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

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

MEETING OF THE TRUST BOARD IN PUBLIC
WEDNESDAY 2 JUNE 2021

A meeting of the Trust Board will take place at 9.30am on Wednesday 2 June 2021 in Room 16 of the Bob Champion Research & Education building (BCRE)

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

For Board members, the meeting will be preceded by clinical visits from 8.30am

AGENDA

	Item	Lead	Purpose	Page
1	- Apologies, Declarations of Interest - Chairman's Introduction - Feedback on visits	Chair	Information/ Discussion	
2	Experience of Care – Patient/Family	NF	Information	**2**
3	Minutes of the Board meeting held in public on 07.04.21	Chair	Approval	**5**
4	Matters arising and update on actions	Chair	Discussion	**14**
5	Chief Executive's Report	CEO	Discussion	**15**
6	**Reports for Information and Assurance:**		Information, Assurance and Approval as specified	
	(a) Audit Committee (26.05.21) inc: - Scheme of Delegation and SFIs* (for approval)	SD		**17** **19**
	(b) Quality and Safety Committee (25.05.21) (c) IPR – Quality, Safety and Patient Experience data	GOS ED/NF		**21** **24**
	(d) Finance, Investments and Performance Committee (26.05.21) (e) i) IPR – Performance and Productivity data ii) Finance – Month 1 report	TS CC RC		**40** **42** **75**
	(f) People & Culture Committee (24.05.21) inc: i) Misconduct Policy* & ToRs for approval ii) P&C Committee Annual Report (g) IPR – Workforce data	DR PJ		**93** **95 & 105** **99** **112**
7	Quality Priorities	NF	Approval	**121**
8	Questions from members of the public	Chair	Discussion	
9	Any other business	Chair	Discussion	

***** Documents uploaded to Diligent Resource Centre

Date and Time of next Board meeting in public
The next Board meeting in public will be at 9.30am on Wednesday 4 August 2021 – location/arrangements TBC

REPORT TO TRUST BOARD	
Date	**02 June 2021**
Title	**Experience of Care Stories To Board – Update on the programme to date and future plans.**
Author & Exec Lead	**Sarah Higson, Lead for Patient Engagement & Experience** **Prof Nancy Fontaine, Chief Nurse**
Purpose	**For Information**

2 Background/Context

2.1 The Trust commenced experience of care stories to Board using a new process and template in May 2019.

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

2.3 Listening to patient stories gives us the opportunity to learn about the things that we do well and consider where we can make improvements.

2.4 Each story is approximately 5-7 minutes in length and usually the first item on the Board agenda. This sets the framework for the remainder of the meeting – firmly situated around the experience of care.

3 Key issues, risks and actions

3.1 A structured approach and supporting guidance has been developed for use across the Trust ensuring each story reflects a journey for the Trust in terms of listening, learning and improving.

3.2 The stories featured have covered a range of topics and divisions including cancer services, Learning Disabilities, Cardiology, end of life, dementia, pain management and experiences of being a carer.

3.3 Seven experiences of care have been shared with the Board since then with more being shared and utilised to inform improvements at Divisional Boards and other meetings.

3.4 Stories, using the new process, have also been embedded into the divisional deep dive reporting to the Patient Engagement & Experience Group and are being used within divisional board and other meetings, training and events.

3.5 Each presentation provides the opportunity for an individual voice to be heard, within the wider context of the service or topic and, of vital importance, that information is provided to demonstrate how the story has been used to make improvements within a service or across the organisation.

3.6 Presentations are typically in person, supported by the Patient Engagement & Experience Team and colleagues from the relevant department.

3.7 The Trust is also developing a library of short films encapsulating individual stories – this has proved especially beneficial during the pandemic.

3.8 For example – in April 2021 the Trust Board heard , via a short film, the story of James (17 years of age) who is a young carer – and main carer - for his mother who has a range of physical and mental illnesses and who has been a patient at NNUH.

- The story highlighted the importance of having awareness of, and identifying, Young Carers of patients at NNUH. The action of identifying and involving young carers can improve the care and experience of both patients and carers alike. The story provided an opportunity to really understand the importance of communication and involvement of carers – including young carers – when a cared for person is admitted to NNUH. This example of an Experience of Care from a Young Carer's perspective highlighted the need for the Trust to improve the process of identifying and supporting them, as part of the "triangle of care".
- The story provided the opportunity for reflection and consideration of the key issues facing all carers and especially younger carers. It enable the Board to consider the range of actions identified by the presenters, checking and challenging for assurance and to demonstrate commitment to improvement.

