	0	1	**16**
RGM	Royal Papworth NHS Foundation Trust	N/A	1	0	0	1	1	1	3	0	0	2	3	0	**12**
RQW	Princess Alexandra Hospital NHS Trust	N/A	1	0	2	1	1	0	0	0	1	2	0	0	**8**
RAJ	Southend University Hospital NHS Foundation Trust	N/A	0	2	0	2	2	1	2	3	1	1	0	1	**15**
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0	1	3	1	2	0	0	0	0	0	0	0	**7**
RWG	West Hertfordshire Hospitals NHS Trust	N/A	0	1	5	1	2	2	3	2	2	5	1	1	**25**
RGR	West Suffolk Hospitals NHS Trust	N/A	1	0	0	2	0	0	0	0	0	0	1	0	**4**
	East of England Total	**N/A**	**10**	**21**	**24**	**33**	**26**	**20**	**22**	**24**	**14**	**26**	**15**	**14**	**249**
	England Total	**N/A**	**240**	**248**	**248**	**296**	**291**	**315**	**285**	**267**	**252**	**257**	**229**	**253**	**3181**

*The official trajectory for East Suffolk & North Essex has not yet been published since the creation of this Trust in July 2018. The trajectory presented has been calculated by adding together the trajectories for the previous Ipswich Hospital and Colchester Hospital NHS Trusts

Public Health England | Healthmatters | **Breaking the chain of infection**



Infection Prevention and Control Annual Report 2018-2019

Table 9			
NNUH performance for *Pseudomonas* BSI – number of cases			
Financial Year	**Community Origin**	**Hospital Origin (on or after day 3)**	**Total**
2018-19	**30 (67%)**	**15 (33%)**	**45**
2017-18	**33 (77%)**	**10 (23%)**	**43**

Public Health England

Table 10 **Pseudomonas aeruginosa**

Count of hospital onset cases per month

Trust Code	Acute Trust Name	Trajectory	2018 April	May	June	July	August	September	October	November	December	2019 January	February	March	Total
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	1	1	2	0	0	1	2	0	1	2	1	0	**11**
RC1	Bedford Hospitals NHS Trust	N/A	1	0	0	1	0	0	0	0	0	0	0	0	**2**
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	3	1	3	2	3	2	1	1	0	1	2	1	**20**
RWH	East & North Hertfordshire NHS Trust	N/A	1	0	1	0	1	0	0	0	0	1	0	1	**5**
RDE	East Suffolk & North Essex NHS Foundation Trust	N/A	0	0	1	0	0	0	0	4	0	0	0	1	**6**
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	0	0	0	0	1	0	1	2	0	1	1	0	**6**
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0	0	1	0	3	0	0	2	0	0	0	0	**6**
RQ8	Mid Essex Hospital Services NHS Trust	N/A	0	0	1	1	1	1	2	1	0	0	0	3	**10**
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	2	2	1	0	0	0	0	2	0	0	0	1	**8**
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	4	0	0	2	1	3	0	4	0	0	1	0	**15**
RGN	North West Anglia NHS Foundation Trust	N/A	0	1	1	1	1	3	0	1	0	3	0	1	**12**
RGM	Royal Papworth NHS Foundation Trust	N/A	0	0	0	0	0	0	0	1	1	0	0	0	**2**
RQW	Princess Alexandra Hospital NHS Trust	N/A	0	0	0	0	0	0	1	0	0	0	0	0	**1**
RAJ	Southend University Hospital NHS Foundation Trust	N/A	2	2	1	2	0	0	2	0	0	0	0	0	**9**
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	0	0	0	0	0	0	0	1	0	1	0	0	**2**
RWG	West Hertfordshire Hospitals NHS Trust	N/A	0	0	0	0	0	1	0	1	0	1	0	0	**3**
RGR	West Suffolk Hospitals NHS Trust	N/A	0	0	0	0	0	0	0	0	0	0	1	0	**1**
	East of England Total	**N/A**	**14**	**7**	**12**	**9**	**11**	**11**	**9**	**20**	**2**	**10**	**6**	**8**	**119**
	England Total	**N/A**	**123**	**104**	**124**	**149**	**127**	**145**	**146**	**126**	**114**	**132**	**109**	**118**	**1517**

*The official trajectory for East Suffolk & North Essex has not yet been published since the creation of this Trust in July 2018. The trajectory presented has been calculated by adding together the trajectories for the previous Ipswich Hospital and Colchester Hospital NHS Trusts

Public Health England Healthmatters **Core components of infection prevention and control programmes**

Image 3

Infection Prevention and Control Annual Report 2018-2019

Methicillin Susceptible and Methicillin Resistant *Staphylococcus aureus*

The bacteria Staphylococcus aureus is commonly found colonising the skin and mucous membranes of the nose and throat. It is capable of causing a wide range of infections from minor boils to serious wound infections, however most people carry this organism harmlessly. In hospitals, it can cause surgical wound infections and bloodstream infections. Mandatory reporting includes all isolates, whether true infections or contaminated blood cultures and will initially be attributed to the Trust if the positive specimen is taken on or after day 3 of admission.

MRSA Blood Stream Infection

All *Staphylococcus aureus* blood stream infections require reporting. They will then get split according to their resistance to antibiotics and are then reported separately as Methicillin Sensitive *Staphylococcus aureus* (MSSA) and Methicillin Resistant *Staphylococcus aureus* (MRSA). Surveillance and reporting of MRSA blood stream infection continues with the limit set at 0 avoidable cases. See tables 11 & 12.

Table 11

NNUH MRSA BSI attribution and number of cases				
Financial Year	**Community Origin**	**Hospital Origin (on or after day 3)**	**Third Party+**	**Total**
2018-19	**2**	**1 (likely contaminant)**		**3**
2017-18	1	0	2	3
2016-17	1	0	2	3
+ After arbitration was found to be not attributable to CCG or NNUH Third party attribution is no longer available from 2018-19				

Public Health England

Table 12 Methicillin-resistant Staphylococcus aureus

Count of all cases identified by acute trust per month

Trust Code	Acute Trust Name	Trajectory	2018 April	May	June	July	August	September	October	November	December	2019 January	February	March	Total
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	5	1	0	1	1	1	0	0	1	3	0	0	**13**
RC1	Bedford Hospitals NHS Trust	N/A	0	0	0	0	0	0	0	2	0	0	0	0	**2**
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	1	1	0	0	1	1	1	1	1	2	4	1	**14**
RWH	East & North Hertfordshire NHS Trust	N/A	1	3	0	1	0	0	2	1	0	0	0	0	**8**
RDE	East Suffolk & North Essex NHS Foundation Trust	N/A	1	0	0	0	0	1	2	1	1	0	0	0	**6**
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	1	0	0	0	0	0	0	1	0	0	0	0	**2**
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0	0	0	0	2	0	1	0	1	0	1	1	**6**
RQ8	Mid Essex Hospital Services NHS Trust	N/A	3	0	2	0	3	2	1	2	1	1	0	1	**16**
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	0	0	0	0	0	0	1	0	0	0	0	0	**1**
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	1	0	0	1	0	0	0	0	1	0	0	0	**3**
RGN	North West Anglia NHS Foundation Trust	N/A	1	0	0	1	0	1	1	2	1	0	1	0	**8**
RGM	Royal Papworth NHS Foundation Trust	N/A	1	0	0	0	0	0	0	1	0	0	0	0	**2**
RQW	Princess Alexandra Hospital NHS Trust	N/A	1	0	1	0	0	0	0	0	0	0	0	1	**3**
RAJ	Southend University Hospital NHS Foundation Trust	N/A	0	0	0	0	0	1	0	3	1	1	2	3	**11**
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	2	0	0	0	0	0	0	0	0	0	0	0	**2**
RWG	West Hertfordshire Hospitals NHS Trust	N/A	0	3	0	1	1	1	0	1	1	1	3	0	**12**
RGR	West Suffolk Hospitals NHS Trust	N/A	1	0	0	0	1	0	0	0	0	0	0	0	**2**
	East of England Total	**N/A**	**20**	**8**	**3**	**5**	**10**	**8**	**9**	**15**	**9**	**8**	**11**	**7**	**113**
	England Total	**N/A**	**77**	**70**	**55**	**68**	**69**	**71**	**74**	**71**	**73**	**65**	**57**	**55**	**805**

*The official trajectory for East Suffolk & North Essex has not yet been published since the creation of this Trust in July 2018. The trajectory presented has been calculated by adding together the trajectories for the previous Ipswich Hospital and Colchester Hospital NHS Trusts

Following the MRSA BSI there was a thorough post infection review undertaken with clinicians, IP&C team from NNUH and CCG and then discussed at relevant governance meetings.

In order to further raise awareness and share lessons and good practice, a summary of the incident was the topic of the August IP&C OWL which was sent to all clinical staff.

INFECTION PREVENTION & CONTROL (IP&C) O.W.L.

Image 4

Organisation Wide Learning from IP&C – August 2018

Key lessons from Clostridium difficile cases discussed at August's Post Infection Review (PIR) meeting

C. difficile objective for 2018/19 is 48 trajectory cases. To date we have had 2 trajectory cases, 10 non-trajectory cases and 5 HAI C. diff cases awaiting a PIR meeting in September.

Learning/Lapses to date:

- Start stool charts on admission for patients with a history of loose stools at home
- Do not repeat C. difficile testing during the same episode unless specifically discussed with a Microbiology Consultant (Clinical Guideline for Management of all patients with suspected or confirmed Clostridium Difficile Infection)
- **Other lesson**: Stool collected in CAI time frame, however due to delay in sending and no time/date on sample this was classed as an HAI

The government set healthcare providers the challenge of demonstrating zero tolerance of MRSA Blood Stream Infection in 2013

- **NNUH had a hospital acquired MRSA Blood Stream Infection in July 2018**
- **Summary of Post Infection Review meeting August 2018**
- Given the clinical picture, and a subsequent negative blood culture (prior to starting antibiotic treatment for the MRSA bacteraemia) the overall impression is that the positive blood culture is **unlikely** to represent a genuine MRSA infection
- **Contributing factors**
  - Frailty, protracted set of illnesses, immunocompromised, long hospital stay including 42 days in CCC, multiple antibiotics- all appropriate, multiple devices- managed well
- **Good practice**
  - MRSA policy followed after initial screen, patient was informed and given information leaflet (duty of candour), good record keeping (other than blood culture),clinical treatment real time and focused, treatment continued, good co-operation with investigation, patient discharged home well
- **Identification of lessons**
  - Initial MRSA screening swabs were incorrectly labelled
    - This could have helped identify whether she was admitted with MRSA
  - Details of the blood culture were not documented in the notes
    - Blood culture stickers provided in blood culture packs should be used to document details

THIS PATIENT HAS HAD A BLOOD CULTURE TAKEN USING THE SAVING LIVES BEST PRACTICE GUIDANCE.
DATE: TIME: SITE:
Sign: Designation:
Print: Contact no:
Clinical Indications:
WRITE BLOOD CULTURE SET BAR CODES HERE.

Infection Prevention and Control Mandatory updates

Infection Prevention & Control patient contact mandatory training updates are running every week in the Benjamin Gooch and can be booked via the online training booking system or by contacting the mandatory training department.

Upcoming September Dates: Thur 6th 14:30 – 15:30, Wed 12th 14:05 – 15:05 & Thur 20th 14:00 – 15:00

IP&C OWL…Helping us all to become wiser about preventing and controlling infection

MSSA Blood Stream Infection

It remains that there is no national objective for MSSA. See table 13 & 14.

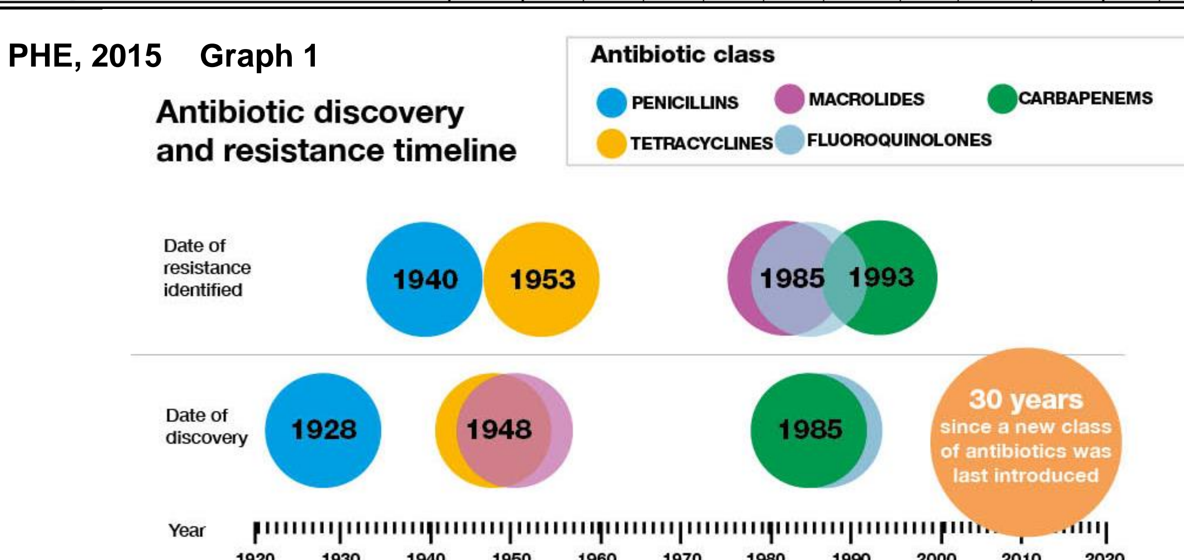
Table 13

NNUH MSSA BSI attribution and number of cases			
Financial Year	**Community Origin**	**Hospital Origin on or after day 3**	**Total**
2018-19	**87 (88.8%)**	**11 (11.2%)**	**98**
2017-18	63 (76.8%)	19 (23.2%)	82
2016-17	73 (80.2%)	18 (19.8%)	91

Public Health England **Table 14** **Methicillin-sensitive Staphylococcus aureus**

Count of acute trust apportioned cases per month

Trust Code	Acute Trust Name	Trajectory	2018 April	2018 May	2018 June	2018 July	2018 August	2018 September	2018 October	2018 November	2018 December	2019 January	2019 February	2019 March	Total
RDD	Basildon & Thurrock University Hospitals NHS Foundation Trust	N/A	2	1	2	2	3	4	2	0	2	3	3	0	**24**
RC1	Bedford Hospitals NHS Trust	N/A	2	0	1	3	0	0	1	0	1	0	0	1	**9**
RGT	Cambridge University Hospitals NHS Foundation Trust	N/A	4	3	4	2	1	3	5	2	2	5	2	3	**36**
RWH	East & North Hertfordshire NHS Trust	N/A	2	3	0	1	2	2	0	2	2	1	0	1	**16**
RDE	East Suffolk & North Essex NHS Foundation Trust	N/A	1	0	0	2	0	1	1	1	5	4	2	4	**21**
RGP	James Paget University Hospitals NHS Foundation Trust	N/A	3	0	3	1	1	1	3	0	1	2	2	0	**17**
RC9	Luton & Dunstable Hospital NHS Foundation Trust	N/A	0	0	0	0	0	0	1	0	4	0	1	3	**9**
RQ8	Mid Essex Hospital Services NHS Trust	N/A	0	3	0	1	1	3	1	2	1	0	0	1	**13**
RD8	Milton Keynes Hospital NHS Foundation Trust	N/A	0	0	2	1	4	2	3	2	1	1	0	3	**19**
RM1	Norfolk & Norwich University Hospitals NHS Foundation Trust	N/A	1	1	0	2	3	3	0	0	0	0	0	1	**11**
RGN	North West Anglia NHS Foundation Trust	N/A	2	4	2	1	1	1	4	2	1	3	4	1	**26**
RGM	Royal Papworth NHS Foundation Trust	N/A	0	1	0	0	1	1	1	1	0	0	0	0	**5**
RQW	Princess Alexandra Hospital NHS Trust	N/A	0	0	1	1	3	0	0	0	0	0	1	2	**8**
RAJ	Southend University Hospital NHS Foundation Trust	N/A	0	0	1	1	2	0	1	1	1	0	0	0	**7**
RCX	The Queen Elizabeth Hospital King's Lynn NHS Trust	N/A	1	0	0	1	1	0	1	0	0	0	2	2	**8**
RWG	West Hertfordshire Hospitals NHS Trust	N/A	3	3	3	0	1	2	0	3	3	1	1	3	**23**
RGR	West Suffolk Hospitals NHS Trust	N/A	1	2	0	0	0	0	1	1	0	0	1	2	**8**
	East of England Total	**N/A**	**23**	**23**	**19**	**19**	**24**	**23**	**26**	**17**	**24**	**20**	**19**	**27**	**264**
	England Total	**N/A**	**267**	**303**	**248**	**271**	**292**	**258**	**290**	**266**	**287**	**282**	**267**	**291**	**3322**



Audit Programme

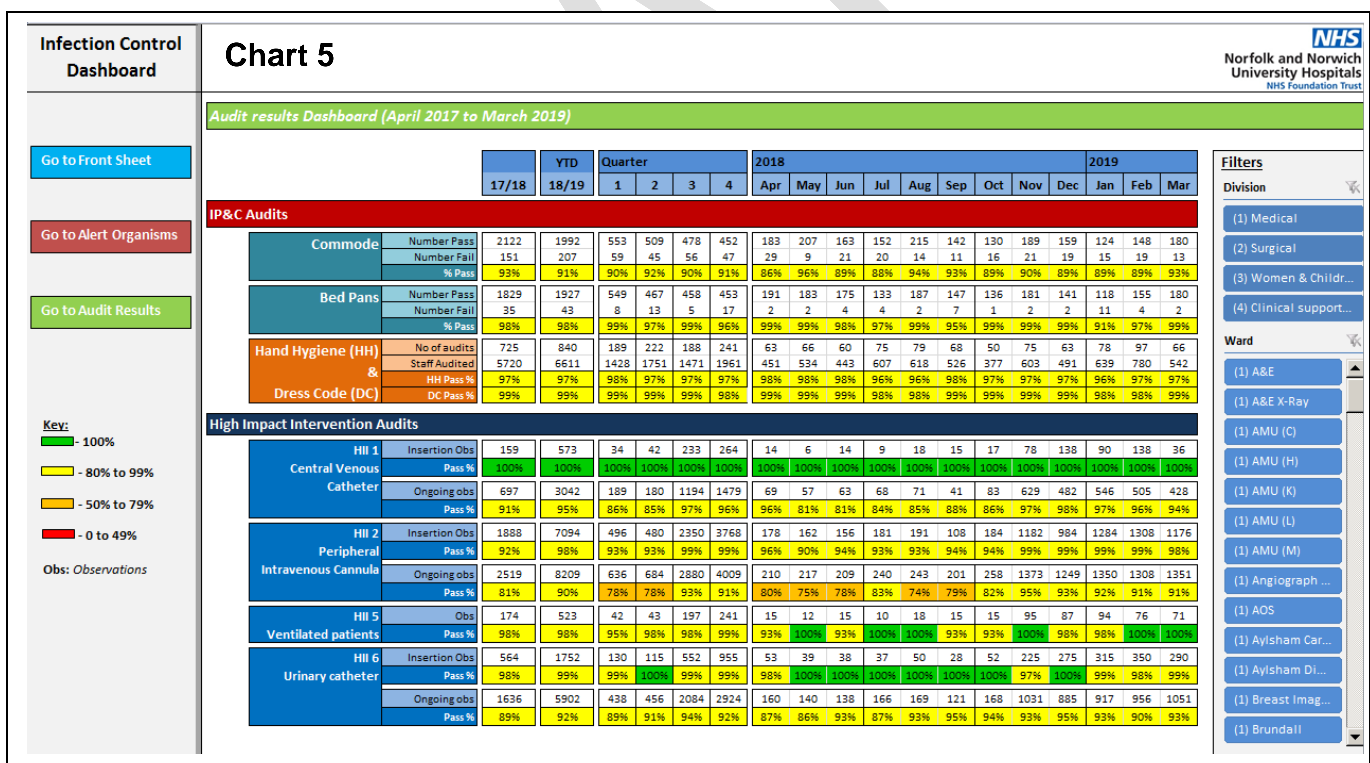
A comprehensive programme of audits is co-ordinated by the IP&C team, working collaboratively with ward nurses and IP&C link practitioners. The aim is to audit a wide range of IP&C practice, equipment and environmental cleanliness this including hand hygiene, commode and bedpan audits, beverage bay and dirty utility. An annual isolation audit is also undertaken across the Trust.

Care bundles to prevent infection associated with peripheral cannulas, central venous catheters and urinary catheters are audited along with the care bundle to prevent ventilator associated pneumonia. The introduction of an update to the High Impact Intervention care bundle changes was also shared in poster format.

The audit cycle facilitates review and promotes continuous improvement. Any areas of non-compliance are highlighted so that action to facilitate improvement can be taken.

Since September 2018 the IP&C team have been designing and piloting an electronic IP&C audits to be used on a commercial audit system which will go live in May 2019.

Audit results are shared with clinical areas and can also be accessed via the intranet on the IP&C electronic dashboard where they can be viewed by individual area, division or whole trust. See Chart 5.



Audit results Dashboard (April 2017 to March 2019)

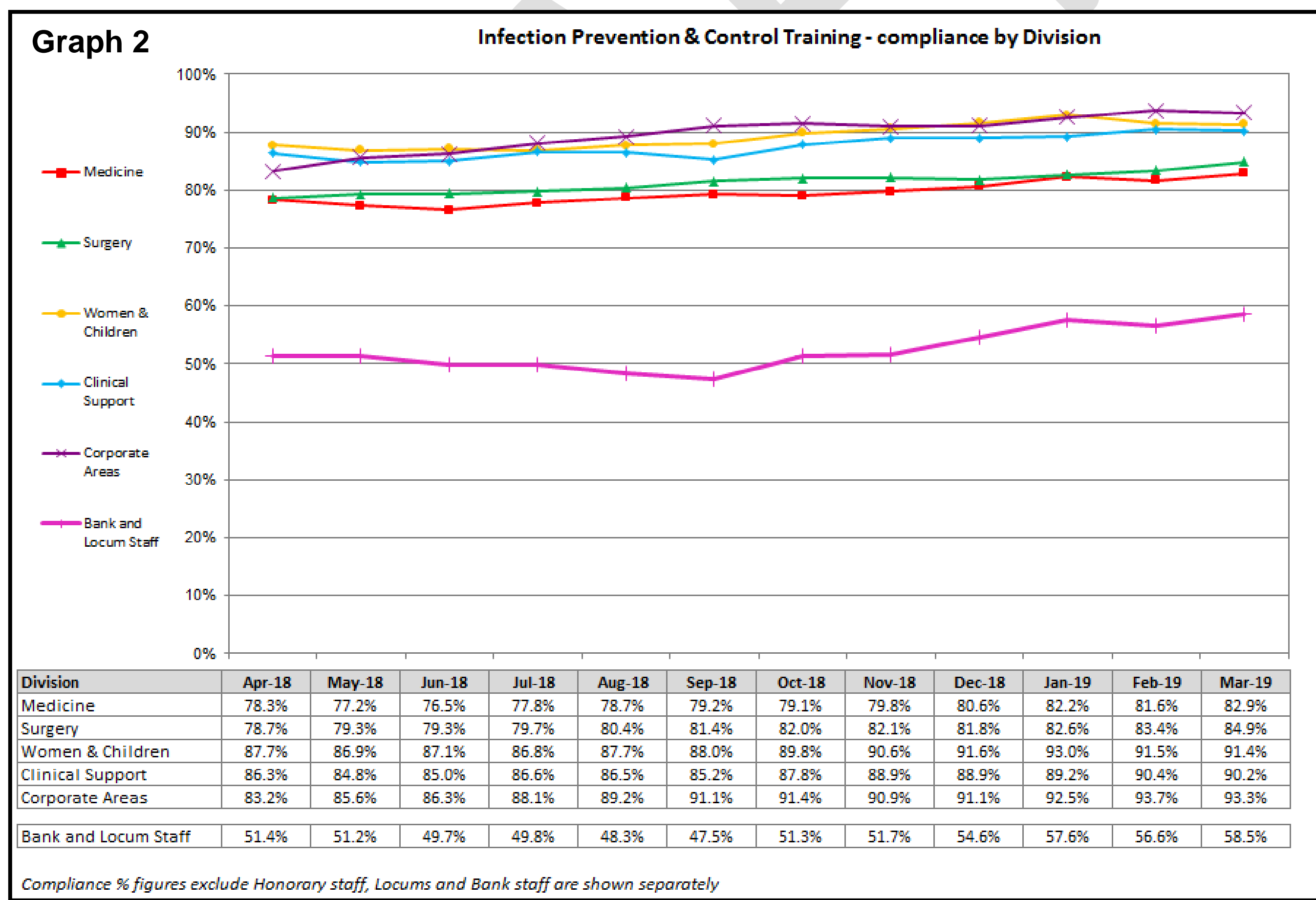
Audit	Measure	17/18	YTD 18/19	Quarter 1	2	3	4	2018 Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2019 Jan	Feb	Mar
IP&C Audits																			
Commode	Number Pass	2122	1992	553	509	478	452	183	207	163	152	215	142	130	189	159	124	148	180
	Number Fail	151	207	59	45	56	47	29	9	21	20	14	11	16	21	19	15	19	13
	% Pass	93%	91%	90%	92%	90%	91%	86%	96%	89%	88%	94%	93%	89%	90%	89%	89%	89%	93%
Bed Pans	Number Pass	1829	1927	549	467	458	453	191	183	175	133	187	147	136	181	141	118	155	180
	Number Fail	35	43	8	13	5	17	2	2	4	4	2	7	1	2	2	11	4	2
	% Pass	98%	98%	99%	97%	99%	96%	99%	99%	98%	97%	99%	95%	99%	99%	99%	91%	97%	99%
Hand Hygiene (HH) & Dress Code (DC)	No of audits	725	840	189	222	188	241	63	66	60	75	79	68	50	75	63	78	97	66
	Staff Audited	5720	6611	1428	1751	1471	1961	451	534	443	607	618	526	377	603	491	639	780	542
	HH Pass %	97%	97%	98%	97%	97%	97%	98%	98%	98%	96%	96%	98%	97%	97%	97%	96%	97%	97%
	DC Pass %	99%	99%	99%	99%	99%	98%	99%	99%	99%	98%	98%	99%	99%	99%	99%	98%	98%	99%
High Impact Intervention Audits																			
HII 1 Central Venous Catheter	Insertion Obs	159	573	34	42	233	264	14	6	14	9	18	15	17	78	138	90	138	36
	Pass %	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Ongoing obs	697	3042	189	180	1194	1479	69	57	63	68	71	41	83	629	482	546	505	428
	Pass %	91%	95%	86%	85%	97%	96%	96%	81%	81%	84%	85%	88%	86%	97%	98%	97%	96%	94%
HII 2 Peripheral Intravenous Cannula	Insertion Obs	1888	7094	496	480	2350	3768	178	162	156	181	191	108	184	1182	984	1284	1308	1176
	Pass %	92%	98%	93%	93%	99%	99%	96%	90%	94%	93%	93%	94%	94%	99%	99%	99%	99%	98%
	Ongoing obs	2519	8209	636	684	2880	4009	210	217	209	240	243	201	258	1373	1249	1350	1308	1351
	Pass %	81%	90%	78%	78%	93%	91%	80%	75%	78%	83%	74%	79%	82%	95%	93%	92%	91%	91%
HII 5 Ventilated patients	Obs	174	523	42	43	197	241	15	12	15	10	18	15	15	95	87	94	76	71
	Pass %	98%	98%	95%	98%	98%	99%	93%	100%	93%	100%	100%	93%	93%	100%	98%	98%	100%	100%
HII 6 Urinary catheter	Insertion Obs	564	1752	130	115	552	955	53	39	38	37	50	28	52	225	275	315	350	290
	Pass %	98%	99%	99%	100%	99%	99%	98%	100%	100%	100%	100%	100%	100%	97%	100%	99%	98%	99%
	Ongoing obs	1636	5902	438	456	2084	2924	160	140	138	166	169	121	168	1031	885	917	956	1051
	Pass %	89%	92%	89%	91%	94%	92%	87%	86%	93%	87%	93%	95%	94%	93%	95%	93%	90%	93%

Infection Prevention and Control Annual Report 2018-2019

Staff Training and Supervision

The IP&C team support and undertake the following staff training:-

- Mandatory training:
  - Non-clinical staff - IP&C updates available via nationally accredited e-learning package bi-annually
  - Clinical staff - IP&C training is delivered via face to face training sessions from the IP&C team bi-annually and includes the consultants mandatory training programme
- Corporate face to face induction for all new starters
- Deliver IP&C training in partnership with University of East Anglia for undergraduate nurses, physiotherapists, occupational therapists & Speech and Language therapists and return to practice student nurse cohorts.
- Our IP&C support workers teach on the Nursing Assistant induction training course.
- Bespoke departmental training when we have IP&C nurse capacity or an active incident.
- Junior doctors preparation for professional practise course each August.
- Monthly Invasive device and enhanced practice study sessions.
- Awareness campaigns and study sessions.
- Ad-hoc via incident management meetings, serious incident group, root cause analysis and opportunistic training in the clinical areas.



Division	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Medicine	78.3%	77.2%	76.5%	77.8%	78.7%	79.2%	79.1%	79.8%	80.6%	82.2%	81.6%	82.9%
Surgery	78.7%	79.3%	79.3%	79.7%	80.4%	81.4%	82.0%	82.1%	81.8%	82.6%	83.4%	84.9%
Women & Children	87.7%	86.9%	87.1%	86.8%	87.7%	88.0%	89.8%	90.6%	91.6%	93.0%	91.5%	91.4%
Clinical Support	86.3%	84.8%	85.0%	86.6%	86.5%	85.2%	87.8%	88.9%	88.9%	89.2%	90.4%	90.2%
Corporate Areas	83.2%	85.6%	86.3%	88.1%	89.2%	91.1%	91.4%	90.9%	91.1%	92.5%	93.7%	93.3%
Bank and Locum Staff	51.4%	51.2%	49.7%	49.8%	48.3%	47.5%	51.3%	51.7%	54.6%	57.6%	56.6%	58.5%

Compliance % figures exclude Honorary staff, Locums and Bank staff are shown separately

The slow improvement in the compliance with IP&C mandatory training in locum and bank staff is being addressed and the HICC committee request regular progress reports. See graph 2.

Infection Prevention and Control Annual Report 2018-2019

IP&C Team Training

1. 6 members of the team attended a regional IPS conference in June 2018.
2. The IP&C team are part of a Norfolk wide group looking at reducing urinary tract infections. A number of the group members attended the NHSI Gram-negative workshops.
3. 3 IP&C Nurses attended One Together assessment conference in November 2018.
4. 1 IP&C Nurse attended Foundations of Quality Improvement workshop in November 2018.
5. 1 IP&C Nurse attended Infection Prevention Society IV conference in November 2018.
6. ICD and Senior Nurse attended an NHSI CDI workshop.

Colleagues Gaining IP&C Experience With The Team

This year we had attachments from 2 microbiology registrars as part of their training, colleagues from other IP&C teams, housekeepers, and student nurses. Visits ranged from a full day to 2 months. Our aim is for our visitors to get a broad understanding of IP&C and fulfil their pre agreed objectives by shadowing various members of the team.

We are always pleased to share our specialist knowledge and skills with colleagues who want to visit the team whether it is for a day or longer.

IP&C International Awareness Week

Each year the whole IP&C team get involved in raising awareness about key IP&C matters during international Infection Prevention Week in October. This year we focussed on updating clinical staff about new updates to the high impact intervention audits and also antimicrobial resistant organisms. See image 5.

Image 5

IP&C Link Practitioner's

The IP&C Team continued to provide support to the IP&C link practitioners in the Trust.

IP&CT updated the link practitioner profile, whose role will be supported by their line managers and endorsed by the Chief Nurse, Divisional nurse, Matrons and Clinical Directors. This year we have asked that every area nominates a band 6 link practitioner as well as encouraging other designations of staff to undertake the role.

Meetings have taken place throughout the year with a variety of topics covered. These were attended by IP&C link practitioners from across the organisation, who were encouraged to use these hours towards their Continuing Professional Development (CPD). See table 15.

Table 15

IP&C Link Practitioner meetings 2018-19		
28/06/2018	**06/12/2018**	**28/03/2019**
Agenda • Introduction and Intro new IP&C staff • Presentation from Shulke • Hand hygiene for staff, patients and visitors • IP&C OWLS-How to use them in practice • Link staff Q&A/sharing best practice	**Agenda** • Presentation Mark Webber on CPE • Presentation from Schulke • CPE guidelines and how to use them on the ward • Link staff Q&A/sharing best practice	**Agenda** • Introducing the IP&C Champion role • NHSI Feedback • Hand decontamination • Appropriate use of personal protective Equipment • Clean equipment and environment • Back to Basics

DRAFT

The aims of the IP&C link practitioner role are;

- To champion a positive culture of Infection Prevention & Control
- To monitor and promote high IP&C standards to improve the care of service users
- To share, monitor and promote safe evidence based practice in your area, using current guidance i.e. epic 3.
- Act as a liaison and support for their team.
- Provide positive feedback to members of their team to support celebration of success (RCN 2012).
- Improve knowledge, awareness of policies, guidelines and new legislation.

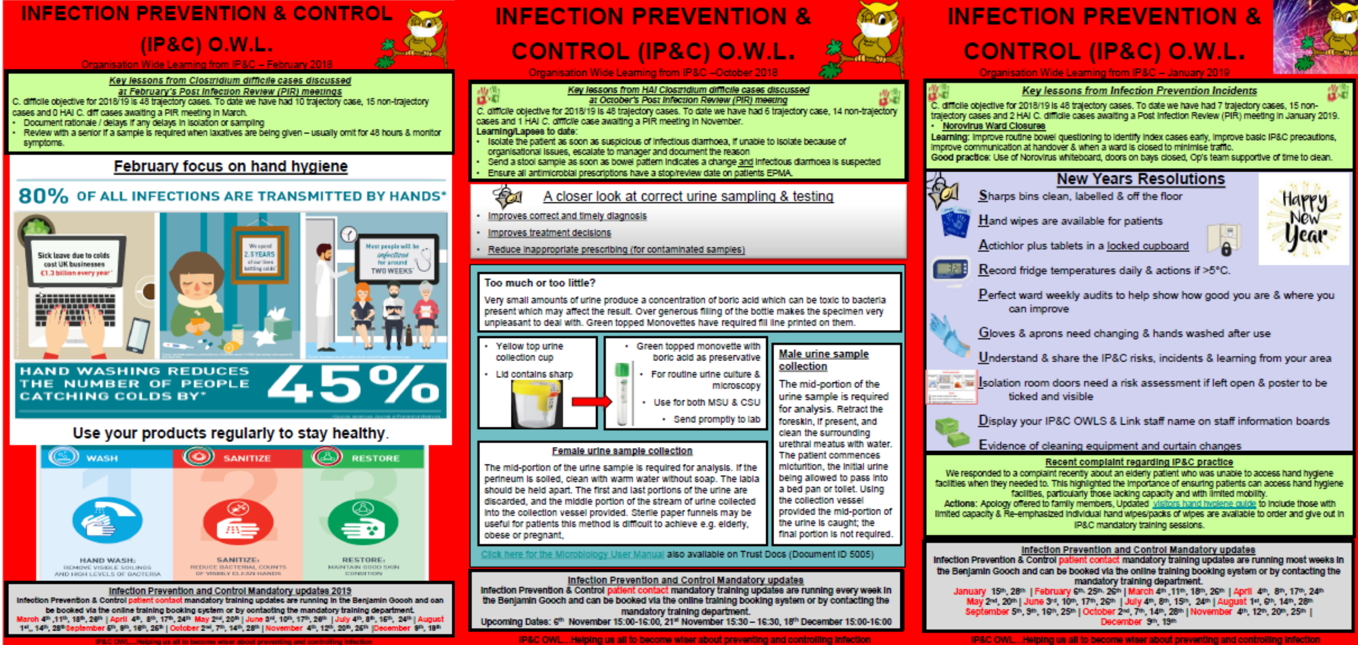
Infection Prevention and Control Annual Report 2018-2019

Organisation Wide Learning (OWL,

The IP&CT continues to produce a monthly organisational wide learning (OWL), see image 6. In the form of a poster, sharing Trust wide IP&C information and learning such as;

- Monthly learning from post infection reviews (PIR)
- Key IP&C messages
- Current or upcoming IP&C topics
- Highlighting areas of good practice
- Highlighting areas of improvement

Three examples of the OWL from the year are shown below, **Image 6**



Movement of Service Users

Moving or not moving patients can impact significantly on IP&C in particular when there is Norovirus and Influenza circulating in the community and requires a co-ordinated approach.

There are daily operational department meetings that the IP&C nurses attend if there are any IP&C concerns that impact operationally. The IP&C team work closely with the site Operations Team, in particular when there is increased numbers of Influenza or Norovirus cases within the Trust and during on-call.

The IP&C and operational teams have developed electronic boards to assist staff in highlighting areas that have confirmed/suspected Influenza or Norovirus and include information on community hospitals or care homes with suspected or known cases. Via the electronic ward view the ward teams show the reason for a single room being in use which both the operations and IP&C teams have access to view. Via the patient administration system there are individual patient alerts in place to assist in single room planning for patients with known previous infections/alert organisms.

Hygiene Code Compliance Criteria 2:
Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections.

Environmental Cleaning Services

The role of the designated cleaning lead has been undertaken by a Divisional Nurse Director (DND). The environmental cleaning is undertaken by an external contractor who work closely with the facilities and IP&C team. The medical equipment is cleaned by Trust staff.

Cleaning of the environment, equipment and estates issues are monitored through regular joint audits attended by both Trust and Provider staff using Cleaning for Credits (C4C) software. See tables 16, 17 & 18.

Table 16

NNUH remote sites - Cleaning for Credits (C4C) audit scores							
Area	**Number of Audits**			**Average Score**			**Target Range**
	2016-17	2017-18	**2018-19**	2016-17	2017-18	**2018-19**	
Cotman Centre admin	54	72		95%	97%		95-100%
Francis Centre admin	11	12		87%	90%		95-100%
Grove Road	7	12		96%	98%		95-100%
Rouen Road	54	72		95%	97%		95-100%

Table 17

NNUH Cromer Hospital site- Cleaning for Credits (C4C) audit scores							
Area	**Number of Audits**			**Average Score**			**Target Range**
	2016-17	2017-18	**2018-19**	2016-17	2017-18	**2018-19**	
Wards	24	27		98%	**97%**		95-100%
A&E (MIU)	12	12		98%	**97%**		95-100%
Theatres	24	25		99%	**98%**		95-100%
Clinics/Admin	43	50		98%	**97%**		95-100%

Table 18

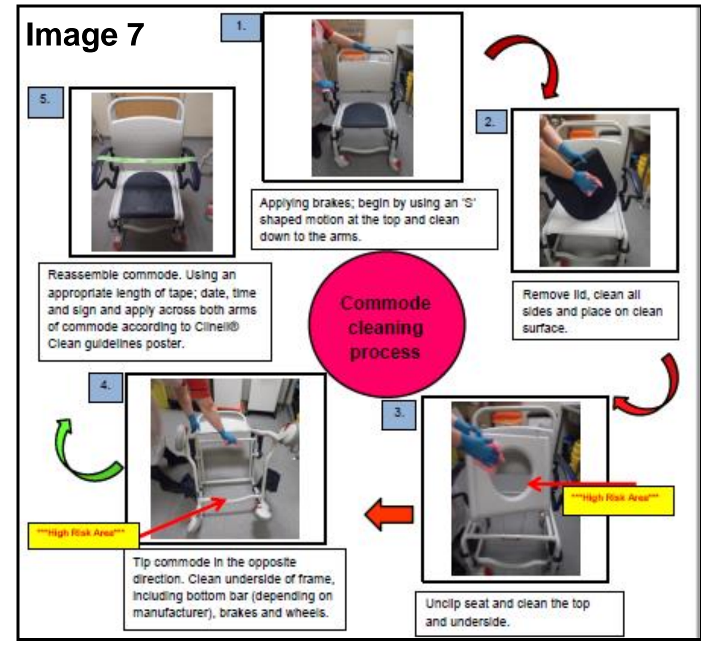
NNUH Colney Site - Cleaning for Credits (C4C) audit scores							
Area	**Number of Audits**			**Average Score**			**Target Range**
	2016-17	2017-18	**2018-19**	2016-17	2017-18	**2018-19**	
Wards	412	420	**419**	96%	96%	**96%**	90%-95%
A&E	48	48	**52**	96%	96%	**96%**	90%- 95%
Theatres	264	264	**156**	97%	97%	**98%**	90%-95%
Clinics/Admin &Public Areas	1215	1220	**1080**	96%	97%	**97%**	90%-95%

Table 19

Number of commodes audited and average percentage pass across NNUH sites		
Financial Year	**Total No of Commodes audited**	**Percentage Pass**
2018-19	**1992**	**91%**
2017-18	2282	94%
2016-17	2377	93%

Commode and Bedpan Cleanliness

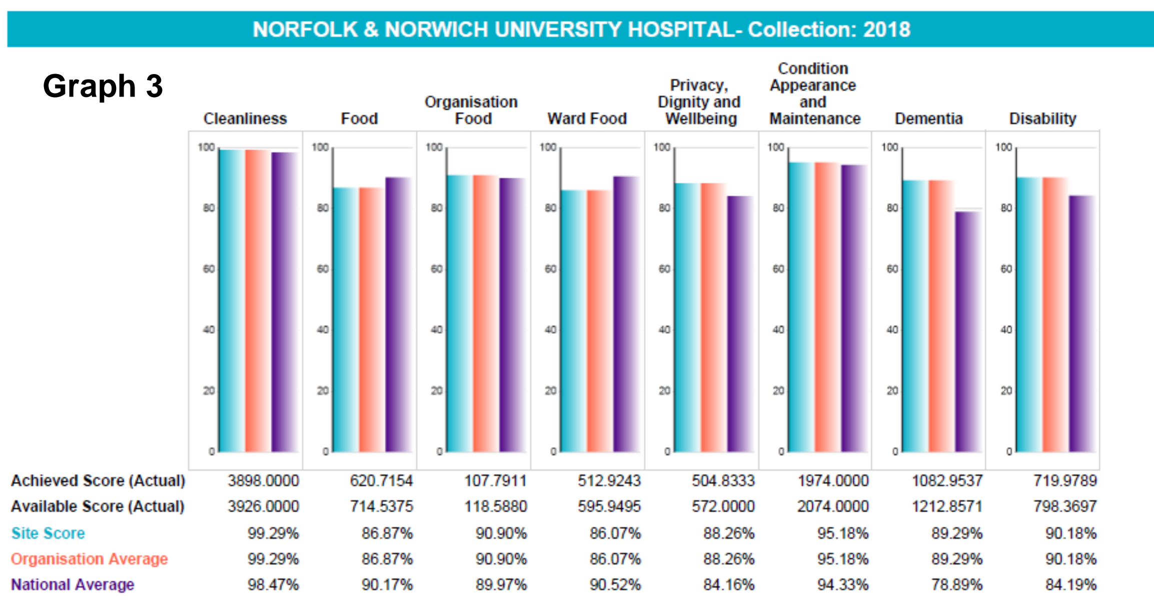
The IP&C support workers maintain a continuous programme of commode and bedpan audits Trust wide with practical training provided. See image 7 & table 19.



Infection Prevention and Control Annual Report 2018-2019

The annual Patient-Led Assessments of the Care Environment (PLACE) was in May 2018. The assessments provide a framework for the appraisal of the non-clinical aspects of the Trust with at least 50% of the team being patient assessors.

The NNUH scores for cleanliness and condition, appearance and maintenance were a fraction above the national average. See graph 3.



	Cleanliness	Food	Organisation Food	Ward Food	Privacy, Dignity and Wellbeing	Condition Appearance and Maintenance	Dementia	Disability
Achieved Score (Actual)	3898.0000	620.7154	107.7911	512.9243	504.8333	1974.0000	1082.9537	719.9789
Available Score (Actual)	3926.0000	714.5375	118.5880	595.9495	572.0000	2074.0000	1212.8571	798.3697
Site Score	99.29%	86.87%	90.90%	86.07%	88.26%	95.18%	89.29%	90.18%
Organisation Average	99.29%	86.87%	90.90%	86.07%	88.26%	95.18%	89.29%	90.18%
National Average	98.47%	90.17%	89.97%	90.52%	84.16%	94.33%	78.89%	84.19%

Copyright ©2018, Health and Social Care Information Centre. NHS Digital is the trading name of the Health and Social Care Information Centre.

Waste Management including Sharps, *(information contributed by Health and Safety Lead Advisor*

The overall responsibility for correct processing of waste in the Trust sits with the Health and Safety team. The Trust Waste Policy applies to all sites although the Facilities Management (FM) companies with operational responsibility differ across the sites.

Monitoring and audit of the policy is done through various channels:

- Clinical waste streams are audited by the FM companies on sites where more than 5,000 tonnes of clinical waste is produced annually (NNUH, Colney, Microbiology) to comply with Environment Agency guidance. These audits have recently been completed and the results shared with the Trust.
- Clinical waste is monitored on a daily basis by the FM companies to ensure it has been placed in the correct stream before leaving site. This involves a visual check of bin content and observation of items entering the compactors. Waste bags are NEVER decanted or opened unless there is any suspicion of them containing incorrect waste.
- NNUH (via FM provider) changed waste contractor during 2018 and duty of care visits have been carried out accordingly.

The safe handling and disposal of sharps is covered by the Prevention of Injury from Needlesticks and Sharps Injuries policy which also sits with the Health and Safety team.

Compliance with the policy is monitored on an ongoing basis by:

- The H&S team and Health and Wellbeing team via Datix incident reports.
- The Inoculation Incident group monitors incident trends and receives any risk assessment generated in respect of non-compliance.

The provider of sharps bins changed during 2018 (FM provider decision) and there has been an ongoing changeover programme. The new supplier audit programme should be commencing April 2019 on a quarterly basis.

Laundry

The hospital laundry is managed offsite at a facility in Derby. In order to gain assurance that the proper procedures and processes are being followed a duty of care visit took place in October 2018 with IP&C representation. See image 8.

Image 8

DRAFT

Hygiene Code Compliance Criteria 3:
Ensure appropriate antibiotic use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.

Prudent Use of Antibiotics *(information contributed by Specialist Antimicrobial Pharmacist)*

Antimicrobial Report 2018-2019

We have continued our programme of regular audits, policy review and ward rounds. We have worked towards achieving the targets laid out by reducing the impact of serious infections (Antimicrobial resistance and Sepsis) CQUIN. The Antimicrobial Subgroup Committee meets quarterly to review antimicrobial prescribing issues and reports to the Drugs, Therapeutics and Medicines Management Committee. The Lead Antimicrobial Pharmacist is assisted by Specialist Antimicrobial Pharmacist (Maternity Leave September 2017 onwards). Whilst the Specialist Antimicrobial Pharmacist has been on maternity leave we have had pharmacy support from a Band 6 pharmacist. A Consultant Microbiologist provides medical support.

Antimicrobial Ward Rounds

Weekly ward rounds included Vascular and General Surgery Ward, Surgical Wards and all Older People's Medicine (OPM) Wards. Orthopaedic Ward rounds are on hold as of February 2018 due to staff shortages in Microbiology. These are in addition to a number of other well established clinical rounds that include antimicrobial review – e.g. NICU, Critical Care Units and Haematology and Oncology.

The antimicrobial rounds review patients who are on IV antibiotics, two or more antibiotics, β-lactam/inhibitor combinations, cephalosporins, quinolones, gentamicin or vancomycin and these patients are discussed with clinical teams if any concerns are identified. The rounds also provide opportunity to promote IV to oral switch where appropriate, and encourage review of prescription in terms of rational choice and duration of the course.

In addition to the above, weekly review of patients being treated with meropenem including attending the wards has taken place. Review of patients on piperacillin/tazobactam takes place when time allows.

Antimicrobial Consumption

Antimicrobial consumption is measured in defined daily doses (DDDs). This allows comparison across time and across institutions. We have a well-developed programme that allows us to monitor antibiotic use over time for anywhere in the hospital and prescribing statistics and trends are reviewed as part of the standing agenda of the Antimicrobial Subgroup. The target of reduction in the use of broad spectrum antibiotics as part of the CQUIN have resulted in an overall increase in antimicrobial consumption in 2018-2019, with a corresponding reduction in consumption of broad spectrum antibiotics including carbapenems.

Audit

Trust wide antibiotic audits to monitor and improve antimicrobial prescribing and use were carried out in May 2018, October 2018 and March 2019 and results circulated via HICC, Monthly Infection control report and AMSC.

DRAFT

CQUIN

Since April 2016 antimicrobial stewardship has been a priority in the form of the Antimicrobial Resistance and Stewardship (AMR) CQUIN 2016-2017 and has been continued to be a part of the Sepsis CQUIN 2018-2019. The AMR section of the Sepsis CQUIN 2018-2019

1. Reduction of 2% in total antibiotic usage (for both in-patients and out-patients) per 1,000 admissions.
2. Reduction of 2% in total usage (for both in-patients and out-patients) of carbapenems per 1,000 admissions.
3. Increase the proportion of antibiotic usage (for both in-patients and out-patients) within the Access group of the AWaRe* category;
   - Access group ≥55% of total antibiotic consumption (as DDD/1000adm)

   OR

   - Increase by 3 percentage points from baseline 2016 calendar year. The Access group includes the following antibiotics: (TB drugs excluded)
   - Phenoxymethylpenicillin
   - Nitrofurantoin
   - Metronidazole
   - Gentamicin
   - Flucloxacillin
   - Doxycycline
   - Co-trimoxazole
   - Amoxicillin
   - Ampicillin
   - Benzylpenicillin
   - Benzathine Benzylpenicillin
   - Procaine Benzylpenicillin
   - Oral Fosfomycin
   - Fusidic Acid (sodium fusidate)
   - Pivmecillinam
   - Tetracycline
   - Trimethoprim

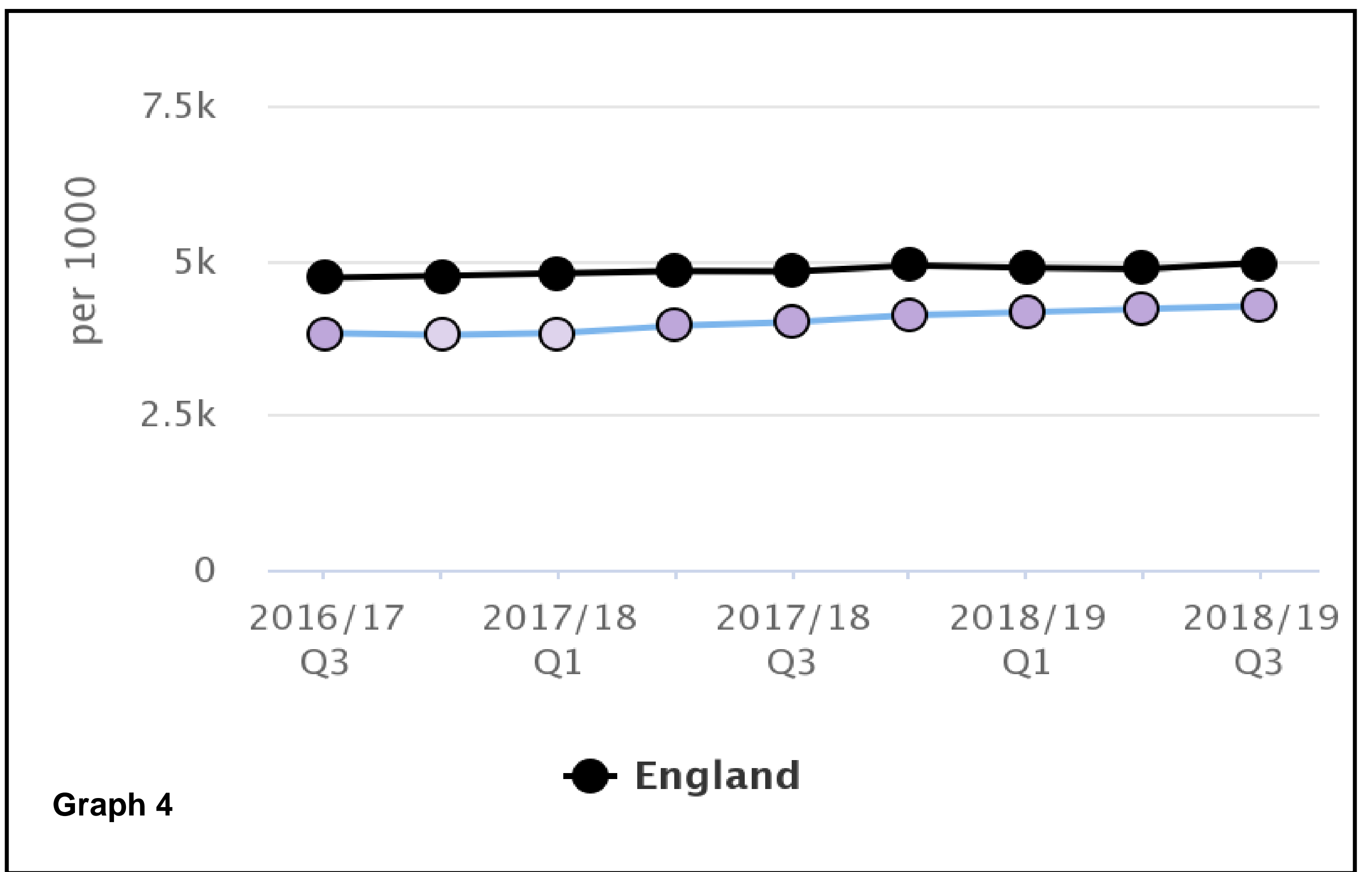
In addition to this we have assisted in the efforts to meet the 72 hour antibiotic review target of the Sepsis CQUIN.

The final outcome decision from the CCG for 2018/19 is awaited. The graphs below are available from the Public Health England fingertips website and provide a graphical representation of the Trust's performance against these criteria.

Total antibiotic consumption

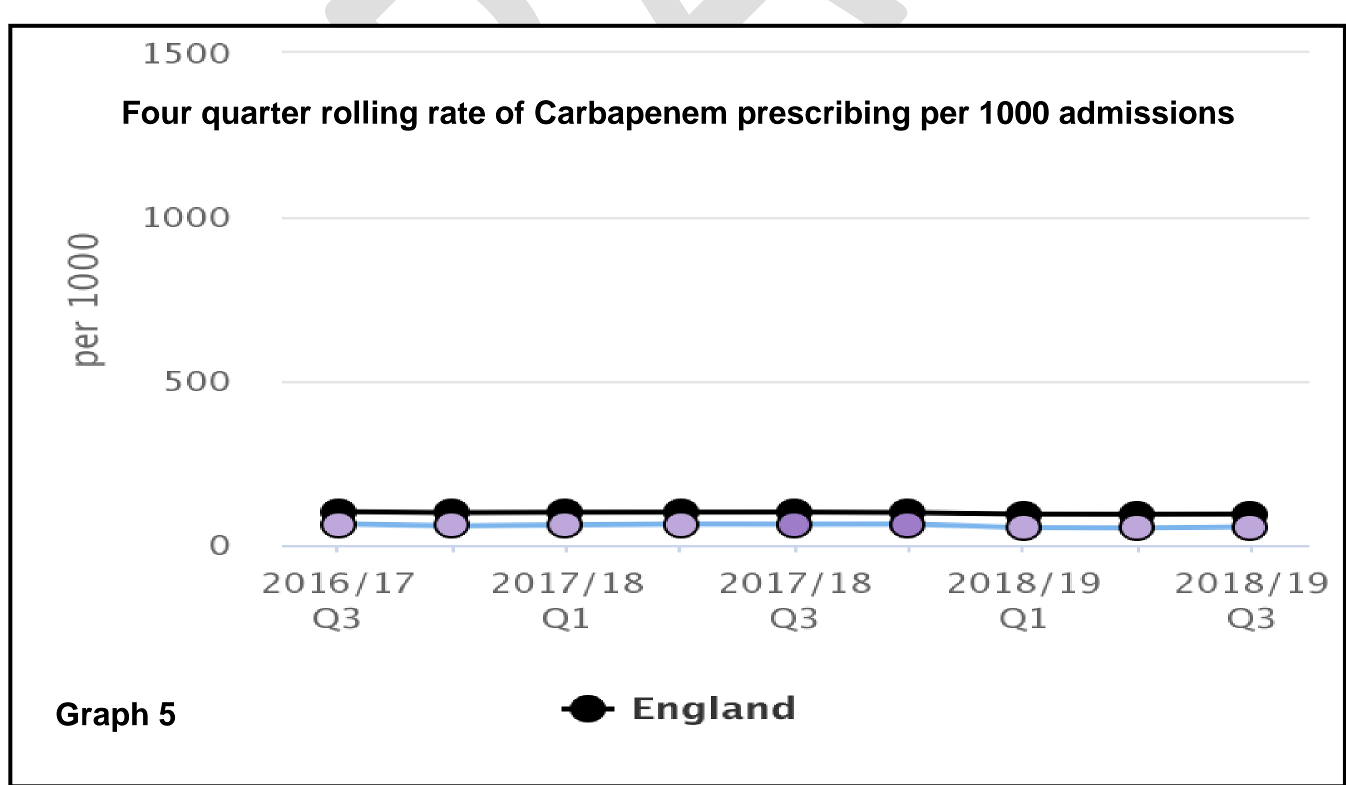
Four quarter rolling rate of total antibiotic prescribing per 1000 admissions

DRAFT



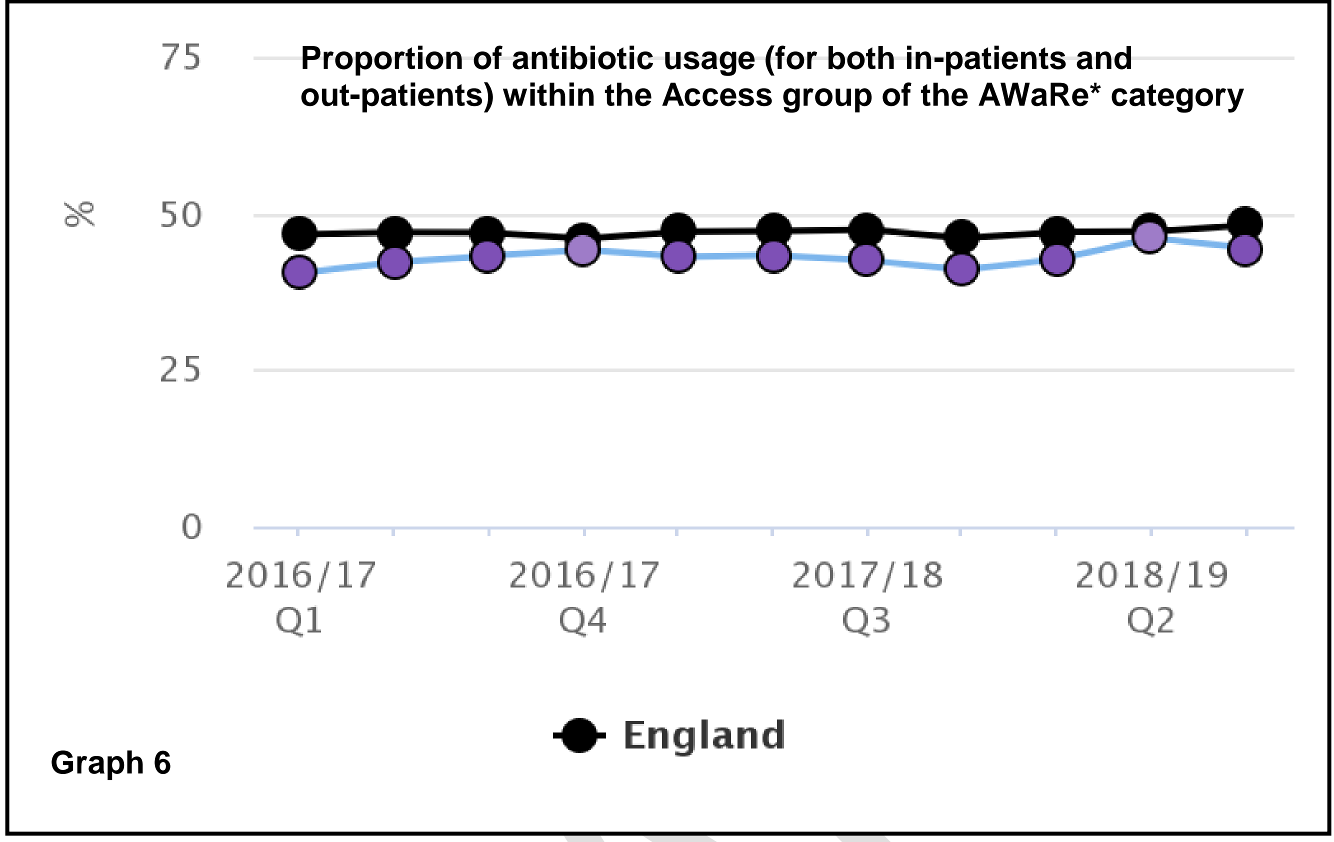
Graph 4

Carbapenem consumption



Four quarter rolling rate of Carbapenem prescribing per 1000 admissions

Graph 5



Graph 6

Activities undertaken to support the delivery of the CQUIN in 2018-2019 included;

- Use of EPMA and IT
- Antibiotic reports are generated for the wards. Passwords are made available for clinical staff to log in and review these reports.
- Revisions to Antibiotic Policies and development of new Policies
- All existing Trust Antimicrobial Policies have been reviewed and relaunched to provide alternative choices to the use of broad spectrum antibiotics where clinically safe. Wherever appropriate, the antimicrobial team have met with specialty Consultants to discuss and agree modifications to policy.
- Development of a review prompt sticker which was placed in the notes to prompt an appropriate review of antibiotics for those patients identified as being on the Sepsis pathway, see image 9:

Image 9

Antibiotic Review at 24 to 72 hours

(Reviewed by ……………………….Grade………….(ST3 or above)

Decision (please tick):

☐ **Stop**
☐ **IV to oral switch** with a documented review date or duration of the oral antibiotic
☐ **OPAT** (Outpatient Parenteral Antibiotic Therapy)
☐ **Continue** with new review date or duration
☐ **Change** antibiotic with escalation to broader spectrum antibiotic with a documented review date or duration
☐ **Change** antibiotic with de-escalation to a narrower spectrum antibiotic with a documented review date or duration
☐ **Change** antibiotic e.g. to narrower/broader spectrum based on blood culture results with a documented review date or duration

If pt to remain on IV antibiotics please complete

☐ Patient is nil by mouth or not absorbing
☐ No oral antibiotic option available
☐ Patient not clinically improving
☐ Deep seated infection
☐ Based on microbiology advice

Next review……………………………………(date)

Representation at appropriate committees

Drugs, Therapeutics and Medicines Management Committee (DTMM), Hospital Infection Control Committee (HICC) and CCG Antimicrobial Subcommittee.

Forward Planning

Team plans for 2019-20 include:

- Continuation and development of antimicrobial ward rounds with a change in microbiology consultant lead form 01/04/19
- Trust wide audits
- Working towards achieving the new AMR CQUIN:
  - Improving the management of lower Urinary Tract Infection in older people
  - Improving appropriate antibiotic surgical prophylaxis in elective colorectal surgery

DRAFT

Hygiene Code Compliance Criteria 4:
Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion

Information for Service Users, Visitors and Carers

The IP&C team have developed a number of information leaflets for service users, visitors and carers to cover all the main infections and infection prevention. These and other information about IP&C can be found on the NNUH website http://www.nnuh.nhs.uk/articles/

When promoting awareness campaigns the IP&C team include service users, visitors and carers and make themselves easily accessible to the public by siting themselves in a public areas as well as attending clinical areas

The IP&C team regularly update the information and work closely with the communications department especially over the winter when Norovirus and Influenza are circulating in the community. IP&C information is shared in a number of ways including:

- Face to face discussion
- Via IP&C link practitioners
- Awareness campaigns
- Information leaflets
- Trust information booklet
- Noticeboards
- Switchboard answer phone messages
- Press statements via the NNUH web site
- Via local radio and media
- Social networking e.g. Twitter and Facebook

DRAFT

Hygiene Code Compliance Criteria 5:

Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people.

Patient Alerts and Surveillance of Alert Organisms e.g. MRSA, *Clostridium difficile,*

The IP&C team use software to monitor patient alerts. This assists in the early detection of a patient re-admitted with an alert organism/infection or a cluster of the same alert organism in the same area allowing for timely intervention. The non-urgent alert organisms are monitored at a weekly surveillance meeting with the ICD.

Screening is undertaken on all emergency and elective admissions for MRSA. This enables any patients found to be positive whilst in the Trust to have topical decolonisation and if required antimicrobial treatment, see table 20.

There are 2 electronic boards designed by the IP&C team which are available on the intranet for staff to see if there is Norovirus or Influenza in any areas of the hospital and community healthcare settings that have suspected or confirmed Norovirus or Influenza outbreaks.

Table 20

MRSA Screening for Emergency and Elective Patients - numbers of Patient Screened

Financial Year	Emergency Screened Patients	Elective Screened Patients
2018-19	**96.12%**	**96.50%**
2017-18	96.3%	94.1%
2016-17	96%	96.93%

As discussed earlier there is a screening process in place for patients that may be at risk of CPE or are a previously known case, see table 21.

Table 21

Carbapenamase-Producing Enterobacteriaceae - numbers of Patient Screened

Financial Year	Admission in UK high risk hospital in last year	Hospital admission abroad in last year	Screened for other reasons (e.g. Holiday for Renal Dialysis patients)	Total
2018-19	**166**	**125**	**57**	**348**
2017-18	161	129	28	318
2016-17	138	91	4	233

DRAFT

Infection Prevention and Control Annual Report 2018-2019

Period of Increased Incidence (PII) and Supportive Measures

IP&C Supportive Measures are undertaken for areas having a PII, 2 or more HAI *C. difficile,* MRSA or ESBL results are received from the same ward within 28 days the IP&C team support ward areas with additional audits and education. These measures aim to support and educate staff to reduce PII of infection. Ward staff are trained to undertake the audits so they understand clearly what measures are required to reduce the risks of cross infection.

These audit results are monitored weekly by the IP&C team and additional interventions planned with the ward management team, see table 22 & 23.

Table 22

Number of episodes of supportive measures due to a PII				
Financial Year	**MRSA**	***C. difficile***	**Influenza**	**ESBL**
2018-19	**4**	***2***	**0**	**1**
2017-18	0	5	4	1
2016-17	2	3	N/A	0

Outbreaks and Serious Incidents

Table 23

Number of episodes of outbreak or serious incident				
Financial Year	**MRSA**	***Pseudomonas aeruginosa***	**Influenza**	**Norovirus Ward closure**
2018-19	**1**	**1**	**0**	**7**
2017-18	1	0	1	1

Indwelling device audit

The High Impact Intervention care bundles highlight critical elements of each procedure or care process, the key actions required and provide a means of demonstrating reliability through the audit process.

The care bundles at the NNUH were updated in November 2018 in line with national changes and are available to access electronically on the IP&C department page. Changes in practice involved extending peripheral cannula dwell time to 7-10 days providing there are no signs of infection and the cannula remains clinically indicated (epic, 2014).

Changes were highlighted to staff across the Trust and auditors in each area were provided with update training. This provided an opportunity to raise the profile of the importance of following the care bundle guidance. This has reflected positively in the results for 2018/19, see table 24 & image 10.

Table 24

High Impact Intervention Audit Scores			
High Impact Intervention care bundle audit	2016-17	2017-18	**2018-19**
Central venous catheter care	89%	93%	**95%**
Peripheral intravenous cannula	82%	84%	**90%**
Ventilated patients	91%	98%	**98%**
Urinary catheter	90%	90%	**92%**

DRAFT

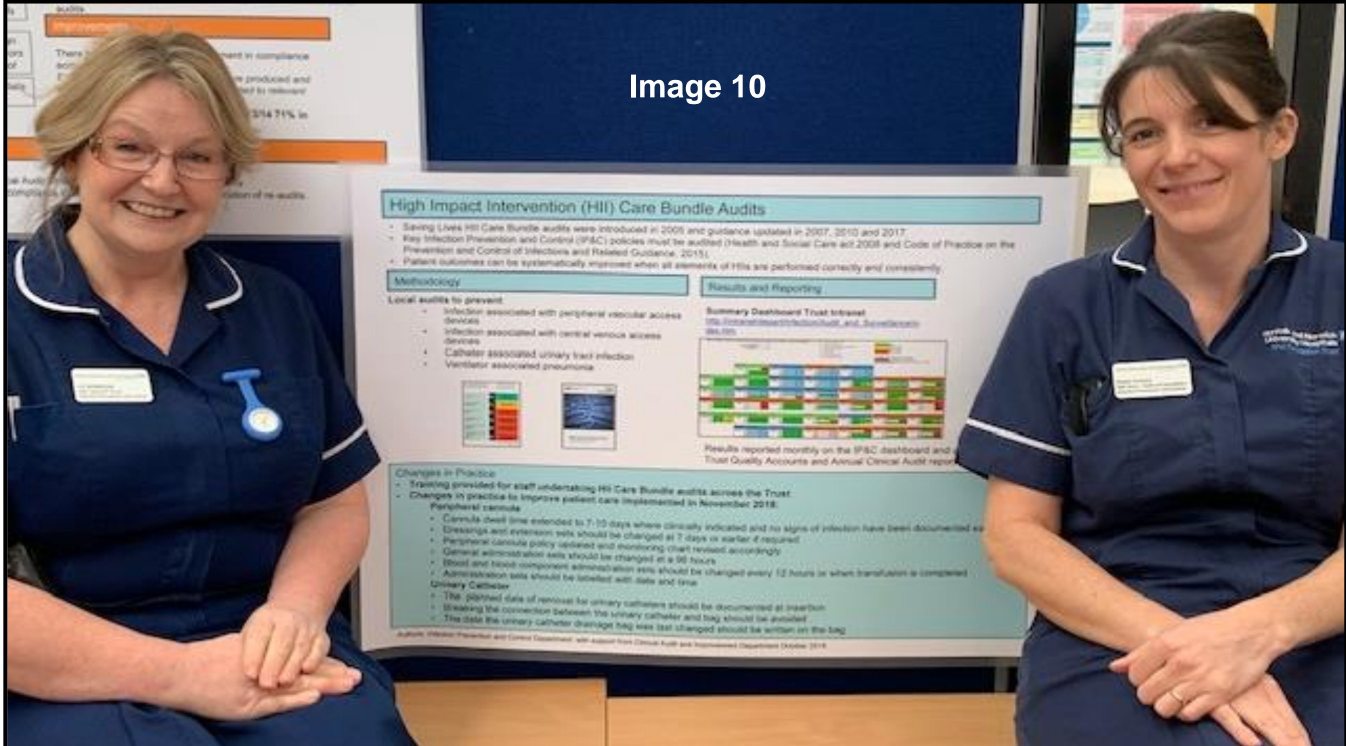


Image 10

Preventing Surgical Site Infection

The One Together assessment toolkit was utilised in 2018 to assess the vascular surgical pathway. This involved the IP&C team working collaboratively with the vascular theatre team in liaison with staff across the surgical patient pathway from pre-assessment to discharge.

The One Together initiative was developed as a quality improvement collaborative between the Association of Perioperative Practice (AfPP), the Infection Prevention Society (IPS), the College of Operating Department Practitioners (CODP) and the Royal College of Nursing (RCN) to support and promote best practice.

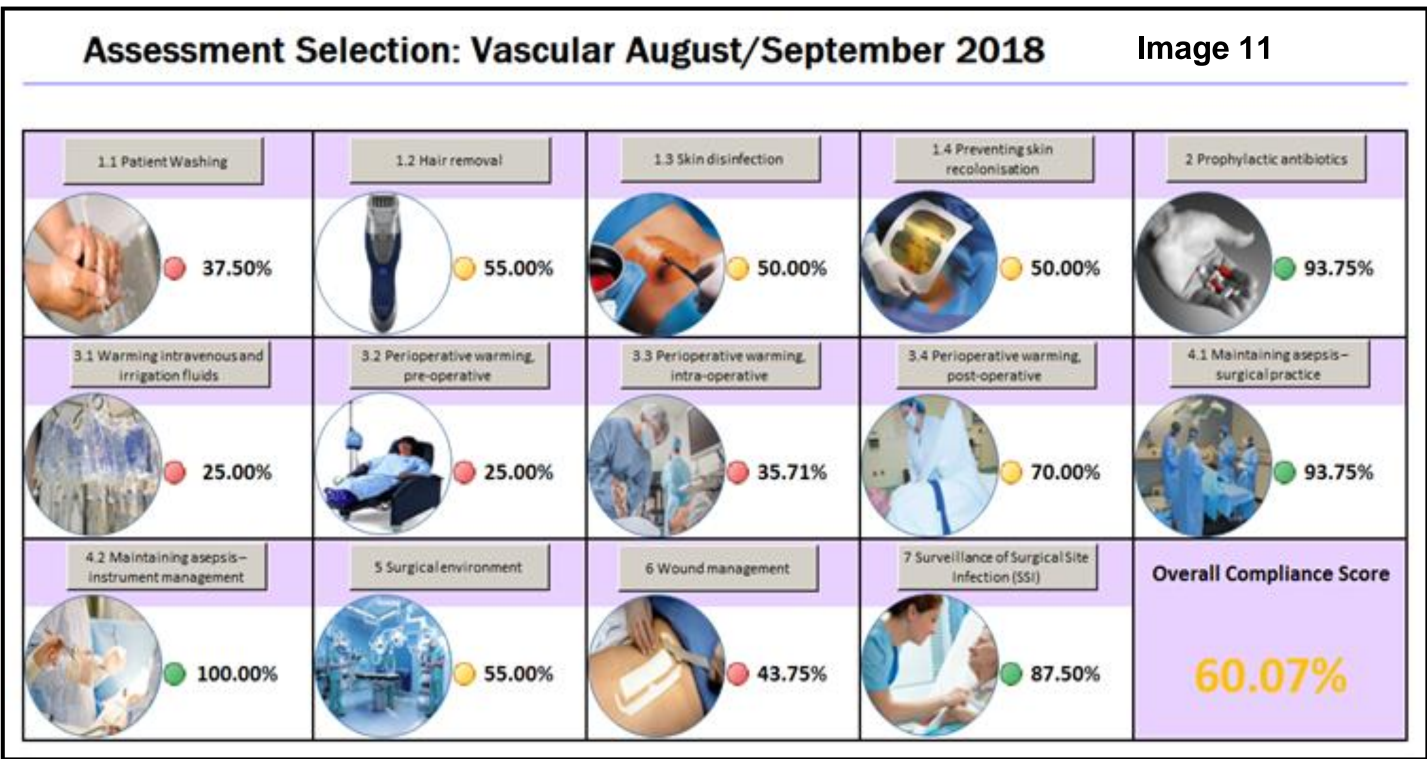


Image 12

Audit of Compliance with Isolation Guidelines and Single Room Use

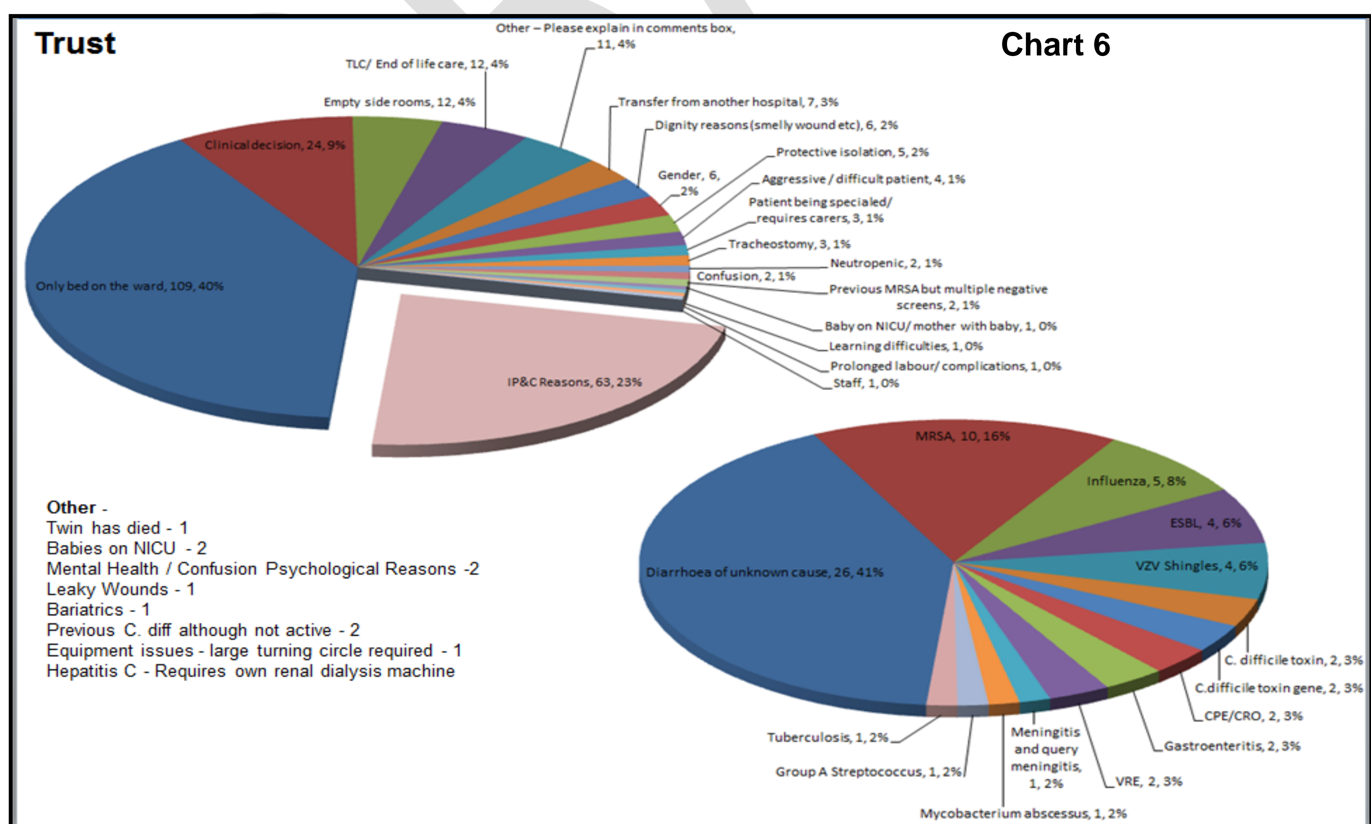
An annual audit of compliance with the Isolation guidelines was undertaken in October 2018 to provide assurance that practice aligns with the guidelines (Health and Social Care Act, 2008). It also provided information on how the single rooms in the Trust are utilised.

All patients with confirmed or suspected infection require isolation. The number of patients in a single room for IP&C reasons was 23% in comparison to 34% in 2017. 87% of patients requiring isolation for IP&C reasons were provided with a single room, however there are some patients who are risk assessed as unsafe to isolate for a variety of reasons and in these situations the risks are mitigated with alternative measures. The electronic ward view system highlights those requiring isolation for IP&C reasons facilitating correct placement of these patients.

Overall compliance with the audit was 77%, with the main issue being single rooms without dedicated observation equipment. The results were shared Trust wide along with an action plan to facilitate improvement, see table 26 & chart 6.

Table 25

NNUH - Isolation and Single Room Use Audits	
Financial Year	**Overall Compliance %**
2018-19	**77%**
2017-18	79%
2016-17	77%



Central Venous Catheter (CVC) Surveillance

A continuous surveillance programme monitors the CVC infection rates in adults. The overall infection rate remains below the Matching Michigan reference point of 1.4 per 1000 line days. Quarterly results are shared with Trust staff at practice development training sessions and in the IP&C monthly report, see table 26 & 27.

Table 26

NNUH CVC related infections			
CVC infections are measured by rate per 1000 line days	2016-17	2017-18	**2018-19**
Renal	0.85	0	**0.68**
Haematology	1.7	2.4	**1.57**
Other areas	1.09	1.1	**1.05**
Overall	0.31	0.46	**0.68**

Table 27

NNUH PICC related infections	
PICC infections are measured by rate per 1000 line days	2018-19
Haematology	0
Other areas	0.129
Overall	0.098

Orthopaedic Surgical Site Surveillance (*information contributed by Orthopaedic Senior Surgical Assistant)*

Hip, Knee and Fracture Neck of Femur

The Trauma and Orthopaedic department undertakes continuous Surgical Site Surveillance for Hip and Knee replacements and Fractured Neck of Femur procedures.

Mandatory Public Health England data is submitted for one quarter each year. July – September 2018: Knee data obtained an Alert Notification (High Rate), which has been fully discussed through department's governance process. This was raised with PHE due to current surveillance process not reflecting our current patient cohort: high risk surgery and high risk patients.

The validated rates of infection (identified prior to discharge and on readmission) for Orthopaedic categories were: see table 28.

Table 28

Orthopaedic Surgical Site Surveillance			
Calendar Year	**Hip - PHE 0.6%**	**Knee - PHE %** Changed from 0.4% to 0.6%	**# Neck of Femur - PHE % 1.1**
2018 SSI %	**0.36%**	**68/PHE 0.4%**	**0.71%**
2017 SSI %	0.63%	0.39 / 0.4%	0.57%
2016 SSI %	0.32%	1.1 / 0.6%	0.12%

Spinal Surgery: Voluntary submission (*Information contributed by Orthopaedic Surgical Care Practitioners)*

Continuous surveillance undertaken, but only October – December (Q4 18) submitted to PHE. 2018 High infection rate is currently under review by spinal consultant led teams. See table 29.

Table 29

Spinal Surgery Site Surveillance: Voluntary submission		
Calendar Year	**Spinal SSI %**	**PHE SSI %**
2018	**1.70%**	**1.4%**
2017	0.58%	1.4%

Other Surgical Site Surveillance

Vascular surgery surveillance

There has been continuous systematic SSI surveillance in vascular surgery since 2009. During 2018 the SSI rates have been between 2.3% and 8.5%. 80% of SSI were superficial and 20% deep. Only 20% were identified during the initial hospital stay, with 80% identified post initial discharge. With shorter hospital stays SSI is likely to occur following discharge (Limon et al, 2014). Therefore undertaking post discharge surveillance facilitates a truer evaluation of SSI.

Alongside measuring the SSI rates an assessment of the vascular surgical pathway utilising the One Together assessment tool was undertaken in 2018. Collaborative working with the multidisciplinary team was undertaken during the assessment and evaluation of the results. See table 30.

Table 30

Post vascular surgery surgical site infection rates				
Year	**April-June SSI %**	**June-July SSI %**	**Oct-Dec SSI %**	**Jan-March SSI %**
2018-19	**8.5%**	**2.3%**	**4.2%**	**7.2%**
2017-18	7.7%	10.8%	6%	3.2%
2016-17	3.4%	2.4%	0%	3.7%

Caesarean section surgery

There has been continuous systematic SSI surveillance following C section since 2010. Collaborative working between the obstetric department and IP&C has reduced SSI rates from 19.1% to 1.1%. An on-going cycle of feedback and review at clinical governance meetings and IP&C training sessions for midwives continues to sustain improvement. See table 31.

Table 31

Post caesarean section surgical site infection rates				
Year	**April-June SSI %**	**June-July SSI %**	**Oct-Dec SSI %**	**Jan-March SSI %**
2018-19	**2.4%**	**3.8%**	**1.1%**	**4.2%**
2017-18	5.5%	2.4%	1.7%	5.2%
2016-17	3.4%	4.8%	3.8%	1.7%

DRAFT

Audit Programme

Hand Hygiene and Dress Code Audits

The IP&C team oversee a rolling programme of Hand Hygiene and Dress Code audits across the Trust. The audit assesses compliance with the Hand Hygiene policy and observes the opportunity for the World Health Organization (WHO) 5 moments of hand hygiene in clinical areas throughout the Trust. If scores are below 95% guidance is provided on actions required to improve. Audit scores are displayed on the IP&C electronic dashboard by ward/department, division and overall Trust.

All IP&C mandatory training includes Hand Hygiene advice and a screen saver is consistently visible in ward areas reminding staff of the importance of the 5 moments. Staff are encouraged to strive for 100% compliance and act as role models, challenging and educating others in best practice. See table 32.

Table 32

Number of hand hygiene and related dress code audits and average percentage pass in NNUH			
Financial Year	Number of Audits	Percentage Pass	
		Hand Hygiene	Dress code
2018-19	**840**	**97%**	**99%**
2017-18	737	97%	99%
*2016-17	569	97%	99%
***Frequency of re-auditing for scores >95% changed in 2016-17 from monthly to 2 monthly. Scores <95% lead to a re-audit within 1 week.**			

Global Hand Hygiene Day

For Global Hand hygiene awareness day in May 2018 we hosted a stand in the west atrium to talk to staff, patients and the public about hand care, glove use and the availability of patient hand wipes to promote good hand hygiene for patients unable to get to a hand wash basin. See image 14.

Image 14

Beverage Bay and Dirty Utility Audits

Beverage bay and dirty utility audits were undertaken across the Trust in November and December 2018. Audit results were shared and areas were then able to address any areas of non-compliance.

Since undertaking these audits the audit elements have been incorporated within an IP&C electronic audit. See table 33 and image 15.

Table 33

NNUH beverage bay and dirty utility compliance audits 2018	
Beverage bay audit score	Dirty utility audit score
85.6%	84.5%

Image 15

Dirty Utility Poster Guide

Norfolk and Norwich University Hospitals NHS Foundation Trust

TRUST DOCS ID:13253

TRUST DOCS ID:13252

From IP&C dept

TRUST DOCS ID:10711

TRUST DOCS ID:10527

These must all be displayed in the dirty utility area.

Doc ref: 609

TRUST DOCS ID:12150

TRUST DOCS ID:10190

TRUST DOCS ID:12077

Doc ref: 609

Hygiene Code Compliance Criteria 6:
Systems to ensure that all care workers (including contractors and volunteers) are aware of the discharged of and discharge their responsibilities in the process of preventing and controlling infection.

All staff including volunteers joining the Trust are required to attend an IP&C induction session and thereafter mandatory IP&C training. Compliance with IP&C training is monitored by the training department.

In addition there are other opportunities for raising staff awareness such as link staff meetings, ad hoc education and teaching and planned study and awareness raising days.

Image 16

There is in place the Trust official visitors and contractors procedure document and along with all policies and guidelines, is available to staff via the intranet. IP&C specific documents are on the intranet, IP&C department page or as a shortcut on the desktop screen of each PC monitor and can be accessed by clicking on the NNUH IP&C symbol.

Hygiene Code Compliance Criteria 7:
Provide or secure adequate isolation facilities.

We undertake an annual isolation room audit to assess why patients are in single rooms, how many patients who require isolation facilities are not in single rooms and how those in isolation are managed.

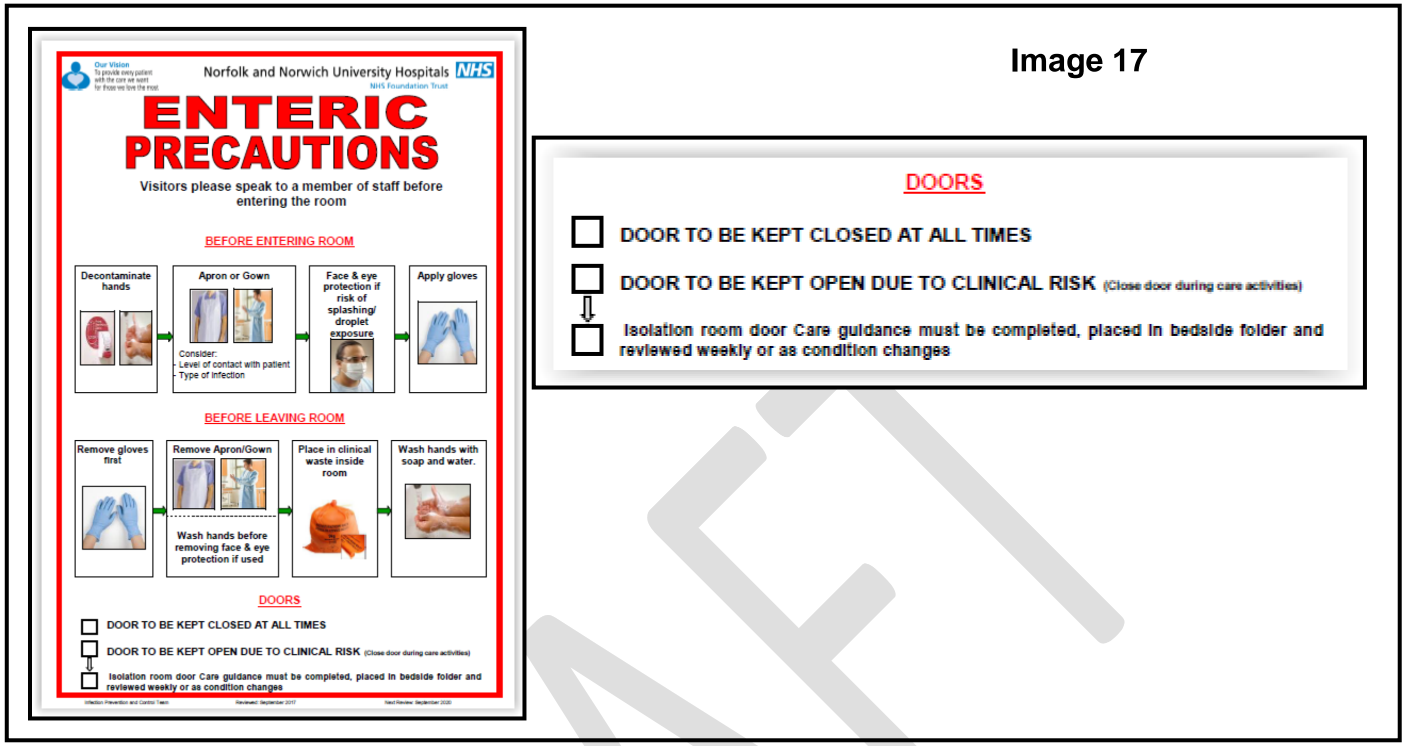
The majority of single room accommodation on each ward is en-suite and can be used for isolation of infectious and suspected infectious patients. In addition the respiratory ward has two single en-suite rooms that have negative pressure ventilation for severe respiratory disease e.g. multi-drug resistant Tuberculosis.