4 Conclusions/Outcome/Next steps

4.1 Specific outcomes from the young carer story:

- Continuing to work with local Young Carer networks to ensure we are capturing the young/young adult carer experience and feedback
- Continuing to provide regular Young Carer Awareness Training (which also covers Adult Carer Awareness Training)
- Working with colleagues to improve existing patient records and provide better opportunity for recording identified carers.
- Working in collaboration with our Carers Forum to develop ways to support those in caring roles to self-identify, which in turn will enable support from hospital to be accessed by those who need it – as an acute hospital, this will primarily be around signposting for carers assessment sand to local support services.
- Planning a Carers Audit to be circulated June-August to capture the experiences of carers across all caring experiences (e.g. Young Carers, Adult Carers, Parent Carers). Results of this audit will inform future actions for improvement.
- Co-hosting a joint virtual Carers Conference during Carers Week (9th June) in collaboration with Queen Elizabeth Hospital Kings Lynn and James Paget University Hospitals. This conference will cover content relating to the ongoing work detailed above and provides opportunity to bring

carers' collective experiences across the Norfolk and Waveney acute hospitals together for shared learning.

- James' story will be shared widely during Carers' Week activities, used in awareness sessions and used to evaluate progress against the actions plan via the Carers' Forum and PEEG.
- James' story has also be picked up by Sheffield Hospitals as a vehicle to share young carer experiences and as an exemplar for 'storytelling'

4.2 **Future plans for using shared experiences of care - 'storytelling'**

The Patient Engagement & Experience Team are collaborating with the Patient Panel, Maternity Voices Partnership, Clinical Support Services Divisional Patient Panel and Quality Improvement (QI) colleagues to develop the model for storytelling further to support and drive improvements. Some key principles already identified:

- Storytelling should be fostered and promoted to benefit high-quality, design and delivery of services. There should be advantages for patients and the Hospital.
- An expert team should be formed to provide oversight and assist in developing local and departmental "buy-in" to this model. A small number of initial Storytelling Experiences may be harnessed for the start-up phase. An early requirement will be defining a systematic assessment process to capture the data that will be central for quality assurance.
- A variety of techniques to enhance the use of Storytelling will be explored to enhance both the quantitative and qualitative data capture, eg use of films, Living Labs and Journey Mapping
- An assessment tool will be developed which captures and presents information captured through Storytelling and the resulting service change or redesign.
- Consideration of the breadth of use for the Experience of Care Storytelling Tool will be made to support embedding across all divisional boards, specialities, training and education.

Recommendations:

The Board is recommended to receive this report for information and to note plans for further experience of care presentations to forthcoming Boards – August and November. The focus for the August will be around experiences of care for those with accessible information requirements. This will link with the work underway to address health inequalities.

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MINUTES OF TRUST BOARD MEETING IN PUBLIC

HELD ON 7 APRIL 2021

Present:	Mr D White	- Chairman
	Dr P Chrispin	- Non-Executive Director
	Mr R Clarke	- Chief Finance Officer
	Mr C Cobb	- Chief Operating Officer
	Prof E Denton	- Medical Director
	Ms S Dinneen	- Non-Executive Director
	Mr J Foster	- Non-Executive Director
	Mrs J Hannam	- Non-Executive Director
	Mr S Higginson	- Chief Executive
	Mr P Jones	- Chief People Officer
	Dr G O'Sullivan	- Non-Executive Director
	Prof D Richardson	- Non-Executive Director
	Mr T Spink	- Non-Executive Director
In attendance:	Ms F Devine	- Director of Communications
	Mr J P Garside	- Board Secretary
	Mr S Hackwell	- Director of Strategy
	Mr A Lundrigan	- Chief Information Officer
	Ms A Prem	- Associate Non-Executive Director
	Ms V Rant	- Assistant to Board Secretary
	Mrs D Whittaker	- Deputy Director of Nursing
	Members of the public and press	

21/011 **APOLOGIES, DECLARATIONS OF INTEREST AND CHAIRMAN'S INTRODUCTION**

Apologies were received from Professor Fontaine, for whom Mrs Whittaker attended as deputy. No conflicts of Interest were declared in relation to matters for consideration by the Board.

Mr White expressed gratitude on behalf of the Board to all our staff, for their continued efforts and hard work in maintaining services for patients during this challenging period.

21/012 **EXPERIENCE OF CARE - PATIENT/FAMILY STORY – JAMES' YOUNG CARER STORY**

The Board listened to the experience of James, who was the main young carer for his mother and their experiences of admission and discharge at NNUH.