During refurbishment, redesign and movement of wards some single room accommodation has been repurposed leading to a reduction in isolation facilities at NNUH.

An electronic system called Wardview is in operation for ward staff and the operations centre staff to track patient placement and identify why patients are in a single room. This system allows easily accessible reports to determine how many single rooms are in use for isolation reasons, clinical reasons, end of life care and no reason recorded (see below example). This system allows rapid assessment of the allocation of isolation facilities and fewer referrals to IP&C out of hours for advice with risk assessment of isolation.

DRAFT

Changes were also made to the isolation posters in response to CQC feedback to improve communication for when an isolation room door needs to be left open due to a clinical risk. There are now specific risk assessment templates that clinical staff can utilise to record the risk. See image 17.



Hygiene Code Compliance Criteria 8:
Secure adequate access to laboratory support as appropriate.

Laboratory, *information contributed by Chief Bio-medical Scientist*

The laboratory services for NNUH are provided by the Eastern Pathology Alliance (EPA). EPA is a county-wide pathology network service providing Clinical Biochemistry, Immunology, Toxicology, Haematology, Blood Transfusion, Andrology and Microbiology services to primary and secondary care providers across Norfolk and Waveney. The network operates a hub and spoke model with blood science laboratories at the 3 acute hospitals in Norfolk.

Microbiology is centralised at the Norwich Research Park Innovation Centre (NRPIC) close to the main NNUH site and provides services to all three acute Trusts in Norfolk including NNUH and to all GPs within Norfolk and Waveney. It is divided into Bacteriology, TB, Mycology, Virology, Serology and Molecular Sections.

Microbiology provides a 7 day service as follows

Laboratory Operational Hours	
Monday – Friday	**08:00 – 21:00**
Saturday	**08:00 – 16:00**
Sunday / Bank Holidays	**09:00 – 17:00**

Out of operational hours is covered by an on-call agreement for both technicians and Microbiology Consultants.

DRAFT

Hygiene Code Compliance Criteria 9:
Have and adhere to policies, designed for the individual's care and provider organisations that help to prevent and control infections.

IP&C Policies

NNUH has a robust process for keeping guidelines and policies up to date. The IP&C team share new and reviewed documents via the weekly communications bulletins. They widely consult when developing a new document and it is signed off by the HICC.

All IP&C and associated policies and guidelines are easily accessible to staff via a number of electronic routes. See Image 18

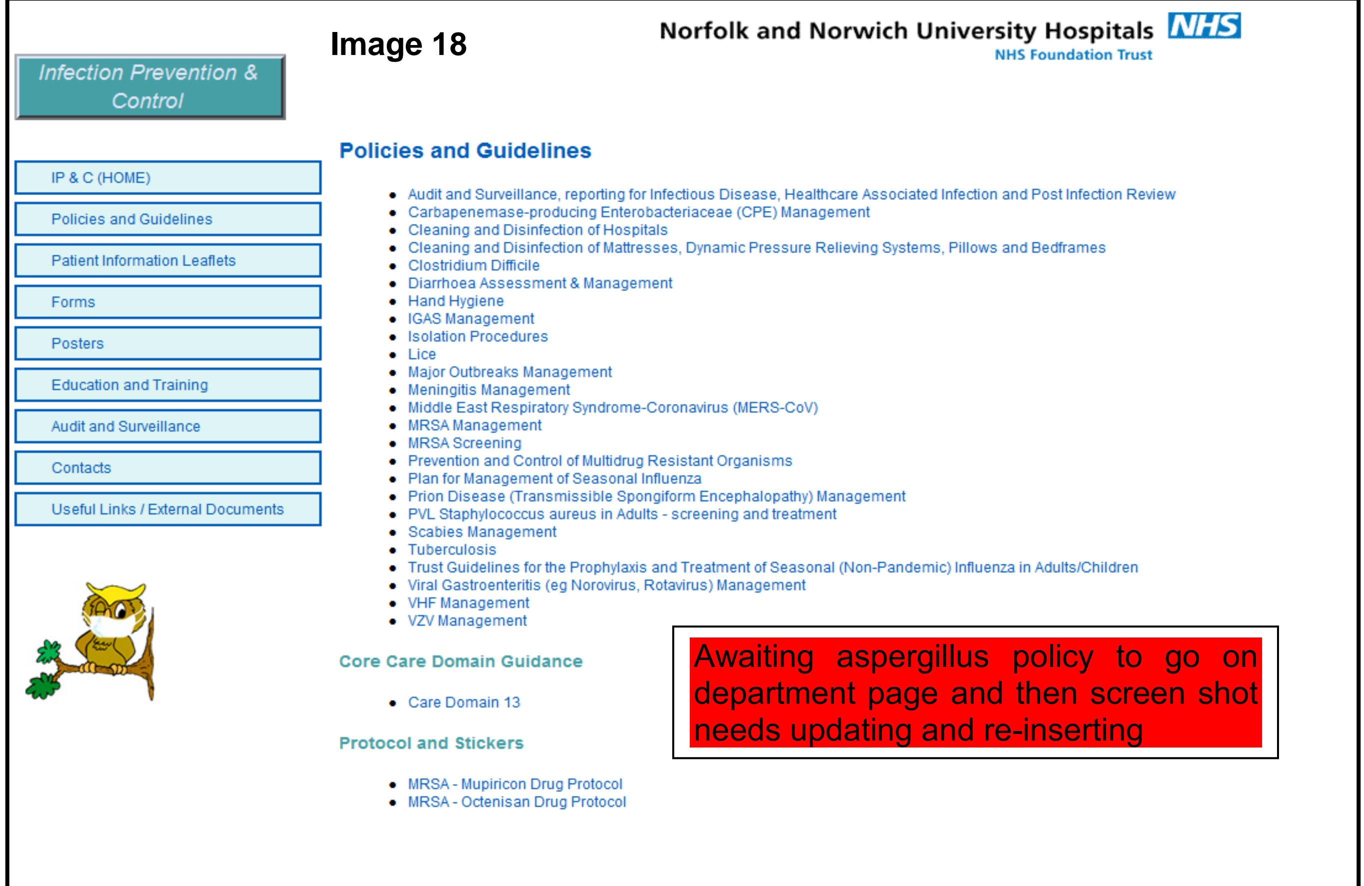


Image 18

Hygiene Code Compliance Criteria 10:
Providers have a system in place to manage the occupational health needs of staff in relation to infection.

Workplace Health and Well-Being (*information contributed by head of WHWB)*

All staff have access via self-referral route to gain appropriate occupational health advice. Monday - Friday 08.30am - 17.00 OH advice is available via our OH Duty nurse. Out of hours infection related OH advice is available via the 24/7 website on our intranet.

Full suite of WHWB in house procedures available in relation to prevention and management of communicable infections. Trust guidelines are also present. Easy accessible advice for staff is found via the 24_7 pages.

Policies created by the infection control team are reviewed by WHWB.

Immunisations for staff are available and provided in line with Green Book
All staff who have patient contact (clinical & non clinical) are required to have an immunisation review. This commences with their pre-placement health questionnaire. If immunisations for their specific role are not complete then they are required to attend WHWB for an immunisation assessment. At the time of the assessment the relevant immunisations are offered whilst advising the worker the importance of complying with Public Health England guidance. The WHWB team keep up to date with new guidance and review both Trust guidelines and WHWB procedures accordingly. If any new guidance requires to review the immunisation status of existing staff then this is undertaken.

In line with PHE guidance all staff can access a test for Hep B / C or HIV if requested. Those staff who are Exposure Prone procedure workers will have the appropriate tests prior to undertaking this activity. Any staff member found to be positive, will have a consultation with the Consultant Occupational Health Physician who will advise on fitness for work and further monitoring and refer to Hepatologist or Sexual health services if required for further monitoring and treatment.

All staff are required to contact WHWB in the event of an accidental occupational exposure to blood and body fluids. A risk assessment is undertaken by our duty nurse and appropriate follow screening and treatment is undertaken.

Staff members who require emergency treatment following an accidental occupational exposure to blood / body fluids will be seen by the Consultant occupational health physician. If the incident occurs out of hours then this is undertaken by the A&E department and then advised to contact WHWB for further support and follow up the next working day.

The annual flu vaccination programme is co-ordinated by WHWB each year. This vaccination is offered to all staff and in 2018-19 a total of 83% of Trust staff received the vaccine.

DRAFT

Infection Prevention and Control Annual Report 2018-2019

References and further reading

Clostridium difficile infection objectives for NHS organisations in 2018/19, guidance on sanction implementation and notification of changes to case attribution definitions from 2019, NHSI, May 2018, available at:

http://allcatsrgrey.org.uk/wp/download/infection_control/CDI_objectives_18_19.pdf

Guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infections from March 2018, NHS England, March 2018, available at:
https://improvement.nhs.uk/documents/2512/MRSA_post_infection_review_2018_changes.pdf

Guidance for the laboratory investigation, management and infection prevention and control for cases of *Candida auris,* PHE, August 2017 v2.0 available at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/637685/Updated_Candida_auris_Guidance_v2.pdf

Infection Prevention and Control Commissioning Toolkit Guidance and information for nursing and commissioning staff in England, RCN and IPS, January 2016, available at:
https://www.rcn.org.uk/professional-development/publications/pub-005375

Limon, E., Shaw, E., Bardia, J.M., Piriz, M., Escofet, R., Guidol,F & Pujol,M (2014) Post-discharge surgical site infections after uncomplicated elective colorectal surgery: impact and risk factors. The experience of the VINCat Program. *Journal of Hospital Infection* 86 127-132.

One Together Infection Assessment Toolkit, AfPP, IPS, CODP, RCN, 3M available at:
https://www.ips.uk.net/professional-practice/onetogether-infection-control-assessment-toolkit/

Preventing healthcare associated Gram-negative bloodstream infections: an improvement resource, PHE, May 2017 available at:

https://improvement.nhs.uk/documents/984/Gram-negative_IPCresource_pack.pdf

RCN (2012) The role of the link nurse in infection prevention and control (IPC): developing a link nurse framework.

https://www.rcn.org.uk/professional-development/publications/pub-004310

Saving Lives: reducing infection, delivering clean and safe care, DH, June 2007, available at:
http://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078134

The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance, DH, July 2015 available at:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/449049/Code_of_practice_280715_acc.pdf

Infection Prevention & Control

Annual Programme

April 2019 – March 2020

Written & Compiled by:

Infection Prevention & Control Team

May 2019

Infection Prevention and Control Annual Report 2018-2019

Drivers	Actions	Evidence or Anticipated Outcome	Lead	By when/ Frequency	RAG Comments
DH - The Health and Social Care Act 2008 Code of Practice on the prevention and control of infections and related guidance, July 2015	Review and update NNUH compliance with the Code of Practice on the prevention and control of infections and related guidance, July 2015	• To monitor at HICC quarterly • Board minutes • HICC minutes	IP&C team/DND's and Governance leads	By July	Meeting with DNDs for divisional updates being organised
Contract with CCG	Required to send the board approved IP&C plan and annual report to CCG IP&C team. Electronic version of both documents to be sent to CCG once ratified by board	• Board minutes • HICC minutes • Acknowledgement of receipt from CCG	DIPC		
Contract with CCG	IP&C monthly report - to include: Antibiotic policy audit compliance results or similar antibiotic review process HII Audit programme compliance results and Hand Hygiene/Dress Code audit results.dashboard	• Email evidence of sending report to CCG	DIPC		
Contract with CCG	The provider will be required to send any copies of all external IP&C focus visits/inspections that are not publically available to CCG IP&C team.	• Email evidence of sending to CCG • HICC minutes	DIPC	Within 5 working days from receipt of final report	
Code of Practice – Criterion 1 1.5 Activities to demonstrate that infection prevention and cleanliness are an integral part of quality assurance	Report Key IP&C performance indicators to the board via the Integrated Performance Report [IPR]. IS prepares report with input from IP&C	• Board minutes	Exec for IP&C/DIPC	Monthly	

Infection Prevention and Control Annual Report 2018-2019

C. difficile specific Drivers	Actions	Evidence or Anticipated Outcome	Lead	By when/ Frequency	RAG Comments
NHS England and NHS Improvement ***C. difficile* objective** New attribution of cases according to new guidelines (HOHA and COHA attributable to the Trust).	*C. difficile* cases attributed to NNUH to be below objective of 35. Continue work proven to result in low rates of *C. difficile* infection (CDI) as described in *C. difficile* policy and annual report.	**No more than 7 HAI C. diff cases per quarter** **Q1 = Q2 = Q3 = Q4 =** • Published by PHE [government national statistics] • HICC minutes • Monthly IPR board minutes • Monthly IP&C report • IP&C dashboard for Trust staff • Learning disseminated by OWL •	IP&C Team	Throughout	
Contract with CCG Complete a Root Cause Analysis/PIR for all cases of *Clostridium difficile* which occur post 72 hours of admission to the Trust	Joint PIR undertaken monthly with CCG and NNUH staff for each CDI diagnosed by toxin EIA identified on or after day 3 of admission or toxin positive cases who have been an inpatient within the last 4 weeks. CCG to agree those that are non-trajectory [no lapses in care] with a view to exclusion from contractual penalty.	**C. diff trajectory cases per quarter** **Q1 = Q2 = Q3 = Q4 =** • HICC minutes • Monthly IPR board minutes • Monthly IP&C report • Email to CCG showing summary of PIR meeting showing outcome	Admin co-ordinator	Monthly	
	Lessons learnt and any action plans will be monitored by relevant divisional governance groups with updates on progress to HICC quarterly by division	• HICC minutes • Div Governance minutes	Matrons and divisional governance leads	Quarterly	

MRSA specific Drivers	Actions	Evidence or Anticipated Outcome	Lead	By when/ Frequency	RAG Comments
NHS England and NHS Improvement MRSA objective	No avoidable MRSA bacteraemias Maintain a 'zero tolerance' approach to hospital attributable MRSA bacteraemia Continue work proven to result in low rates of MRSA bacteraemias described in MRSA guidelines and annual report.	**NNUH attributable MRSA bacteraemia cases per quarter** **Q1 = Q2 = Q3 = Q4 =** • Published by PHE [government national statistics] • Quarterly HICC meeting minutes • Monthly IPR board minutes • Monthly IP&C report • IP&C dashboard for Trust staff • Div Governance minutes	IP&C Team If a case occurs actions and any learning shared by Divisional Triumvirates	Throughout	
Contract with CCG Assist in the supply of information for MRSA bacteraemia Post-infection Review (PIR) process where the patient has had healthcare contact with the Provider	CCG informed of an MRSA bacteraemia within 3 working days from result Full PIR undertaken for any cases identified on or after day 3 of admission. Assist in completing PIR with CCG for cases identified on pre day 3 of admission or had recent hospital contact.	• Email of draft copy of completed PIR form sent to CCG • MRSA bacteraemia meeting minutes.	DIPC/Lead IP&C Nurse IP&C nurses	Within 3 working days from a positive result	
Contract with CCG Implement the agreed Post Infection Review (PIR) action plan	Lessons learnt and any action plans will be monitored by relevant divisional governance groups with updates on progress to HICC quarterly by division	• Quarterly HICC meeting minutes • Monthly IPR board minutes • Monthly IP&C report • IP&C dashboard for Trust staff • Div Governance minutes	Matrons and divisional governance leads	As a case occurs	

MSSA specific Drivers	Actions	Evidence or Anticipated Outcome	Lead	By when/ Frequency	RAG Comments
NHS England and NHS Improvement	Continue to minimise the number of cases of MSSA bacteraemia identified on or after day 3 of admission. Similar, or lower, rate of MSSA bacteraemias as 2016-17 reported as **18** by PHE in Government national statistics	**MSSA HAI bacteraemia cases per quarter** **Q1 = Q2 = Q3 = Q4 =** • Published by PHE [government national statistics] • Quarterly HICC meeting minutes • Monthly IPR to board • Monthly IP&C report • IP&C dashboard for Trust staff		Throughout	
	PIR currently undertaken by IP&C team for any MSSA bacteraemia cases identified on or after day 3 of admission. Determine whether there were any associated lapses in care.	• Quarterly HICC meeting minutes • IP&C dashboard for Trust staff • Div Governance minutes	IP&C Team		

DRAFT

Other alert organism Drivers	Actions	Evidence or Anticipated Outcome	Lead	By when/ Frequency	RAG Comments
PHE reporting • E. coli bacteraemias • Klebsiella spp. bacteraemias • Pseudomonas aeruginosa bacteraemia's	Reduce the number of cases of gram negative bacteraemia cases identified on or after day 3 of admission Any significant themes will be identified and improvement measures will be planned with clinical teams. Lessons learnt and any action plans will be monitored by relevant divisional governance groups with updates on progress to HICC quarterly by division Plan to reduce catheter usage and reduce UTI's along with correct antimicrobial prescribing and improved guidance for urine sampling	**E. coli bacteraemia [all cases]** **Q1 = Q2 = Q3 = Q4 =** **Klebsiella spp. Bacteraemia [all cases]** **Q1 = Q2 = Q3 = Q4 =** **Pseudomonas aeruginosa bacteraemia [all cases]** **Q1 = Q2 = Q3 = Q4 =** • Rates published by PHE [government national statistics] • HICC meeting minutes • Monthly IPR to board • Monthly IP&C report • IP&C dashboard		Monthly	

DRAFT

Surveillance Drivers	Surveillance/Actions	Evidence/Feedback	Lead	By when/ Frequency	RAG Comments
Code of Practice – Criterion 9 m. Reporting of infection to Public Health England or local authority and mandatory reporting of healthcare associated infection to Public Health England **NHS England and NHS Improvement -** E.coli Objectives **PHE** of Klebsiella and Pseudomonas bacteraemia's	Enhanced surveillance and continuous data collection and data entry via Public Health England (PHE) HCAI data capture system (DCS) - of *C. difficile,* MRSA, MSSA, E.coli,	• CEO signs off data monthly • Rates published by PHE [government national statistics]	IP&CT & Micro	Monthly Throughout	
	Enhanced surveillance and continuous data collection and data entry via Public Health England (PHE) HCAI data capture system (DCS) - of Klebsiella sp. and Pseudomonas aeruginosa bacteraemia	• CEO signs off data monthly • Rates published by PHE [government national statistics]	IP&CT & Micro	Monthly Throughout	
	Continuous mandatory surveillance by lab: VRE	• CEO signs off data monthly • Rates published by PHE [government national statistics]	Micro	Monthly Throughout	
	Surveillance of confirmed CPE cases sent to PHE	• Review the Safety thermometer data for the Trust: number of catheters and catheter associated urinary tract infections (CAUTI). • Update the Trust guideline for the use and care of urethral and suprapubic catheters to reflect current guidance. This will include guidance on when it is appropriate to dipstick urine and why. • Update the Urinary catheter monitoring chart to reflect the guidelines . • Provide guidance on collecting urine samples and provide a patient information leaflet on Urinary Tract Infection (UTI). • Work with the group promoting hydration and utilise resources that show the colour of urine as a guide to dehydration.	IP&C & Micro	As and when a case occurs Throughout	

Surveillance Drivers	Actions	Evidence/Feedback	Lead	By when/ Frequency	RAG Comments
Code of Practice Criterion 1 Systems to manage and monitor the prevention and control of infection.	Vascular surgical site infection voluntary surveillance scheme using PHE protocol	• HICC meeting minutes • Div Governance minutes	IP&C	Ongoing	
	C section surgical site infection voluntary surveillance scheme	• HICC meeting minutes • Div Governance minutes	IP&C	Ongoing	
Mandatory to report 1 quarter a year	Continuous surveillance of hip and knee replacement and spinal surgical site infection through participation in the PHE national mandatory surveillance scheme	• Rates published by PHE • HICC meeting minutes • Div Governance minutes	Ortho SSIS lead	Ongoing	
	Advice and support surgical division with the commencement of colorectal surgical site surveillance	• HICC meeting minutes • Div Governance minutes	Surgery		
	Continuous surveillance of Central line related blood stream and exit site infections in adults outside the Critical Care Complex	• HICC meeting minutes • Div Governance minutes	IP&C	Ongoing	
MRSA Bacteraemia reduction	Renal MRSA –	• HICC meeting minutes • Div Governance minutes	IP&C	Twice a year	

DRAFT

Infection Prevention and Control Annual Report 2018-2019

Audit Drivers	Ref.	Audit/Actions	Evidence/Feedback	Lead audit & actions	By when/ Frequency	RAG comments
Contract with CCG 90% of eligible cases are screened for MRSA according to provider's guideline		Elective and emergency admission screening compliance audits - MRSA guidelines Electronic audit provided by IS, Trust require compliance to be >95%	• HICC minutes • Monthly IPR board minutes • Monthly IP&C report • Nursing Dashboard • Div Governance minutes	Electronic audit Actions undertaken by Matrons	Monthly report emailed out from Information services	
Code of Practice – Criterion 1 1.5 Activities to demonstrate that infection prevention quality assurance should include: an audit programme to ensure that policies have been implemented		Inpatient isolation audit - Isolation guidelines Undertaken across the whole Trust on a single day	• HICC minutes • Email to divisional Triumvirates, matrons and ward managers • Div Governance minutes	IP&C undertake audits Actions signed off by divisional Triumvirates or Governance leads	Annually	
		Hand Hygiene audit - Hand Hygiene policy	• Monthly IPR board minutes • IP&C dashboard for Trust staff • Nursing Dashboard • HICC meeting minutes • Div Governance minutes • Div Governance minutes		Ward areas audited 2 monthly Outpatient areas audited 3 monthly. Re-audit in a week if < 97%	
		Commode & bed pans audit - C.*difficile,* Assessment and Management of diarrhoea and cleaning guidelines	• Monthly IPR board minutes • IP&C dashboard for Trust staff • Nursing Dashboard • Div Governance minutes		Monthly	
Code of Practice – Criterion 1 CQC report recommendations		Cohort audits where patients with the same infectious organism are nursed in a multiple bed room When cohorting is being undertaken	• Div Governance minutes	Matrons undertake audits Actions signed off by divisional	As required	
		Side room used for isolation to have doors shut or completed risk assessment	• Annual isolation audit report and divisional feed back • Immediate feedback to Individual wards at time of audit where they are not compliant		As required	

Audit Drivers	Ref.	Audit/Actions	Evidence/Feedback	Lead audit & actions	By when/ Frequency	RAG Comments
Code of Practice Criterion 1 Systems to manage and monitor the prevention and control of infection.		Credit for cleaning [C4C] audits Trust staff undertake audits in conjunction with SerCo and Trust Facilities	• HICC minutes • Monthly IPR board minutes • Nursing Dashboard • Div Governance minutes	Matrons	Monthly	
Matrons Charter		Perfect ward IP&C Audits	• HICC minutes • Monthly IPR board minutes • Nursing Dashboard • Div Governance minutes		As per the SOP or more frequently if required	
DH Saving Lives Delivering clean safe care		High Impact Intervention care bundle audits, CVC. Peripheral cannula, urinary catheter, renal catheter and prevention of ventilator associated pneumonia	• IP&C dashboard for Trust staff • Nursing Dashboard • Div Governance minutes	Matrons	Monthly	
One Together Assessment Toolkit – AfPP, ips, CODP, RCN & 3M		One Together assessment of the surgical pathway – orthopaedic	• Feedback to theatre and surgical teams • Discuss actions at clinical governance	IP&C/theatres do audits Actions by theatres and surgical teams	Assessment	
		One Together assessment of the surgical pathway vascular	• Feedback to theatre and surgical teams • Discuss actions at clinical governance		Assessment commenced	

REPORT TO THE TRUST BOARD

Date	**26 July 2019**
Title	**Quality Programme Board update following meeting on 11.06.19**
Author **Exec lead**	**Jane Robey, Head of Improvement** **Nancy Fontaine, Chief Nurse**
Purpose	**For Information**

1 Background/Context

The Quality Programme Board met on 11 June 2019.

The following documents are attached:

a) Agenda
b) Evidence Group Outcome Reports
c) Change control reports for U15.1, U18.1 and the IP&CR recommendations.
d) Risk register

2 Key Issues/Risks/Actions

Items of note considered at the meeting included:

<table>
<tr><th></th><th>Issues considered</th><th>Outcomes/decisions/actions</th></tr>
<tr><td>1</td><td>Highlight reports</td><td>
<table>
<tr><th></th><th>Number of recommendations</th><th>Red</th><th>Amber</th><th>Green</th><th>Blue</th><th>Black</th></tr>
<tr><td>June</td><td>157</td><td>11%</td><td>6%</td><td>47%</td><td>10%</td><td>25%</td></tr>
<tr><td>May</td><td>82</td><td>23%</td><td>13%</td><td>11%</td><td>45%</td><td>7%</td></tr>
<tr><td>April</td><td>81</td><td>22%</td><td>12%</td><td>15%</td><td>49%</td><td>1%</td></tr>
<tr><td>March</td><td>76</td><td>24%</td><td>12%</td><td>9%</td><td>55%</td><td></td></tr>
<tr><td>February</td><td>75</td><td>16%</td><td>21%</td><td>19%</td><td>44%</td><td></td></tr>
<tr><td>January</td><td>67</td><td>12%</td><td>16%</td><td>33%</td><td>39%</td><td></td></tr>
<tr><td>December</td><td>65</td><td>15%</td><td>19%</td><td>37%</td><td>29%</td><td></td></tr>
<tr><td>November</td><td>65</td><td>9%</td><td>32%</td><td>45%</td><td>14%</td><td></td></tr>
<tr><td>October</td><td>65</td><td>6%</td><td>46%</td><td>40%</td><td>8%</td><td></td></tr>
<tr><td>September</td><td>64</td><td>40%</td><td>33%</td><td>27%</td><td>0%</td><td></td></tr>
</table>
The 77 new recommendations arising from the May 2019 CQC report were discussed for the first time. To keep the number of recommendations to a manageable figure, any June 2018 recommendations that were directly superseded by a May 2019 recommendation have now been closed and archived. A paper was tabled showing the mapping of old to new recommendations; the archiving of 24 of the June 2018 recommendations was approved by the group. Any outstanding actions from the archived recommendations have been captured under the new recommendations.
</td></tr>
<tr><td>2.</td><td>Change control</td><td>

U15.1 ED Mental Health risk assessments – the deadline was extended from 31st January to 30th September 2019
U18.1 ED Governance and assurance - the deadline was extended from 31st March to 1st October 2019, with interim performance updates scheduled from now until the revised deadline date to assess progress against the trajectory.
IP&CR recommendations – the deadline was extended from 31st May to 30th June.

</td></tr>
<tr><td>3.</td><td>Outcome of the Evidence Group</td><td>
The Evidence Group met:

on 23rd May for a deep dive review into the evidence in relation to Urgent and Emergency Care in respect of the Section 29A notices as well as the CQC recommendations. The outcome of the meeting is

</td></tr>
</table>

		listed in the bullet points below. ○ New recommendations – 2 x Green, 3 x Amber, 3 x Red. ○ Blue recommendations – 1 x Black, 2 x Blue, 1 x Red. ○ Recommendations for consideration to become Blue – 2 x Blue, 1 x Green ○ Red recommendations – 4 x Red ○ Amber and Green recommendations – 2 x Green. • on 6th June to review the evidence in respect of three recommendations, in addition to ten recommendations brought back for review. Of the thirteen recommendations: ○ Two were archived as BLACK ○ Four were confirmed as remaining BLUE ○ Four were confirmed as remaining RED ○ One was confirmed as remaining AMBER ○ One was upgraded from AMBER to GREEN ○ One was downgraded from BLUE to RED The Evidence Group is scheduled to meet again at 8.30am on 27th June 2019, at which meeting the Committee is due to conduct a 'deep dive' review into the NHSi IP&C recommendations.
4.	Risk register	No new risks were added to the Risk Register; the register was not reviewed during the meeting.

3 Conclusions/Outcome/Next steps

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

- Highlight reports from Trust-wide and functional areas for June.
- Recommendations assured as 'Complete and Evidenced' by the 27th June and 4th July Evidence Groups

Recommendation:

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

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

QUALITY PROGRAMME BOARD AGENDA

Tuesday 11th June 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.	Feedback from 28th May ED QAA	RRS	Discussion	Slide presentation
5.	Outcome of Evidence Groups held on 23rd May and 6th June	RRS	Discussion	Documents
6.	Change control – U15.1 U18.1 IP&CR	RRS	Discussion	Documents
7.	Archiving and mapping of old to new recommendations	RRS	Discussion	Document
.8.	PowerBI presentation, focusing on: - New May 2019 - New 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	PowerBI presentation
9.	AOB			

Date and Time of next meeting: Tuesday 9th July 2019, 09:00 hours, Boardroom

REPORT TO THE QUALITY PROGRAMME BOARD	
Date	**23rd May 2019**
Title	**Outcome of Evidence Group**
Author & Lead	**Jess Woodhouse** **Rosemary Raeburn Smith**
Purpose	**For Information**

1 Background/Context

The Evidence Group met on 23rd May for a deep dive review into the evidence in relation to Urgent and Emergency Care in respect of the Section 29A notices as well as the CQC recommendations.

The group reviewed the evidence for suitability, relevance, and completeness, using an appreciative enquiry approach, assessing the quality of the evidence supplied by the SRO and action leads and the current level of assurance for each recommendation.

2 Outcome

The outcome of the meeting is listed in the bullet points below. The group provided guidance as to the additional evidence required to improve against the recommendations and offered suggestions how this could be achieved. These recommendations will be brought back to future meetings, when the supplementary evidence will be reviewed.

- New recommendations – 2 x Green, 3 x Amber, 3 x Red.
- Blue recommendations – 1 x Black, 2 x Blue, 1 x Red.
- Recommendations for consideration to become Blue – 2 x Blue, 1 x Green
- Red recommendations – 4 x Red
- Amber and Green recommendations – 2 x Green.

3 Conclusions/Outcome/Next steps

The Evidence Group is scheduled to meet again at 8.30am on 6th June 2019, at which meeting the Committee is due to review a number of recommendations that are either being brought back for review or submitted for consideration to become Blue.

Recommendation:

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

1. Apologies and declarations of interest

NHSi; Karen Kemp; Debbie Whittaker; Alice Richardson.

No declarations of interest were made.

2. Persons in attendance

The following people attended the meeting:

- Nancy Fontaine (NF), Chief Nurse NNUH (Chair)
- Erika Denton (ED), Medical Director, NNUH
- Rosemary Moore (RM), Patient Panel Lead
- Rosemary Raeburn-Smith (RRS), Programme Director for Quality
- Stacy Hartshorn (SH), Improvement Manager, NNUH
- Jess Woodhouse (JW), Improvement Manager, NNUH
- Gemma Lynch (GLy), Governance Compliance Manager, NNUH
- Andrea Dyke (AD), Mental Health Deputy Matron, NNUH
- Joel Fiddy (JF),), Governance and Risk Management (Theatres), NNUH
- Gemma Lawrence (GLa), Mental Health Matron
- Claire Nash (CN), MH Improvement Manager, NNUH
- Lisa Read (LR), Quality and Patient Safety, N&SN CCG
- April McKay (AM), ED ACP
- Simon McKay (SM), ED Consultant
- Rachael Cocker (RC), Divisional Nurse Director, Winter Room
- Bethany White (BW), Clinical Educator, NNUH
- Alan Bell (AB), Clinical Educator, NNUH
- Annie Large (AL), Matron, Radiology
- Rees Millbourne (RM), Head of Medical Director's Office
- Frank Sutherland (FS), A&E Consultant
- Caroline Kavanagh (CK), associate Medical Director, Winter Room
- Cursty Pepper (CP), Winter Operations Director
- Andree Glaysher (AG), Clinical Governance Manager – Medicine
- Sarah Higson (SH), Lead for Patient Engagement & Experience
- Lauren Walker (LW), Children's Emergency Department Matron
- Ed Aldus (EA), Operations Manager, ED
- Sara Shorten (SS), MCA Matron
- Katie Smith (KS), Improvement Support Officer
- Julia Buck (JB), HR Business Partner
- Emma Chapman (ED), Matron, Children's Services
- Tarek Kherbeck (TK), Chief of Service, ED

Observers

- Francois Dubois, Deputy Finance Director, Poitiers University Hospital, France
- Subhash Balhara, Consultant, Intensive Care, Denmark
- Florien Leesum, Departmetn Manager, The Netherlands

3. Section 29a recommendations – November 2017

SH recapped the recommendations from the Section 29A notice received in November 2017.

4. Section 29a recommendations – March 2019

SH recapped the recommendations from the Section 29A notice received in March 2019.

5. Black recommendations – Closed and not for discussion

These were included for information only and not discussed.

6. New Recommendations

Ref.	Recommendation	Outcome of Review
U26.1	The trust must ensure all staff complete mandatory training and complete the appropriate level of safeguarding adults and children training. Status: New Recommendation: awaiting confirmation of delivery timescales	Status: Amber Improved induction planned for new starters. 2 mentor days cancelled in April due to staff shortages. Overall timeline to achieve by 1st October. Policy to be amended to restrict study leave, professional leave and pay progression unless compliant. Back with improvements in 2 months.
U27.1	The trust must ensure it employs enough nursing staff with the right qualifications, skills, training and experience to keep patient's safe from avoidable harm and to provide the right care and treatment Replaces U4.1 The trust must review its nursing and medical staffing numbers for the urgent and emergency services and plan staffing acuity accordingly Status: New Recommendation: awaiting confirmation of delivery timescales	Status: Green. Adult nursing – recruitment drive has been underway, increased senior team and vacancy rate down to 0.9 WTE. Nursing structure being reviewed. Continuous recruitment of B5 team. Reviewing allocated template for shifts.
U28.1	The trust must ensure it employs enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Replaces U4.1 The trust must review its nursing and medical staffing numbers for the urgent and emergency services and plan staffing acuity accordingly Status: New Recommendation: awaiting confirmation of delivery timescales	Status: Red. Medical staffing – Senior Decision Maker is advised by college to be ST4 and above. ACPs to be developed, national trials to uplift to ST5/6 equivalent. Dept is short 6-10 Consultants. Agency Consultants being considered. 34 candidates have been shortlisted for Fellows posts.

U29.1	The trust must ensure that all managers appraise staff's work performance and held supervision meetings to monitor and improve staff performance. Status: New Recommendation: awaiting confirmation of delivery timescales	Status: Red.
U30.1	The trust must ensure that patients access services to receive the right care at the right time and that during times of high demand access to care was is managed by staff to consider patients with urgent needs. Replaces U9.1 Improve performance times in relation to national time of arrival to receiving treatment (which is no more than one hour), four-hour target and monthly median total time in ED. Status: New Recommendation: awaiting confirmation of delivery timescales	Status: Amber. Dept is aiming to meet local contract trajectories. A new set of national criteria will be coming. Improvements have been noted in ambulance handovers with average handover time down to 22 minutes.
U31.1	The trust must ensure all staff are clear on leadership within the department, identifying staff roles and responsibilities to coordinate and effectively manage patient care. Status: New Recommendation: awaiting confirmation of delivery timescales	Status: Amber. Three recommendations to be combined as they are closely related. Roles and responsibilities are being defined for ED and Site Ops. Fiona Read (culture consultancy form) has been in. Further initiatives will include use of BUILD framework, leading with pride, a worry box and graffiti board.
U32.1	Managers across the service must promote a positive culture that supports and values staff, and creates a sense of common purpose based on shared values. Status: New Recommendation: awaiting confirmation of delivery timescales	
U33.1	The trust must engage with its staff team proactively to implement change Status: New Recommendation: awaiting confirmation of delivery timescales	
U34.1	The trust should ensure it improves its performance for percentage of all TARN eligible patients having their data submitted to the audit. Status: New Recommendation: awaiting confirmation of delivery timescales	Status: Red. Dept now has a Trauma Lead (FS). A CQUIN had been proposed, however the Trust opted out.
U35.1	The trust must ensure it has a specific vison and plan for the emergency department to meet the needs of the patients. Replaces U21.1 The trust should ensure that the emergency department strategy is regularly reviewed. Status: New Recommendation: awaiting confirmation of delivery timescales	Status: Green. Strategy is being worked on with staff engagement via sessions & survey monkey, draft vision in place. Aiming for HMB in July. Need to ensure patient voice is included.

7. Blue Recommendations

Ref.	Recommendation	Outcome of Review
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 Status: Blue December 2018 No Outstanding actions	Status: Remains Blue. Skills, knowledge and and competence are good and additions to Perfect Ward are being made. SS is training clinical educators. However, practice is not yet embedded. Review in Sept.
U14.1	Ensure that sepsis training is available to all staff providing urgent and emergency care Status: Blue Outstanding action: Current compliance in January was 37%, February 63% against a 90% target. The Training sessions due to take place in April did not occur. The currently compliance is 68.5%	Status: Turns from Blue to Red. Planned training sessions have been cancelled. Training rebooked for June. Plan for training medical staff needed. Review in July.
TW 33.1	The Trust should review the support managers provide to support staff in times of increased demand. Status: Blue	Status: Remains Blue. Processes are not robust or embedded yet. Winter debrief planned.
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. Status: For consideration to turn black as covered in TW6.2	Status: Turn from Blue to Black. Policies and processes are in place.

8. Actions for consideration to become blue

Ref.	Recommendation	Outcome of Review
U7.1	The trust must ensure audio and visual separation between adults and children being assessed and waiting within the emergency department and minor injuries unit Status: Red Audit data needed	Status: Turn from Red to Blue. SOP is in place and process working at Norwich site. Query over whether this should apply at Cromer also. To continue auditing.
U23.1	The trust should ensure that information is gathered to monitor whether areas within the urgent and emergency service are being utilised as intended Status: Red	Status: Turn from Red to Blue. Data is on symphony and auditable, but not currently reviewed or discussed. Review end July.

U15.1	The trust must ensure there are effective governance processes in place to ensure timely and appropriate capacity and risk assessments for mental health patients are undertaken Status: Pending ED audit results and Clinical Governance Minutes New risk assessment in place. No weekly audit data has been received from the department yet. Results and actions arising are needed. This will be going to Clinical Governance. GL is making some minor changes to the form format following feedback.	Status: Remains Red. To be Green following change control if agreed. MHRA form has been reviewed, audited and amended. A new form was approved at MH Board with new audit to commence in June. Change control to ask for deadline extension to end Sept.

9. Red Recommendations

Ref.	Recommendation	Outcome of Review
U16.1	The trust must review and monitor the use of the Clinical Decisions Unit for patients who present with mental health requirements, to ensure that patients are protected from potential harm Status: Overdue awaiting audit details	Status: Remains Red. Audit process launched 1st May, monthly report. Anecdotally only 1 patient re-reviewed on entrance to CDU out of approx. 20.
U11.1	Ensure that there is a local audit programme in place for the service, that action plans are in place and necessary improvements are made to practice following audit. Status: Red Outstanding actions: 1 audit has been sent, more required	Status: Remains Red. To be Green following change control if agreed. Three recommendations to be combined as they are closely related. Dept has new CG lead. Audit and SIG learning to be reviewed and included in ED newsletter, FS confident, though admin support needed. Change control to request new deadline for 1st October and to review in Septs evidence group.
U18.1	The trust must ensure that effective governance and quality assurance processes are in place to measure service improvement. Including escalation of concerns and monitoring of actions arising from meetings, local audits, recommendations from regulators and external reviews. Status: Red Outstanding: Pending Clinical Governance sustained changes.	
U19.1	The trust must ensure that effective processes are in place, and monitored, to ensure clinical policies and guidelines are regularly reviewed and updated in line with national guidance. Status: Red Outstanding: Pending reviewed policies, 52 have been reviewed and completed leaving 51 plus 19 which have expired since the last evidence group.	

10. Amber and Green Recommendations

Ref.	Recommendation	Outcome of Review
U 2.1	The trust must ensure that there is a system in place, which is adequately resourced, to ensure that patients are assessed, treated and managed in a time frame to suit their individual needs. (The trust should review its use of the Rapid Assessment	Status: Remains Green. The RATs is variable, an MDT group has been established to review RATs

	and Treatment (RAT) system and ensure this is embedded into practice.) Status: RATs Trial underway to change working practices.	processes. A one day trial has happened, another trial is planned for early June.
U 5.1 U 6.1	Ensure that there is one registered children's nurse at all times within the children's emergency department and take necessary action to increase the number of registered children's nurses employed. Ensure a good skill mix within the children's ED nursing workforce. Status: Amber	Status: Remains Green. 9 out of 14 nurses are EPLS trained, ensuring one trained per shift. Roster needs amending to reflect. By end Dec should have 3 trained Paeds nurses 24/7.
U 17.1	The trust should continue to monitor and actively recruit to ensure that there is an adequate number of nursing and medical staff with the appropriate skill mix to care for patients in urgent and emergency services. Status: Amber	Not discussed.
U 25.1	The Trust must ensure staff respond appropriately to changing risks to patients who use their services. Status: Green	Not discussed.
TW 6.2	The trust must embed the recently formalised processes for review and assessment of escalation areas to reduce the risk to patient safety Status: Amber	Not discussed.

11. AOB

Thanks were offered to the Improvement and ED Teams for the hard work and improvements made.

12. Date and Time of Future Meetings

Thursday 6th June 08:30 - 10:00 Board Room

REPORT TO THE QUALITY PROGRAMME BOARD	
Date	**6th June 2019**
Title	**Outcome of Evidence Group**
Author & Lead	**Jane Robey** **Rosemary Raeburn Smith**
Purpose	**For Information**

1 Background/Context

The Evidence Group met on 6th June to review the evidence in respect of three recommendations, in addition to ten recommendations brought back for review. The Agenda 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 the quality of the evidence supplied by the SRO and action leads and the current level of assurance for each recommendation.

2 Outcome

Of the thirteen recommendations:

- Two were archived as BLACK
- Four were confirmed as remaining BLUE
- Four were confirmed as remaining RED
- One was confirmed as remaining AMBER
- One was upgraded from AMBER to GREEN
- One was downgraded from BLUE to RED

The group provided guidance as to the additional evidence required to turn the other recommendations BLUE, 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 Evidence Group is scheduled to meet again at 8.30am on 27th June 2019, at which meeting the Committee is due to conduct a 'deep dive' review into the NHSi IP&C recommendations.

Recommendation:

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

1. Apologies and declarations of interest

2. Persons in attendance

The following people attended the meeting:

- Nancy Fontaine (NF), Chief Nurse NNUH (Chair)
- Erika Denton (ED), Medical Director, NNUH
- Alison Leather (AL), Chief Quality Officer, NN/SN CCG
- Rosemary Raeburn-Smith (RRS), Programme Director for Quality
- Jane Robey (JR), Head of Improvement Team, NNUH
- Abbe Swain (AS), Improvement Manager, NNUH
- Jess Woodhouse (JW), Improvement Manager, NNUH
- Gemma Lynch (GLy), Governance Compliance Manager, NNUH
- Joel Fiddy (JF), Governance and Risk Management (Theatres), NNUH
- Karen Kemp (KK), Associate Director of Quality and Safety, NNUH
- Tracey Fleming (TF), Divisional Clinical Support Director, NNUH
- Rees Millbourne (RM), Medical Director's team, NNUH
- Oli Loveless (OL), Senior Improvement Officer, NNUH
- Clair Anderson (CA), Senior Improvement Officer, NNUH
- Rayhaan Rahaman (RR), Consultant Radiologist, NNUH
- Angela Large (AL),Critical Care Matron, NNUH
- Nick Pember (NP), Cardiology Senior Specialist Charge Nurse, NNUH
- Sarah Gooch (SG), HR Business Partner, NNUH
- Julia Kazimierczak (JK), Radiology Service Manager, NNUH
- Louise Reilly (LR), Practice Development & Governance Manager, NNUH
- Sarah Pask (SP), Head of Organisational Development & Learning, NNUH

2. Review of open actions

OPEN ACTIONS FROM EVIDENCE GROUP 02/05/2019		
Ref.	**Action**	**Owner**
TW 14.1	JW to find out why sessions are being cancelled and ensure this doesn't happen in future - Closed	JW
	JW to arrange a meeting with NF, DL, JW and Sarah Pask to identify a way to update ESR - Closed	JW
TW 25.1	JW to put on agenda for discussion at QPB in May Closed	JW
TW18.1	JW to roll out screensaver and liaise with Sarah Egleton to amend face to face health records training Closed	NF
S3.1	NF to raise cancellation of meetings with radiology with Tracey Fleming Closed	JF
S4.1	JF to send info to AE for discussion at Div Board Closed	NF
	NF to discuss with CODs Closed	NF
TW19.1	CN to discuss with senior matrons to identify staff groups that need to be trained in priority order Closed	CN
	CN to raise a change request to change deadline to 31st October and submit to May QPB - Closed	CN
AOB	Identify an early June date for a further deep dive into IP&C Closed	RRS

3. Actions for Review and potential sign Off

Outcome of evidence reviews

Ref.	Recommendation	Outcome of Review
Recommendations brought back for review		
TW 1.1	The trust must ensure that mandatory training attendance improves to ensure that all staff are aware of current practices. **Status prior to meeting prior to meeting: Red** **Outcome of previous evidence group:** First presentation at Evidence Group	Outcome: RED Review date: 3 months (September) **Action(s): NF** to raise the issue of mandatory training non-attendance at HMB in order to highlight the importance of this issue to the Divisions **RRS** to arrange a Deep Dive into this issue in September, at organisational and divisional level – Divisions to present their position.
DI5.1	The trust should ensure effective processes are in place for the timely completion of diagnostic reports. **Status prior to meeting: Amber** **Outcome of previous evidence group**: First presentation at Evidence Group – evidence was submitted by means of a presentation from the department. CQC Evidence (1).pptx	Outcome: GREEN Review date: 4 months (October) **Action(s): JW** to add further evidence to the evidence repository to show that processes are written down to ensure sustainability of the process.
DI7.1	The trust should ensure that diagnostic imaging services are provided on a seven-day basis, in line with national guidance. **Status prior to meeting: Amber** **Outcome of previous evidence group:** First presentation at Evidence Group	Outcome: AMBER Review date: 4 months (October) **Action(s): None specific**
DI2.1	The trust must ensure that specialist personal protective equipment, such as the integrity of lead aprons, is checked on a regular basis. **Status prior to meeting: Blue**	Outcome: BLUE Review date: 4 months (October) **Action(s): None specific**

	Outcome of previous evidence group: Last reviewed on 29th November and turned BLUE with the following actions: • **Action:** Ensure the area of the CQC report is included in the evidence overview • **Action:** Enquire into action plan to address training compliance gaps	
DI4.1	The trust must ensure that the environment, equipment storage, medicines management and infection control procedures are appropriate in the interventional radiology unit. (S) (NB – refers to CT/MRI anaesthetics area) **Status prior to meeting:** **Blue** **Outcome of previous evidence group:** Last reviewed on 29th November and turned BLUE with the following actions: • **Action:** Evidence of the 3 radiology support workers starting in January along with details of their extended HCA training to be added to the repository	Outcome: BLACK Review date: No further review required **Action(s): None specific**
DI6.1	The trust should ensure that diagnostic imaging equipment remains fit for use through the implementation of a capital replacement programme. **Status prior to meeting:** **Blue** **Outcome of previous evidence group:** Last reviewed on 7th February and turned BLUE with no further actions	Outcome: BLUE Review date: 4 months (October) **Action(s): None specific**
TW3.1	The Trust must ensure that staff annual appraisal completion improves **Status prior to meeting:** **Red** **Outcome of previous evidence group:** Last reviewed on 4th April and turned RED with the following actions: • **Action:** KJ (via Jeremy Over or Ashley Judd) to find out how much notice is given. • **Action:** KJ (via Jeremy Over or Ashley Judd) to provide breakdown by service and staff group. • **Action:** NF to take forward for monitoring via Divisional Performance Accountability Meetings • **Action:** KJ (via Jeremy Over or Ashley Judd) to complete outcome box on Evidence Form with Oli Loveless	Outcome: RED Review date: 3 months (September) **Action(s): RRS** to arrange a Deep Dive into this issue in September, at organisational and divisional level – Divisions to present their position.
TW18.1	The trust must ensure that computers are locked and that patient healthcare records are stored securely. **Status prior to meeting:** **Red**	Outcome: RED Review date: Once audit results are ready

	Outcome of previous evidence group: Last reviewed on 4th April and turned red with the following actions: • **Action:** JW to plan rapid improvement cycle with Vimmi, including adjusting IG elearning training and induction learning. • **Action :** NF to send out a safety alert • **Action :** RRS to raise a Datix re weight of notes audit QAA	**Action(s): None specific**
TW23.1	The trust must ensure that incidents are reported and investigated in a timely way by trained investigators **Status prior to meeting:** **Blue** **Outcome of previous evidence group:** Submitted to evidence group 7th March 2019 and turned BLUE. Reviewed as part of evidence group deep dive 28th March. Agreed next review at June's evidence group. • **Actions:** None outstanding.	Outcome: RED Review date: 3 months (September) **Action(s): RRS** to arrange a Deep Dive into this issue in September, at organisational and divisional level – Divisions to present their position
TW28.1	The trust should ensure that effective processes are in place for correct handling and disposal of clinical waste, including sharps bins, and that storage of chemicals is secure in line with the Control of Substances Hazardous to Health (COSSH) guidelines. **Status prior to meeting:** **Blue** **Outcome of previous evidence group:** Submitted to evidence group 29th November turned BLUE with the following actions: • **Actions:** JF to provide evidence on better waste management in theatres • **Action:** Sharp bin checks to be added to QAA	Outcome: BLACK Review date: No further review required **Action(s): None specific**
TW31.1	The trust should ensure that specialist personal protective equipment is checked on a regular basis and worn appropriately by staff. **Status prior to meeting:** **Red** **Outcome of previous evidence group:** Last reviewed on 27th December and turned RED with the following actions: • **Action**: FIT testing training needs to be prioritised in ED, Hethel, Mulbarton and Mattishall (now Gunthorpe). •	Outcome: RED Review date: **Action(s): JW** – to investigate data for Hethel Ward and clarify the ED Medical/Emergency Services Medical Staff categories
TW34.1	The trust should ensure that staff carrying out Root Cause Analysis (RCA) investigations for serious incidents receive appropriate RCA training.	Outcome: BLUE Review date: 3 months (September)

	Status prior to meeting: Blue **Outcome of previous evidence group:** Submitted to evidence group 27th December and turned BLUE. Reviewed as part of deep dive 28th March 2019. No further review required via Evidence Group. Part of business as usual. Submitted to evidence group to provide update on action and provide training update. • **Action:** Include detail regarding joint investigations within evidence.	**Action(s): None specific**
TW36.1	The trust should review its communication aids available to assist staff to communicate with patients living with a sensory loss, such as hearing loss. **Status prior to meeting:** Blue **Outcome of previous evidence group:** Submitted to evidence group 27th December and turned BLUE. Reviewed as part of deep dive 28th March 2019. Agreed next review at June's evidence group. • **Actions:** None outstanding.	Outcome: BLUE Review date: One month (July) **Action(s): AS** to add further evidence to the repository

New Actions

Ref.	Action	Owner
TW1.1 Mandatory training	**NF** to raise the issue of mandatory training non-attendance at HMB in order to highlight the importance of this issue to the Divisions	NF
	RRS to arrange a Deep Dive into this issue in September, at organisational and divisional level – Divisions to present their position.	RRS
DI5.1 Timely radiology reporting	**JW** to add further evidence to the evidence repository to show that processes are written down to ensure sustainability of the process.	JW
TW 3.1 - Appraisals	**RRS** to arrange a Deep Dive into this issue in September, at organisational and divisional level – Divisions to present their position.	RRS
TW23.1 – Incident reporting and investigation	**RRS** to arrange a Deep Dive into this issue in September, at organisational and divisional level – Divisions to present their position.	RRS
TW31.1 – PPE fit testing	JW to investigate data for Hethel Ward and clarify the ED Medical/Emergency Services Medical Staff categories	JW
TW36.1 – Communication aids	**AS** to add further evidence to the repository	AS

4. AOB

5. Date and Time of Future Meetings

Thursday 27th June 08:30 - 10:00 Room 24 near NICU

Quality Improvement Plan (QIP) Change Control Request

Date	11th June 2019
Title	Quality Improvement Plan (QIP) change control request
Author(s): **SRO:**	Stacy Hartshorn, Improvement Manager Dr Caroline Kavanagh, AMD for Winter
Purpose	To request approval from the Quality Programme Board to amend the outcome completion date for QIP action U15.1
Summary including	(see below)

CQC Recommendation:
The trust must ensure there are effective governance processes in place to ensure timely and appropriate capacity and risk assessments for mental health patients are undertaken

We will have achieved GOOD when:
The service has a robust process to monitor the quality of medical documentation, including a programme of weekly audits to evaluate compliance with use of:
- The deliberate self-harm proforma
- Mental capacity assessment, including second stage assessments
- Risk assessments for patients with MH concerns to ensure steps are taken to keep patients safe.
- The ED Adult Mental Health Triage Form with the results presented at clinical governance meetings and the mental health board, and disseminated monthly through the ED newsletter

Proposed revised outcome completion date: 30th September 2019

ID	Original Date submitted to CQC	Target Completion Date	Revised Target Completion Date
U15.1	31/01/2019	31/01/2019	31/01/2019

Action Required (✓)	FOR DISCUSSION AND APPROVAL

Our Values: People-focused Respect Integrity Dedication Excellence

REPORT TO THE QUALITY PROGRAMME BOARD	
Date	**27th June 2019**
Title	**Outcome of Evidence Group**
Author & Lead	**Jane Robey** **Rosemary Raeburn Smith**
Purpose	**For Information**

1 Background/Context

The Evidence Group met on 27th June for a deep dive review into the evidence in relation to Infection Prevention and Control recommendations.

The group reviewed the evidence for suitability, relevance, and completeness, using an appreciative enquiry approach, assessing the quality of the evidence supplied by the SRO and action leads and the current level of assurance for each recommendation.

2 Outcome

All six of the recommendations were rated as RED, as despite the evidence of significant improvement, further work is still required to sustain and embed the improvements. The group provided guidance as to the additional evidence required to improve against the recommendations 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 Evidence Group is scheduled to meet again at 8.30am on 4th July 2019, at which meeting the Committee is due to review a number of recommendations that are either being brought back for review or submitted for consideration to become Blue.

Recommendation:

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

1. Apologies and declarations of interest

- Lisa Read (LR), Quality and Patient Safety, N&SN CCG
- Alison Leather (AL), Chief Quality Officer, NN/SN CCG
- Kate Keeling (KK), Divisional Nurse Director, Medicine Division, NNUH
- Erika Denton (ED), Medical Director, NNUH

No declarations of interest were made.

2. Persons in attendance

The following people attended the meeting:

- Nancy Fontaine (NF), Chief Nurse NNUH (Chair)
- Alan Thorne (AT), Improvement Director, NHSi
- Velda Ismay (VI), SERCO
- Jason Kong (JK), SERCO
- Clair Anderson (CA), Senior Improvement Officer, NNUH
- Jane Robey (JR), Head of Improvement Team, NNUH
- Abbe Swain (AS), Improvement Manager, NNUH
- Rosemary Raeburn-Smith (RRS), Programme Director for Quality
- Jess Woodhouse (JW), Improvement Manager, NNUH
- Sarah Morter (SM), Senior Nurse, IP&C NNUH
- Lucy Weavers (LW), Divisional Nurse Director, Women & Child Division, NNUH
- Heather Watts (HW), Divisional Nurse Director, Surgery Division, NNUH
- Tracey Fleming (TF), Divisional Clinical Support Director, CSSD, NNUH
- Rachael Cocker (RC), Divisional Nurse Director, Winter Room
- Suzanne Nurse (SN), Matron NNUH
- Bethany White (BW), Clinical Educator, NNUH
- Gemma Lynch (GLy), Governance Compliance Manager, NNUH
- Oliver Mason (OM), ED staff nurse, NNUH
- Joel Fiddy (JF),), Governance and Risk Management (Theatres), NNUH
- Karen Kemp (KK) Associate Director of Quality and Safety, NNUH
- Caroline Kavanagh (CK), associate Medical Director, Winter Room
- Rebecca Goldsmith (RG), ED IP&C link lead, NNUH
- Andree Glaysher (AG), Clinical Governance Manager – Medicine
- Liz Morrison (LM), IP&C team, NNUH
- Barbara Jackson (BJ) , Midwifery Manager AN/PN Services, NNUH
- Lauren Walker (LW) , Senior Sister, ED, NNUH
- Frances Bolger (FB), Chief of Division, Women & Child Division, NNUH

Actions from meeting on 25th April:

Ref.	Action	Owner
IP&CR S1.1	Add meeting minutes and QAA evidence to the repository	CA

3. New Recommendations

Ref.	Recommendation	Outcome of Review
IP&CR TW1.1	The Trust must ensure patient safety through the provision of good Infection Prevention & Control (IP&C) and cleaning systems & standards. **Status prior to meeting**: Amber **Progress discussed during meeting**: • Significant improvements made since April in some areas. Perfect Ward was implemented in all IP areas on 1st May; OP areas are shortly to move to Perfect Ward. • Link nurses have been reinvigorated; attendance at meetings has improved; there is internal challenge at IP&C meetings. At ward and unit level there is much better engagement. Every area (without exception) now has an IP&C link person. • Ward level staff have begun to demonstrate their willingness to challenge the standard of cleaning and clinical cleaning if they have concerns; this is an encouraging and vital cultural shift. • In ED IP&C issues are overseen by a multi-disciplinary group – attendance includes a consultant, ACPs and nurses; engagement is improving amongst medical staff. There is a palpable air of challenge, e.g. around compliance with hand hygiene and bare-below-the-elbows standards. • In addition to the daily and weekly IP&C audits, there are at least two Quality Assurance Audits per week; IP&C performance has improved since the QAA programme was implemented. • Surveillance is through divisional performance meetings. There are twice weekly IP&C meetings. Work is in progress to improve reporting, as currently it is not easy to produce reports from Perfect Ward. • There is now heightened awareness of IP&C issues, standards and expectations. There is a feeling that the issues are now 'owned' at ward level. Behaviours have changed, and ownership is palpable. • Datixes are being raised for failed audits; there are still a few red areas, but over 50% of areas are now green. Themes are beginning to emerge, including: fridge temperatures, estates minor works issues, electronic equipment, sharps bins, limescale. The Audits have focused teams on looking at estates and furnishings in a different way. • Audit data is more reliable, as areas have become more familiar with the audit process and the standards required; standards have raised and expectations are now higher. • We now have a clearer understanding of the problems; we have sustainable IP&C processes and audit processes in place. • Headway has been made with SERCO, but there is still some way to go. There should now be traction on the remaining SERCO issues, followings high level discussions that have recently taken place. These high level discussions are	Outcome: RED Review date: To be set. **Action(s): None specific**

	ongoing. • A new piece of software has been implemented to track C4C performance.	
IP&CR M1.1	The Medical Division must ensure patient safety through the provision of good Infection Prevention & Control (IP&C) and cleaning systems & standards. **Status prior to meeting**: Green **Progress discussed during meeting**: • Rolled out Perfect Ward across all IP areas and also in Weybourn and Cardiology outpatients; there are a few pockets of inconsistent compliance with the daily checks – these are being addressed. • The weekly audits show that there is consistent compliance with completing audit; however, some areas have self-scored highly, and these high scores have not been corroborated by the audits carried out by the IP&C team. The discrepancy in standards and expectations is being addressed. • There is less clutter on the wards; ward staff are more proactive at highlighting minor works issues such as limescale build-up. • Issues remain with couches and trolleys. • In IP areas the issues are predominantly in respect of keyboards, broken bins, sharps bins, floor scrubs, limescale and items stored under U-bends • Some progress is evident in respect of the big estates issues – a date has been set for the renovation of the Kilverstone shower area and for the conversion of the big bathroom on Dunston; some minor works are underway on Earsham • Some of the C4C questions are being adapted into Perfect Ward to improve monitoring of C4C issues. • All medicine division sluices now have aprons and gloves in situ • Up to date cleaning schedules are now in place across Medicine – the next step is to get ward staff to challenge when the schedules aren't being followed, and how to manage non-compliance. • Lots more people have been trained in C4C. • Kimberley performance has significantly improved; one particular challenge is around commode management, as the ward has so many commodes • A new process of monitoring commode cleanliness is in place across the Division (wards are determining their own process). • There is good attendance from Medicine at the Joint Patient Services (JPS) meetings. • There was a good discussion at SIG from medicine wards re audit failures especially in respect of limescale; raising the issues has increased leverage on SERCO • With respect to hand hygiene and uniform compliance, the new dress code policy was approved by staff side; this means that compliance can be monitored against an agreed policy.	Outcome: RED Review date: To be set **Action(s): None specific**

IP&CR S1.1	The Surgical division must ensure patient safety through the provision of good Infection Prevention & Control (IP&C) and cleaning systems & standards. **Status prior to meeting**: Green **Action(s) from 25th April meeting:** Add meeting minutes and QAA evidence to the repository (CA). **Progress discussed during meeting**: • Daily checklists are in place in wards and theatres; Perfect Ward is used on the wards and some of the theatres, but further work is required to roll out Perfect Ward across the Outpatient areas • Every Monday the matrons check Perfect Ward compliance • All sluices now have gloves and aprons; there are some minor works outstanding (gel dispensers and apron holders) on DPU - these are being chased • C4C audits are now attended by a senior nurse; matrons have been trained in C4C audits, and will carry out some random audits • In respect of the uniform dress code, an audit process is in place in theatres; there has been improvement in compliance re nail varnish, false nails and false eyelashes, but pockets of poor jewellery standards. This is being addressed. • There is a discrete Critical Care action. A recent Perfect Ward audit of CCC showed some areas of poor compliance. The CCC waiting room has carpet, which is now on the schedule for cleaning. • Chairs require replacement across the Division – this is a work in progress and is a historical issue so can't be resolved overnight. • Cleaning of escalation areas is a concern – DPU and surgical AEC now being cleaned during the day when there are escalation patients in situ – it can be a challenge to shift the night time cleaning at short notice.	Outcome: RED Review date: To be set **Action(s): None specific**
IP&CR WR1.1	The Winter Room Division must ensure patient safety through the provision of good Infection Prevention & Control (IP&C) and cleaning systems & standards. **Status prior to meeting**: Amber **Progress discussed during meeting**: • Discharge suite uses Perfect Ward very well and has good compliance • Raising IP&C awareness across the Division has been a challenge and there has been significant improvement in this respect. • A task and finish group focused on IP&C; this has now transitioned to an ongoing project to ensure ongoing surveillance • Perfect Ward has been challenging re the insufficiency of iPads – this is being addressed.	Outcome: RED Review date: To be set **Action(s): None specific**

	• Perfect Ward results are discussed at the weekly meeting; the aim is to embed this into the ED governance meeting. There is improvement, but some way to go. • Cleaning schedules have been improved; heavy cleaning has been switched from night to day to facilitate better surveillance and monitoring; this has led to better challenge from the ward staff • Some further work is required with SERCO to ensure consistent performance • Overnight floor scrubbing is now monitored by the ED floor coordinator; check and challenge is now becoming evident. • A temporary Octagon service variation has been actioned to provide a handyman. Issues requiring correction are raised at a joint SERCO/Trust/Octagon walkaround on the 3rd Friday of the month, and these issues are then actioned on the 4th Friday of every month by the handyman. • There has been an improvement in attendance in C4C training; there is a sustainable level of C4C training in place, monitored through eRoster. • Mandatory IP&C training compliance has improved • The Majors cubicles are now fit for purpose from a PPE perspective • Uniforms have been ordered for ACPs and consultants; in time there will also be a uniform for junior doctors. • Posters will be placed around the department to encourage patients to challenge hand hygiene/use of PPE/uniform policy etc.	
IP&CR WC1.1	The Women & Children's Division must ensure patient safety through the provision of good Infection Prevention & Control (IP&C) and cleaning systems & standards. **Status prior to meeting**: Amber **Progress discussed during meeting**: • Started with paper matron rounds, and struggled with the consistency. Now there is a consistent process in place. • Consistency of the standards of the audit has improved – standards and expectations are clearer. • Many staff are now trained to carry out C4C audits • Children's wards are challenging from a space perspective • The Buxton bathroom will be renovated in July • There were issues on NICU; to mitigate the risk of pseudomonas screens are now in place to prevent water splashback • Hand hygiene audits are consistently at 100% on both wards • The washing machine in the Buxton sluice will be removed before the next external inspection. • The fish tank on Buxton ward will also be removed and replaced with a virtual fish tank before the next external inspection. • Embedding the audits has been a challenge on Cley ward as both sides of the ward carry out audits; this is being addressed • Fridge temperatures are one of the biggest challenges – the plan is to gradually replace domestic fridges with industrial fridges	Outcome: RED Review date: To be set **Action(s): None specific**

	• Furniture is also a challenge – some chairs aren't fit for purpose. Replacements have been ordered.	
IP&CR CSS1.1	The Division of Clinical Support Services must ensure patient safety through the provision of good Infection Prevention & Control (IP&C) and cleaning systems & standards. **Status prior to meeting**: Green **Progress discussed during meeting**: • Work has been ongoing with staff to instil the importance of IP&C for ALL staff, so that there is universal ownership of the issues. • Audits are still 50% paper based – ipads have been ordered so hopefully all areas will be on Perfect Ward by the end of July • An escalation process has been put in place to ensure that the triumvirate is alerted of any areas of poor compliance, enable swift remedial action • More staff have been trained in C4C; the aim is to have a staff representative on all C4C audits	Outcome: RED Review date: To be set **Action(s): None specific**

Outcome summary:
Progress in Trustwide and Divisional action plans acknowledged by the group; consensus that further evidence of performance and sustainability is required for completion of all action plans.

New Actions

Ref.	Action	Owner
IP&CR X1.1		
IP&CR X1.1		
IP&CR X1.1		

4. AOB

5. Date and Time of Future Meetings

Thursday 4th July 08:30 - 10:00 Room 22 near Guist Ward

Quality Improvement Plan (QIP) Change Control Request

Date	11th June 2019
Title	Quality Improvement Plan (QIP) change control request
Author(s): **SRO:**	Stacy Hartshorn, Improvement Manager Dr Caroline Kavanagh, AMD for Winter
Purpose	To request approval from the Quality Programme Board to amend the outcome completion date for QIP action U18.1
Summary including	**CQC Recommendations:** U18.1 The trust must ensure that effective governance and quality assurance processes are in place to measure service improvement. Including escalation of concerns and monitoring of actions arising from meetings, local audits, recommendations from regulators and external reviews. U11.1 The trust must ensure that there is a local audit programme in place for the service, that action plans are in place and necessary improvements are made to practice following audit. U19.1 The trust must ensure that effective processes are in place, and monitored, to ensure clinical policies and guidelines are regularly reviewed and updated in line with national guidance **We will have achieved GOOD when:** A documentation audit programme and associated action plan is in place, with the audit results presented at clinical governance meetings and disseminated through the ED newsletter. The audit to cover: • cannula insertion and documentation • IP&C e.g. commode and bed pan cleaning, cleaning log audits • deliberate self-harm risk assessment completion • use of PPE • MH documentation (including MH triage form and safeguarding referrals) ED Clinical Governance meetings take place monthly, with multi-disciplinary attendance, and are fully and comprehensively minuted to evidence that all agenda items are discussed and that audit outcomes and action plans are reviewed. All audit plans are complete including the dates. That audit samples are appropriate and not too low and that all audits have associated action plans. All audits with action plans should have a date of repeat audit planned.

Our Values: People-focused Respect Integrity Dedication Excellence

	• The Deliberate Self Harm and Shared Decision Making Policies have been reviewed, and updated versions are available to all staff on Trust Docs and ED notice boards • Compliance with the ED SOP for ambulant patients is monitored at monthly clinical governance meeting, as evidenced by Agendas and meeting minutes • Compliance with the ED Protocol for the Management of Patients with a Mental Health Need within the ED Interview Room is monitored at monthly clinical governance meeting, as evidenced by Agendas and meeting minutes • An up to date risk assessments is in place for all areas used for the assessment and treatment of patients with MH concerns • The Consent working group has completed all the actions on its Action Plan, and the plan has been signed off at a Clinical Governance meeting. **Proposed revised outcome completion date: 1st October 2019**
Action Required (✓)	FOR DISCUSSION AND APPROVAL

ID	Original Date submitted to CQC	Target Completion Date	Revised Target Completion Date
U11.1	1/9/2018	31/3/2019	1/10/2019
U18.1	31/3/2019	31/3/2019	1/10/2019
U19.1	31/3/2019	31/3/2019	1/10/2019

REPORT TO THE TRUST BOARD

Date	**26 July 2019**
Title	**Quality Programme Board update following 9th July 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 9th July 2019.

The following documents are attached:

a) Agenda
b) Critical Care presentation
c) Evidence Group Outcome Reports

2 Key Issues/Risks/Actions

Items of note considered at the meeting included:

<table>
<tr><th></th><th>Issues considered</th><th>Outcomes/decisions/actions</th></tr>
<tr><td>1</td><td>Highlight reports</td><td>
<table>
<tr><th></th><th>Number of recommendations</th><th>Red</th><th>Amber</th><th>Green</th><th>Blue</th><th>Black</th></tr>
<tr><td>July</td><td>157</td><td>15%</td><td>10%</td><td>39%</td><td>10%</td><td>26%</td></tr>
<tr><td>June</td><td>157</td><td>11%</td><td>6%</td><td>47%</td><td>10%</td><td>25%</td></tr>
<tr><td>May</td><td>82</td><td>23%</td><td>13%</td><td>11%</td><td>45%</td><td>7%</td></tr>
<tr><td>April</td><td>81</td><td>22%</td><td>12%</td><td>15%</td><td>49%</td><td>1%</td></tr>
<tr><td>March</td><td>76</td><td>24%</td><td>12%</td><td>9%</td><td>55%</td><td></td></tr>
<tr><td>February</td><td>75</td><td>16%</td><td>21%</td><td>19%</td><td>44%</td><td></td></tr>
<tr><td>January</td><td>67</td><td>12%</td><td>16%</td><td>33%</td><td>39%</td><td></td></tr>
<tr><td>December</td><td>65</td><td>15%</td><td>19%</td><td>37%</td><td>29%</td><td></td></tr>
<tr><td>November</td><td>65</td><td>9%</td><td>32%</td><td>45%</td><td>14%</td><td></td></tr>
<tr><td>October</td><td>65</td><td>6%</td><td>46%</td><td>40%</td><td>8%</td><td></td></tr>
<tr><td>September</td><td>64</td><td>40%</td><td>33%</td><td>27%</td><td>0%</td><td></td></tr>
</table>
</td></tr>
<tr><td>2.</td><td>Change control</td><td>
• No change control papers were submitted in July
</td></tr>
<tr><td>3.</td><td>Outcome of the Evidence Group</td><td>
The Evidence Group met:
• on 27th June for a deep dive review into the evidence in relation to the NHSi IP&C recommendations. All six of the recommendations were rated as RED, as despite the evidence of significant improvement, further work is still required to sustain and embed the improvements.
• on 4th July to review the evidence in respect of ten recommendations, in addition to three recommendations brought back for review. Of the thirteen recommendations:
○ 1 was archived as BLACK
○ 1 was confirmed as remaining BLUE
○ 1 was confirmed as remaining RED
○ 1 was confirmed as remaining AMBER
○ 5 were confirmed as remaining GREEN
○ 2 were downgraded from GREEN to AMBER
○ 1 was downgraded from AMBER to RED
○ 1 was downgraded from GREEN to RED
The Evidence Group is scheduled to meet again at 8.30am on 1st August
</td></tr>
</table>

		2019, at which meeting the Committee is due to conduct a ‘deep dive’ review into the Section 29a ED recommendations.
4.	Risk register	No new risks were added to the Risk Register; the register was not reviewed during the meeting.

3 Conclusions/Outcome/Next steps

The Quality Programme Board is scheduled to meet again at 9am on Tuesday 13th August 2019, at which meeting the Committee will review:

- Highlight reports from Trust-wide and functional areas for July.
- Recommendations assured as ‘Complete and Evidenced’ by the 1st August and 8th August Evidence Groups

Recommendation:

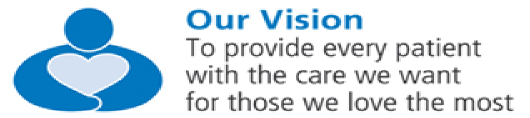
The Board is recommended to note the work of its Quality Programme Board.

QUALITY PROGRAMME BOARD AGENDA

Tuesday 09th July 2019 Boardroom 0900-12:00 Hours

	Item	Lead	Purpose	Format
1.	Apologies and declarations of interest	CEO		Verbal
2.	Presentation from the Critical Care Team	CCC triumvirate	Discussion	Presentation
3.	Review of actions, minutes and matters arising	Exec Directors and CODs	To note and discuss	Document
4..	OAG Deep Dives	CEO	Discussion	Verbal
5..	Outcome of Evidence Groups held on 27th June and 4th July	NF	Discussion	Documents
6.	Revision to ToR for QPB and Evidence Group	JR	Discussion	Documents
7..	PowerBI presentation, focusing on: - New May 2019 - New 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	PowerBI presentation
8.	AOB			

Date and Time of next meeting: Tuesday 13th August 2019, 09:00 hours, Boardroom

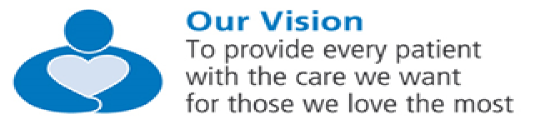


Critical Care

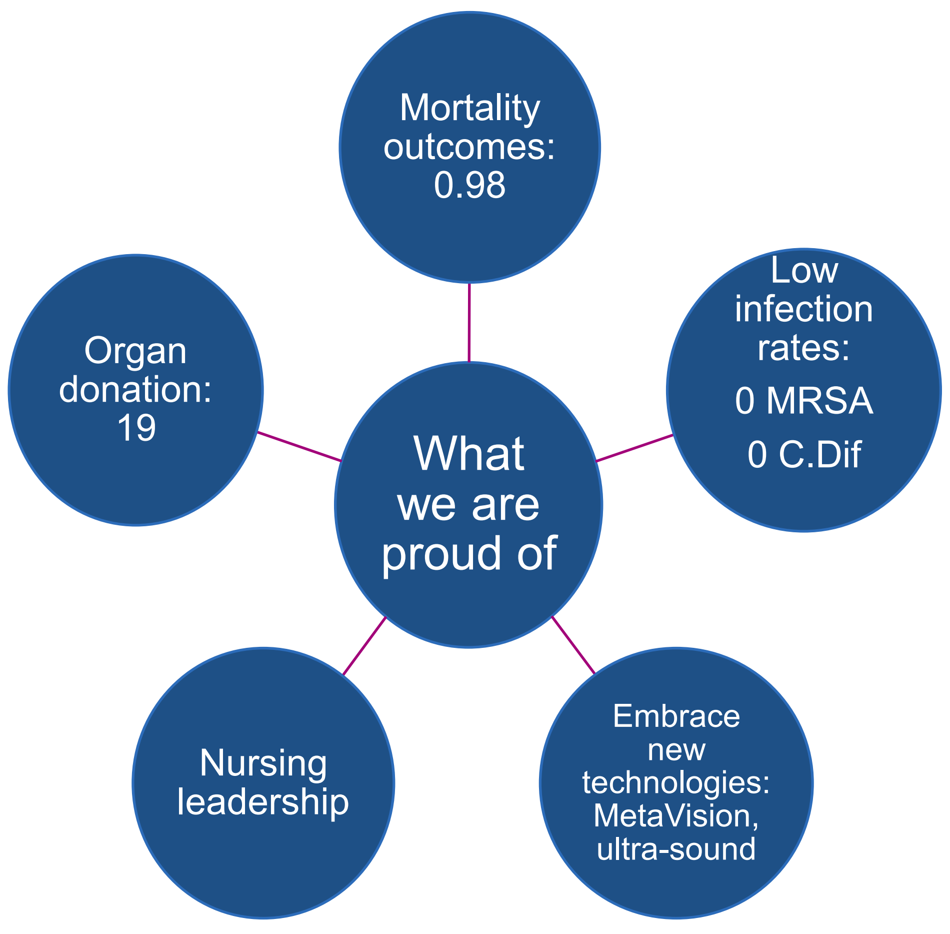
Quality Programme Board
Tuesday 9th July 2019

Ratings for Norfolk and Norwich Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Critical care	Requires improvement →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Requires improvement ↓ Apr 2019	Requires improvement ↓ Apr 2019



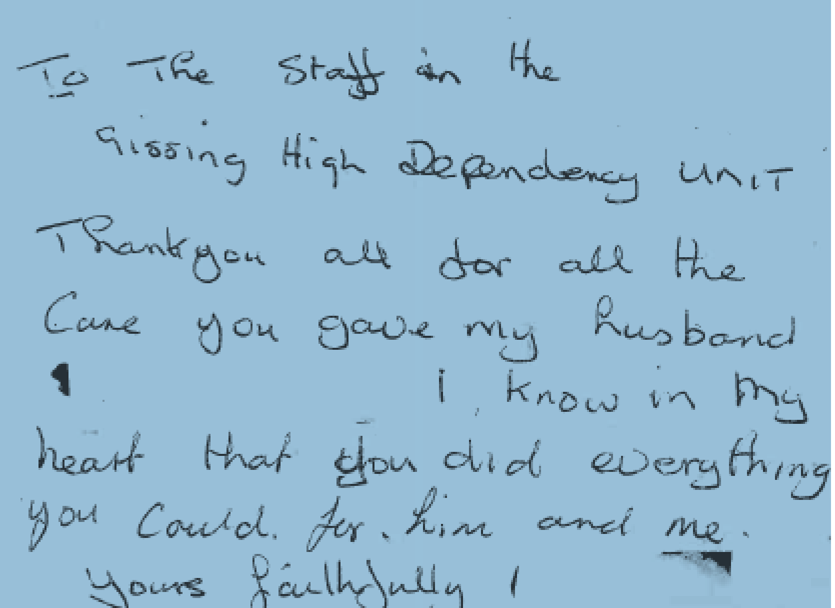
Where are we now..

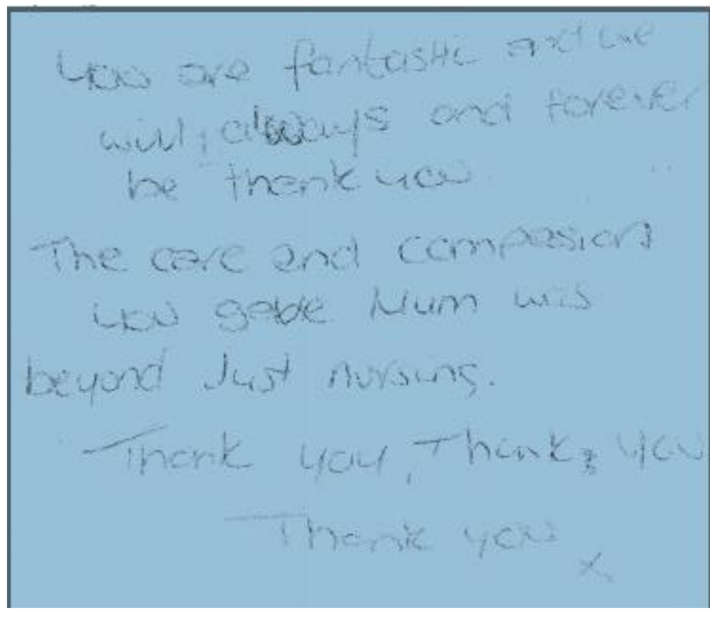


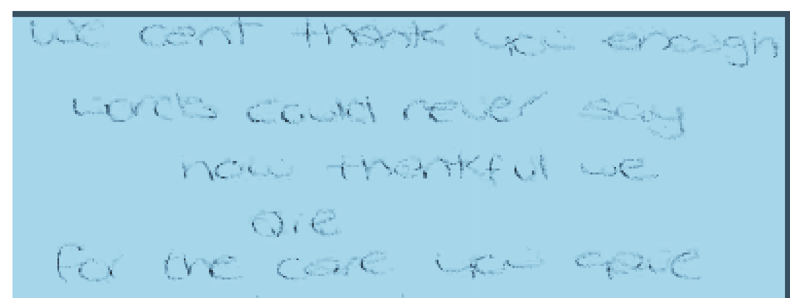
When the CQC were here, we were told that as a critical care, we could be outstanding – this is something that we are striving for and we aim to be outstanding by 2021.

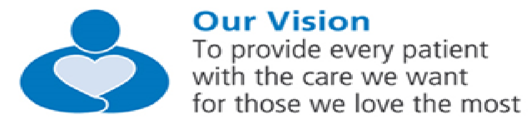
Our Values People focused Respect Integrity Dedication Excellence

Feedback


To The Staff in the
Gissing High Dependency UNIT
Thankyou all for all the
Care you gave my husband
I know in my
heart that you did everything
you could. for him and me.
Yours faithfully

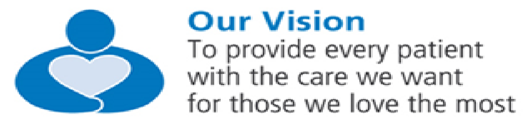

You are fantastic and we
will always and forever
be thank you
The care and compassion
you gave Mum was
beyond just nursing.
Thank you, Thank you
Thank you x


We cant thank you enough
words could never say
how thankful we
are
for the care you gave



Critical Care – Must do / Should do themes

24/7 Service	Care of children	Mental Health and Wellbeing
Availability of a supernumerary clinical nurse coordinator for the critical care service 24 hours a day, seven days a week	Introduction of dedicated, child-friendly area within the critical care service for admitted children and young people	Introduce the Lester tool, or equivalent, to support the health assessment of people living with severe mental health conditions
Continue improving nursing staff numbers for the critical care service	Ensure written and agreed procedure in place for the emergency admission of children and young people to the critical care service	Cover mental health and emotional wellbeing of patients in the audit programme for critical care.
Consideration of a critical care outreach team or rapid response team who is available 24 hours a day, seven days a week	Evaluate the friends and family test (FFT) regularly in critical care and introduce a child-friendly feedback system for children and young people who use the service	

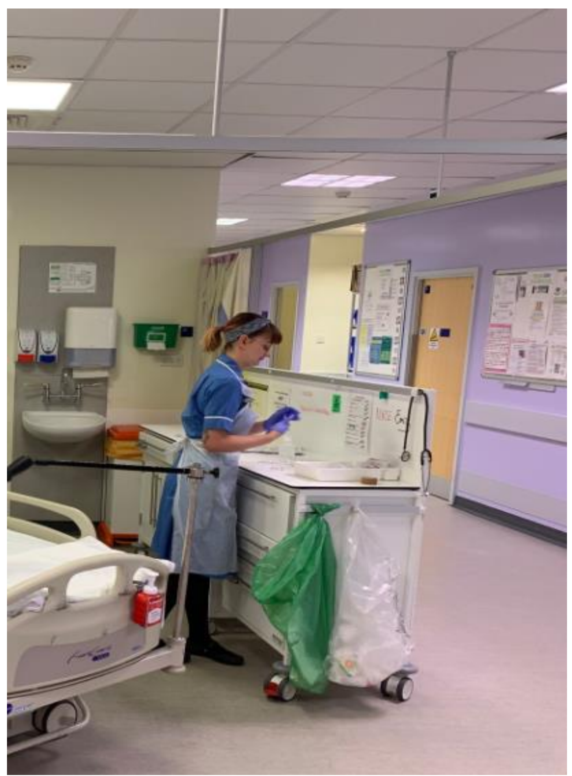


24/7 Service

- ✓ Staffing - 4 supernumerary staff rostered as per Intensive Care Standards with effect from May

Ongoing challenges

- Staff maybe redeployed to other areas impacting compliance with standards and CQC recommendation

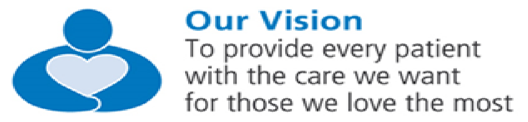


Our Values P eople focused R espect I ntegrity D edication E xcellence

✓ Staffing numbers fully established for 24 beds

Ongoing challenges and next steps

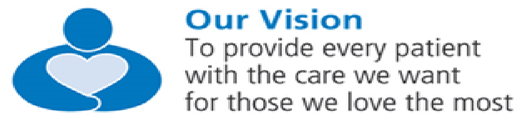
- Current establishment needs to reflect 21 nurses per shift currently staffed for 19 per shift as other disciplines within establishment – working with finance
- Skill mix – business case being developed to reflect Critical Care needs
- Additional pharmacy support required to meet DO5 standard



24/7 Service

✓ Additional roles – innovation

- ODPs for airway management support across the hospital
- Rehab assistants
- ACCPs in training to be part of the junior doctor rota by February 2020



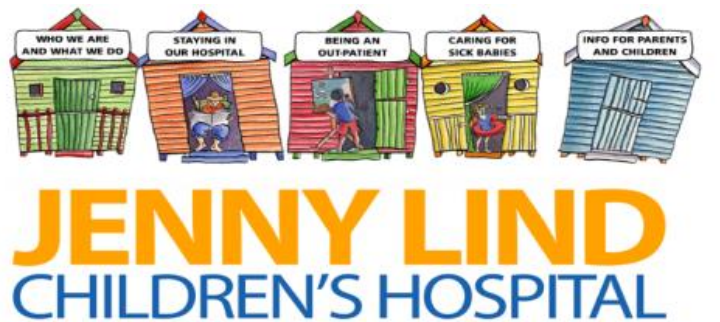
24/7 Service
Critical Care Outreach Service

- ✓ Currently being reviewed
- ✓ First meeting carried out which established the proposed outreach service. Action plan regarding next steps has been created

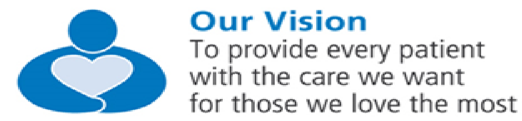
Next steps

- Business case required
- Training needs analysis to carried out

Care of Children



- ✓ Working with Children's division on suitable environment. Looking at art work, movable objects (light projector), iPad, aromatherapy
- ✓ Friends and Family Test being developed (pants and tops)
- ✓ Standard Operating Procedure for care of emergency admission of children in place

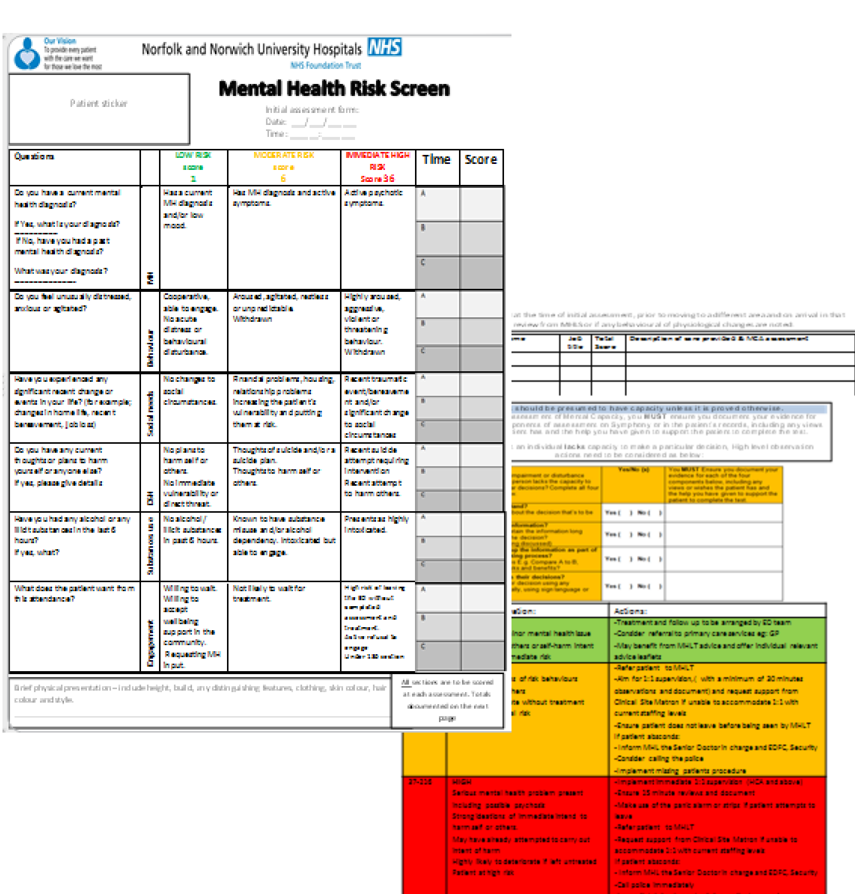


Mental Health and Wellbeing

✓ Risk assessments used in emergency department being updated and will then be used for Critical Care

Next steps

- Implementation of risk assessment by 1st August
- Expansion of follow up clinic for patients in critical care longer than 4 days
- Care plan to be developed which will address patient's emotional wellbeing
- Audit of risk assessments to commence 1st September



Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

Mental Health Risk Screen

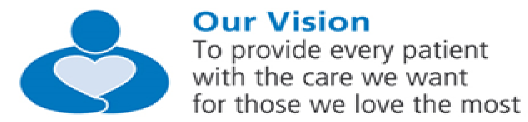
Patient sticker

Initial assessment form:
Date: __/__/____
Time: ____:____

Questions		LOW RISK score 1	MODERATE RISK score 6	IMMEDIATE HIGH RISK Score 36	Time	Score
Do you have a current mental health diagnosis? If Yes, what is your diagnosis? If No, have you had a past mental health diagnosis? What was your diagnosis?	MH	Has a current MH diagnosis and/or low mood.	Has MH diagnosis and active symptoms.	Active psychotic symptoms.	A B C	
Do you feel unusually distressed, anxious or agitated?	Behaviour	Cooperative, able to engage. No acute distress or behavioural disturbance.	Aroused, agitated, restless or unpredictable. Withdrawn	Highly aroused, aggressive, violent or threatening behaviour. Withdrawn	A B C	
Have you experienced any significant recent change or events in your life? (for example; changes in home life, recent bereavement, job loss)	Social needs	No changes to social circumstances.	Financial problems, housing, relationship problems increasing the patient's vulnerability and putting them at risk.	Recent traumatic event/bereavement and/or significant change to social circumstances	A B C	
Do you have any current thoughts or plans to harm yourself or anyone else? If yes, please give details	DSH	No plans to harm self or others. No immediate vulnerability or direct threat.	Thoughts of suicide and/or a suicide plan. Thoughts to harm self or others.	Recent suicide attempt requiring intervention Recent attempt to harm others.	A B C	
Have you had any alcohol or any illicit substances in the last 6 hours? If yes, what?	Substance use	No alcohol / illicit substances in past 6 hours.	Known to have substance misuse and/or alcohol dependency. Intoxicated but able to engage.	Presents as highly intoxicated.	A B C	
What does the patient want from this attendance?	Engagement	Willing to wait. Willing to accept wellbeing support in the community. Requesting MH input.	Not likely to wait for treatment.	[illegible]	A B C	

Brief physical presentation – include height, build, any distinguishing features, clothing, skin colour, hair colour and style.