James explained that his mother suffers with a range of physical and mental illnesses and was admitted to hospital via the Emergency Department in September 2020. The Board was informed that as a young carer, James had not been involved in discussions about his mother's care and treatment decisions. He had not been given an opportunity to share his knowledge and to give our staff insight into his mother's health and wellbeing. James and his mother experienced anxiety, stress and poor experience, which they felt could have been avoided if James had been identified and involved throughout.

The experience of James suggested that young carers were not being identified as consistently as adult carers, highlighting the need to raise awareness of young carers. James' story has now been used to drive improvements in identification and support of young carers at NNUH. A You Tube clip has been shared widely and Young Carers Action Day and was well received.

The Board was informed that we have been working with the Hospital Carers Forum and in partnership with Norfolk Young Carers to understand the experiences of carers and to involve young carers in improvements. Key actions identified are:

- embedding methods for identifying/recording all carers;
- training/education to improve awareness and support provided to young carers;
- engaging with young carers in the community to understand and learn from their experiences.

Board members thanked James for sharing his story and the Patient Experience Team in driving improvements following this feedback.

Non-Executives asked if experiences of this nature are shared with Social Care Services to ensure continued support for patients and carers when they return home. Ms Allen of the Patient Experience Team explained that we have been working with a range of carer organisations across Norfolk and via the Carers Forum in order to identify collaborative approaches. The Carers Strategy Charter for Norfolk aims to facilitate collaborative working between organisations across the region.

Non-Executives questioned the changes that a young carer would see if they came into hospital now. Ms Allen indicated that staff should be more aware and identifying young carers more rapidly as a consequence. We are monitoring experiences of young carers to determine if their experiences are improving. Work is also underway to increase carer awareness of their rights, support available and to ensure staff are able to support them.

Non-Executives questionned if the Trust provides a link to support services that are available for young carers and highlighted that there is a need to implement a robust discharge process to ensure ongoing care. Ms Higson of the Patient Experience Team explained that a policy for working with family carers has been refreshed in partnership with community groups to co-design ways of working with carers to address issues across Norfolk and Waveney. The Trust was awarded the Carers Tick in recognition of being carer friendly which indicates a positive direction of travel. Issues around discharge processes will be picked up in the wider programme of improvement that is underway across the organisation.

The Chairman thanked James for sharing his story. Our approach on patient engagement is strengthening. The Board is committed to ensuring improvement and recognises that it is fundamentally important that we listen and work with all carers, irrespective of age or gender. It has been positive to learn of all the improvement work underway in response to this feedback.

21/013 **MINUTES OF PREVIOUS MEETING HELD ON 3 FEBRUARY 2021**

The minutes of the meeting held on 3 February 2021 were **agreed** as a true record for signature by the Chairman.

21/014 **MATTERS ARISING**

The Board reviewed the Action Points arising from its meeting held on 3 February 2021 as follows:

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

21/015 **CHIEF EXECUTIVE REPORT**

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

Mr Higginson expressed gratitude from the Executives, to our staff for their work during one of the most challenging periods in NHS history. Staff have risen repeatedly to the challenge.

Particular mention was made with respect to Estrella Catalan (Staff Nurse, A&E Department) who sadly died in February after contracting Covid. Estrella had worked for the Trust for more than 18 years and was a hugely respected, loved and dedicated member of the Emergency Department team and the Acute Stroke Team.

Mr Higginson reported that there have been 660 deaths due to Covid since April 2020. The number of patients has reduced significantly from 350 in January 2021 to 1 on 6 April 2021. The vaccination programme is continuing for staff and members of the public and we are grateful for the fantastic efforts of staff in making this programme a success.

The easing of pressure comes with the responsibility to reorganise and prepare for services to recover from the disruption of the last year. We are now facing a challenging period as we re-start services and begin to treat the backlog of 60,000 elective patients. We are looking at how services can be restarted safely and that safety standards are maintained. Provision of services virtually will continue as much as possible in order to limit the number of people on-site.

We are continuing to reflect on the results of the Staff Survey to identify improvements that can be put in place. We will be holding a series of 'Listening into Action' events to engage with staff and seek their feedback on issues of concern regarding facilities and challenges they are currently facing.

Financially, we have delivered against the Plan and the Finance Team were thanked for their work towards this achievement.

The Trust was proud to take part in the Novovax Research Trial and over 500 people were recruited. The Trust will now be taking part in a Recovery Trial which will look at the longer term effects of Covid.

21/016 **COVID 19 PANDEMIC UPDATE**

The Board received a report from Mr Cobb with regard to recent activity in response to the Covid pandemic and the current operational position.