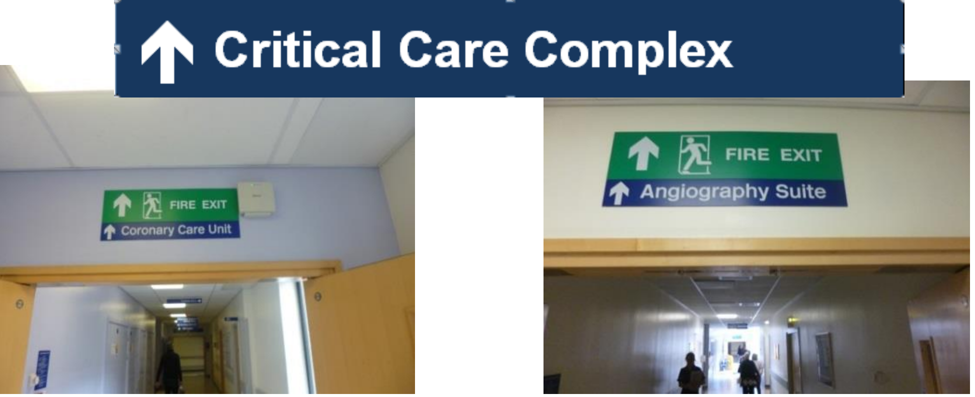
All sections are to be scored at each assessment. Totals documented on the next page



Environment

- ✓ Investigating change of curtains in line standards – reviewed by facilities and department – awaiting confirmation of proposal

- ✓ Signage – investigated and discussions taking place with facilities



Infection Prevention & Control

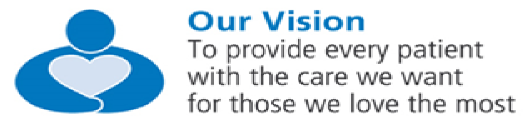
✓ Action plan in place with weekly updates being provided

Focus on

- Dust
- Clean me stickers
- Replacing damaged chairs
- PPE usage by nursing staff
- Hand Hygiene and bare below the elbows

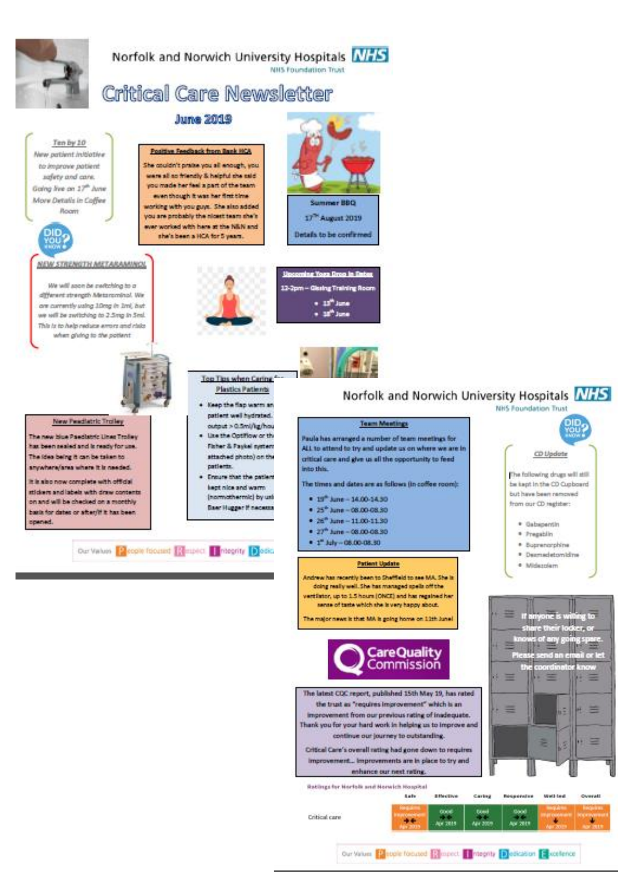
Next steps

- Internal audits being carried out
- NHSi inspection to take place 16th July



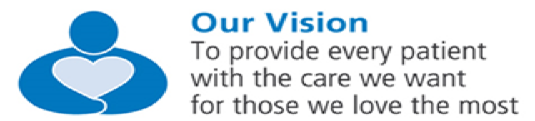
Vision

- ✓ CCC is part of The East of England Critical Care Operational Delivery Network. This network consists of 18 critical care services and other stakeholders
- ✓ Staff are familiar with the trust's set of values
- ✓ Critical Care Newsletter
- ✓ Trust's vision and values displayed throughout the service
- ✓ Availability of minutes to be shared with staff


Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust
Critical Care Newsletter
June 2019

Summer BBQ
Details to be confirmed

CareQuality Commission

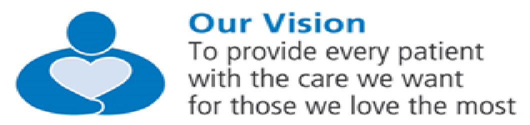


Vision

- CQC noted the service's broad vision and strategy is aligned to local plans in the wider health and social care economy, to meet the needs of the local population

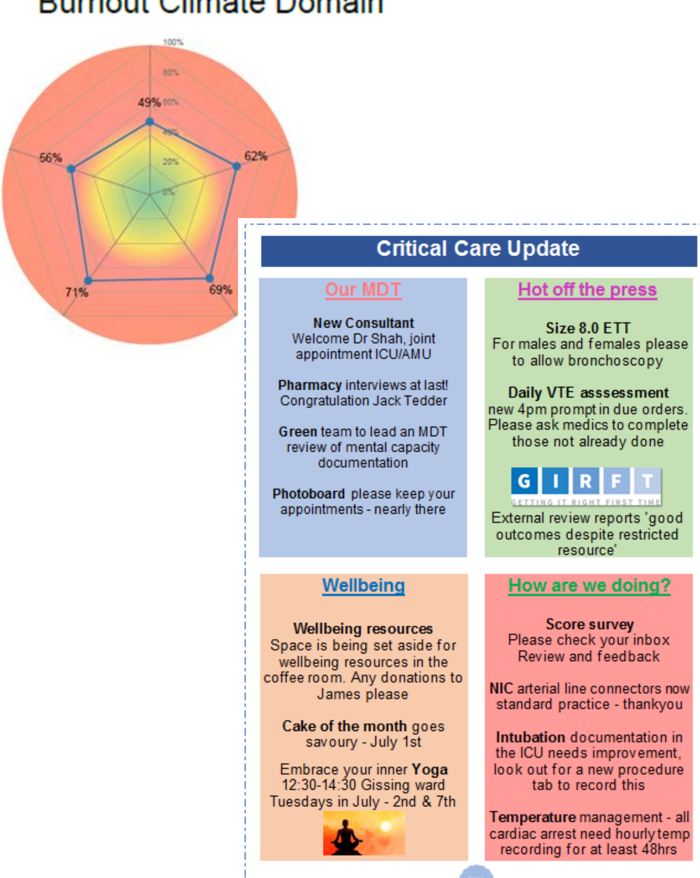
Next steps

- Sessions with staff
- Formalise vision and strategy



Further work carried out

NNHT Critical Care Complex
Burnout Climate Domain



Critical Care Update

Our MDT

New Consultant
Welcome Dr Shah, joint appointment ICU/AMU

Pharmacy interviews at last! Congratulation Jack Tedder

Green team to lead an MDT review of mental capacity documentation

Photoboard please keep your appointments - nearly there

Hot off the press

Size 8.0 ETT
For males and females please to allow bronchoscopy

Daily VTE asssessment
new 4pm prompt in due orders. Please ask medics to complete those not already done

GIRFT
External review reports 'good outcomes despite restricted resource'

Wellbeing

Wellbeing resources
Space is being set aside for wellbeing resources in the coffee room. Any donations to James please

Cake of the month goes savoury - July 1st

Embrace your inner **Yoga** 12:30-14:30 Gissing ward Tuesdays in July - 2nd & 7th

How are we doing?

Score survey
Please check your inbox
Review and feedback

NIC arterial line connectors now standard practice - thankyou

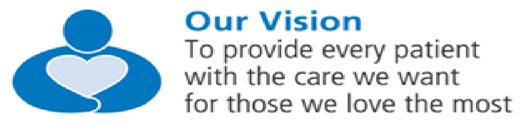
Intubation documentation in the ICU needs improvement, look out for a new procedure tab to record this

Temperature management - all cardiac arrest need hourly temp recording for at least 48hrs

- New triumvirate in place

Work that has been carried out following staff survey

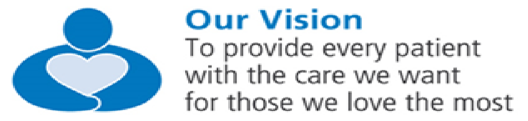
- Set up a wellbeing group – regular free yoga, access to psychologist
- Regular meetings with all staff groups
- Increased number of staff as well as supernumerary staff on every shift
- Action plan to support staff who are redeployed



What else could we do?

Next steps..

- Working with staff regarding culture
- How do we know they are listened to?
- How do we continue to use the SCORE survey to measure safety culture?
- Staff engagement
- Cross divisional working



Critical Care

Critical Care aim to be:

- Good in 2020 Good
- Outstanding 2021 Outstanding

REPORT TO THE QUALITY PROGRAMME BOARD	
Date	**4th July 2019**
Title	**Outcome of Evidence Group**
Author & Lead	**Jane Robey Rosemary Raeburn Smith**
Purpose	**For Information**

1 Background/Context

The Evidence Group met on 4th July to review the evidence in respect of ten recommendations, in addition to three recommendations brought back for review. The Agenda 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 the quality of the evidence supplied by the SRO and action leads and the current level of assurance for each recommendation.

2 Outcome

Of the thirteen recommendations:

- 1 was archived as BLACK
- 1 was confirmed as remaining BLUE
- 1 was confirmed as remaining RED
- 1 was confirmed as remaining AMBER
- 5 were confirmed as remaining GREEN
- 2 were downgraded from GREEN to AMBER
- 1 was downgraded from AMBER to RED
- 1 was downgraded from GREEN to RED

The group provided guidance as to the additional evidence required to turn the other recommendations BLUE, 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 Evidence Group is scheduled to meet again at 8.30am on 1st August 2019, at which meeting the Committee is due to conduct a 'deep dive' review into the ED section 29a recommendations.

Recommendation:

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

1. Apologies and declarations of interest

- Erika Denton (ED), Medical Director, NNUH
- Rosemary Raeburn-Smith (RRS), Programme Director for Quality, NNUH
- Rosemary Moore, Patient Panel chair, NNUH
- Kate Keeling, Divisional Nurse Director, NNUH
- Karen Kemp (KK), Associate Director of Quality and Safety, NNUH

2. Persons in attendance

The following people attended the meeting:

- Nancy Fontaine (NF), Chief Nurse NN, NNUHUH (Chair)
- Alison Leather (AL), Chief Quality Officer, NN/SN CCG
- Jane Robey (JR), Head of Improvement Team, NNUH
- Graham Bunting (GB), Senior Improvement Officer, NNUH
- Abbe Swain (AS), Improvement Manager, NNUH
- Jess Woodhouse (JW), Improvement Manager, NNUH
- Gemma Lynch (GLy), Governance Compliance Manager, NNUH
- Joel Fiddy (JF), Governance and Risk Management (Theatres), NNUH
- Rees Millbourne (RM), Medical Director's team, NNUH
- Clair Anderson (CA), Senior Improvement Officer, NNUH
- Jon Green (JG), Director of System Transformation, NNUH
- Nick Pember (NP), Senior Specialist Charge Nurse, Cardiology, NNUH
- Rachel Emberson (RE), Sister, Ophthalmology Out-patients, NNUH
- Caroline Barry (CB), Palliative Care Consultant, NNUH
- Sarah Egleton (SE), Head of Health Records, NNUH
- Lisa Sant (LS), Neurology Specialist Headache Nurse
- Fiona Reading (FR), OPM Outpatients, NNUH
- Michelle Roberts, Surgical Outpatients, NNUH
- Perry Djahit (PD), Trust Risk Manager, NNUH
- Lucy Harness (LH), Sister, Fracture Clinic, NNUH
- Denise James (DJ), Sister, In-patient Theatres (Recovery), NNUH
- Lisa Read (LR), Clinical Quality & Patient Safety Manager, North and South Norfolk CCG
- Lucy Weavers (LW), Divisional Nurse Director, Women and Children's Division, NNUH

In attendance

Jenny Edmonds, ACP ED

2. Review of open actions

Ref.	Action	Owner
TW1.1 Mandatory training	**NF** to raise the issue of mandatory training non-attendance at HMB in order to highlight the importance of this issue to the Divisions Complete and closed	NF
	RRS to arrange a Deep Dive into this issue in September, at organisational and divisional level – Divisions to present their position. Complete and closed	RRS
DI5.1 Timely radiology reporting	**JW** to add further evidence to the evidence repository to show that processes are written down to ensure sustainability of the process. Complete and closed	JW
TW 3.1 - Appraisals	**RRS** to arrange a Deep Dive into this issue in September, at organisational and divisional level – Divisions to present their position. Complete and closed	RRS

TW23.1 – Incident reporting and investigation	**RRS** to arrange a Deep Dive into this issue in September, at organisational and divisional level – Divisions to present their position. Complete and closed	RRS
TW31.1 – PPE fit testing	JW to investigate data for Hethel Ward and clarify the ED Medical/Emergency Services Medical Staff categories Complete and closed	JW
TW36.1 – Communication aids	**AS** to add further evidence to the repository Complete and closed	AS

3. Actions for Review and potential sign Off

Outcome of evidence reviews

Ref.	**Recommendation**	**Outcome of Review**
Recommendations for discussion – Outpatient deep dive		
O1.1	The trust should ensure that there is ongoing monitoring of the outpatient service, including the re-development of an outpatient dashboard **Status prior to meeting:** Green **Outcome of previous evidence group:** First presentation at Evidence Group **Progress discussed during meeting**: Lots of work done on Professional Standards in Outpatients. There are aligned to the PRIDE values. It is possible to capture around 75% of standards automatically via Perfect Ward – this will be piloted in a few areas and then rolled out across all OP areas. The 5 year OP strategy will be presented at HMB in July or August; this is linked across the STP and (hopefully) will lead to standardisation across the two other acute hospitals in Norfolk. Decision was made NOT to centralise outpatients. A relatively strong governance structure is in place, with fortnightly governance meetings, patient panel involvement and a monthly steering group meeting. This gives sufficient oversight and mitigates the risk of not having a centralised outpatient service. The Outpatient Forum has good multi-disciplinary attendance. The challenge is to get medical staff on board.	Outcome: GREEN Review date: 2 months (September) **Action(s):** None specific
O4.1	The trust should ensure that the management of referrals into the organisation reflects national guidance in order that the service meets referral to treatment times. **Status prior to meeting:** Green **Outcome of previous evidence group:** First presentation at	Outcome: GREEN Review date: 2 months (September) **Action(s):** AL will discuss RAP sign off with Mark Burgis

	Evidence Group **Progress discussed during meeting**: Relates to RTT recovery plan; the national guidance is to reduce the waiting list, not necessarily to achieve 92%; this is enshrined in the RAP, though this hasn't been signed off by commissioners. We are broadly on track to achieve. **ACTION**: AL will discuss RAP sign off with Mark Burgis	
O5.1	The trust should ensure that there is an effective process for risk management. **Status prior to meeting: Green** **Outcome of previous evidence group:** First presentation at Evidence Group **Progress discussed during meeting**: The risk register isn't easily split to separate outpatient areas specifically; 19 risks were over 2 years old. Still about 25 risks on the register. No risks have been added since April 2019, and all risks are all being reviewed. There was no risk review process in place; staff in general are still unclear about how to raise a risk on the register. Individual specialities manage risk differently. Greater ownership at Divisional level is required to provide assurance that there is sufficient oversight of risk at local level. The situation is improving in Medicine; there is good oversight in Surgery. Next steps: add more risks to the risk register; separate out the outpatient risks to improve oversight. Carry out training so that staff know how to add risks to the risk register. Schedule a visit to trust that is outstanding across all outpatient domains. **Action**: JG to raise outpatient risks at the Risk Oversight Committee (for a deep dive review). **Action:** GL to investigate if there is a way to separate out outpatient risks.	Outcome: GREEN Review date: 1 month (August) **Action(s):** JG to raise outpatient risks at the Risk Oversight Committee (for a deep dive review). **Action:** GL to investigate if there is a way to separate out outpatient risks.
O6.1	The trust should ensure that medicines are stored securely and in line with national guidance. **Status prior to meeting: Green** **Outcome of previous evidence group:** First presentation at	Outcome: AMBER Review date: 1 month (August) **Action(s):** GB to bring up to date performance

	Evidence Group **Progress discussed during meeting**: The issue is that we don't follow best practice when storing medicines, especially ambient room temperatures; this is not on the risk register. Thermometers have been ordered; ambient temperatures are now audited daily via Perfect Ward. Pharmacy team carry out QAAs – awaiting evidence. Ophthalmology is around 95% compliant. Once current performance is known a trajectory can be set. There is poor awareness of current performance. **Action(s):** GB to bring up to date performance information re medicine management and ambient temperatures to the August Evidence Group.	information re medicine management and ambient temperatures to the August Evidence Group.
O7.1	The trust should ensure that equipment is maintained and fit for use. **Status prior to meeting: Green** **Outcome of previous evidence group:** First presentation at Evidence Group **Progress discussed during meeting**: Teams are inconsistently (or never) receiving monthly reports showing maintenance data. Without this evidence, teams have no evidence that their equipment is being maintained.	Outcome: RED Review date: 2 months (September) **Action(s): None specific**
O3.1	The trust must ensure that patient records are stored securely. **Status prior to meeting: Green** **Outcome of previous evidence group:** First presentation at Evidence Group **Progress discussed during meeting**: Lots of work done to date; long term strategy to implement an EDMS, but in the meantime need to improve practice. All departments use laminated confidential sheets to protect the notes; however, this is still not sufficient to ensure confidentiality. Geography and layout of department influences storage of notes and impacts on confidentiality. Because of the non-standard layout of outpatient departments, bespoke solutions are required	Outcome: AMBER Review date: 2 months (September) **Action(s): None specific**

	for each area. Next steps: Need to produce guidance for areas; need to target specific departments (the hot spots); need to ascertain if any investment is required (e.g. lockable trolleys); need to learn from outstanding Trusts (though unfortunately many of these have moved to electronic notes); needs to be put on the risk register, with mitigation clearly stated.	
O2.1	The trust must ensure that the use and monitoring of the World Health Organisation (WHO) and five steps to safer surgery checklist is embedded across all relevant areas. **Status prior to meeting:** **Amber** **Outcome of previous evidence group**: First presentation at Evidence Group **Progress discussed during meeting**: The CQC identified areas of good and poor practice; poor areas are learning from areas of good practice. Now have a record of all known LOCCSIPS; the audit plan is in place. Training of staff in WHO and LOCSSIPS is a work in progress. New policy should be approved imminently.	Outcome: AMBER Review date: 2 months (September) **Action(s): None specific**
Recommendations for Bring Back Review		
S3.1	The trust must ensure that the World Health Organisation (WHO) and five steps to safer surgery checklist is completed appropriately, and that learning from incidents and regular monitoring processes become embedded to empower staff to challenge and report any poor practice. **Status prior to meeting:** **Blue** **Outcome of previous evidence group:** 4th April remains BLUE. Next review July. • **Action:** AS/JF ensure WHO learning is disseminated to all other areas that would find the learning useful (e.g. radiology, cath labs) for discussion at governance meetings **Progress discussed during meeting**: Processes of monitoring are now embedded; good buy in from clinicians; now a culture in place of submitting a Datix report if there are incidents. Targeted work done at Cromer; Joel Fiddy visits Cromer monthly, and WHO compliance is now embedded in their governance. Evidence is presented at surgical clinical governance meetings.	Outcome: BLUE Review date: 3 months (October) **Action(s):** JF to seek consensus decision from Divisional Board re. when WHO will be sufficiently embedded to be considered black.

	Action: JF to seek consensus decision from Divisional Board re. when WHO will be sufficiently embedded to be considered black.	
TW36.1	The trust should review its communication aids available to assist staff to communicate with patients living with a sensory loss, such as hearing loss. **Status prior to meeting:** **Blue** **Outcome of previous evidence group:** Last reviewed on 6th June and remained BLUE with the following actions: • **Action:** AS to add further evidence to the repository. **Progress discussed during meeting**: A video about the hospital will be trialled on the website. AIS meetings are scheduled monthly. Oversight is embedded.	Outcome: BLACK Review date: No further review required. **Action(s): None specific**
TW30.1	The trust should ensure morbidity and mortality meeting minutes include sufficient detail of background information, discussions and those in attendance. **Status prior to meeting:** **Amber** **Outcome of previous evidence group:** Last reviewed 07 March remains AMBER due to insufficient assurance with the following actions: • **Action**: JR to speak to ED to discuss the possibility of an exploratory review into this subject. • **Action**: NH to share structured deep dive approach with NF. **Progress discussed during meeting**: Lots of work done to date; templates have been uploaded onto the mortality system for clinicians to use, however compliance isn't embedded throughout all specialties. Respiratory. paediatrics and CCC are outstanding – gold standard. A band 3 assistant is being recruited to help with administration; also about to recruit to the ME support practitioner role.	Outcome: RED Review date: 3 months (October) **Action(s): None specific**
Recommendations for Potential Sign Off		
TW22.1	The trust must review 'do not attempt cardio-pulmonary resuscitation' (DNACPR) forms to ensure they are completed fully and in line with trust policy and national guidance.	Outcome: RED Review date: 3 months (October)

	Status prior to meeting: Red **Outcome of previous evidence group:** First presentation at Evidence Group **Progress discussed during meeting**: Awareness raising and education drive re MCA, best interests etc. Resus attempts are now flagged in SIG meetings; this has led to helpful feedback. Re-audit shows that documentation remains poor; there needs to be a shift in emphasis, as failure to have and record the conversations is a breach of the law. A robust quality assurance process is required, carrying out identity checks to ensure we're resuscitating the right people; weekly documentation checks; monthly checks on MCA, targeted checks and training. From a process viewpoint, electronic communication of DNACPR audits is now in place and a PAS alert triggers at the front door. It would be desirable to have a link to Ward View and nursing handover to flag awareness of DNACPR patients. Next steps: ReSPECT. In a year's time we'll be able to replace the DNACPR form completely with ReSPECT, but in the meantime improving documentation is vital. A series of improvement events will be scheduled to raise awareness. **ACTION:** JR to liaise with CB to progress the improvement events re DNACPR awareness. Involve Patient Panel and Sarah Higson.	**Action(s):** JR to liaise with CB to progress the improvement events re DNACPR awareness
Mat9.1	The trust should ensure that staff and women are aware of the complaints process. **Status prior to meeting: Green** **Outcome of previous evidence group:** First presentation at Evidence Group **Progress discussed during meeting**: An audit was carried out; PALs information is now available in all departments. Ward Boards (Responsive element) now show the responses to complaints. Staff awareness has improved – this is assessed through the Perfect Ward – the results of the PW audits show that staff are aware of how to respond to complaints. Still some work to do re. learning from complaints and showing that the patient experience reflects the work done to improve awareness of complaints.	Outcome: GREEN Review date: 2 months (September) **Action(s):** LW to arrange an audit to assess staff awareness.

	Action: LW to arrange an audit to assess staff awareness of complaints processes and outcomes.	
S11.1	The trust should improve the environment, particularly in the day surgery (and interventional radiology units) **Status prior to meeting:** **Green** **Outcome of previous evidence group:** First presentation at Evidence Group **Progress discussed during meeting**: SOP now in place for the use of the DPU as an escalation area. Bigger piece of work required re the escalation plan (DPU, JPU, Cley). **Action(s):** JF to ask Rosemary Moore and Sarah Higson to do a walk through DPU to assess if the environment is acceptable from a patient experience perspective.	Outcome: GREEN Review date: 1 month (August) **Action(s):** JF to ask Rosemary Moore and Sarah Higson to do a walk through DPU

New Actions

Ref.	Action	Owner
O4.1	AL will discuss RTT RAP sign off with Mark Burgis	AL
O5.1	JG to raise outpatient risks at the Risk Oversight Committee (for a deep dive review).	JG
	GL to investigate if there is a way to separate out outpatient risks.	GL
O6.1	GB to bring up to date performance information re medicine management and ambient temperatures to the August Evidence Group.	GB
S3.1	JF to seek consensus decision from Divisional Board re. when WHO will be sufficiently embedded to be considered black.	JF
TW22.1	JR to liaise with CB to progress the improvement events re DNACPR awareness	JR
Mat9.1	LW to arrange an audit to assess staff awareness of complaints processes and outcomes.	LW
S11.1	JF to ask Rosemary Moore and Sarah Higson to do a walk through DPU to assess if the environment is acceptable from a patient experience perspective.	JF

4. AOB

5. Date and Time of Future Meetings

Thursday 1st August 08:30 - 10:00 Boardroom

REPORT TO THE TRUST BOARD	
Date	**26 July 2019**
Title	**Quality and Safety Committee Meetings on 06.06.19 and 25.07.19**
Author	**John Paul Garside (Board Secretary) on behalf of Dr O'Sullivan (Committee Chair)**
Purpose	**For Information**

1 Background/Context

The Quality and Safety Committee met on 6 June 2019 and 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 matters in accordance with its Terms of Reference, items of note considered at the meeting included:

	Issues considered	Outcomes/decisions/actions
1	Divisional/Specialty Focus – Cromer & District Hospital	The Committee held its meeting at Cromer & District Hospital and visited clinical areas, including out-patients, day case, MIU and renal unit. The Committee also visited the Davison Wing, reviewing the plans for refurbishment to create the North Norfolk Macmillan Centre. The plans for additional capacity and improved environment were discussed and the Committee noted the potential for increased services and activity on the Cromer site. Skype facilities are being established to aid communication & integration between staff at Cromer & NNUH.
2	Equipment Replacement programme Update (BAF 1.5)	Given the risk profile associated with equipment failure and obsolescence, as reflected on the Corporate Risk Register, the Committee received an update on the developing equipment replacement programme. This involves consultation with divisions and clinical teams and will inform future capital plans and applications. NHS Supply Chain has been commissioned to carry out an equipment audit which will be used to establish a 5-year equipment replacement programme. The Committee was informed that in the meantime there is a process in place for identification and escalation of equipment-related risks, with escalation to NHSI for urgent capital as required.
3	Divisional Performance and Accountability Framework (BAF 4.5)	The Committee reviewed the draft Divisional Performance and Accountability Framework and agreed to receive this as a regular item at future meetings.
4	Public Registration of Clinical Trials	Given the Committee's remit with regard to overseeing research activity in the Trust, it received assurance with regard to arrangements for the public registration of clinical trials – to maximise the public benefit from clinical research.
5	Acute Services Integration - Q&S related issues	The Committee was updated with regard to the arrangements for quality and safety under the Acute Services Integration/Lead Provider proposals.
6	CQIA Update	The Committee received its regular report confirming the operation of the Clinical Quality Impact Assessment process, by way of assurance that our

		schemes for financial savings are balanced alongside our commitment to quality. A number of deferrals were noted – as evidence of scrutiny.
7	CQC Insight Report	The Trust's rating in the monthly CQC Insight report is showing ongoing improvement and is on the boundary of Requires Improvement and Good. It now reflects the improved HSMR but is adversely affected by our A&E performance.

3 Conclusions/Outcome/Next steps

By the time of the Board meeting, the Committee will have met again on 25 July 2019 and at its meeting the Board will be updated on Committee discussions. Again the Agenda is **attached** and meeting papers have been circulated to Board members for information.

Recommendation:

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

MEETING OF THE QUALITY AND SAFETY COMMITTEE - 6 JUNE 2019

A meeting of the Quality and Safety Committee will take place at 13.00 on 6 June 2019 in the meeting room of Cromer and District Hospital.

AGENDA

The meeting will commence with clinical visits to the hospital and the site for refurbishment of the Davison Wing.

	Item	Lead	Purpose	Page
1	Apologies and Declarations of Interest			
2	Reflections on visits	All	Discussion	
3	Minutes of meeting held on 4 April 2019 & matters arising	Chair	Approval & Discussion	3
Strategic & risk–based focus				
4	Divisional/Specialty Focus – Cromer Matron Anita Martins and Matt Keeling (Deputy Divisional Operations Director) to attend		Discussion	
5	Equipment Replacement programme Update **(BAF 1.5)**	SH	Discussion	10
6	Divisional Performance and Accountability Framework **(BAF 4.5)**	Execs	Discussion	14
7	Mortality Surveillance (Dr Foster +/- HED) **(BAF 2.1)**	ED	Discussion	28
8	Corporate Risk Register – Clinical risks	KK	Discussion	33
9	Correspondence relating to Public Registration of Clinical Trials	ED	Information	40
10	Draft Quality Strategy update	ED/NF	Information	Verbal
11	Inpatient Survey Results	NF	Discussion	Verbal
12	Acute Services Integration - Q&S related issues - update	KK/SH	Information	Verbal
Standing items				
13	CQIA Update	PMO	Information	42
14	CQC Insight Report	Execs	Information	53
15	Clinical Incidents, inquests and Claims	KK/JPG	Information	65
16	Matters referred from the QPB	MD/NF	Information	Verbal
Committee business				
17	Committee Work Programme & Agenda for next meeting & date for circulation of papers	Chair	Agreement	98
18	Reflections on the meeting & Any other business	Chair	Discussion	

Date and Time of next meeting: The next meeting will be from 9am to 12pm on 25 July 2019 at the Norfolk and Norwich University Hospital

MEETING OF THE QUALITY AND SAFETY COMMITTEE

25 JULY 2019 - AGENDA

A meeting of the Quality and Safety Committee will take place from 9am to 12pm on 25 July 2019 in the Chief Executive's Office of the Norfolk and Norwich University Hospital

---

The meeting will commence with clinical visits to AMU

	Item	Lead	Purpose	Page
1	Apologies and Declarations of Interest			
2	Reflections on visits			
3	Minutes of meeting held on 6 June 2019 & matters arising	Chair	Approval & Discussion	2
Strategic & risk–based focus				
4	Divisional/Specialty Focus – Division of Medicine *(inc Selected SI report* (W145739 – Brundall Ward)		Discussion	To Follow
5	Staffing reports: 5.1 medical 5.2 non-medical	NF/ED	Information	9 13
6	6.1 Matters referred from Research Oversight Board 6.2 Research Annual Report 2018/19	ED	Discussion	28
7	Clinical Governance Structure 7.1 Clinical Safety and Effectiveness Sub-board Work Programme 7.2 Patient Engagement and Experience Sub-board Work Programme	ED/NF	Information	84 87
8	Inpatient Survey, results and actions	NF	Discussion	92
9	Draft Quality Strategy 2019/20	ED/NF	Discussion	102
10	Clinical Audit Plan and actions arising	ED	Information	114
11	Infection Prevention and Control Annual Report - 2018/19	NF	Discussion	176
Standing items				
12	CQIA Update	PMO	Information	235
13	Serious Incidents, Claims, Complaints and Compliments	KK/JPG	Discussion	243
14	Corporate Risk Register – Clinical risks	KK	Discussion	263
15	CQC Insight Report	MD	Information	Attached
Committee business				
16	Agenda for next meeting & pre-meeting discussions	Chair	Agreement	271
17	Reflections on the meeting and any other business	Chair	Discussion	

Date and Time of next meeting:
The next meeting will be from 2pm to 5pm on 5 September 2019 at the Norfolk and Norwich University Hospital

Quality and Safety Improvement Strategy 2019-2023

Name of document author:	Barbara Hercliffe
Job title of document author:	Head of Patient Safety Improvement
Name of document author's Line Manager:	Karen Kemp
Job title of author's Line Manager:	Associate Director – Quality and Safety
Division responsible for document:	Corporate – Risk & Patient Safety
Date document written / revised:	30/04/2019
Assessed and approved by (committee):	
Date Approved	dd/mm/yyyy
Ratified by or reported as approved to (if applicable):	(*Relevant*) **Committee or Sub-Board**
To be reviewed before: This document remains current after this date but will be under review	Date: 31/03/2020
For use in:	Trust-wide
For use by:	All Staff
Key words:	Quality Improvement, Patient Safety, Risk Management, Strategy
Reference and / or Trust Docs ID No:	11663
Version No:	V3.0
Description of changes (for revised versions):	New Strategy 2019- 2023
Compliance links:	CQC – Well Led

Forward by
Prof Erika Denton, Medical Director and Prof Nancy Fontaine, Chief Nurse

We are pleased to present our Quality and Safety Improvement Strategy for 2019 to 2023. It supports our 'journey to outstanding' and the achievement of our vision ***"to provide every patient with the care we want for those we love the most"*** and is underpinned by our core values.

We have set out our quality priorities for the next five years, to improve patient safety, clinical effectiveness and the experience of those who use our services. These are the areas where we know we can make the greatest difference.

Just as importantly, however, we will equip our staff with the tools, techniques, training and support needed to deliver quality improvements in all areas, day in day out. In particular, we will develop a QI Faculty and widen access to quality improvement training for all our staff .

The Board is committed to making both the care we provide, and the experience of the staff who work in our hospitals and community services outstanding. We will engender a culture in which our staff can make quality their priority, and will support and empower them to make changes; we will remove barriers to quality improvement and maintain an open and honest dialogue on where we need to go further for our patients.

We want this strategy to become the compass that guides us towards being an outstanding hospital where staff are valued and patients feel safe in our care. We will plan, manage and measure the improvements we make, and we will hold ourselves to account for delivering planned improvements and for facilitating a focus on quality at all levels.

We know we have challenges in the light of recent Care Quality Commission reports and we need to strengthen our safety culture, to support the Trust out of 'special measures' and towards being an outstanding hospital.

We know that when we work together, great things happen, and with the greater focus on quality and safety improvement outlined above, we are confident that we can deliver measurable improvements for our patients in the next five years.

This strategy will evolve over the coming years and we will ensure that as many people as possible, particularly our staff and patients, can share their views and shape our quality plans going forward.

Norfolk and Norwich University Hospitals

NHS Foundation Trust

Quality and Safety Improvement Strategy Summary
"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**

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Act | Plan | Study | Do

LifeQI

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.

Norfolk and Norwich University Hospitals
NHS Foundation Trust

Quality Priorities
What we aim to achieve by when .

Setting Direction and Priorities for the Strategy

We want to ensure that everyone in our local community who may use our services has absolute confidence that our care and treatment is safe and completely patient centred. The Quality and Safety Improvement Strategy sets out how NNUH aims to continuously improve to ensure that we deliver high quality care and continue to put patients at the heart of all we do.

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: Patient and staff experience, Safe systems and Effectiveness

Our Quality Strategy underpins our quality objectives to continually improve patient experience, safety and effectiveness of care.

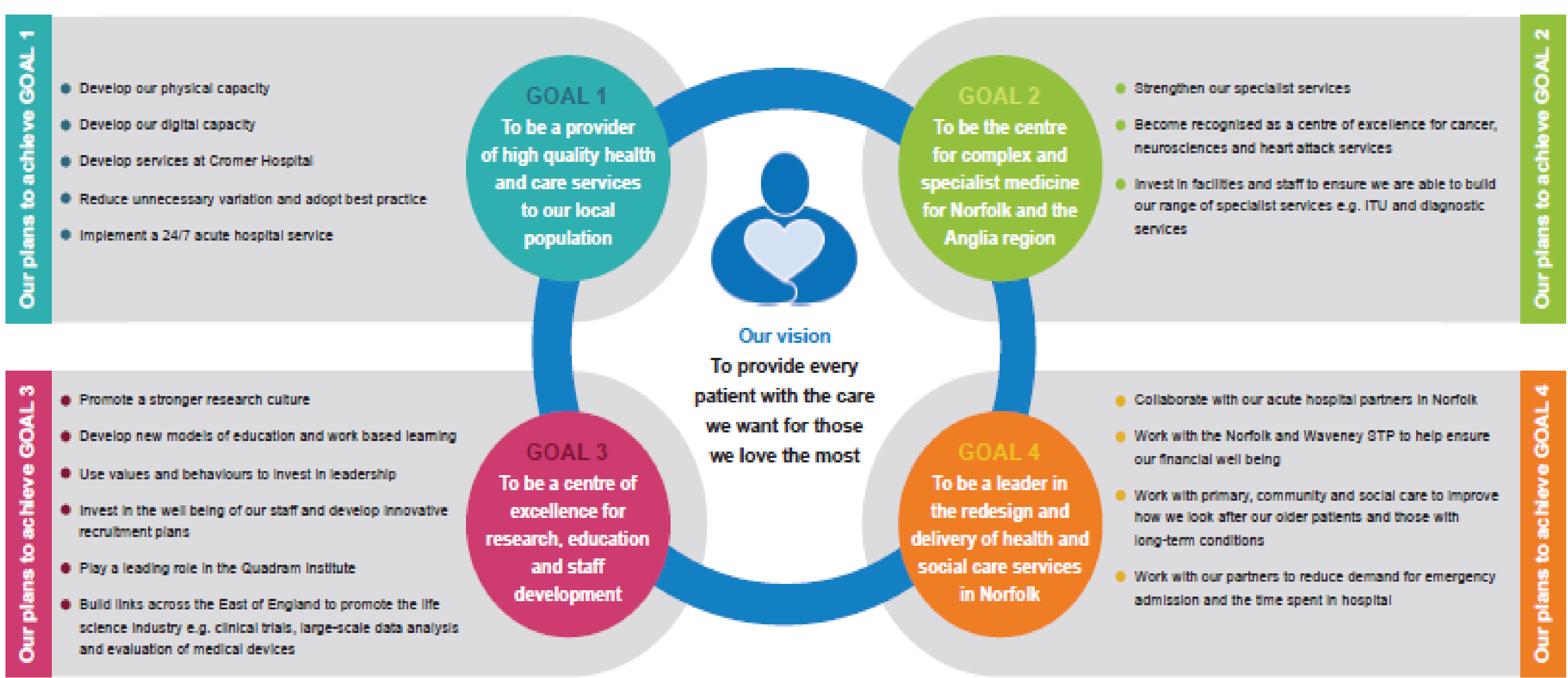
- It will ensure that challenges facing the Trust are met without compromising quality of care
- Ensure that lessons are learned when things go wrong and meaningful actions taken
- Allow us to recognise when quality is not as good as it should be and empower staff to change it for the better
- Help teams and individuals see the contribution they make to improving quality
- We will demonstrate delivery of national and locally defined quality priorities by clearly defining and measuring what we aim to achieve by when

Patient and Staff Experience	Safe systems	Effectiveness
Listening and responding to patients and their carers/ families going forward and using patient feedback and experience to design and improve services.	We aim to give every patient consistently safe, high quality and compassionate care. Reduce avoidable harm from failures in care and failure to rescue	Adhering to evidence, guidelines and standards to identify and implement best practice Development and use of systems and structures that promote learning across the organisation and services.
As measured by:- • Friends and family test • Improved scores in key questions national patient surveys • 10% improvement in scores in key questions of national staff surveys • Improving response rate and feedback real-time patient and carers surveys • Increased response rate from children, young people and their families (from agreed baseline) • Increase from baseline (to be agreed) in the handling and responding to complaints and concerns raised at the point of care.	As measured by:- • 95% patients screened for sepsis according to Trust policy • 95% of admitted patients will have observations recorded accurately using NEWS2 • 20% reduction in hospital acquired pressure ulcers • 10% reduction in falls with harm • 80% of older in patients receive key falls prevention actions • 100% of named children link nurses have paediatric competences	As measured by:- • 100% Duty of Candour compliance • 95% Serious Incident investigations are fully completed within 60 days • 95% of action plans completed from complaints and serious incidents within agreed timescales • Evidence that themes from serious incidents and complaints and mortality reviews and utilised to prioritise our improvement programme. • 95% of cases requiring SJR completed in line with policy • 100% of children and young people requiring high dependency or critical care are looked after in dedicated environment • Antimicrobial Resistance – Lower Urinary Tract Infections in Older People & Antibiotic Prophylaxis in Colorectal Surgery

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

Aim of the Quality and Safety Improvement Strategy

The Quality & Safety Improvement Strategy describes our Quality priorities (what we will do) as well as our QI methodology (how we do QI) to support our journey to outstanding and the delivery of the organisation's vision and five year plan: ***"to provide every patient with the care we want for those we love the most"***



Introduction to Quality Improvement

In August 2017, the Care Quality Commission (CQC) rated the Trust as inadequate, on the basis of this inspection, the Chief Inspector of Hospitals recommended that the trust be placed into special measures..

We have a Quality Improvement Plan that will support us out of special measures and there is a also clear strategic direction to adopt a trust wide quality improvement approach to support our 'journey to outstanding' .

This five year Quality and Safety Improvement Strategy will be the driving force to sustain a culture of continuous learning and improvement . It is focused on developing capability for teams so that Quality Improvement (QI) becomes a frontline activity where staff are able to listen to patients and implement changes that make a real difference to patient care and experience.

Rather than being a short-lived trend, QI will be a consistent part of our culture that gives us and the people we serve confidence about the long-term sustainability of the quality of care.

The core measures demonstrating success of the QI&S strategy by 31st March 2023 will be:

- Reduce the incidence of patient harm from failures in care and failure to rescue
- Evidence that we are listening and responding to patients and their carers/ families
- Evidence that we are adhering to evidence based good practice
- We will be rated as an 'outstanding ' organisation with a culture of continuous learning and improvement.

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

Quality Improvement – The term 'quality improvement' refers to the systematic use of methods and tools to try to continuously improve quality of care and outcomes for patients.
'The process of adopting and embedding QI across an organisation was often described by hospital trusts as a journey, with several common elements described (FIGURE 1)

Quality improvement in hospital trusts Sharing learning from trusts on a journey of QI Care Quality Commission 2018

FIGURE 1

Our Quality and Safety Improvement Strategy describes our strategic intent for embedding QI methodology across the Trust and our ambition to build a culture of learning and continuous improvement at all levels.

- Our patients will be at the centre of QI and will be involved as true and equal partners
- 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 and shared across the organisation
- We will see improved patient experience and patient safety metrics
- The focus on quality and safety first will be a consistent part of our culture, from ward to Board.

Safety Science and Culture:

We see effective organisational culture as essential to the success of our strategy. We will truly prioritise quality and safety through an inspiring vision and positive reinforcement, not through blame and punishment.

It is well-recognised that the safety culture in a team affects its ability to deliver safe care, improve and learn. Professor Don Berwick's 2013 report, *'A Promise to Learn – a commitment to act'*, made a series of recommendations to improve patient safety, noting that *'Culture will trump rules, standards and control strategies every single time, and achieving a vastly safer NHS will depend far more on major cultural change than on a new regulatory regime.'*

Embedding the goal of providing safe care into the culture of the organisation is a prerequisite to achieving lasting improvement. However, transforming culture is a complex endeavour. In promoting a just culture, we will address two issues of balancing a positive culture with the need for accountability.
The fair treatment of staff supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame.
Supporting staff to be open about mistakes allows valuable lessons to be learnt so the same errors can be prevented from being repeated. In any organisations or teams where a blame culture is still prevalent, this will be a powerful driver in promoting cultural change.

Understanding human factors and ergonomics is a key element of building a better patient safety system. Training in human factors alongside other patient safety education, incident investigation and learning from deaths will be incorporated into the QI and Safety curriculum to embed patient safety expertise throughout the workforce.

QI Methodology

The 'Model for Improvement' is the framework we are using to drive **continuous improvement**.

Care Quality Commission State of Care report in 2017 found that almost all the trusts rated as outstanding had a clear model for QI across the trust.

Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

Act | Plan | Study | Do

QI Methodology and Tools

There are a range of different methods and tools available and we have adopted the Institute for Healthcare Improvement (IHI) Model for Improvement (MFI) as our chosen QI methodology.

It is simple for all staff to use and is a widely understood methodology that has been successfully used in many healthcare settings. Furthermore it builds on the existing knowledge and skills of many of our staff, and harnessing that enthusiasm and knowledge from frontline staff will enable us to make progress faster.

The model utilises the Plan, Do, Study, Act (PDSA) cycle to facilitate change from the front line by rapidly testing changes on a small scale before scaling up.

This approach encourages altered behaviours, working together, creative thinking, and fundamentally, using measurement to guide improvement.

We will be using the **Life QI** electronic platform to help create and deliver improvement projects at every level and in every setting. It is a simple system to access, provides overview of all QI activity without having to ask for information or reports and encourages sharing of learning.

Based around the IHI Model for Improvement, it supports teams to plan, monitor and report the progress of their improvement projects, as well as connect with other member of the QI community, facilitating collaboration and shared learning.

Quality, Service Improvement and Redesign (QSIR) curriculum

Leading improvement · Project management · Measurement for improvement · Sustainability of improvement · Engaging and understanding others · Creativity in improvement · Process mapping · Demand and capacity

Quality Service Improvement and Redesign (QSIR).

Building capacity in our front line staff is vital if the aims outlined in this strategy are to come to fruition. Whilst we want to create a movement, success will be limited if we are empowering and enabling staff to take control of these improvement projects without the skills to bring their plans to fruition. In order to achieve our aims, we therefore need to invest in the education and training of our workforce.
Our first cohort of staff have enrolled with the NHS Improvement QSIR College. This programme develops candidates to a level where they are assessed and accepted as associate members of the QSIR Teaching Faculty and go on to skill up people within our own organisation and wider health system. Our aims include delivering the QSIR training programme to staff and building a support network for staff undertaking QI projects.
Staff completing improvement work will be mentored throughout their project they will then be expected to become 'champions for change' themselves.
There will be an understanding that support given to achieve improvement is repaid by sharing learning and skills with peers. This will enable the network of expertise to expand throughout the organisation.
This approach is designed to support an integrated and planned approach to develop QI capacity and capability across the organisation and grow a network of people with QI skills and experience.

QI and Safety Improvement Faculty

How we will build the capacity and capability for improvement

The Quality Improvement Strategy highlights the importance of developing capability by providing training on quality and safety improvement on an on-going basis, commensurate with the role of the individual.

This is the start of a movement within NNUH to enhance and promote QI across the Trust. The development of the **NNUH QI and Safety Improvement Faculty** led by a cohort of QI and patient safety experts within the Trust, will support the work to build and sustain the capability and capacity amongst the workforce.

We recognise that not everyone in the organisation needs the same depth of knowledge about QI concepts, methods and tools. We are committed to using a ' Dosing Formula' as described in the document 'Building Capacity and Capability for Improvement' Our dosing model (FIGURE 2:) establishes targeted levels of knowledge and skills of improvement concepts, methods and tools through a variety of delivery methods (including virtual learning, independent study, face-to-face workshops and, most importantly, experiential learning.)

It articulates a progression of learning that begins with building general awareness throughout all roles in an organisation and culminates with a few individuals developed with deep expertise.

Dosing Formula	Capability building	Outcomes & Staff engagement
0.5%	Expert 35	Individuals with a deep understanding and appreciation of improvement, able to inspire and lead, and deal with complexity across boundaries.
5%	Practitioner 300	Individuals who can teach and coach others in Improvement methods and can spread changes beyond their own area .
25%	Champion 1870	Staff who are confident in QI methods and have delivered an improvement project in their own area *'leading improvement projects'*
50%	Foundation 3750	Staff are aware of improvement methods and have attended face to face or E-Learning training. *'Doing the day job and improving it'*
100%	All Staff 7500	All staff are aware of our approach to improvement. *'engaged staff with an interest in improvement'*

We will strengthen our approach to recognising and sharing quality by building a network of staff throughout the organisation based on The Health Foundation's Q initiative.
'Q' aims to connect people with improvement expertise across the UK, fostering continuous sustainable improvement in health and care.

We will replicate this model within NNUH and our system partners and ensure opportunities are available for people to come together as an improvement community to enhance their improvement skills, share ideas, and collaborate to improve quality and safety

Currently there are 9 NNUH staff who are members of 'Q' and we would like to see the number grow over the coming years by actively promoting Q recruitment across the Trust.

How we will listen and respond to the patient voice.

Patient and Public Involvement

Our patients are our most important partners in our journey to outstanding. The aim of this strategy is to achieve a culture that welcomes authentic patient partnership – in their own care and in the processes of designing and delivering care, quality improvement and the measuring and monitoring of safety.

We have a long term commitment to listening and learning from the experiences of patients and carers.
We want to develop this further by encouraging patients to work with us to form mutually beneficial partnerships to embed 'Co-production ' into our approach. We will develop patient leadership and participation to drive service design and improvements which maximise patient and carer experience

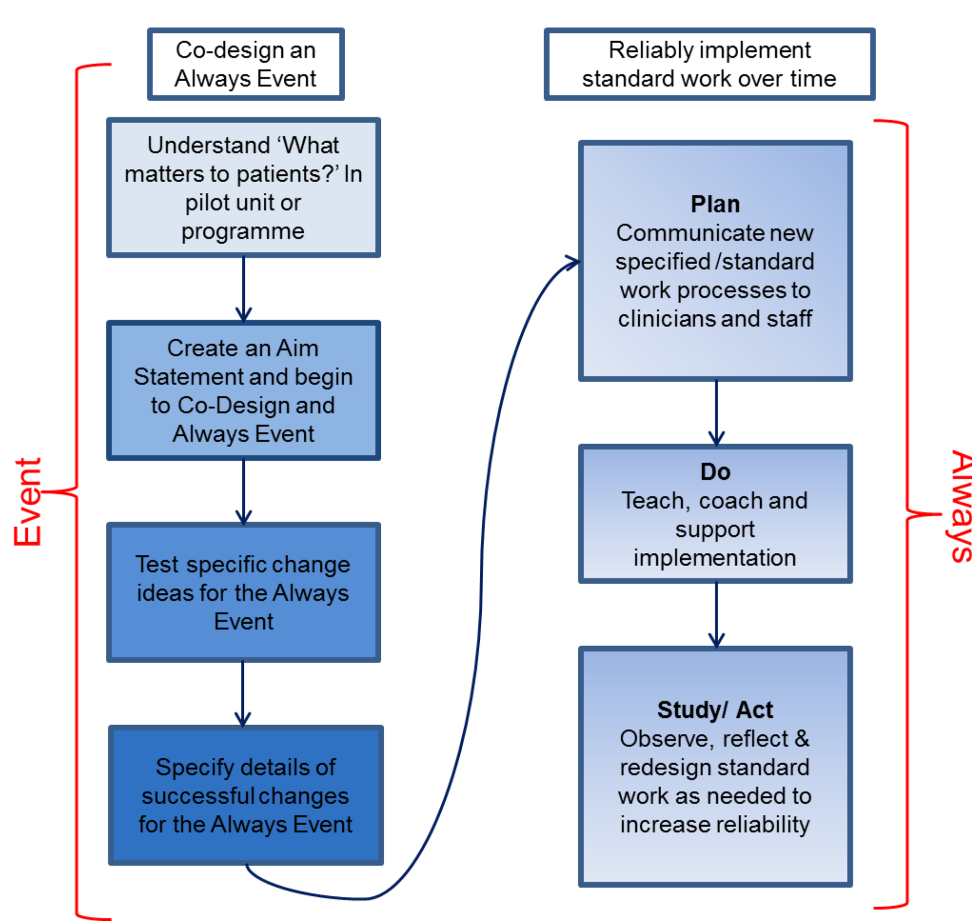
Patients and their carers should be present, powerful and involved at all levels of healthcare .

The Trust will adopt **Always Events®** as our approach to strengthen the voice of those using our services, their carers, families and our staff – enabling a pro-active shift from a sole focus on "what is the matter ?" to include an inquiry into "what matters to you?"

Always Events® are defined as "those aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the delivery system",

This is a good resource to tackle unwarranted variation and to focus on ensuring that the right care and support is delivered for everyone at a consistently high standard.

IHI Always Events® Framework is a way to accelerate improvement efforts and enhance experiences of care for patients, their family members or other care partners, and staff.



IHI's Always Events Framework®

Genuine partnerships between patients, service users, care partners, and clinicians are the foundation for co-designing and implementing reliable care processes that hold promise for transforming care experiences.

Norfolk and Norwich University Hospitals

NHS Foundation Trust

Appendix 2 : Aligning Trust Vision, Improvement Plan and Quality Strategy

Five Year QI Vision	Y1 2019	Y2 2020	Y3 2021	Y4 2022	Y5 2023

Quality Plan

- **Special Measures** — Focus: 'must/should do' actions
- **Getting to 'GOOD'** — Transforming services
- **Journey to OUTSTANDING** — Becoming the best & leading the way

Change vehicle

- **Project Management** — Transactional; compliance led
- **Embedding QI Methodology and Faculty** — Transformational; vision led

Strategic goals

We will be:
A provider of high quality healthcare to our local population
The centre for complex & specialist medicine for Norfolk & the Anglia region
A recognised centre for excellence in research, education and innovation
A leader in the redesign & delivery of health & social care services in Norfolk

Set goals for next five years

Quality Strategy

- Strategic Intent for QI
- Leadership for QI
- Building improvement skills
- Building a culture of improvement
- Putting patients at the centre of QI
- Applying systems thinking in QI

Our Values People focused Respect Integrity Dedication Excellence

Be an Improver
Be Collaborative
Be Outstanding

Quality Improvement Strategy
Appendix 3: Quality Strategy Driver Diagram

Aim: Our strategic intent by April 2023 we will be an outstanding organisation with an established and embedded a culture of long term learning and continuous improvement

Building a QI Safety Culture at all levels

1. Safety Culture assessment and actions to improve
2. Embedding Human Factors principles into daily work
3. Communication and celebrating QI work internally and externally
4. Transparency and duty of candour
5. Supporting staff when things go wrong
6. Reduction in harm incidents

Leadership for Quality and Safety Improvement

1. Role of Board members in leading improvement
2. Role of patient leaders in quality improvement
3. Connecting QI Strategy with organisational strategy and business as usual
4. Culture and teamwork
5. Safe staffing levels
6. Leading projects and project management

Building QI skills and learning at all levels

1. QI Curriculum & teaching resources
2. QI Faculty including QI experts and coaches
3. Support peer to peer learning and exchange of ideas: LifeQI, Quality dashboards, Newsletters, Quality and Safety OWLs
4. Improvement projects and programmes aligned to strategic quality priorities

Systems view of quality and safety

1. Support QI across STP and partner organisations
2. Learning shared across STP
3. Safer systems designed around patient safety
4. Integrated care programmes and pathways
5. Whole system flow programmes
6. Technology as an enabler

A driver diagram is a visual display of our theory of what “drives,” or contributes to, the achievement of our strategic aim. It shows the relationship between the overall aim, the primary drivers (sometimes called “key drivers”) that contribute directly to achieving the aim, the secondary drivers are the projects or work streams that will be required to achieve the aim,

Appendix 4 : CQC Well Led Domain
Quality improvement, innovation and sustainability

Signs of a mature Quality Improvement approach across the organisation	
1. Quality strategy available on website and intranet that explicitly mentions quality improvement and sets the organisation's quality improvement goals	
2. Quality appears to be the priority at the Board from agenda and minutes, with a specific report on quality that is accessible publicly.	
3. The Board looks at data as time series analysis, and makes decisions based on an understanding of variation.	
4. Clear and consistent improvement method for the organisation, and demonstrable across all areas/operations of the organisation.	
5. Presence of a central team dedicated to supporting quality improvement, with expertise in the improvement method and tools	
6. 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	
7. Structures in place to oversee quality improvement work, with multiple executive directors involved in regular provider-level overview.	
8. Robust, regular and local support in place across all areas of the organisation to support teams using QI to solve complex quality issues	
9. Quality improvement work across the organisation demonstrates alignment – projects at team level align with strategic objectives for the organisation	
10.Demonstrable use of measurement on a routine basis to monitor progress of QI work against outcomes and ensure sustained improvement.	
11.All Executive team and clinical leaders are able to talk about their role in leading quality improvement, supporting teams in their quality improvement work and	
12.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.	

Integrated Performance Report

July 2019 (June 2019 data)

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

Norfolk and Norwich University Hospitals

NHS Foundation Trust

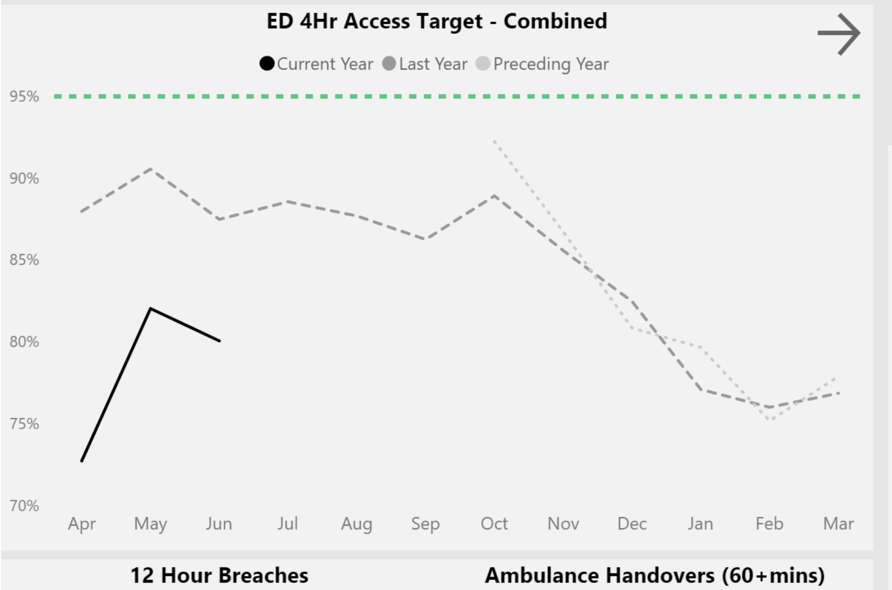
Norfolk and Norwich University Hospitals NHS Foundation Trust

NNUH Integrated Performance Report

ED Performance

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

Month Selector: Most Recent



12 Hour Breaches

10
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

Ambulance Handovers (60+mins)

500
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

ED Combined Performance

Month	2018	2019
June	87.5%	80.1%

12 Hour Breaches

M	2018	2019
Jun	0	12

Ambulance Handovers

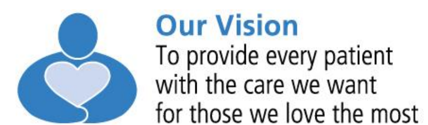
M	2018	2019
Jun	61	92

Data Observations

June's four-hour type 1 performance decreased slightly to 72.7%. The combined (reportable) standard was 80.1% compared to May's 82.1%.
There were twelve 12-hour breaches in June, a 12 month high. All were mental health breaches, in need of an external bed.
In June, we had an average of 418 ED attendances per day. This is the highest daily average experienced in the Trust.
Since October 2018, Ambulance conveyances have remained relatively static at approximately 131 per day. In June 92 (2.3%) of ambulance conveyances took 60 mins or longer to handover, an increase from 11 (0.3%) in May. 48% of ambulance arrivals met the target to hand over within 15 minutes, a decrease from 59.4% in May.
Conversion rate reduced slightly to 24.4% in June. The Conversion rate has been averaging at 24.7% since February, an improvement from 27.7% in January.
Quality measures remain low with initial assessment within 15 minutes at 33.1% and those receiving treatment within 60 minutes at to 25.1%.

Management Comments and Actions

The average ED activity has increased again with a new average of 418 attendances a day; this is reflective of the slight dip in performance compared to the previous month with 80.1% in June. Ambulance attendances continue to follow the same trend - the 92 >60 min breaches were related to specific challenged days associated with high volumes in ED and poor flow combined with workforce challenges. Recruitment plans are progressing and we anticipate 4 new consultants will start over the next 8 weeks (3x locums from the Dan Boden agency and 1 substantive). Minors and paed performance continue to be a priority area and small incremental improvements are being seen with paediatrics achieving 100% on some days. The targeted action plan and trajectory have been refreshed to expedite progress.

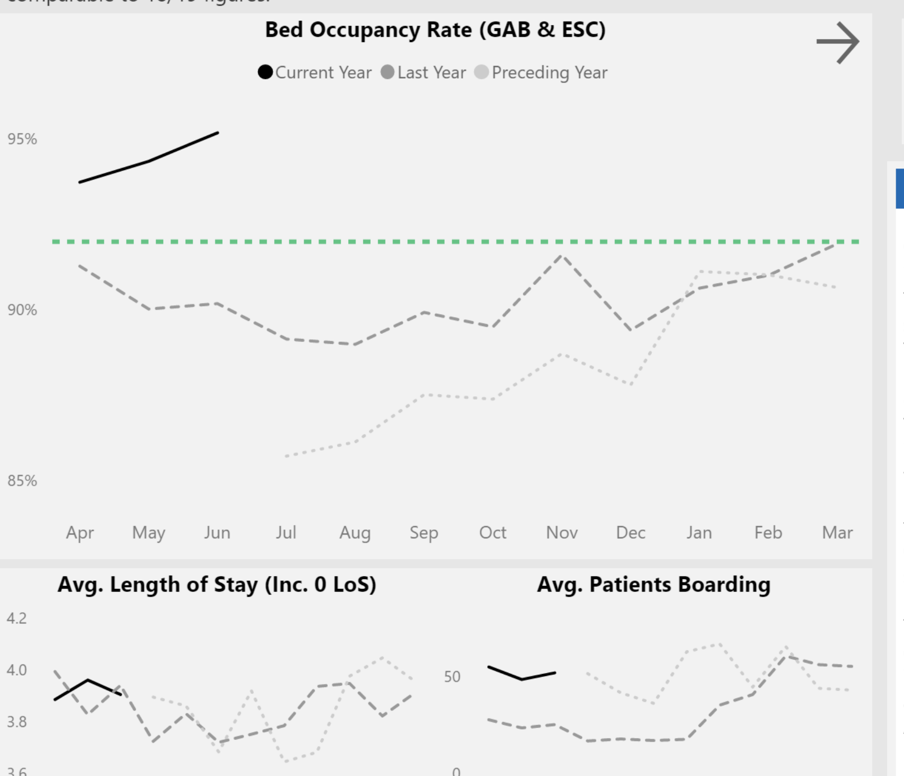


Patient Flow

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

Month Selector

Most Recent



Bed Occupancy Rate		
Month	2018	2019
June	90.2%	95.2%

Avg. LoS (Inc. 0)		
M	2018	2019
Jun	3.9	3.9

Avg. Patients Boarding		
M	2018	2019
Jun	25.3	52.0

Data Observations

Bed occupancy rate increased to 95.2% in June from 94.3% in May. Bed occupancy rate has been increasing since December 2018.
The average length of stay has remained relatively static since December (approx 3.9 including 0 LoS). The average LoS in June was in line with the the 6-month average at 3.9 (including 0 LoS) and 5.6 (excluding 0 LoS).
The average number of boarders in June was 52, and increase from 48.5 in May. This is a slight increase following a four-month downward trend. There were more boarders on Sundays than on any other day of the week in June.
On average, there were 112 patients with a length of stay of 21 days and over in June, a decrease from May's average of 122.
The daily average number of delayed transfers of care patients in June was 31.8, a decrease from 40.7 in May. Most delays were attributed to local authorities.
An average of 28.5 patient per day were discharged by 11:00 am in June. This is slightly lower than the 6-month average of 29.3

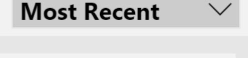
Management Comments and Actions

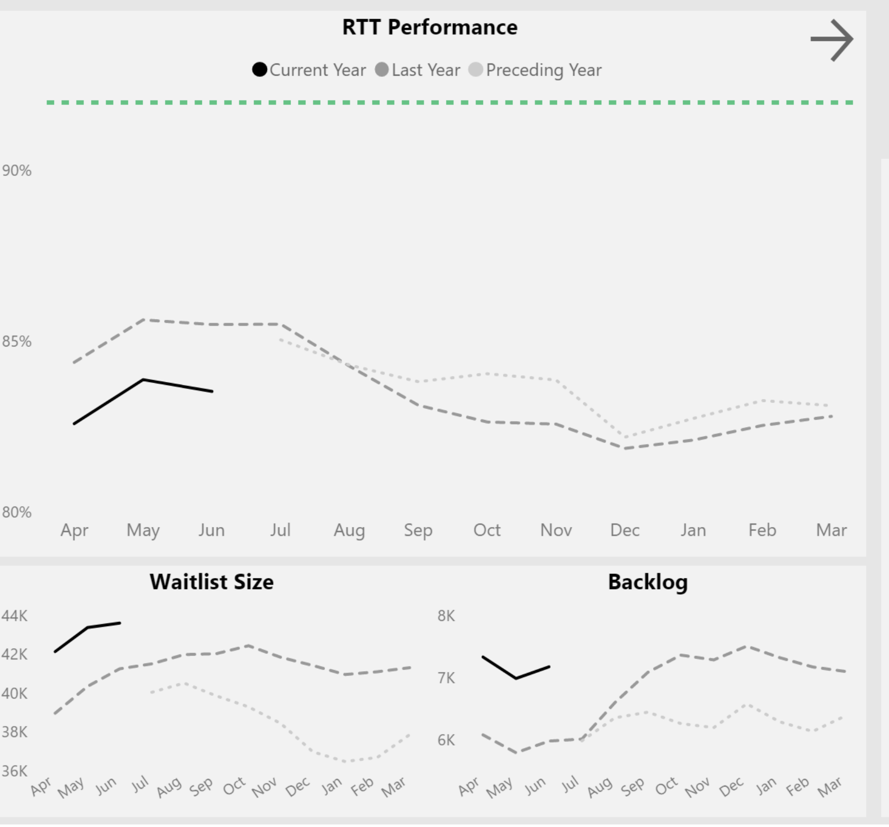
In June we have reduced the average LLOS >21 day stay patients from 122 to 112 (June target was 108); the revised approach of splitting the reviews over 2 days and increasing scrutiny are having a further positive impact and the current performance is 105 against the July trajectory of 96. A dedicated Discharge Improvement Group is being set up to work closely with system partners to continue to target the DTOC delays - the average has reduced in June to 31.8 but we need to achieve 22 to deliver 2.5%.

Norfolk and Norwich University Hospitals NHS Foundation Trust

RTT Performance

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





RTT Performance			Waiting List			Backlog		
Month	2018	2019	M	2018	2019	M	2018	2019
June	85.5%	83.5%	Jun	41,274	43,629	Jun	5,985	7,181

Data Observations

RTT Performance has decreased by 0.4 percentage points to 83.5%.
Both the waiting list size and backlog have increased to 43,629 and 7,181 respectively.
Compared to June 18 the waiting list and backlog are higher and performance is lower with trends very much in line with last year.
There are no patients waiting over 52 weeks however patients waiting over 40 weeks is up to 559 which is a similar level to last month's 552.
Orthopaedics and Gynaecology are still the worst performers within the 40+ week category.

Management Comments and Actions

• Waiting list is showing further increases over 18 weeks due to high levels of cancellations and increase in urgent/cancer case mix pushing routine waits out.
High levels of cancellations due to lack of capacity continue to impact on the elective programme.
Reduction in PA's and WLI due to pension tax continues to reduce capacity.
Clinical Harm management processes in place.
Draft RTT RAP reforecast complete and awaiting commissioner demand management schemes.
Exploration and agreement for further insourcing lists to include GA throughout July and August.
Theatre efficiency programme remains in place but insuffiecint theatre capacity and regular escalation into DPU remains an issue.

Norfolk and Norwich University Hospitals

NHS Foundation Trust

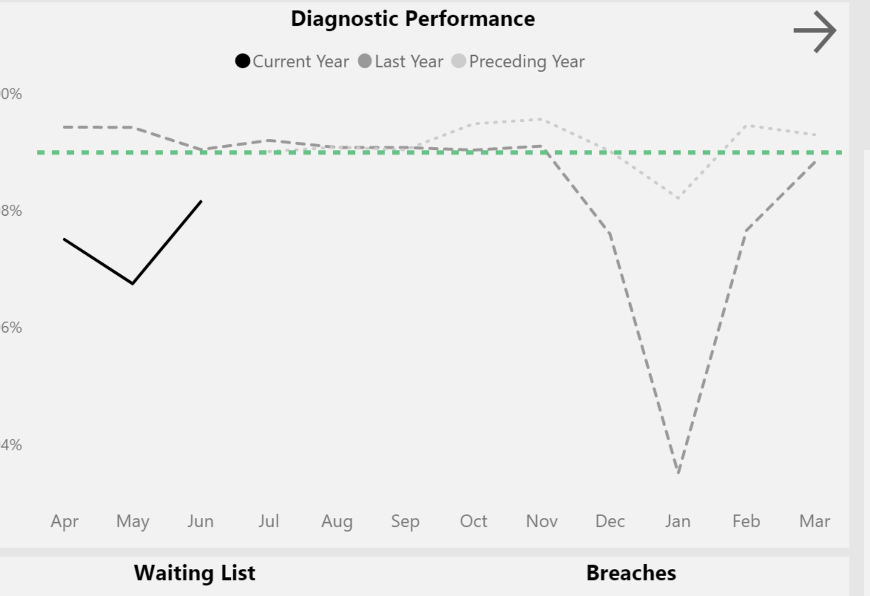
Norfolk and Norwich University Hospitals NHS Foundation Trust

DM01 Diagnostics

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

Month Selector

Most Recent



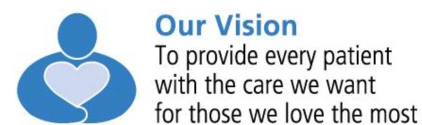
Diagnostic Performance			Waiting List			Breaches		
Month	2018	2019	M	2018	2019	M	2018	2019
June	99.0%	98.2%	Jun	11,247	11,407	Jun	107	210

Data Observations

Performance has increased to 98.2% from 96.8%. This is down on last year where we were achieving the 99% standard.
The waiting list has decreased slightly from last month by 307 patients, and breaches are down to 210 from 382.
The areas that have breached the standard include MRI (119) , cystoscopy (15), urodynamics (8), gastroscopy (13), cardiology (13) and audiology assessments (8).
MRI accounts for the majority share of all the breaches with a higher number of patients waiting for diagnostic.

Management Comments and Actions

There has been a significant increase in demand for MRI from GP's since October 2018, this coupled with the 121 hours of unplanned downtime for MRI in June has resulted in high levels of breaches.
Plans are being worked on to provide extra capacity, including outsourcing, overtime and in-sourcing of extra vans.
13 Cardiology breaches in June were as a result of a process issue which has been identified and resolved.
Audiological breaches in June were as a result of sickness, which has now resolved.
Cystoscopy and Gastroscopy issues in June remain with capacity issues for GA lists in theatres and long term sickness within the consultant team.
Gastroscopy GA list business case approved, due to commence in Sept 19 pending recruitment of theatre staff.
Aggregate DM01 performance is expected to achieve in Sept 19

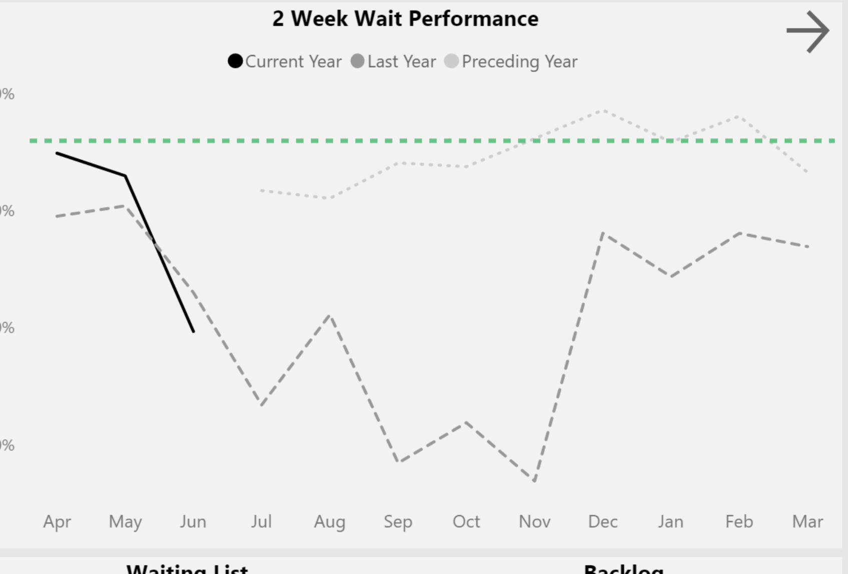


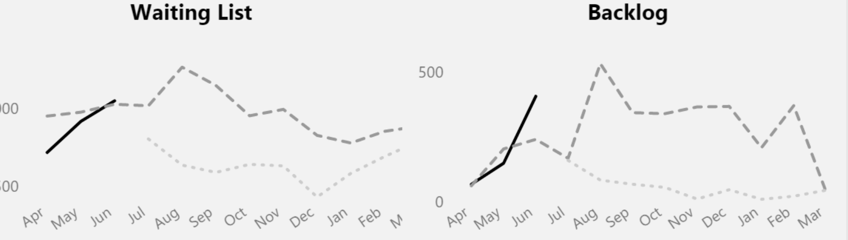
Norfolk and Norwich University Hospitals
NHS Foundation Trust

Cancer Performance: 2ww

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

Month Selector: Most Recent





2ww Performance		
Month	2018	2019
June	83.0%	79.7%

Waiting List		
M	2018	2019
Jun	1,029	1,051

Backlog		
M	2018	2019
Jun	242	408

Data Observations

Provisional June data shows a decline in performance at 79.7% vs. a target of 93%, compared to 93.0% in May. This coincides with a decrease in provisional Dermatology performance to 48.8% in June 19 compared to 95.8% in May 19. Activity for dermatology has remained steady between March 19 and June 19, however there has been a consistent increase in referrals received between Feb 19 (402) and June 19 (552), with a peak in May 19 (602). This is comparable to 12 months previous, with 538 referrals received in June 18.
Overall, there has been a 174% increase in breaches, rising from 153 in May 19 to 419 in June 19. Inadequate capacity is recorded as the cause of delay in 93% of cases. Both the WL and Backlog have continued to increase from the previous month, with WL increasing from 919 to 1051 (14%) and BL increasing from 150 to 408 (172%).

Management Comments and Actions

Decline in performance due to breaches in Skin and Lower GI. Dermatology have been tasked with populating a weekly activity plan showing how and where additional clinic activity will be sourced to meet demand. Lower GI have seen another step change in referral demand which has not been able to be accomodated within the usual safety valve mechanism of clinics, as straight to test capacity has been historically pre-set at a fixed level. To ensure long term sustainability endoscopy will look to increase their capacity for straight to test 2WW, Radiology will look to set up a straight to test CT Colonoscopy service and clinic capacity has already been increased by 45%. This will equate to all points of delivery haveing ring fenced capacity to meet at least the 85th percentile of demand. In the short term additional clinics on top of this increase will run in July and August to reduce the net waiting time down to below 14 days.

Norfolk and Norwich University Hospitals

NHS Foundation Trust

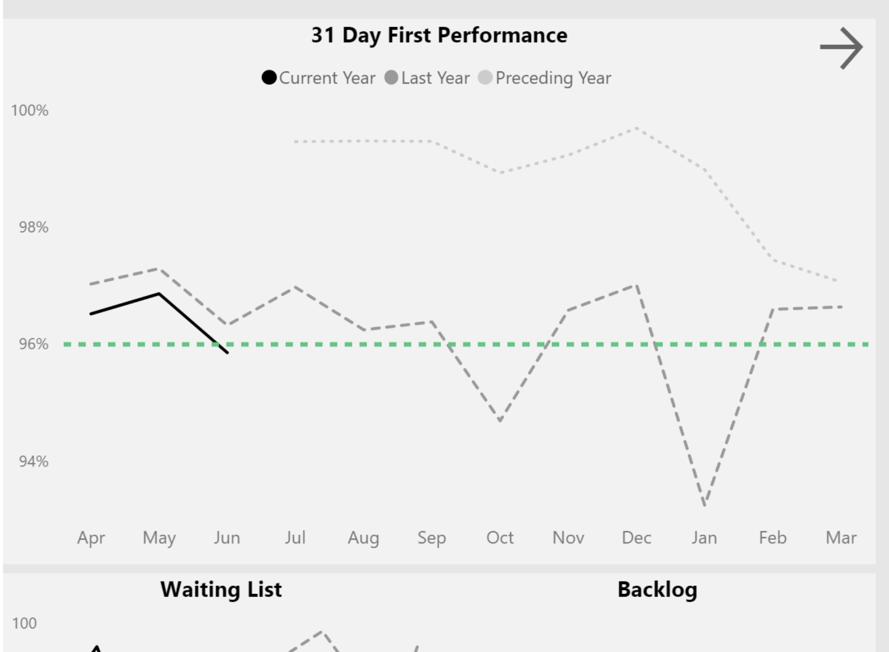
Information Services | Norfolk and Norwich University Hospitals NHS Foundation Trust

Cancer Performance: 31 Day

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

Month Selector

Most Recent



31 Day Performance			Waiting List			Backlog		
Month	2018	2019	M	2018	2019	M	2018	2019
June	96.3%	95.9%	Jun	83	59	Jun	8	15

Data Observations

Provisional June data shows a decline in performance at 93.3% vs. target of 96% compared to 96.9% in May. The waiting list size has decreased by 35% between May 19 (91) and June 19 (59) and there has been a rise in the backlog from 11 to 15. There has been an increase in breaches from 11 (May 19) to 20 (June 19), with inadequate capacity recorded as the cause of delay in 67% of cases.

Management Comments and Actions

June data validation not yet complete. Once validated it will show compliance against the 96% standard.

Norfolk and Norwich University Hospitals

NHS Foundation Trust

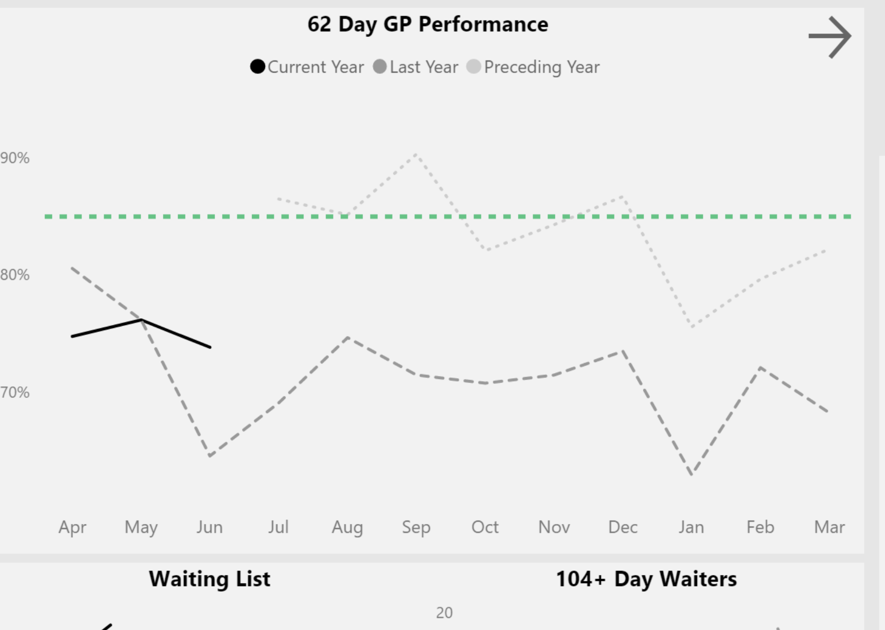
Norfolk and Norwich University Hospitals NHS Foundation Trust

Cancer Performance: 62 Day

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

Month Selector

Most Recent



62 Day Performance		
Month	2018	2019
June	64.6%	73.8%

Waiting List		
M	2018	2019
Jun	2,187	2,383

104+ Day Waiters		
M	2018	2019
Jun	6	9

Data Observations

Provisional June data shows a decline in performance at 73.4% vs. target of 85% compared to 76.2% in May. This follows on from a trend of improvement between March 19 and May 19. Activity has decreased by 14.7% between May 19 (170) and June 19 (145).

The waiting list has increased by 11.7% between May 19 (2134) and June 19 (2383) whilst the backlog has decreased from 109 to 87. There has also been an increase in the 104+ day waiters, from 5 (May 19) to 9 (June 19).

Diagnostic delay has been recorded as the single largest cause of delay for June 19, attributed to 39% of cases. This is followed by inadequate capacity in 19.5% of cases.

Management Comments and Actions

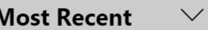
June activity data is not yet complete and is unvalidated. Therefore caution should be exercised in it's current interpretation. Post validation, June is forecast to deliver >75% performance which is comparable to April and May and remains above trajectory. The current priority is on delivering sufficient activity for all points of delivery within the Prostate and Colorectal pathways to prevent build up of cumulative incremental delays and therefore breaches of the 62 day standard. As these are high volume pathways that significantly contribute to breaches an improvement in performance over QTR2 and 3 is forecast in our trajectory.

Waiting List

2K
1K
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

104+ Day Waiters

20
10
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar



Norfolk and Norwich University Hospitals

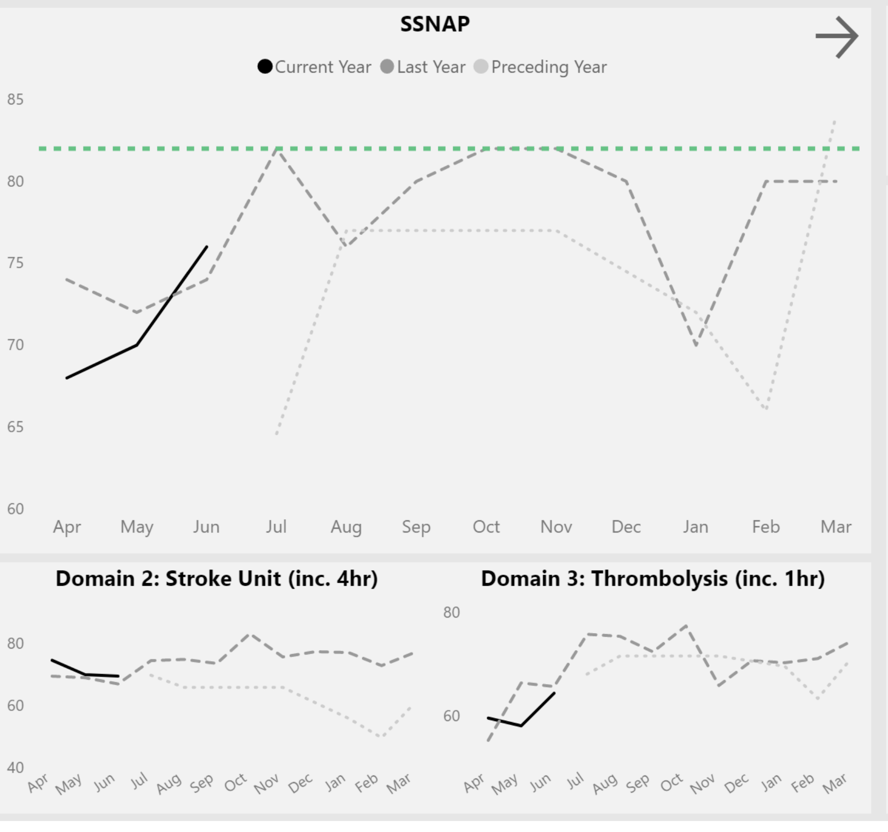
NHS Foundation Trust

Norfolk and Norwich University Hospitals NHS Foundation Trust

Stroke

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

Month Selector: Most Recent



Month	MetricName	2018	2019
June	SSNAP - Score	74	76
	Domain 2 - Score	67	70
	Domain 3 - Score	66	64

Month	MetricName	2018	2019
June	SSNAP - Grade	B	B
	Domain 2 - Grade	D	D
	Domain 3 - Grade	C	C

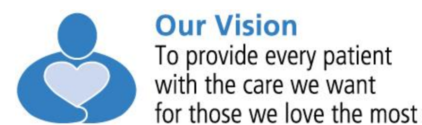
Data Observations

Overall SSNAP score in June was 76 which is an increase of 6points compared to last month. This is also slightly above the position for June 2018 (74).
Both potential and diagnosed stroke numbers were slightly lower this month compared to last month, but remain relatively static overall, at 317 and 104, respectively.
Domain 2 has remained static from last month, with a score of 70, this is a slight improvement on last year's position (67).
Domain 3 has improved on last month's score, from 58 to 64, bringing it back in line with last year's performance (66).

The Domains 1-10 SSNAP grades are as follows:
Grade A: 5, 6 &10
Grade B: 4, 7 & 9
Grade C: 1, 3 & 8
Grade D: 2

Management Comments and Actions

6% increase in overal score, now at 76, taking it to a B for June 2019.
Lower number of potential and diagnosed Strokes in comparison to May 2019.
Lack of an EEAST pre-alert is still the main cause for admission breaches.
Therapy standards in all 3 domains have improved.
Standards by discharge dropped to B with two patients not screened and two not referred.



Norfolk and Norwich University Hospitals

NHS Foundation Trust

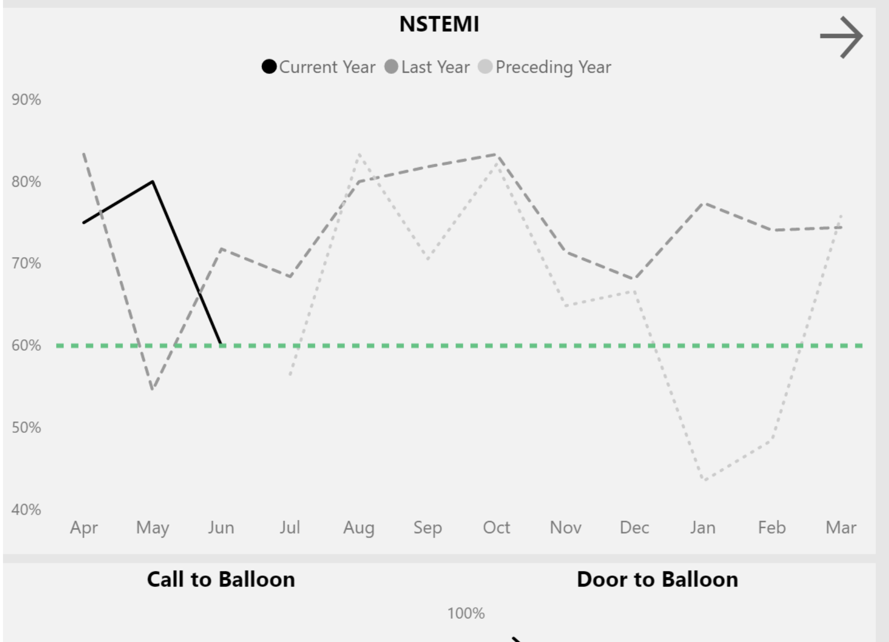
Norfolk and Norwich University Hospitals NHS Foundation Trust

Cardiology

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

Month Selector

Most Recent



NSTEMI			Call to Balloon			Door to Balloon		
Month	2018	2019	M	2018	2019	M	2018	2019
June	71.8%	60.0%	Jun	80.0%	78.9%	Jun	85.4%	81.6%

Data Observations

NSTEMI within 72 Hrs - Standard Delivered. Where we did not achieve the reasons were mainly due to comorbidities and lack of capacity. PPCI call to balloon with 150 minutes - Standard Delivered. Where we did not achieve this was primarily due to long journet times to NNUH or conflict with another PT mid procedure. PPCI door to balloon within 60 minutes - Standard Delivered. We did not achieve for more complex cases or due to conflict with another PT mid procedure.

Management Comments and Actions

Despita a temporary reduction in lab capacity in June all standards delivered. We continue to work with EEAST to support their scene/journey times.