Mr Cobb informed the Board that as of 6 April, there were 41 Covid patients in hospital, with one patient in Critical Care. The operational position during the pandemic had been disrupted by the need to repurpose ward spaces to treat Covid patients but as pressure has eased, we have now restored all but a few areas to their core speciality purpose.

A second review of our Covid response is underway to identify learning outcomes, which can be applied in preparedness for any third wave in the Autumn. The Covid Command Team who were re-deployed to manage our Covid response, will be released back to their Divisions within the next two months.

Over 50,000 vaccinations have been administered via the NNUH Vaccination Centre (33,000 first dose and 18,000 second dose). It is anticipated that the Vaccination Centre will close in June and the unit will return to ongoing care of hospital patients.

Mr Cobb explained that moving into Local Covid State 1 will remove local restrictions on segregation and management of patients via the green, yellow and red pathways. All patients will be tested and moved to an isolation unit if they are confirmed to be positive. Visiting restrictions will remain in place but will continue to be reviewed.

Professor Denton highlighted that recovery trajectories will be difficult to achieve as the throughput of patients will continue to be limited by measures to prevent infection, such as additional cleaning. Extra staff have been deployed to assist to mitigate the impact on productivity but we know it may not be possible to achieve the level of activity that was achieved prior to Covid.

21/017 **REPORTS FOR INFORMATION AND ASSURANCE**

(a) Audit Committee (31.03.21)
The Board received a report from Mr Foster as Chair of the Audit Committee.

Mr Foster reported that the Committee had ratified the appointment of KPMG as External Auditors for a 3-year term with an option to extend appointment by a further 2 years. The Committee also agreed appointment of RSM as Internal Auditors for a 3-year term from 1 April 2021.

The Board was informed that the Trust received positive assurance opinions in audits on Business Continuity; Accounts Receivable; Accounts Payable; Elective Waiting List; Risk Management; and Complaints.

Four audits receiving partial assurance opinions were reviewed: HR Policies; Agency & Bank Usage; Payroll; and ED Standard Operating Procedures and the Committee sought assurance on how IA recommendations will be implemented over the next few months.

Risks on the Corporate Risk Register have continued to be reviewed and risks have been re-graded, reflecting operational challenges over the last year.

On the recommendation of the Committee, the Board **approved** the updated Terms of Reference for the Board of Directors and associated Schedule of Matters Reserved.

On the recommendation of the Committee, the Board **approved** the updated Terms of Reference for the Audit Committee.

(b) Quality and Safety Committee (30.03.21)
The Board received a report from Dr O'Sullivan as Chair of the Quality & Safety Committee.

Dr O'Sullivan reported that the Committee had discussed concerns around mental health care for children and young people and the adequacy of commissioned services for these patients. It is understood that the increasing number of patients with mental

health difficulties presenting through ED represents a national trend and this has been flagged with commissioners.

The Committee reviewed the Clinical Audit Plan and processes. The Committee was pleased to hear that Audit Facilitators are in place within the Directorates, to support focus on learning from audits.

The Dementia Strategy was recommended by the Committee for the Board's approval.

(c) IPR – Quality, Safety and Patient Experience

Professor Fontaine informed the Board that the number of pressure ulcers are reducing as the number of Covid cases decreases. The raised level of pressure ulcers in critical care and Covid 'red' areas is thought to have been due to the acuity of patients, medical device use, reduced 'face to face' reviews and reduced staffing during the period. A Pressure Ulcer Improvement Programme has been established with a target 20% reduction over the next 12 months and pressure ulcer avoidance will be one of the learning points to include n the Covid Lessons Learned exercise.

Professor Denton reported that mortality rates have increased over the last 12 months. The national denominators for measuring mortality rates have not yet been adjusted to reflect the changed clinical circumstances of Covid and this therefore disrupts normal interpretation of the metrics.

A mortality alert (essential hypertension) was issued and a review will be undertaken through the SJR process. Increased sharing of learning from coding and mortality data is being facilitated through Clinical Coding Clinicians. There is evidence that SHMI rates are higher due to issues with palliative care and ortho-geriatric provision. We will be establishing extra ortho-geriatric wards post-Covid and it is hoped that this will support SHMI reduction.

Mortality is reviewed through the Quality & Safety Committee as part of its regular agreed Work Programme and the Board will be updated accordingly.

(d) Finance, Investments and Performance Committee (22.03.21 & 31.03.21)

The Board received a report from Mr Spink as Chair of the Finance, Investments & Performance Committee.