Mortality Rate

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

Month Selector

Most Recent

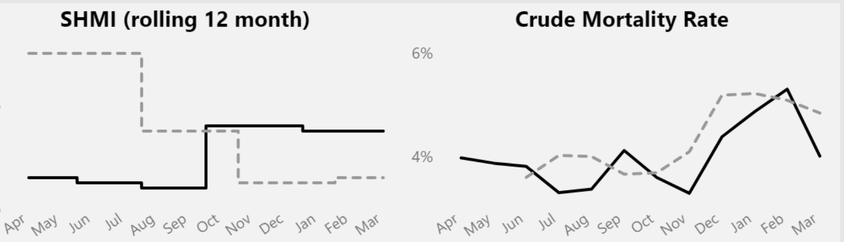
	HSMR		SHMI			Crude Mortality		
Month	2018	2019	M	2018	2019	M	2018	2019
March	96.9	86.9	Mar	107	108	Mar	4.8%	4.0%

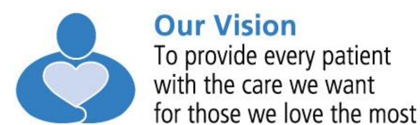
Data Observations

The Trust's HSMR score reached 90.32 in Mar 19, a return to steady decline since a brief increase in Feb 19. The Oral specialty saw a sharp increase causing it to have the second highest value next to Obstetrics and Gynaecology. The Trust's Weekend HSMR remains higher at 92.61 than it's Weekday HSMR at 89.50. No new SHMI release means the Trust's score remains at 107.50 in Mar 19. After a period of incline the Trust's Crude Mortality has seen a decrease in Mar 19 to 3.99% compared to 5.11% in Feb 19, which was the highest the Trust has seen in a 12 month period. This comes with a fall in deaths to 303 in the month.

Management Comments and Actions

The M&M and SJR process will look at the unexpected oral speciality deaths with an examination into the particulars surrounding the patient's death to look at the level of care provided and determine whether any improvements can be made or learning shared.
The weekend HSMR being higher than the weekday HSMR is known and not unqiue to NNUH, but common for acute trusts and the reasons are not all acute trust dependent. The Trust has an action plan to improve compliance with all the National 7 day Service Standards which will redress some weekend/weekday variation.





Norfolk and Norwich University Hospitals
NHS Foundation Trust

Information Services | Norfolk and Norwich University Hospitals NHS Foundation Trust

NNUH Integrated Performance Report

Infection Control

Monitoring the hospital's exposure to harmful infections. These metrics are submitted to Public Health England as part of their ongoing national surveillance into Health Care Associated Infections, the results of which are made public. Please note - new methodology for reporting C. difficile began in April 2019.
Please note all information presented here is showing cumulative Financial Year to Date.

Month Selector: Most Recent

	E. Coli FYTD		MRSA FYTD		C. diff FYTD	Klebsiella FYTD		Pseudo. FYTD	
	Jun 2018	Jun 2019	Jun 2018	Jun 2019	Jun 2019	Jun 2018	Jun 2019	Jun 2018	Jun 2019
	15	8	0	0	3	2	2	4	2

E. Coli (Trust Apportioned)
Current Year, Last Year, Preceding Year
50, 0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

Hosptial Acq. MRSA
1.0, 0.5, 0.0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

HOHA C. difficile
4, 3, 2
Apr May Jun

Klebsiella (Trust Apportioned)
20, 10, 0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

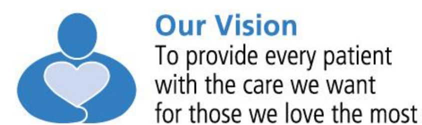
Pseudonomas (Trust Apportioned)
10, 0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

Data Observations

- Hospital attributable Clostridium difficile [C. diff] is 3 HOHAs and 3 COHAs, awaiting CCG review for assignment of trajectory/non trajectory. To date 3 trajectory cases counting towards the NNUH annual objective of < 35 cases.

Management Comments and Actions

- Outbreaks, Denton ward have been 77 days without a new HAI case of MRSA. Dunston ward have been 145 days without a new HAI MRSA and 72 days without an HAI C. diff case. IP&C continue to undertake additional monitoring.
- 7 wards are still awaiting overdue ventilation duct cleaning. Options appraisal paper went to hospital management board on 25/016/19. Due to lack of a suitable space to decant patients to it was agreed that until such a time as space can be identified that Option 2 - enhanced cleaning and swabbing of patients would be implemented.
- Audit of Trust patient food fridges undertaken W/C 24/06/19. Only 19.5 % of fridges had had appropriate action if they went >5oc, areas aware.
- ICNet surveillance software used by IP&CT is no longer supported from 30/06/19. It has been added to the risk register as a risk of 20.
- On 16th July 2019, Dr Debra Adams, NHSI undertook an IP&C re-inspection following red rating in February 2019. Trust de-escalated as green rating achieved.



Norfolk and Norwich University Hospitals

NHS Foundation Trust

Information Services | Norfolk and Norwich University Hospitals NHS Foundation Trust

NNUH Integrated Performance Report

Patient Safety

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

Month Selector: Most Recent

Never Events (Cumulative)

Current Year | Last Year | Preceding Year

	Never Events FYTD		Recorded Incidents (DATIX)		Serious Incidents (DATIX)		Pressure Ulcers /1000 bed days		Patient Falls /1000 bed days	
	Jun 2018	Jun 2019	Jun 2018	Jun 2019	Jun 2018	Jun 2019	Jun 2018	Jun 2019	Jun 2018	Jun 2019
	2	1	1,645	2,108	13	22	1.3	0.9	0.0	0.0

Incidents

Serious Incidents

Hosp. Acq. Pressure Ulcers/1000bed days

Patient Falls per 1000 bed days

Data Observations

Siginificant rise in reported incidents to 2108, 96% of which were no or low harm incidents. 22 Serious Incidents were reported for the Trust. 1 was a Never Event following IV infusion of an epidural medication in Surgery. 17 SI's were for ED with the majority (11) relating to breaches of 12hr target for a MH bed. Submission of final SI reports on time has reduced from 6% to 5% compliance. Duty of Candour compliance has improved and was 100% for June. 5 Cat 3 HAPU were reported in month. 5 wards have achieved >100 days free from HAPU - NICU 315; Denton 294; CCU 171; Delivery Suite 153 & EAUS 139.

Management Comments and Actions

Divisional performance with SI submission compliance needs to improve significantly. This will be closely monitored via monthly performance meeting. There continues to be a large backlog of datix incidents that require invesigating. Divisions have been tasked to agree a recovery plan to address this.

Norfolk and Norwich University Hospitals

NHS Foundation Trust

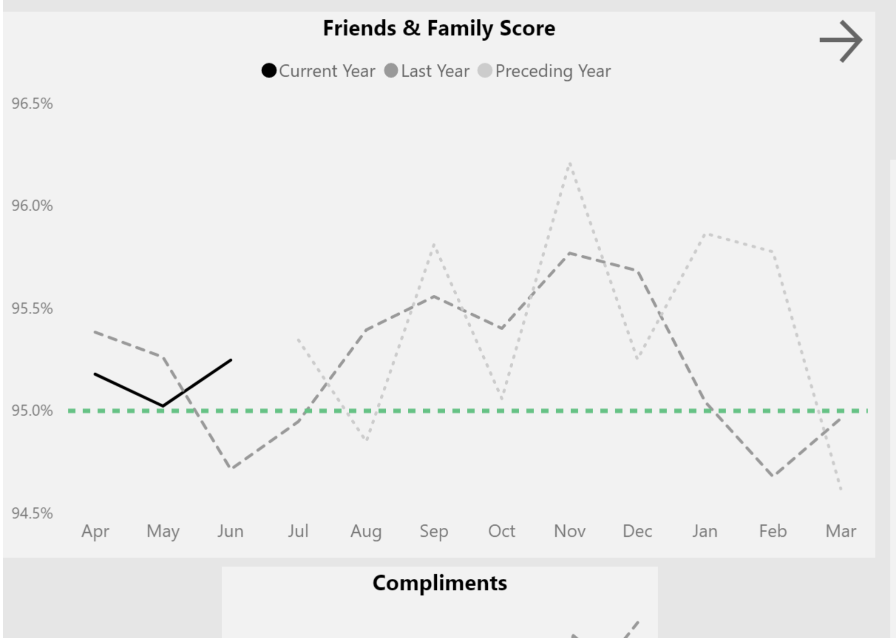
Information Services | Norfolk and Norwich University Hospitals NHS Foundation Trust

Patient Experience

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

Month Selector

Most Recent



Compliments

200
0
Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

Friends & Family		
Month	**2018**	**2019**
June	94.7%	95.2%

Compliments		
M	**2018**	**2019**
Jun	5	183

Data Observations

The FFT score has remained around 95% recommenders, on or above target. Compared with last year there is a slight increase.

Since January 2019 there has been a new way of recording compliments, via Meridian, with individual departments encouraged to record all those they receive directly to Meridian. This has resulted in an increase compared to last year.

Management Comments and Actions

Each department and division reviews their own scores and comments and takes action accordingly; reporting to PEEG. Most compliments reference the caring behaviour and attitude of staff reinforcing the PRIDE values.

Norfolk and Norwich University Hospitals

NHS Foundation Trust

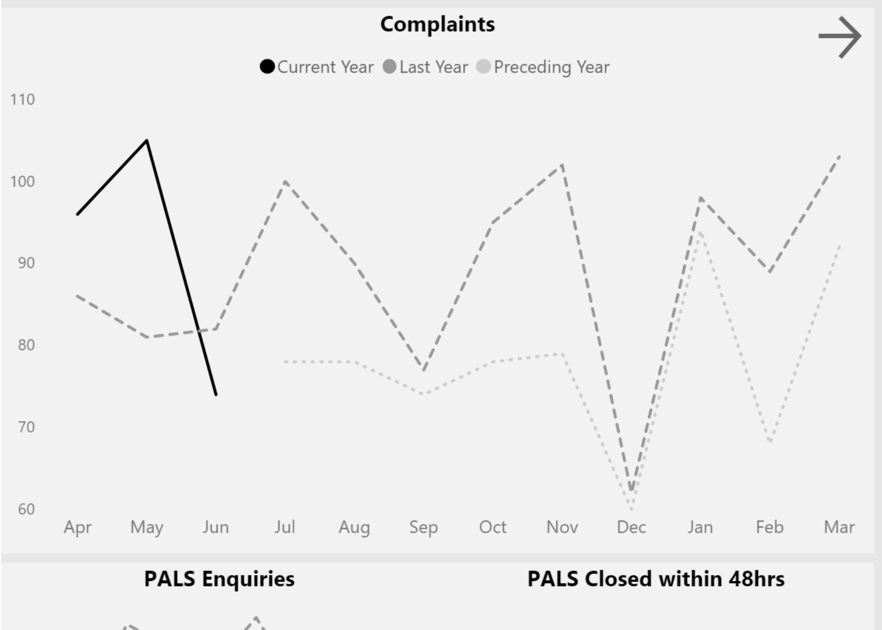
NNUH Integrated Performance Report

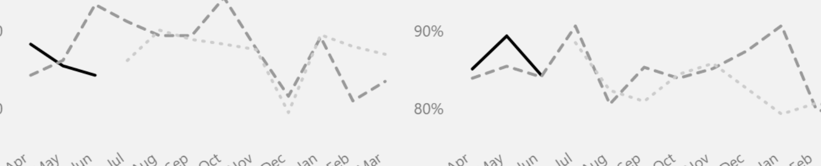
Patient Concerns

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

Month Selector

Most Recent





Complaints			PALS Enquiries			PALS Closed <48hrs		
Month	2018	2019	M	2018	2019	M	2018	2019
June	82	74	Jun	335	244	Jun	84.2%	84.4%

Data Observations

PALS: the number of PALS enquiries has dropped a little over the first quarter this year.

Complaints: The number of complaints has dropped in June, however the number of complaints fluctuates throughout the year as can be seen from previous years' data.

Management Comments and Actions

PALS: Communication and waiting times remain the biggest issues. Each department and division is responsible for reviewing PALS feedback and making improvements where necessary. This is reported through to PEEG.

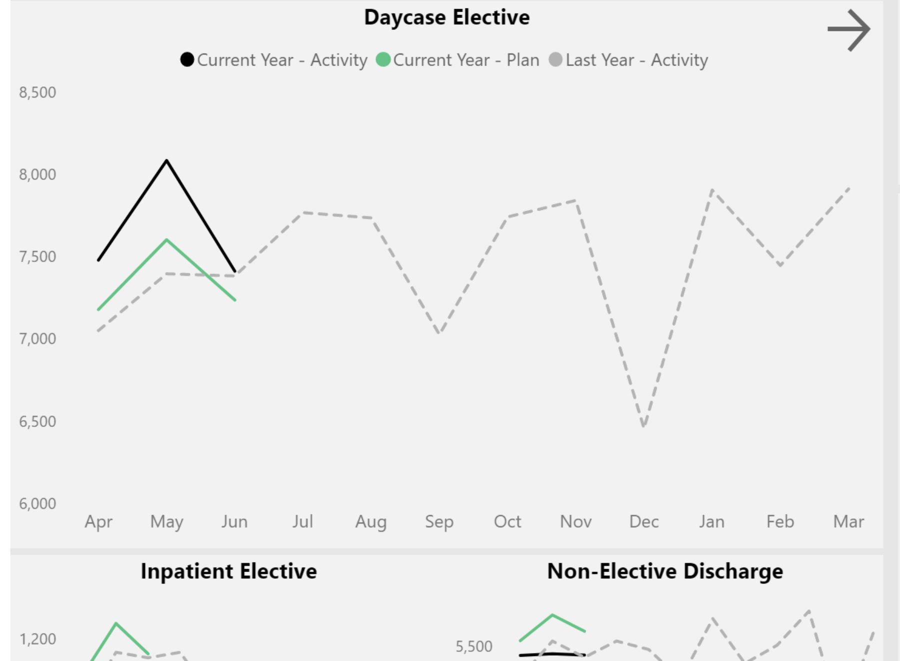
Complaints: Each department and division is responsible for reviewing complaints and making improvements where necessary. This is reported through to PEEG.

Plan vs Activity: Admitted

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

Month Selector

Most Recent



Daycase Elective

Measure	Jun
Current Year - Activity	7,414
Current Year - Plan	7,238
Last Year - Activity	7,385

Inpatient Elective

Measure	Jun
Current Year - Activity	964
Current Year - Plan	1,159
Last Year - Activity	1,147

Non-Elective Discharges

Measure	Jun
Current Year - Activity	5,437
Current Year - Plan	5,610
Last Year - Activity	5,421

Data Observations

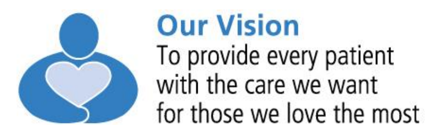
Daycase/RDA: Jun performance was 2.4% (176 cases) over plan and on a parr with June 2018 levels.
Plan over performance was mainly in medicine (Gastro +200 & Clinical Haem +147). Surgery was 78 below plan, with the worst performers being Ophthalmology (-50), Dermatology (-29) and Plastics (-19).
Elective: Jun activity was well down against business plan (by 16.8%) and prior year (by 16%). In Medicine part of this is cardiology switching to daycase.
Surgery once again were down against plan in Urology (-47), Ophthalmology (-22) and Pain Management (-18). Gynaecology was 17 down against plan.
Non Elective: Activity was below plan by 173 (-3.1%) but in line with June 2018 levels. Paediatrics was the single biggest contributor with 110 cases fewer than planned. Even though the 19/20 plan was not phased for seasonality, performance was still 54 cases down on June 2018. Other areas that were down included Respiratory Medicine (-54), General Surgery (-47) and Vascular Surgery (-34).

Management Comments and Actions

Daycase/RDA
Cardiology in particular has seen a switch of activity from elective to daycase due to recording changes which were not anticipated in the plan. There is no monetary impact. This will be monitored going forward.
Closely monitoring impact of Aylsham suite on dayase performance skewing trends.

Elective
Work is being done within the Performance Meetings to understand areas of underperformance better and work up appropriate speciality action plans, particularly in Surgery.

Non Elective
Joint work is ongoing between Women and Children's Division and Commissioning Info Dept to further understand the drivers for under performance in this area.



Norfolk and Norwich University Hospitals

NHS Foundation Trust

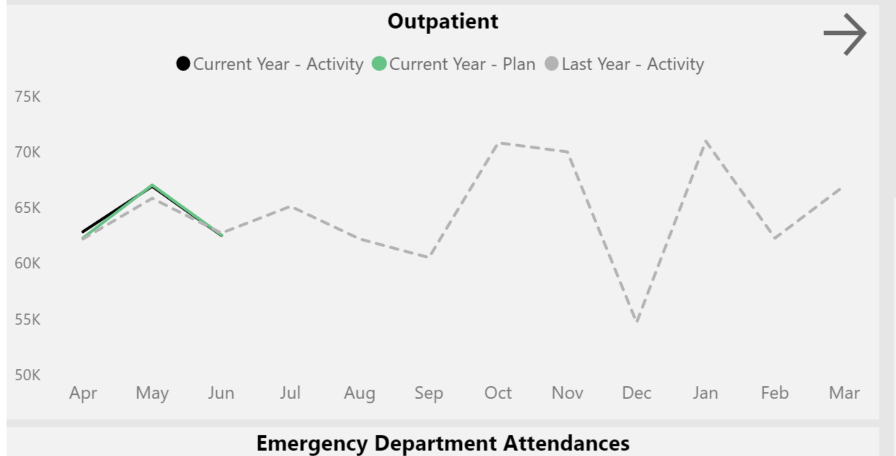
Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

Plan vs Activity: Non-Admitted

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

Month Selector

Most Recent



Emergency Department Attendances

13,000
12,500
12,000
11,500
11,000

Apr May Jun Jul Aug Sep Oct Nov Dec Jan Feb Mar

Outpatient

Measure	Jun
Current Year - Activity	62,537
Current Year - Plan	62,576
Last Year - Activity	62,750

Emergency Department

Measure	Jun
Current Year - Activity	12,536
Current Year - Plan	11,995
Last Year - Activity	11,798

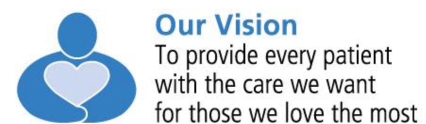
Data Observations

Outpatient: Consultant Led News were on a parr with prior year levels and 0.4% up on plan, driven by gains in ENT (+262), T&O/Spinal (+96), Dermatology (+116) and Gastro (+108). Surgery as a whole was down with losses in General Surgery (-287), Urology (-114), Ophthalmology (-139) and Oral (-106). Consultant Led Follow Ups were down against plan by 550 (-1.5%) and against prior year levels by -1.6%. Underperformance in medicine was the biggest driver, including Gastro (-182), Rheumatology (-275) and Neurology (-156). This was slightly offset by surgery over performance, particularly ENT (+160), Ophthalmology (+160) and Oral Surgery (+116). W&C were under plan, due to underperformance of 123 in paediatrics. Non Consultant outpatients were up against plan across the board, but particularly in Therapies (+233), General Surgery (+107) and Plastics (+130)

A&E: Performance up against plan by 541 attendances (+4.5%) and increase of 471 on June 2018 performance (+6.3%).

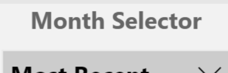
Management Comments and Actions

Outpatient: Possibility of block for outpatient follow-ups for chronic medical conditions being considered by the Division, although this may be superseded by overall minimum income guarantee / block discussions that are now starting with CCGs.



Norfolk and Norwich University Hospitals

NHS Foundation Trust

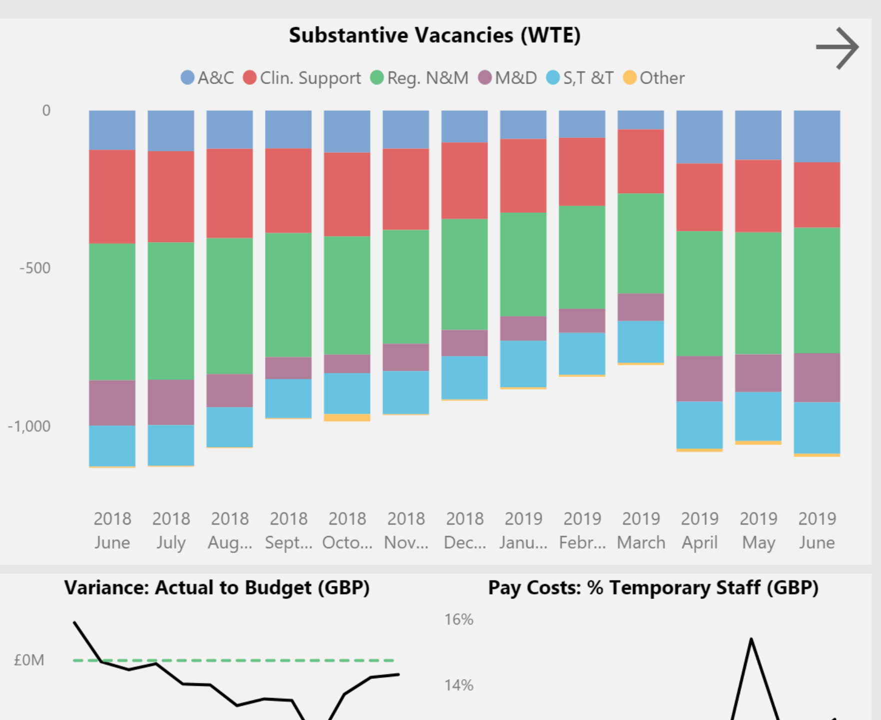


Workforce

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

Month Selector

Most Recent



Vacancies							
Month	A&C	Clin. Support	Reg. N&M	M&D	S,T &T	Other	Total
June	-164	-207	-397	-156	-163	-10	**-1,097**

Spend Variance	
M	2019
Jun	-0.34M

% Temp Spend	
M	2019
Jun	13.0%

Data Observations

Overall, in the last twelve months to 30th June 2019, there are 448.2 additional staff, an increase of 6.6% across NNUH as a result of service developments and capacity and quality investments.
In the last 24 months there has been an increase of 761.4 WTE (6,481.4 staff in post 30-Jun-17).

Management Comments and Actions

The biggest increase in staffing is the clinical support staff category, which is attributable to our success in recruiting healthcare assistants (178.2 additional HCA's since June 2018).
The vacancy gap has widened due to further increases to the establishment from April 2019.

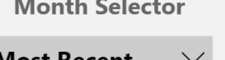
Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

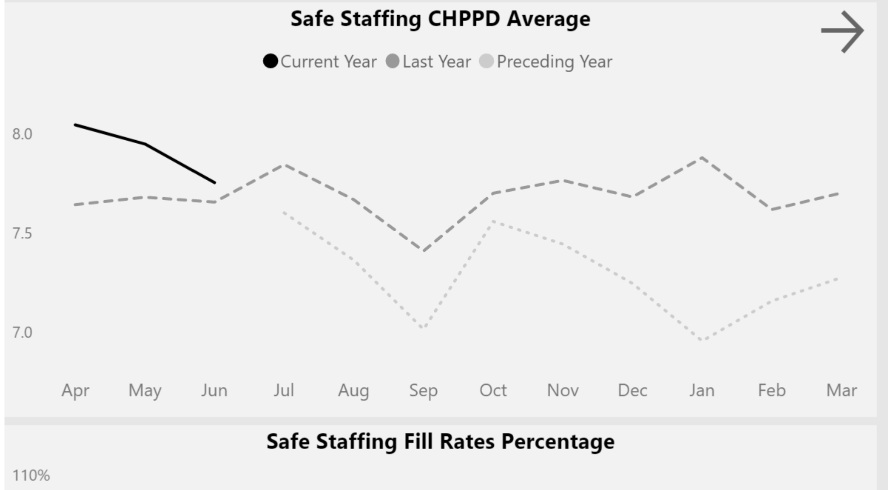
Norfolk and Norwich University Hospitals NHS Foundation Trust

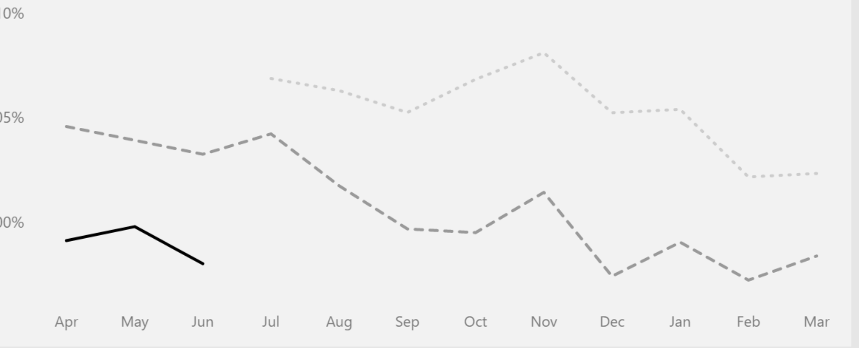
Safer Staffing

These measures provide information on the availability of care for patients. Care hours per patient day (CHPPD) provides information on how many staff are deployed; fill rates record the extend to which rota hours are being filled. By themselves these metrics do not reflect the total amount of care provided on the ward, nor do they directly show whether care is safe, effective or responsive. They should therefore be considered alongside measures of quality and safety.

Month Selector







CHPPD Avg.			Fill Rates %		
Month	2018	2019	M	2018	2019
June	7.7	7.8	Jun	103.3%	98.0%

Data Observations

- The average care hours per patient day is 7.8 an increase of 0.1 compared to the 12 month average.
- Average fill rate for RN on a day is 88.1% and 102.1% for unregistered nurses. Although the overall fill rates reflects a 99% fill rate this does not account for the additional resource required to support enhanced nursing care needs and indicates a reduced skill mix against planned staffing levels.
- RN fill rates fell below 90% in 13 wards out of 33 in June on day shifts and 7 on night shifts
- Red flags have increased by 27 from 315 in May – 'shortfall in RN time' remains to be the top reason.

Management Comments and Actions

- Targeted recruitment continues with RN vacancies of 12.1% in May.
- Safer Staffing Lead driving improvements with evidence of an increase in SafeCare compliance.
- Look-ahead process started.
- 25 TNA interviewed and successful, 7 further TNA prepped for Feb 2020 cohort.
- Staff Back QI project ongoing with milestones identified.
- Temporary workforce booking process under review – supported by Workforce CIP progress meetings.

Norfolk and Norwich University Hospitals

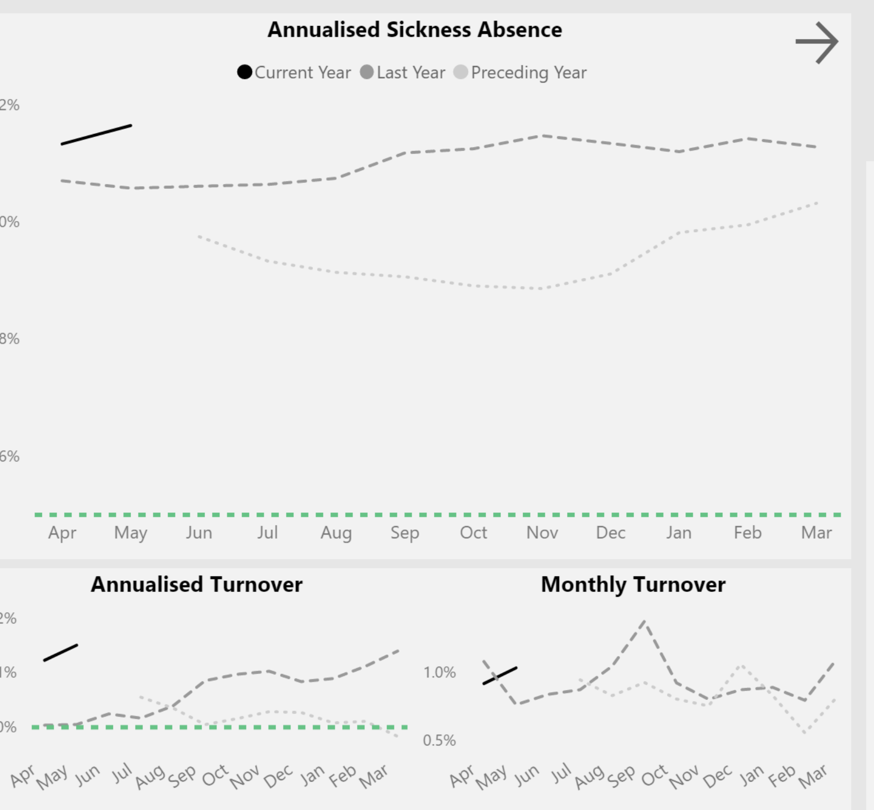
NHS Foundation Trust

Sickness & Turnover Rates

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

Month Selector

Most Recent



Annualised Sickness Absence			Annualised Turnover			Monthly Turnover		
Month	2018	2019	M	2018	2019	M	2018	2019
May	4.1%	4.2%	May	10.1%	11.5%	May	0.8%	1.0%

Data Observations

For sickness, the Operating Plan for 2019/20 has set a challenging 12 month rolling average target of 3.9% for sickness. As at 31 May 2019, the rate is 4.16%.
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).

Management Comments and Actions

The most significant indicator is the rolling 12-month average sickness rate. This still represents a significant reduction in excess of 5.7% on the peak from August 2016 and equates to the equivalent of approximately 21 additional staff (headcount) being available every day. Interestingly, 80.6% of all episodes of sickness absence in 2018 were self-certified yet accounted for just 20.0% of lost sick days. This reinforces the various attendance 'rules' and the need to help keep staff at work or support an early return should they go off sick.
The turnover rate for June 2019 remains at 11.5% and is the highest recorded annualised rate recorded in the past four years. The high level reflects the increase in actual numbers of leavers when compared with June 2018 and reflects the upward trend since December 2018.

Norfolk and Norwich University Hospitals

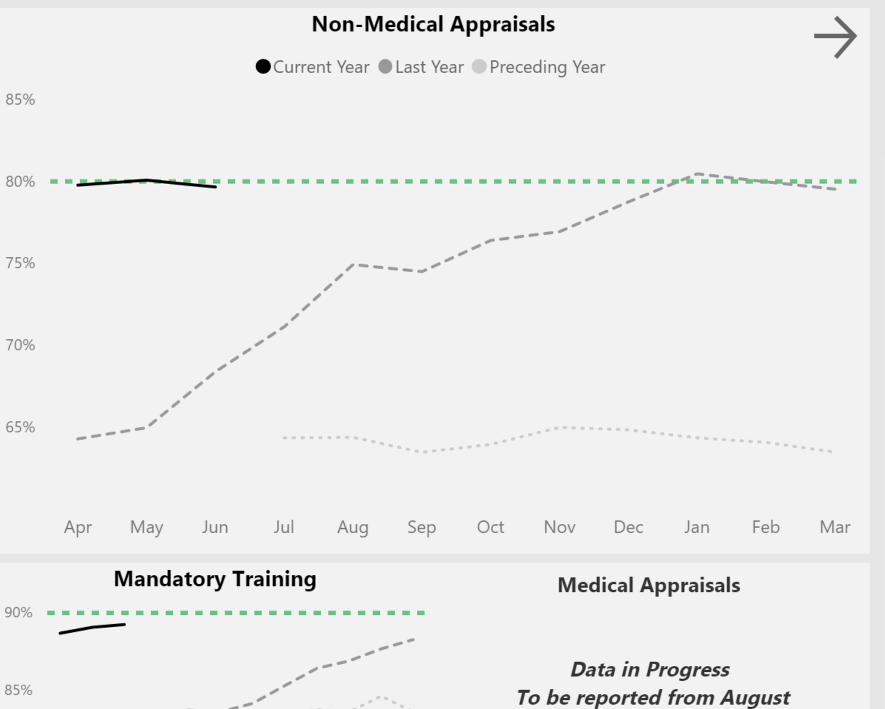
NHS Foundation Trust

Appraisals & Mandatory Training

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

Month Selector

Most Recent



Non-Medical Appraisals			Mandatory Training			Medical Appraisals
Month	2018	2019	M	2018	2019	M
June	68.4%	79.7%	Jun	82.1%	89.3%	

Data Observations

For appraisals, the Operating Plan for 2019/20 reflects an aspiration for 90% compliance but accepting that consistently exceeding 85% compliance would represent excellent progress. Accordingly, the target line on the graphs have been revised.
79.7% of eligible staff (Non-Medical appraisals) have had an appraisal during the last 12 months.
The NHS Staff Survey results 2018 suggest that 87% of our staff have responded that they have been appraised in the last 12 months (up from 83% in 2017).
Just three areas (Surgery, Women and Children and Corporate) are above 80% with just Women and Children above 85%.
For Mandatory Training, there has been a further increase in the monthly compliance rate, taking the June figure to 89.3%
For Mandatory Training, all Divisions and Corporate areas have compliance rates above 85% with three areas (Clinical Support, Corporate and Women & Children) above the target rate of 90%.

Management Comments and Actions

For appraisals, greater management effort is required to support the completion of appraisals in order to increase the compliance rate.
For Mandatory Training, 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.

Core Slide 38

Finance - Lead Director John Hennessey

Executive Summary

- **The reported deficit** for the year to date at month 3 is £13.1m which is £0.05m ahead of plan. In month there was a deficit of £3.4m which was £1.0m ahead of plan.
- **Income** in month 3 income recovered to plan excluding non tariff drugs due to progress towards a block contract for Specialised Commissioning. Without this adjustment and excluding pass through payments the income based on actual activity to date is £1.4m behind budget. Electives are down £1.3m with activity down 11.9%. Non electives are down £1.0m with activity down 3.5%. Day-cases are up £0.45m with activity up 5.9%. A&E up £0.2m with activity up 2.6%. Spire is £0.4m more than plan.
- **Pay** is overspent for the year to date by £1.6m (1.6%). Key areas of overspend are Medicine £0.7m, Urgent & Emergency Care £0.8m and Surgery £0.4m. In all areas the overspend is being driven by temporary staffing costs i.e. locums, bank, agency, overtime. In month pay was overspent by £0.4m.
- **Non Pay** is underspent by £1.0m year to date predominantly due to the release of £0.9m of contingency reserves to offset the deficit.
- **The CIP Target is £26.6m**. The plan for M3 YTD was £2.74m. Of this £0.06m was not achieved.
- **Financial Recovery Plan**: In response to the financial position the Trust has produced and enacted a recovery plan which outlines the strong action being taken to deliver our financial target. Increased scrutiny and challenge has been put in place by the Board and this will continue.

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	39.8	38.4	1.4	117.5	116.8	0.7	478.6	478.6	0.0
NT Drugs	4.4	5.9	(1.5)	15.7	17.7	(2.0)	70.7	70.7	0.0
Other Income	8.5	8.7	(0.2)	25.3	26.0	(0.7)	118.1	118.1	0.0
TOTAL OPERATING INCOME	52.7	53.0	(0.3)	158.5	160.5	(2.0)	667.4	667.4	0.0
Pay Costs	(31.4)	(31.1)	(0.3)	(95.8)	(94.2)	(1.6)	(374.1)	(374.1)	0.0
Drugs	(5.4)	(7.0)	1.6	(18.6)	(21.0)	2.4	(83.8)	(83.8)	0.0
Other Non Pay Costs	(15.9)	(15.7)	(0.2)	(46.5)	(47.5)	1.0	(184.9)	(184.9)	0.0
TOTAL OPERATING EXPENSES	(52.7)	(53.8)	1.1	(160.9)	(162.7)	1.8	(642.8)	(642.8)	0.0
EBITDA	0.0	(0.8)	0.8	(2.4)	(2.2)	(0.2)	24.6	24.6	0.0
Depreciation	(0.7)	(0.8)	0.1	(2.4)	(2.4)	0.0	(10.6)	(10.6)	0.0
Finance Costs	(2.7)	(2.8)	0.1	(8.4)	(8.5)	0.1	(35.6)	(35.6)	0.0
Other - PDC, Disposals & Interest Income	0.0	0.0	0.0	0.1	0.0	0.1	0.1	0.1	0.0
(Deficit)/surplus after tax excluding Donated Additions	(3.4)	(4.4)	1.0	(13.1)	(13.1)	(0.0)	(21.5)	(21.5)	0.0

Norfolk and Norwich University Hospitals

NHS Foundation Trust

June 2019

Core Slide 39

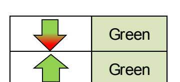
Finance - Lead Director John Hennessey

Income and Expenditure Summary as at M3 - June 2019

The reported I&E position for M3 is a deficit of £3.4m, against budget of £4.4m. This is a £1.0m favourable variance in month (favourable variance of £0.05m YTD).

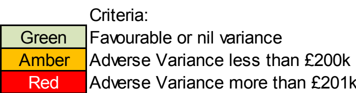
The key in month variances are Clinical Income at £1.35m favourable and Pay at £0.34m adverse (1.1%).

Summary of I&E Indicators

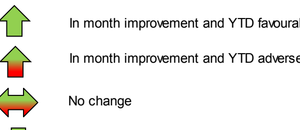
Income and Expenditure	Actual / Forecast £'000	Budget / Target £'000	Variance to Budget (adv) / fav £'000	Direction of travel (variance)	RAG
In month (deficit) / surplus	(3,384)	(4,418)	1,034		Green
YTD (deficit) / surplus	(13,095)	(13,140)	45		Green
Forecast (deficit) / surplus	(21,454)	(21,454)			Green
NHS Clinical Income (exc Drugs) YTD	117,536	116,839	697		Green
Other Income YTD	25,311	25,870	(559)		Red
Pay YTD	(95,757)	(94,181)	(1,576)		Red
Non Pay (exc Drugs) YTD	(46,521)	(47,484)	963		Green
Net Drugs YTD	(2,928)	(3,272)	344		Green
Non Opex YTD	(10,736)	(10,912)	176		Green
CIP Target YTD	2,681	2,742	(61)		Amber

Other Indicators

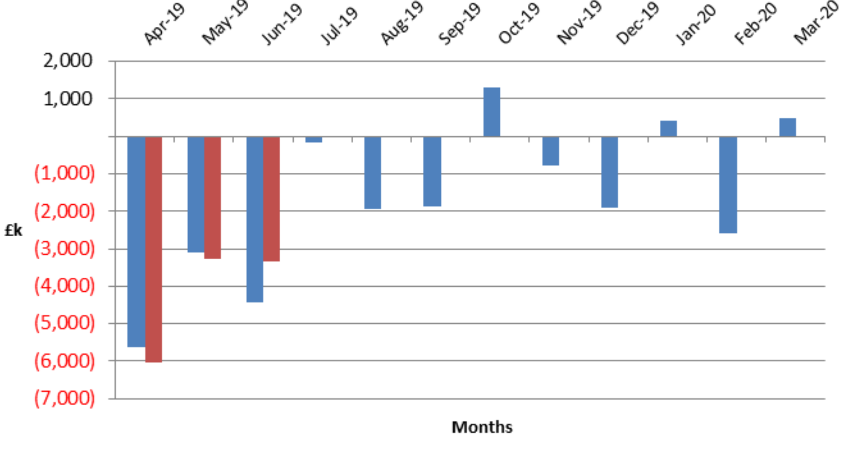
Cash at Bank	5,519	1,155	4,364		Green
Borrowings	(124,280)	(131,478)	7,198		Green

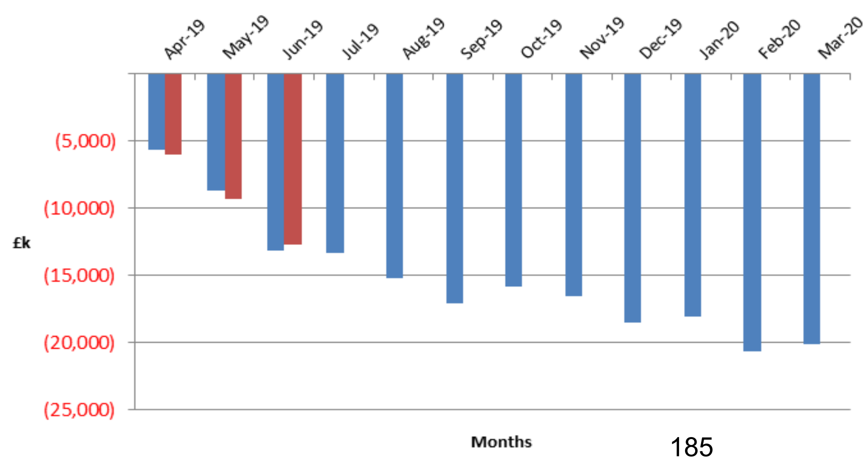


Criteria:
Green — Favourable or nil variance
Amber — Adverse Variance less than £200k
Red — Adverse Variance more than £201k



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





Norfolk and Norwich University Hospitals

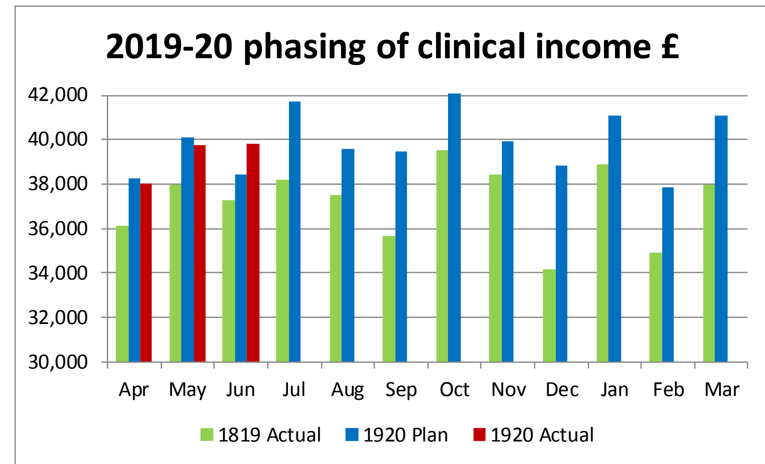
NHS Foundation Trust

June 2019

Core Slide 40 Finance - Lead Director John Hennessey

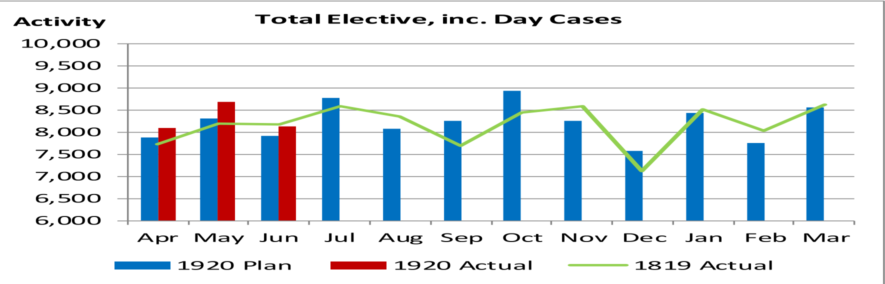
Income Analysis

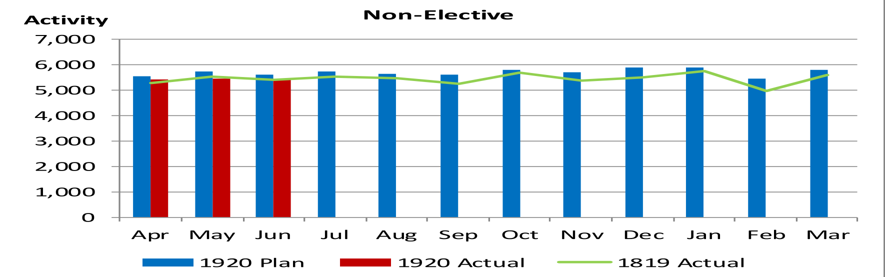
The chart below sets out the monthly phasing of the clinical income plan for 2019/20. This phasing is in line with activity phasing which is how the income is recognised. The phasing is responsive to actual days and working days, hence the monthly variation.

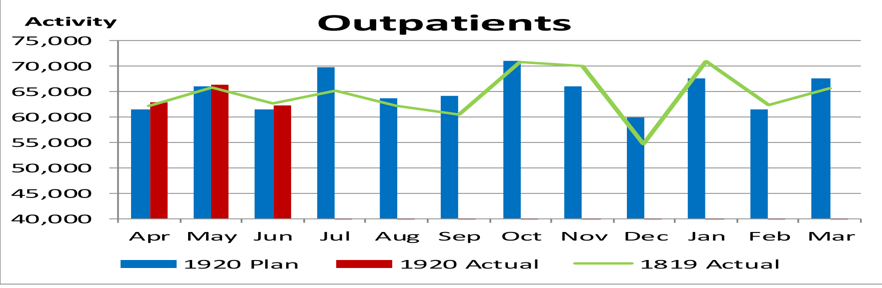


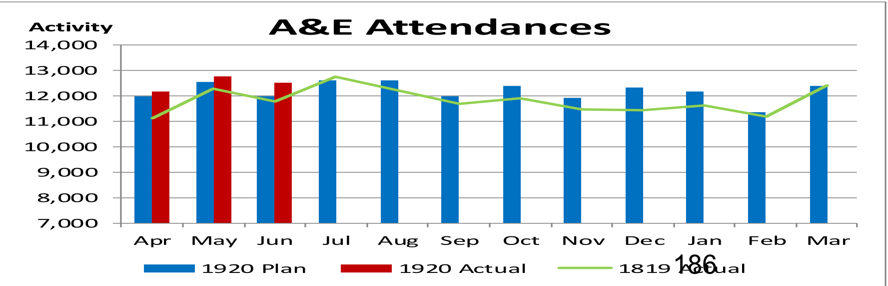
- The income position was ahead of budget for Jun by £1.35m, with under-performance within Surgery (£0.39m), driven by a downside on both Non Elective and Elective Activity. This is offset by a YTD adjustment of £1.1m for the NHSE Block, £0.12m movement in NICU WIP and an assumed case mix improvement of £0.15m

	Current month			Year to date		
Income (£'000s)	Plan	Actual	Variance	Plan	Actual	Variance
Daycase (inc. Reg Day Attd)	4,136	4,295	160	12,584	13,028	444
Elective	3,779	3,479	-299	11,595	10,298	-1,297
Non Elective	13,403	13,017	-386	40,329	39,350	-979
Marginal Rate Reduction	-758	-758	0	-2,275	-2,275	0
Accident & Emergency	1,707	1,718	11	5,199	5,401	202
Outpatients	6,773	6,832	60	20,831	20,948	117
CQUIN	415	409	-6	1,262	1,254	-8
C&V	5,677	5,655	-23	17,276	17,172	-104
Other	3,312	5,151	1,839	10,037	12,359	2,322
Total	**38,444**	**39,798**	**1,354**	**116,839**	**117,536**	**697**









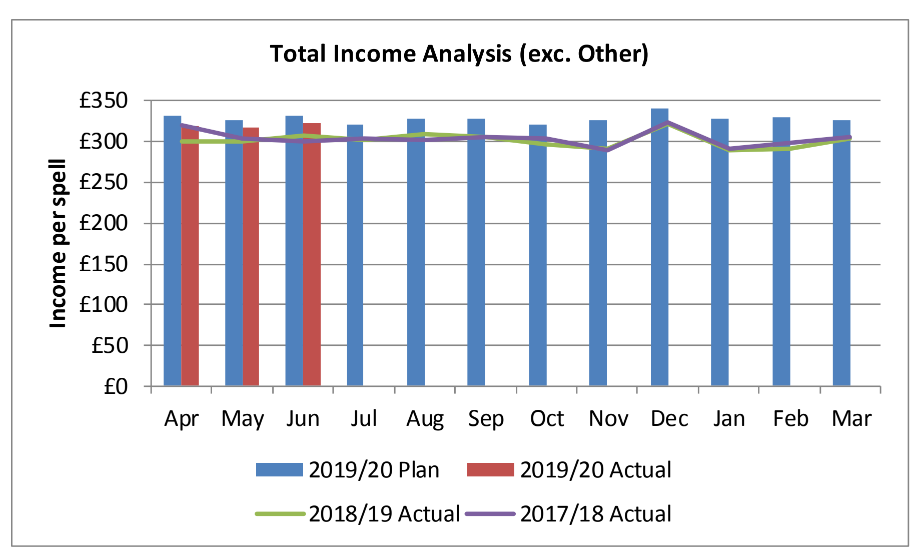
Norfolk and Norwich University Hospitals

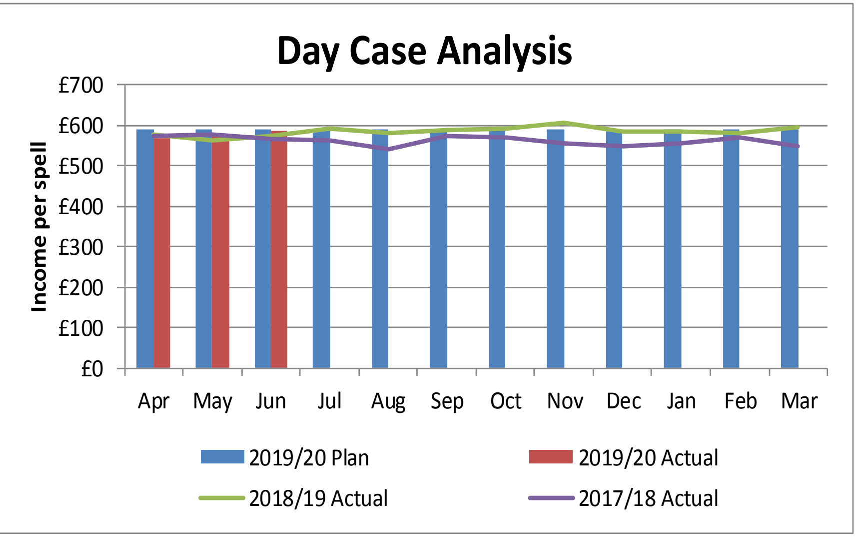
NHS Foundation Trust

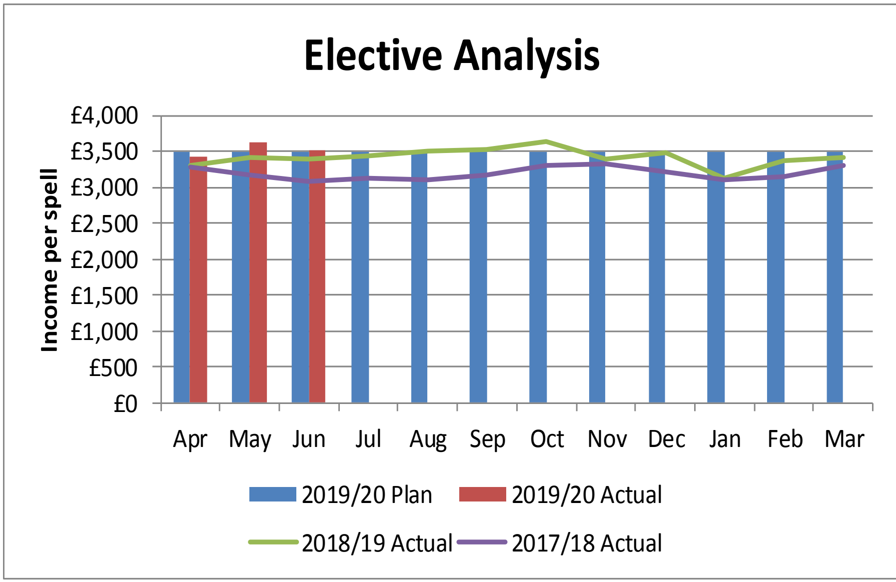
June 2019

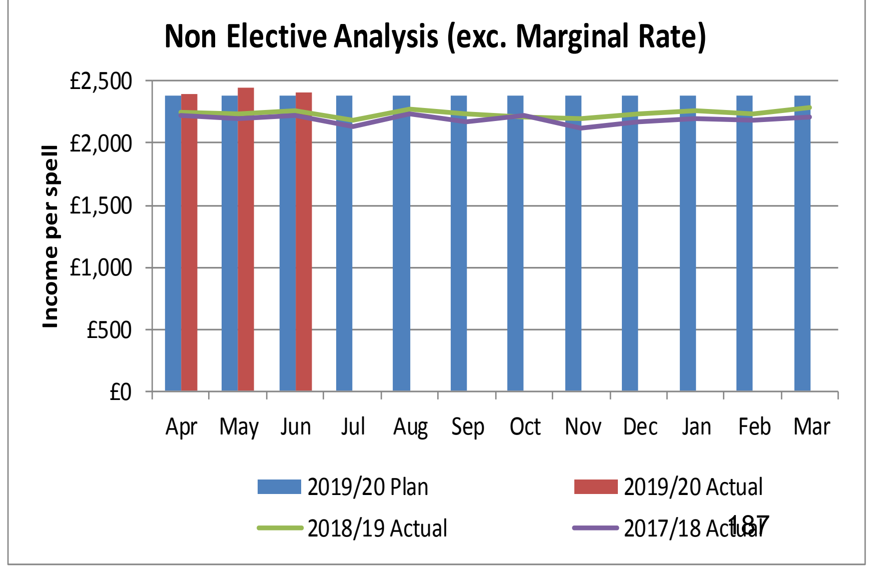
Core Slide 41

Finance - Lead Director John Hennessey









Norfolk and Norwich University Hospitals

NHS Foundation Trust

June 2019

Core Slide 42

Finance - Lead Director John Hennessey

Pay Analysis

Monthly Expenditure (£)						
As at June 2019	Jun-19	May-19	Apr-19	Mar-19	Feb-19	Jan-19
	£'000	£'000	£'000	£'000	£'000	£'000
Budgeted costs in month	**31,065**	**31,220**	**31,895**	**28,217**	**29,422**	**29,402**
Actuals:						
Substantive staff	**27,147**	**27,584**	**28,332**	**25,368**	**26,521**	**26,659**
Medical External Locum Staff*	322	511	363	373	255	241
Medical Internal Locum Staff	797	443	602	813	486	531
Additional Medical Sessions	470	449	431	584	452	441
Nursing Agency Staff*	648	659	696	791	706	728
Nursing Bank Staff	1,034	992	949	992	848	611
Other Agency (AHPs/A&C)*	198	218	259	342	241	307
Other Bank (AHPs/A&C)	147	142	126	157	148	108
Overtime	445	451	762	592	542	510
On Call	198	180	200	213	198	200
Total temporary expenditure	**4,260**	**4,046**	**4,388**	**4,857**	**3,876**	**3,678**
Total Pay costs	**31,407**	**31,630**	**32,720**	**30,225**	**30,397**	**30,337**
Variance Fav / (Adv)	(342)	(410)	(825)	(2,008)	(975)	(935)
Monthly Movement Increase/(Decrease)	(223)	(1,090)	2,495	(172)	60	(139)
Temp Staff costs % of Total Pay	**14%**	**13%**	**13%**	**16%**	**13%**	**12%**
Memo: Total agency spend in month*	**1,168**	**1,389**	**1,318**	**1,506**	**1,202**	**1,276**

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

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

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

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

Premium Pay by Division	Jun-19	May-19	Apr-19	Mar-19	Feb-19	Jan-19
Division	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Medicine 1	357	394	378	385	297	311
Medicine 2	429	417	491	544	446	422
Surgery	1,195	1,230	1,364	1,639	1,260	1,120
Women & Childrens	377	351	355	381	209	215
Emergency Services	822	602	691	608	556	474
AMU & OPM	391	365	343	442	351	310
Clinical Support	385	382	460	520	469	506
Services	101	122	104	122	88	119
R&D Projects	4	4	2	4	2	2
Total	**4,062**	**3,866**	**4,188**	**4,644**	**3,679**	**3,478**

Substantive Staff Growth over 12 month period	Jun-18	Jun-19	12 month Substantive Increase	12 month Substantive Increase %
Staff Group	**WTE**	**WTE**	**WTE**	**%**
A&C	1368.1	1495.2	127.2	9.29%
AHP	569.0	599.2	30.2	5.31%
Apprentices	93.0	70.7	-22.3	-24.03%
Medical	986.3	1058.4	72.0	7.30%
Midwives	208.5	197.7	-10.9	-5.21%
Nursing	2706.0	3000.7	294.7	10.89%
Other	213.7	230.5	16.8	7.86%
Science, Professional Technical	685.0	657.4	-27.7	-4.04%
Grand Total	**6829.7**	**7309.7**	**480.0**	**7.03%**

Norfolk and Norwich University Hospitals

NHS Foundation Trust

Finance

Core Slide 43

Finance - Lead Director John Hennessey

CIP Analysis

FY19/20 YTD CIP Performance

- The Trust has delivered £2.7m of CIPs against a FIP Board approved plan of £2.8m, an under-performance of £0.1m arising through adverse performance in clinical income initiatives offset through over performance across private patient and non-pay initiatives across the Trust.
- £1.6m of the £2.7m of delivered CIP was recurrent, representing 60% of delivery.

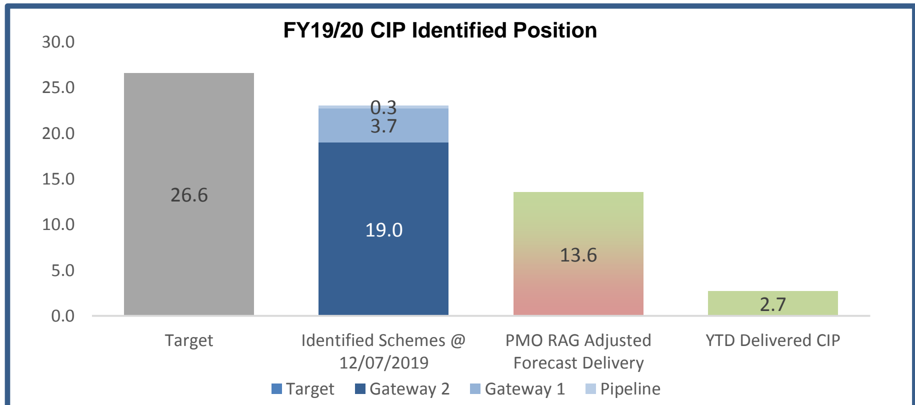
FY19/20 CIP Plan Development

- To date £23.0m of opportunity has been identified to be developed through the Trust's governance gateway process, of which £19.0m has been approved through Gateway 2 and into delivery.
- The risk adjusted forecast delivery for FY19/20 is currently calculated as £13.6m based on the latest forecast financial performance of in delivery schemes, progress against milestone delivery and performance against quality and performance indicators. This presents a risk to achievement of the £26.6m target, however this value will substantially increase as further schemes are approved through Gateway 2.
- A concerted effort is required to convert Gateway 1 approved schemes into delivery as soon as practical to provide additional assurance over the deliverability of the CIP plan.

FY19/20 Performance by Division

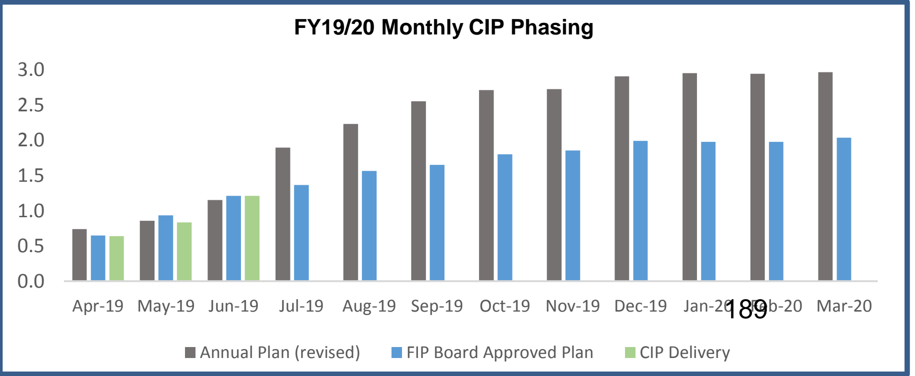
Division	Number of schemes 'In Delivery'	CIP Delivery: YTD FIP Board Approved Plan £'000	CIP Delivery: YTD Actual £'000	CIP Delivery: YTD Variance £'000
Medicine	19	997.1	982.3	(14.8)
Surgery	22	724.1	699.7	(24.4)
Women & Children's	16	258.7	193.8	(64.9)
Clinical Support Services	21	311.0	429.5	118.6
Corporate	8	499.0	375.3	(123.7)
Cross-Divisional*	5	-	-	-
	91	2,789.9	2,680.6	(109.2)
YTD per Annual Plan		2,742.0		
Variance to Annual Plan		47.9		

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



Category	FIP Approved Plan YTD £'000	Actual YTD £'000	Variance £'000
Clinical Income	1,079.9	826.3	(253.6)
Pay*	2.8	91.6	88.7
Non-pay*	1,278.3	1,198.8	(79.5)
Other Income*	429.6	598.3	168.7
Non-Opex	(0.7)	(34.3)	(33.5)
	2,789.9	2,680.6	(109.3)

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



Norfolk and Norwich University Hospitals

NHS Foundation Trust

June 2019

Core Slide 44

Finance - Lead Director John Hennessey

Summary by Division

Medicine

Clinical Income - M03 overachieved by £49k in month due to an increase in day case income in Gastroenterology, Cardiology and Haematology, offset by a decrease in electives, mainly in Cardiology and outpatient follow-up income, mainly in Neurology & Rheumatology. Year to date overachieved by £164k due to an overachievement in day case, unbundled chemotherapy and a decrease in cost and volume income.

Other Income - M03 drugs income underachieved by (£1,308k), (£1,687k) YTD, offset by an underspend on drugs cost.

Pay - M03 overspend of (£214k). Overspending in OPM (£86k) driven by nursing premium expenditure and new clinical fellow posts, Oncology (£49k) driven by nursing premium pay and WLI and locum SHO costs. Gastroenterology (£39k) driven by nursing premium expenditure. Endocrinology (£38k) driven by nursing premium expenditure and not achieving the vacancy factor in medical expenditure.

Non-Pay - M03 drugs cost underspent by £1,349k, £1,813k YTD, offset by an underachievement on drugs income. M03 clinical supplies (£55k), increase in Cardiology stent usage in EP and PCI, (£86k) YTD. Other small overspends of (£40k) in M03 and (£34k) YTD.

Emergency and Urgent care

Clinical Income – Reported through Medical Division

Pay Costs – Overspent by £348k due to £332k (of which £60k relates to prior period) overspend on ED Locums, off set by £45k underspend against substantive budget (including Vacancy Factor), and £106k overspend in ED Nursing, of which Agency: £80k and Bank: £30k

Non Pay Costs – small overspend of £2k

DIVISION INCOME & EXPENDITURE	Jun-19 Actual £k	Jun-19 Budget £k	Jun-19 Variance F/(A) £k	Year to Date Actual £k	Year to Date Budget £k	Year to Date Variance F/(A) £k
MEDICINE						
Total Income	20,146	21,416	(1,270)	63,216	64,765	(1,549)
Pay Costs	(8,677)	(8,463)	(214)	(26,232)	(25,491)	(741)
Non-Pay Costs	(6,352)	(7,606)	1,254	(21,108)	(22,801)	1,693
Total Expenditure	(15,029)	(16,069)	1,039	(47,340)	(48,292)	(951)
SURPLUS/(DEFICIT)	**5,117**	**5,347**	**(230)**	**15,876**	**16,474**	**(598)**
URGENT & EMERGENCY CARE						
Total Income	8	1	7	11	31	(20)
Pay Costs	(2,193)	(1,845)	(348)	(6,428)	(5,635)	(793)
Non-Pay Costs	(339)	(337)	(2)	(1,036)	(1,013)	(23)
Total Expenditure	(2,532)	(2,182)	(350)	(7,464)	(6,648)	816
SURPLUS/(DEFICIT)	**(2,525)**	**(2,181)**	**(343)**	**(7,453)**	**(6,617)**	**(836)**
SURGERY						
Total Income	14,279	14,696	(418)	43,344	44,681	(1,337)
Pay Costs	(9,203)	(9,126)	(77)	(27,820)	(27,475)	(345)
Non-Pay Costs	(4,413)	(4,097)	(316)	(12,498)	(12,266)	(232)
Total Expenditure	(13,616)	(13,223)	(393)	(40,317)	(39,740)	577
SURPLUS/(DEFICIT)	**663**	**1,473**	**(811)**	**3,027**	**4,941**	**(1,914)**

Surgery

Clinical Income - M03 underachieved by £260k (exc CIPs).

Clinical Income CIP value for target for the month was £131k. Main specialties under-delivering on Clinical Income (exc CIPs) included Orthopaedics (£109k), Vascular (£63k), Plastics (£54k) & Oral (£42k).

Pay - overspend of £79k in M03, a reduction on M1 & M2, reflecting CIP failure.

Overspending specialties include Plastics (£75k) where premium pay costs have overspent by £42k in month. Urology & Vascular are both running with lower levels of vacancies in the current year resulting in an overspend against the Vacancy Factor.

The Division has a Vacancy Factor for the month/YTD of £844k/£2,497k. Substantive vacancies totalled £852k/£2,592k.

The (underspend)/overspend on premium pay totalled (£10k)/£162k.

Non Pay - The overspend on Non-Pay (£316k in M3, £232k YTD) is the result of additional Spire costs (offset through income). The overspend in the month relating to Spire is £268k (£506k YTD).

Norfolk and Norwich University Hospitals

NHS Foundation Trust

June 2019

Core Slide 45

Finance - Lead Director John Hennessey

Summary by Division continued

Women's and Children's

Clinical Income - Underachieved by £170k in month. The key area's showing the downturn are obstetrics driven mainly through reduced number of births and NICU which is £100k down in month. YTD Clinical Income is down £731k.

Pay Costs - Continuing to see the same trends into M3 with vacancies still within Paediatrics/NICU nursing but this is mainly being counteracted by an overspend within Paediatric medical locums due to a shortage of junior doctors required to fill the rota.

Non Pay Costs - This is mainly driven by a lower drugs spend

Clinical Support

Clinical Income - £423k over achieved YTD, with Radiology DA and OP (£157k), and the EPA GP work (£122k).

Other Income - £363k under achieved YTD. Mainly due to Drugs underspend (£255k). EPA also underachieving due to reduced private patient work, unidentified CIP and reduced outflow.

Pay Costs - £196k overspent YTD. Main driver here is £230k of unidentified CIP allocated here. In month actual in line with prior month (both substantive and premium pay)

Non-Pay costs - £69k underspent YTD. Includes £255k underspend on drugs (offset by income). £156k overspent on Blood

Services

Other Income - £31k under achieved YTD. This is due to an unidentified CIP target of £105k. This is partially offset by additional STP funding received in trust administration.

Pay Costs - £113k under achieved YTD. This is due to an unidentified CIP target of £250k. This is offset by underspends in Nurse Management, Finance & Planning & Performance who are carrying more vacancies then anticipated.

Non-Pay costs - £250k underspent YTD. £144k in Finance due to the reduction in bad debt provision that is required as well as no longer being required to pay STP membership of £175k per annum. £77k in Trust Admin due to less ad -hoc requirements so far.

DIVISION INCOME & EXPENDITURE	Jun-19 Actual £k	Jun-19 Budget £k	Jun-19 Variance F/(A) £k	Year to Date Actual £k	Year to Date Budget £k	Year to Date Variance F/(A) £k
WOMENS & CHILDREN						
Total Income	5,243	5,421	(178)	15,669	16,374	(704)
Pay Costs	(3,522)	(3,555)	33	(10,628)	(10,706)	78
Non-Pay Costs	(515)	(557)	42	(1,673)	(1,639)	(34)
Total Expenditure	(4,036)	(4,112)	76	(12,301)	(12,345)	(44)
SURPLUS/(DEFICIT)	**1,207**	**1,309**	**(103)**	**3,368**	**4,029**	**(660)**
CLINICAL SUPPORT						
Total Income	3,879	4,013	(134)	12,224	12,165	60
Pay Costs	(5,481)	(5,425)	(56)	(16,506)	(16,310)	(196)
Non-Pay Costs	(2,436)	(2,505)	69	(7,477)	(7,566)	89
Total Expenditure	(7,917)	(7,930)	13	(23,984)	(23,876)	107
SURPLUS/(DEFICIT)	**(4,038)**	**(3,918)**	**(121)**	**(11,759)**	**(11,712)**	**(48)**
SERVICES						
Total Income	647	674	(27)	1,990	2,021	(31)
Pay Costs	(1,983)	(1,956)	(27)	(6,023)	(5,911)	(113)
Non-Pay Costs	(5,346)	(5,394)	48	(16,041)	(16,291)	250
Total Expenditure	(7,329)	(7,351)	22	(22,065)	(22,201)	(137)
SURPLUS/(DEFICIT)	**(6,682)**	**(6,677)**	**(5)**	**(20,075)**	**(20,180)**	**105**
OTHER inc. NON OPEX						
Total Income	8,667	6,798	1,869	22,165	20,373	1,791
Pay Costs	(347)	(694)	347	(2,119)	(2,653)	534
Non-Pay Costs	(5,443)	(5,873)	430	(16,124)	(17,794)	1,670
Total Expenditure	(5,790)	(6,567)	777	(18,243)	(20,447)	(2,204)
SURPLUS/(DEFICIT)	**2,877**	**230**	**2,647**	**3,921**	**(74)**	**3,995**

Other – YTD

Clinical Income – M03 favourable variance of £1.9m of which £1.1m from NHSE Block Adjustment and £0.4m M1 & M2 refresh adjustment. YTD £2.0m

Pay - M03 favourable variance of £347k due to slippage on the appointment of posts held in reserves £80k, Divisional CIP Risk adjustment £160, CEA provision adjustment £90k. YTD £530k

Non-Pay - M03 favourable variance of £430k, mainly being the release of contingency. YTD £1.7m contingency and other various.

Non-Opex - M03 favourable variance of £85k, being Contingent Rent £39k from RPI being less than assumed, Depreciation £25k and Profit on Asset disposals £29k. YTD £17[illegible]k

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

Norfolk and Norwich University Hospitals

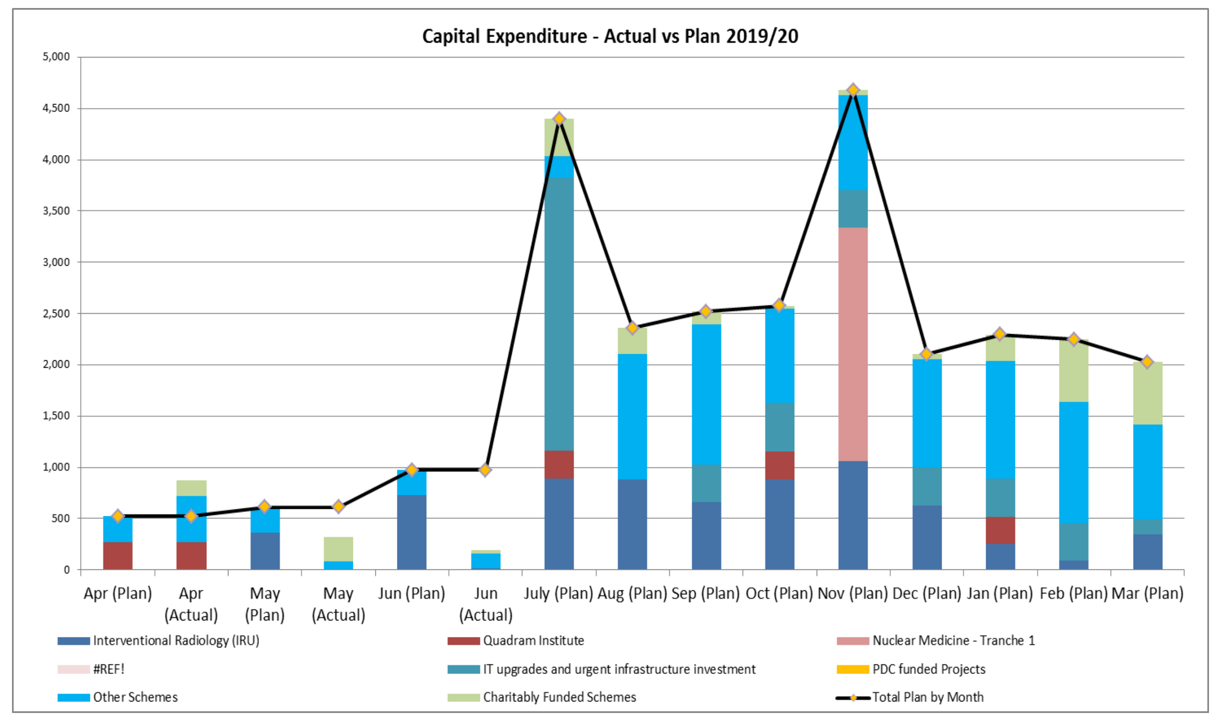
NHS Foundation Trust

June 2019

Core Slide 46

Capital Progress Report

Finance - Lead Director John Hennessey



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

New loan funding £15.8m

IRU approved loan funding £6.8m

Internally funded schemes £2.4m

Charitably funded schemes £2.3m

The total updated 5 year capital plan is £188.9m.

The capital expenditure for the year to date is £1.4m against a plan of £2.1m being a variance of £0.7m.

No drawdown has been made in the YTD against the approved IRU loan.

An application for capital support has been made to NHSI/DHSC which is currently in the process of being reviewed.

Capital expenditure has been overcommitted by 20% nationally and all NHS organisations are required to reduce their programmes. The Trust has agreed to reduce its capital programme by £5.6m from £32.950m to £27.305m.

	Apr Plan £'000	Apr Actual £'000	May Plan £'000	May Actual £'000	Jun Plan £'000	Jun Actual £'000	July Plan £'000	Aug Plan £'000	Sep Plan £'000	Oct Plan £'000	Nov Plan £'000	Dec Plan £'000	Jan Plan £'000	Feb Plan £'000	Mar Plan £'000	TOTAL Plan £'000
Quadram Institute	271	271	0	0	0	0	271	0	0	271	0	0	270	0	0	**1,083**
Interventional Radiology (IRU)	0	0	360	0	726	18	891	882	660	885	1,062	629	250	89	342	**6,776**
Nuclear Medicine - Tranche 1	0	0	0	0	0	0	0	0	0	0	2,273	0	0	0	0	**2,273**
IT upgrades and urgent infrastructure in	0	0	0	0	0	0	2,664	0	370	470	370	370	370	370	150	**5,134**
PDC funded Projects	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Other Schemes	251	453	252	84	246	140	212	1,227	1,363	924	924	1,053	1,145	1,175	923	**9,695**
Charitably Funded Schemes	0	148	0	238	0	38	359	250	125	25	50	50	261	612	612	**2,344**
Total Plan by Month	522		612		972		4,397	2,359	2,518	2,575	4,679	2,102	2,296	2,246	2,027	27,305
Actual to Date		872		322		196										1,390

Core Slide 47

Finance - Lead Director John Hennessey

Statement of Financial Position at 30th June 2019

	Opening Balance as at 1 April 2019 £'000	Plan 31 March 2020 £'000	Plan YTD 30 June 2019 £'000	Actual YTD 30 June 2019 £'000	Variance YTD 30 June 2019 £'000
Property, plant and equipment	232,609	256,528	235,207	231,622	(3,585)
Trade and other receivables	78,154	84,918	79,674	79,698	24
Other financial assets	0	0	0	0	0
Total non-current assets	**310,763**	**341,446**	**314,881**	**311,320**	**(3,561)**
Inventories	10,438	10,574	10,574	10,687	113
Trade and other receivables	28,845	33,505	28,598	32,977	4,379
Non-current assets for sale	0	0	0	0	0
cash and cash equivalents	7,461	1,155	1,155	5,519	4,364
Total Current assets	**46,744**	**45,234**	**40,327**	**49,183**	**8,856**
Trade and other payables	(68,246)	(64,629)	(62,238)	(74,621)	(12,383)
Borrowing repayable within 1 year	(21,233)	(52,819)	(22,042)	(22,042)	0
Current provisions	(282)	(307)	(307)	(280)	27
Deferred Income	(5,851)	(4,764)	(4,764)	(3,033)	1,731
Total current liabilities	**(95,612)**	**(122,519)**	**(89,351)**	**(99,976)**	**(10,625)**
Total assets less current liabilities	**261,895**	**264,161**	**265,857**	**260,527**	**(5,330)**
Borrowings - PFI & Finance Lease	(190,764)	(187,406)	(189,870)	(190,007)	(137)
Borrowings - Revenue Support	(89,871)	(87,991)	(106,222)	(102,014)	4,208
Borrowings - Capital Support	(224)	(29,479)	(3,214)	(224)	2,990
Provisions	(2,131)	(1,702)	(1,844)	(2,076)	(232)
Deferred Income	(5,875)	(4,755)	(4,845)	(5,847)	(1,002)
Total non-current liabilities	**(288,865)**	**(311,333)**	**(305,995)**	**(300,168)**	**5,827**
Total assets employed	**(26,970)**	**(47,172)**	**(40,138)**	**(39,641)**	**497**
Financed by					
Public dividend capital	31,909	31,881	31,881	31,909	28
Retained Earnings (Accumulated Losses)	(73,852)	(94,026)	(86,992)	(86,524)	468
Revaluation reserve	14,973	14,973	14,973	14,974	1
Total Taxpayers' and others' equity	**(26,970)**	**(47,172)**	**(40,138)**	**(39,641)**	**497**

Non-Current Assets

There is some slippage on the capital programme primarily due to a delay in receiving capital support from DHSC of £3.0m YTD.

Trade and Other Receivables

This balance is £4.4m higher than plan YTD. Various - key driver is timing.

Cash

Cash is £4.4m higher than plan at the end of June 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 £12.4m higher than plan YTD.

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

Deferred Income

This balance is £0.7m higher than plan YTD. These are small timing differences.

Borrowings

Total overall borrowings are £7.2m lower than plan.

In year revenue borrowings are £13.0m against a YTD plan of £17.2m. Being £4.2m lower than plan.

In year capital borrowings are £0.0m against a YTD plan of £3.0m. Being £3.0m lower than plan. The Trust has made an application to NHSI/DHSC for capital support.

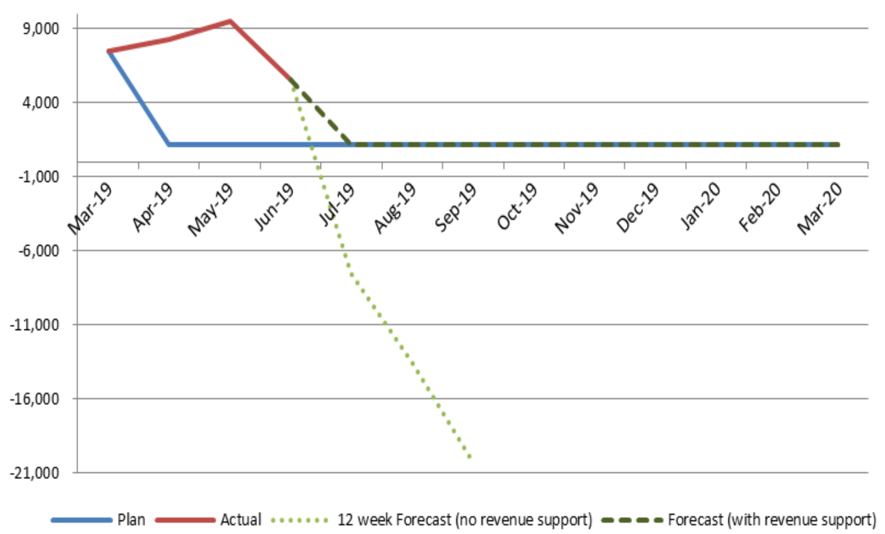
Norfolk and Norwich University Hospitals

NHS Foundation Trust

June 2019

Core Slide 48

Finance - Lead Director John Hennessey



- The graph shows the cash levels since the end of March 2019. Short term timing differences drive the difference between actual and plan.
- The Trust is required to keep a minimum balance of £1 million, hence the closing cash plan every month is circa £1m.
- The future cash loan requirements on current projections are: £8.648m in July (received) and £3.363m in August.
- The borrowings of £124.3m at the end of June 2019 comprise: £16m in 2016/17, £36.4m in 2017/18, £58.9m in 2018/19 & £13.0m in 2019/20. This includes a capital loan of £0.2m drawn down in March 19.
- The interest rates are: 3.5% on £70.8m. 1.5% on the remainder of £53.5m.

NOTE:

- The plan for 2019/20 assumes in year borrowings of £29.3m for revenue. At the start of the year it was £111.3m, bringing total forecast revenue borrowings to £141m.
- Capital Borrowings are planned to be £22.5m following the latest capital plan submission.
- The Trust Board approved borrowing 'limit' is £150m revenue and £25m capital.
- The need for the funds is driven by our operational performance.

	Opening	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
Cum. Borrowings-Plan	111,328	117,835	123,716	131,478	134,332	137,942	144,441	147,849	150,893	158,021	161,091	164,448	170,289
Cum. Borrowings-Actual	111,328	115,964	122,186	124,280									
Variance - (Adverse) / Favourable	0	1,871	1,530	7,198									

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

Income Statement Comparison - for the Month of June

	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	38,902	37,794	36,284	1,108	3%	2,618	7%
Clinical Income - Spire Contract	896	650	694	246	38%	202	29%
NT Drugs	4,421	5,893	5,365	(1,472)	(25%)	(944)	(18%)
Total NHS clinical income	**44,219**	**44,337**	**42,343**	**(118)**	**(0%)**	**1,876**	**4%**
Non NHS clinical income							
Private patients	224	260	90	(36)	(14%)	134	149%
Other - RTA	62	109	113	(47)	(43%)	(51)	(45%)
Total Non NHS clinical income	**286**	**369**	**203**	**(83)**	**(22%)**	**83**	**41%**
Other Income							
R&D	1,732	1,808	1,740	(76)	(4%)	(8)	(0%)
Education & Training	2,051	1,975	1,906	76	4%	145	8%
PSF / FRF / MRET Income	1,987	1,987			0%	1,987	
Other non patient care income	2,548	2,534	2,429	14	1%	119	5%
Total other Income	**8,318**	**8,304**	**6,075**	**14**	**0%**	**2,243**	**37%**
TOTAL OPERATING INCOME	**52,823**	**53,010**	**48,621**	**(187)**	**(0%)**	**4,202**	**9%**
EXPENDITURE							
Employee benefit expenses	(31,407)	(31,065)	(28,118)	(342)	(1%)	(3,289)	(12%)
Drugs	(5,365)	(6,984)	(6,335)	1,619	23%	970	15%
Clinical supplies	(5,399)	(5,547)	(5,331)	148	3%	(68)	(1%)
Non clinical supplies	(8,348)	(8,071)	(7,725)	(277)	(3%)	(623)	(8%)
PFI operating expenses	(2,121)	(2,109)	(1,692)	(12)	(1%)	(429)	(25%)
TOTAL OPERATING EXPENSES	**(52,640)**	**(53,776)**	**(49,201)**	**1,136**	**2%**	**(3,439)**	**(7%)**
Profit/(loss) from operations	**183**	**(766)**	**(580)**	**949**	**(124%)**	**763**	**(132%)**
Non-operating income							
Interest	18	10	9	8	(80%)	9	100%
Profit/(loss) on asset disposals	26	(3)	9	29	967%	17	189%
Total non-operating income	**44**	**7**	**18**	**37**	**529%**	**26**	**144%**
Non-operating expenses							
Interest on PFI and Finance leases	(1,407)	(1,407)	(1,429)		0%	22	(2%)
Interest on Non Commercial Borrowing	(268)	(252)	(114)	(16)	(6%)	(154)	135%
Depreciation	(790)	(815)	(861)	25	3%	71	(8%)
PDC							
Other - Contingent Rent	(1,146)	(1,185)	(1,078)	39	3%	(68)	6%
Total non operating expenses	**(3,611)**	**(3,659)**	**(3,482)**	**48**	**1%**	**(129)**	4%
Surplus (deficit) after tax from continuing operations	**(3,384)**	**(4,418)**	**(4,044)**	**1,034**	**23%**	**660**	**16%**
Memo:							
Donated Asset Additions	38		50	38		(12)	(24%)
Surplus (deficit) after tax and Donated Asset Additions	**(3,346)**	**(4,418)**	**(3,994)**	**1,072**	**24%**	**648**	**16%**

Notes:

Calendar Days	30	30	30
Working Days	20	20	21

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

Income Statement Comparison - Year to 30 June 2019

	Annual Plan	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	*470,145*	115,104	114,891	108,747	213	0%	6,357	6%
Clinical Income - Spire Contract	*8,409*	2,432	1,948	2,073	484	25%	359	17%
NT Drugs	*70,716*	15,691	17,680	16,489	(1,989)	(11%)	(798)	(5%)
Total NHS clinical income	***549,270***	**133,227**	**134,519**	**127,309**	**(1,292)**	**(1%)**	**5,918**	**5%**
Non NHS clinical income								
Private patients	*3,913*	455	780	236	(325)	(42%)	219	93%
Other - RTA	*1,560*	191	329	282	(138)	(42%)	(91)	(32%)
Total Non NHS clinical income	***5,473***	**646**	**1,109**	**518**	**(463)**	**(42%)**	**128**	**25%**
Other Income								
R&D	*21,700*	5,234	5,425	5,174	(191)	(4%)	60	1%
Education & Training	*23,703*	5,962	5,926	5,830	36	1%	132	2%
PSF / FRF / MRET Income	*33,649*	5,957	5,957			0%	5,957	
Other non patient care income	*33,808*	7,512	7,453	5,645	59	1%	1,867	33%
Total other Income	***112,860***	**24,665**	**24,761**	**16,649**	**(96)**	**(0%)**	**8,016**	**48%**
TOTAL OPERATING INCOME	***667,603***	**158,538**	**160,389**	**144,476**	**(1,851)**	**(1%)**	**14,062**	**10%**
EXPENDITURE								
Employee benefit expenses	*(374,007)*	(95,757)	(94,181)	(86,174)	(1,576)	(2%)	(9,583)	(11%)
Drugs	*(83,808)*	(18,619)	(20,952)	(19,670)	2,333	11%	1,051	5%
Clinical supplies	*(65,743)*	(16,353)	(16,720)	(15,827)	367	2%	(526)	(3%)
Non clinical supplies	*(93,934)*	(23,829)	(24,439)	(22,256)	610	2%	(1,573)	(7%)
PFI operating expenses	*(25,386)*	(6,339)	(6,325)	(5,314)	(14)	(0%)	(1,025)	(19%)
TOTAL OPERATING EXPENSES	***(642,878)***	**(160,897)**	**(162,617)**	**(149,241)**	**1,720**	**1%**	**(11,656)**	**(8%)**
Profit/(loss) from operations	***24,725***	**(2,359)**	**(2,228)**	**(4,765)**	**(131)**	**6%**	**2,406**	**(50%)**
Non-operating income								
Interest	*120*	49	30	27	19	(63%)	22	81%
Profit/(loss) on asset disposals	*(36)*	32	(9)	9	41	456%	23	256%
Total non-operating income	***84***	**81**	**21**	**36**	**60**	**286%**	**45**	**125%**
Non-operating expenses								
Interest on PFI and Finance leases	*(16,841)*	(4,225)	(4,225)	(4,286)		0%	61	(1%)
Interest on Non Commercial Borrowing	*(3,971)*	(788)	(717)	(329)	(71)	(10%)	(459)	140%
Depreciation	*(10,649)*	(2,368)	(2,435)	(2,556)	67	3%	188	(7%)
PDC								
Other - Contingent Rent	*(14,802)*	(3,436)	(3,556)	(3,235)	120	3%	(201)	6%
Total non operating expenses	***(46,263)***	**(10,817)**	**(10,933)**	**(10,406)**	**116**	**1%**	**(411)**	**4%**
Surplus (deficit) after tax from continuing operations	***(21,454)***	**(13,095)**	**(13,140)**	**(15,135)**	**45**	**0%**	**2,040**	**13%**
Memo:								
Donated Asset Additions	*1,280*	424		178	424		246	138%
Surplus (deficit) after tax and Donated Asset Additions	***(20,174)***	**(12,671)**	**(13,140)**	**(14,957)**	**469**	**4%**	**2,286**	**15%**

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

Deficit on a control total basis - reportable to NHSI:								
Surplus (deficit) after tax and Donated Asset Additions	*(20,174)*	(12,671)	(13,140)	(14,957)	469	4%	2,286	(15%)
Remove: Donated Asset Additions	*(1,280)*	(424)		(178)	(424)		(246)	138%
Add back: Donated Depreciation	*763*	181	193	203	(12)	(6%)	(22)	(11%)
Adjusted financial performance surplus/(deficit)	***(20,691)***	**(12,914)**	**(12,947)**	**(14,932)**	**33**	**0%**	**2,018**	**(14%)**
CONTROL TOTAL	***(21,691)***	**(13,197)**	**(13,197)**	**786**		**0%**	**(13,983)**	**(1779%)**
Performance against control total	***1,000***	**283**	**250**	**(15,718)**	**33**	**(13%)**	**16,001**	**(102%)**

Notes:

	Actual	Budget	Prior year
Calendar Days	91	91	91
Working Days	61	61	62

MEETING OF THE COUNCIL OF GOVERNORS IN PUBLIC

24 JULY 2019

A meeting of the Council of Governors in public will take place at 10am on 24 July 2019 in the Boardroom at the Norfolk and Norwich University Hospital

---

AGENDA

	Item	Lead Director	Purpose	Page No
1	Apologies, welcome to new members and Declarations of Interest	Chair		
2	Minutes of the meeting held in public on 24.04.19		Approval	**2**
3	Matters arising		Discussion	**7**
4	Chief Executive's Report - Including inpatient capacity plans	CEO	Information	**8**
5	Annual Report and Accounts 2018/19 (i) Financial Statements (p257 at rear of Annual Report) (ii) Report from External Auditors to Governors (p260 or p2-8 of Financial Statements) (iii) Independent Auditors Report relating to Quality Report (p210-213)	CFO	Receive	**22** **Annual Report and Accounts as circulated separately**
	(iv) Non-audit work undertaken by the External Auditors	JPG	Information	**24**
6	Infection Prevention and Control – Annual Report 2018/19 and current position	NF	Discussion	**25**
7	Digital strategy update *(requested by CoG 24.4.19)*	AL	Discussion	
8	Travel Plan update *(requested by CoG 24.4.19)*	SH	Information	**Presentation**
9	Membership Analysis and Update	JB	Information	**84**
10	Advance Notice Questions			
11	Any other business			

Date and Time of next meeting in public
The next Council of Governors meeting in public will be at 10am on 23 October 2019 in the Boardroom of the Norfolk and Norwich University Hospital

---

Distribution: Council of Governors, Board of Directors and Trust website

Contact details: Janice Bradfield, Membership Manager, Norfolk and Norwich University Hospitals NHS Foundation Trust, tel 01603 287 634, e-mail membership@nnuh.nhs.uk