Mr Spink reported that the Committee had received an update on regional discussions regarding the affordability of the Electronic Patient Record scheme. Delay in implementing the EPR increases the risk associated with the current Patient Administration System which is over 20 years old.

The Committee held an additional extraordinary meeting to review the Elective Care Strategy and a series of interventions intended to improve the position in reducing waiting times. Each of these is considered to be an important component of a cumulative plan and business cases will be developed as necessary.

The improved financial position was noted. Further work needs to be undertaken to develop Cost Improvement Plans and the Committee will be focusing on workforce opportunities at its next meeting.

(e) IPR – Finance, Performance and Productivity

Mr Cobb reported that our recovery strategy is focusing on treatment for cancer and urgent (P1 and P2 surgery) patients on the waiting list. Routine non-urgent patients will continue to wait and the number of patients who have been waiting longer than 104 days for treatment is increasing. A harm review panel has been established to

monitor and detect potential harm for those who will come to those patients who are waiting longer for their treatment.

Two-week wait cancer performance has shown signs of improvement in February. Additional breast clinics have been provided at weekends to address the backlog. 62-day cancer performance also improved in February and work will continue in line with national guidelines. Progress will continue to be overseen by the Board's Assurance Committees.

Mr Higginson indicated that planning for the coming year is targeted at enhancing productivity and we will be working with our system partners to develop plans for creating additional capacity. System plans will take time to implement and a significant reduction in waiting lists will not be achieved immediately. We will continue to monitor those patients who are waiting longer in order to ensure they do not come to harm.

Professor Denton informed the Board that the harm review process for patients has grown in line with the growing numbers of patients waiting for treatment. The categories for patients are defined nationally according to urgency and patients are allocated to the relevant categories for treatment.

Mr Clarke reported a year-end financial position of £2.3m surplus against the planned deficit of £11.4m. The favourable position is driven by reduced activity levels, generating underspends across variable costs. The position may improve with finalisation of national settlements for annual leave and other income. There are 17 risks on the strategic financial risk register, 3 of which have improved and 3 have deteriorated, with further work to develop the CIP performance.

(f) People and Culture Committee (29.03.21)

The Board received a report from Professor Richardson as Chair of the People & Culture Committee.

Professor Richardson reported that the Committee had discussed concerns about the impact on staff from the pandemic and a risk around staff retention has been identified. Further reviews are underway to identify the risks arising from staff choosing to take early retirement and the Committee will be updated at its next meeting.

The Divisions are being encouraged to undertake proactive discussions with staff to understand the impact on teams and morale. A transformational leadership style has been encouraged to empower staff to take responsibility and make decisions on service improvements.

There was NED questioning with regard to adoption of a medium term systemic approach to address concerns arising from the Staff Survey over a number of years. It is a need also to ensure that some actions are implemented in the short term and assurance was sought on this.

Mr Jones explained that we are prioritising a number of short term actions at the same time as our programme of listening events. The extent of changes identified from the Staff Survey requires organisation-wide cultural focus over a number of years.
Professor Richardson informed the Board that development of a People and Culture Strategy is to be overseen by the Committee, setting out key objectives and through which the Committee will be able to monitor improvements and benefits gained.

(g) IPR - Workforce

Mr Jones reported that sickness absence spiked during the Second Wave, reflecting the number of Covid cases. The 12-month average sickness rate is 4.45% inclusive of

Covid sickness. We are implementing psychological support to assist staff in the recovery from the pandemic.

Non-Executives requested review of the narrative alongside the workforce metrics on the IPR to enhance assurance. **Action: Mr Jones**

21/018 **RESPONSE TO CQC REPORT**

The Board received a report from Dr Caroline Kavanagh (Associate Medical Director for Urgent and Emergency Care) and Ms Rachel Cocker (Emergency and Urgent Care Nurse Director) in response to the CQC Report and Section 29A Warning Notice.

Dr Kavanagh reported that 9 recommendations (4 most do; 5 should do) were issued following the CQC inspection of Urgent and Emergency Care Services and the associated Quality Improvement Plan outlines the actions to be taken to address those recommendations. A survey is also underway to engage staff in putting forward their ideas on how we can improve our services for emergency patients.

Delivery of improvements under the QIP will rely on wider improvement programmes such as Discharge Planning, Discharge to Assess, Red to Green (R2G) and NNUH Safer Better Faster, which are all aimed at reducing delays in ED by improving the flow of patients through the hospital.

A number of areas have been progressed:

- introduction of new triage processes for monitoring triage times and priority chairs for patients who are at risk of deterioration;
- adoption of new emergency access standards;
- ED nurse staffing levels;
- recruitment of middle grade doctors;
- improvements in infection prevention and control processes;
- improved ED waiting areas and signage;
- appointment of 3 consultants.

Non-Executives reflected on the Section 29A Notice and whether the issues concerned should have been picked-up during our assurance processes which, if optimal, would have identified these issues prior to the inspection.

Mr Higginson explained that we had been working to address gaps in medical staffing for some time prior to the inspection. We have also been working to develop plans to improve performance and there has been good progress in nursing recruitment. Issues were identified with our triage processes and we have identified that this was partly due to the terminology used and this has now been revised in line with that used by the CQC. On the day of the inspection, it was found that there had been gaps in compliance with infection prevention and control policies and this is something that needs reinforcing in daily practice.

Professor Denton explained that we have adopted a proactive shared learning approach in our response and learning is shared via the evidence group across the organisation. Ongoing monitoring will be through the Quality & Safety Committee and this is scheduled in accordance with its Work Programme.

21/019 **DEMENTIA STRATEGY (2021-26)**

The Board received a report concerning the draft Dementia Strategy (2021-26) presented by Ms Elizabeth Yaxley (Dementia Services Manager). The Strategy has been reviewed by the Quality & Safety Committee, with recommendations for revision made.

Ms Yaxley informed the Board that the Dementia Strategy outlines actions to achieve excellence in dementia care and to develop a blended workforce with specialist skills to enhance the experiences of our patients. Actions have been identified under each of the following areas:

- skilled workforce;
- working together;
- assessments;
- person centred care;
- volunteer support;
- environments;
- research;
- governance.

Collaboration with health, social care, voluntary sector, public service and university will continue with the aim of achieving an overarching dementia strategy with unified operational plans putting people with dementia and their carers at the forefront. Mr White welcomed the involvement of families and carers in development of the Strategy.

Non-Executives questioned whether the Strategy could be strengthened if we could outline some measures of success from the perspective of patients - focussed on the experiences of patients and outcomes/changes achieved for patients. There was non-executive questioning about the timeframe for production of the operational plan which will sit alongside the Strategy to enable monitoring/reporting of progress.

Ms Yaxley explained that the operational plan will incorporate measures of success. Work to improve dementia services has been underway for some time and the operational plan will reflect what has been achieved and what further work needs to be carried out.

Mr Lundrigan asked about digital aspirations that would support dementia care and highlighted that these could be incorporated in system-wide digital discussions. Ms Yaxley indicated that we are exploring ways to support people using technology. We are exploring options for funding a dementia support worker in outpatients to support people with a dementia or cancer diagnosis.

The Board's Quality and Safety Committee is scheduled to receive regular updates on dementia care as part of its agreed Work Programme, to include oversight of implementation of the Strategy, Operational Plan and patient-focussed measures of success.

The Board **approved** the Trust's Dementia Strategy (2021-26)

21/020 **QUESTIONS FROM MEMBERS OF THE PUBLIC**

Questions from the public concerned the closure of the Hospital Vaccination Centre in June 2021. Mr Cobb confirmed that prior to closure delivery of the second doses of vaccine would be completed for all those people that had received a first dose at the Centre. Members of the public will still be able to access vaccinations via community routes.

The Board was asked for further detail regarding the collaboration with Spire to provide treatment to patients during the pandemic. Mr Cobb explained that a specific contract with the Spire Hospital had been in place during the pandemic to ensure continued treatment of urgent & cancer patients. We have put in place arrangements for ongoing collaboration, with particular reference to long-waiting patients

21/021 **ANY OTHER BUSINESS**
There was no other business.

21/022 **DATE AND TIME OF NEXT MEETING**
The next meeting of the Trust Board in public will be at 9.30am on Wednesday 6 June 2021 at the Norfolk and Norwich University Hospital.

Signed by the Chairman: …… Date: ……
Confirmed and approved for signature by the Board on 02.06.21 [TBC]

Decisions Taken:

21/013 – approval of minutes	The minutes of the meeting held on 3 February 2021 were **agreed** as a true record for signature by the Chairman.
21/017 ToRs – Board of Directors	The Board **approved** the updated Terms of Reference for the Board of Directors and associated Schedule of Matters Reserved. (Uploaded to Trust Docs on 08.04.21)
21/017 ToRs – Audit Commitee	The Board **approved** the updated Terms of Reference for the Audit Committee. (Uploaded to Trust Docs on 08.04.21)
21/019 Dementia Strategy	The Board **approved** the Trust's Dementia Strategy (2021-26)

Action Points Arising:

	Action
(20/048(b) (Nov '20)) Update to IPR to include Pressure Ulcer target -	21/003 – carried forward: IPR tracking targets % reduction in pressure ulcers and falls – (20/048(b) (Nov '20)) – Carried forward - IPR format – Non-Executives noted that targets had not been included on IPR slides for pressure ulcers and falls and suggested that it would be helpful to include a line on the SPC chart to aid tracking of progress to achieve the target percentage reduction. Professor Fontaine confirmed that this would be reviewed with the Information Services team. **Action: Prof Fontaine**
21/017(g) Workforce IPR narrative	Non-Executives requested review of the narrative alongside the workforce metrics on the IPR to enhance assurance. **Action: Mr Jones**

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Action Points Arising from Trust Board meeting (public) – 07.04.21

Item	Action	Update – June 2021
(20/048(b) (Nov '20)) Update to IPR to include Pressure Ulcer target	21/003 – carried forward: IPR tracking targets % reduction in pressure ulcers and falls – (20/048(b) (Nov '20)) – Carried forward - IPR format – Non-Executives noted that targets had not been included on IPR slides for pressure ulcers and falls and suggested that it would be helpful to include a line on the SPC chart to aid tracking of progress to achieve the target percentage reduction. Professor Fontaine confirmed that this would be reviewed with the Information Services team **Action: Prof Fontaine**	**Board to be updated at meeting**
21/017(g) Workforce IPR narrative	Non-Executives requested review of the narrative alongside the workforce metrics on the IPR to enhance assurance. **Action: Mr Jones**.	Reviewed and subject to discussion/feedback at Board Committees – for further refinement. **Suggest Action closed**.

JPG 28.05.21

REPORT TO THE TRUST BOARD OF DIRECTORS	
Date	**2 June 2021**
Title	**Chief Executive's Report**
Author & Exec lead	**CEO**
Purpose	**For Information/Discussion**

Covid 19. We continue to have small numbers of Covid 19 positive patients in the hospital who we are looking after on Hoveton ward (the Isolation unit) and are at Local Covid State 1. There is considerable uncertainty regarding the latest modelling with some forecast continuing to project an increase in patients from July, linked to the current variant. Given the position we are continuing to limit access to the hospital. Access requires visitors to have undertaken a lateral flow test and visitor numbers remain managed.

2021/22. Last month in my Chief Executives report I set out our strategic priorities for the short term, centred around the need for us to recover from Covid and prepare for future waves alongside making progress on the elective recovery, delivering our financial plan and continuing to improve our quality metrics.

Delivering on what we said we would do in our plans is the first step to us restoring credibility as an organisation with our stakeholders. We achieved this in 2020/21 in what was an unusual year, we now need to deliver this for a second year in 2021/22.

Early indications are that we delivered our activity plan for April in line with the national planning guidance benchmark of 70% of April 2019 activity and we are making good progress on reducing our P2 patients down from 1200 to under 600.

On finance, we are slightly ahead of the financial plan after month 1, based on our agreed budget of the equivalent of a £110m full year underlying deficit, a £4m improvement on the £114m underlying deficit we came into the year with.

Whilst on track to deliver our activity metrics, our overall waiting list is continuing to grow and is now over 65,000 which gives us a significant future risk that we have been discussing at the Finance & Investment and cover in our elective strategy. Our response will need to look at how can we use our capacity more productively as well as targeted investment in new capacity if we are to make progress on the elective backlog.

We are awaiting further planning guidance for the second half of the year but already plan to refresh our capacity planning in Q2 to prepare for this. As we get our hospital services back in long term locations the next phase of our work will need to focus on how we get the most out of our capacity. The work we previously undertook as part of the first phase of the financial strategy analysis identified this as a major opportunity and we will be using the updated model hospital analysis

to review this in more detail in the coming weeks. At one level the answer is simple, we will need to improve our productivity across the whole hospital if we are to make progress over the next 6-18months.

Staff engagement. It was a privilege to attend the closing session of our reverse mentoring programme on the 28th May which many of the leadership team have been part of in recent months. We will be reflecting further with mentors around what action we should now take to make progress on the diversity agenda.

We have launched our Staff Survey Action plan workshops which are continuing for the next few weeks and will inform the action plan that we then adopt across the organisation.

The latest Freedom to Speak Up national index was published on the 27th May. It is drawn from a subset of questions from the staff survey. The Trusts score has slightly increased from 77.5% to 77.6%. Nationally the index has improved to 79.2% from 78.7%. I'd like to say thank you to Fran and her team of speak up guardians for continuing to deliver an excellent service. Whilst we are continuing to improve there remains much to be done. We plan to link next steps to our Staff Survey Action plan response.

We will launch in June our engagement process with staff to help shape the trust 5 year strategy and the commitments and priorities that we have previously discussed at the Board Strategy Group.

ICS. We continue to await further guidance on ICS governance and structure which we understand is imminent. Later in the agenda we will discuss the outcome of the Tripartite Board meeting that was held on 25th May and next steps leading into the Committee in Common on the 14th June.

Research We submitted our Biomedical Research Centre bid on the 26th May for c£7m of funding with a bid based around aspects of ageing. We will hear whether we have made it through to the next round by the 4th August. Irrespective of whether or not we are successful, the bid has given us an opportunity to bring more structure to our research agenda with the UEA and a roadmap for how we can work together in the coming years. The research team have produced a high quality bid.

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

REPORT TO THE TRUST BOARD

Date	**26 May 2021**
Title	**Chair's Key Issues from Audit Committee Meeting on 26.05.21**
Lead	**Julian Foster – Non-Executive Director (Committee Chair)**
Purpose	**For Information, assurance and approval as specified**

1 Background/Context

The Audit Committee met on 26 May 2021. Papers for the meeting were circulated to all Board members for information in the usual way. The meeting was quorate. Dr Peter Harrison and Mr Chris Hind (Public Governors) attended as observers.

At the Extraordinary Trust Board meeting on 26 May, the Board received the report regarding the Committee's work in relation to i) Trust Annual Report and Accounts 2020/21; ii) Licence Self-Certifications; iii) Audit Committee Annual Report. Other matters considered at the meeting included the Corporate Risk Register, Board Assurance Framework, implementation Internal Audit recommendations, work of the Local Counter Fraud Service (LCFS) and use of SFIs.

In addition, the Committee identified the following matters to highlight:

2 Key Issues/Risks/Actions

Issues to Highlight and escalate:		
1	Board Assurance Committees' annual reports	As part of the Committee's oversight of integrated governance in the Trust, it received the Annual Reports from the Quality & Safety Committee, Finance, Investments & Performance Committee and People & Culture Committee. Committee members commended this practice, which provides a powerful overview of activity in the Board assurance committee system 'in the round'.
2	Covid 19 – Reimbursement Report	NHSE/I has commissioned a series of independent reviews of Trusts nationally to examine local financial management and practice under the Extraordinary Covid-19 Cost Reimbursement Framework for the year to Month 6 2020/21. Given the pace of change and extraordinary circumstances of the activity in question, it was unsurprising that some issues were identified but it was notable that these were limited in number and value and none indicated ongoing control issues. The Committee considered that this review revealed that the Trust's processes and response to appropriately manage and control expenditure during the unprecedented circumstances of the pandemic had been impressive.

3	Scheme of Delegation	The Committee **agreed** updates to the Board's Scheme of Delegation, **(as attached),** which are intended to ensure alignment between the SoD and the electronic procurement system (Powergate). These changes are recommended to the Board for approval in accordance with the Schedule of Matters Reserved.
4	Standing Financial Instructions (SFIs)	The Committee considered proposed updates to Standing Financial Instructions: • **Section 9 Non-Pay Expenditure and Procurement and Section 20 Tendering and Contract Procedure** have been refreshed including removing or updating the references to the EU along with role changes • **Section 11 Capital Investment, Private Financing, Fixed Asset Registers and Security of Assets** has been updated to reflect the Trust's new business case process which outlines the rules and guidelines to be followed for staff presenting cases for investment. • **Sections 21 Development and Consultation Process, 22 Associated Documentation and 23 Equality Impact Assessment** have been added to ensure the policy meet's the Trust's general guidelines for non-clinical policies The updated SFIs document has been uploaded to the Diligent Resource Centre and is **recommended for approval**.
5	Code of Conduct for Directors and Governors	The Trust's Code of Conduct sets out expectations with respect to compliance with the Nolan principles of public life and duties of confidentiality. The Committee **reapproved** the Code of Conduct for Directors and Governors without amendment.

3 Conclusions/Outcome/Next steps

The next Committee meeting is scheduled for 29 September 2021.

Recommendation:

The Board is recommended to:

- **note** the work of its Audit Committee and **receive** the Committee Annual Report;
- **approve** the updated Scheme of delegation;
- **approve** the updated Standing Financial Instructions.

C SCHEME OF DELEGATION

Section 1 - Making Agreements

DELEGATED MATTER	AUTHORITY DELEGATED TO	REFERENCE DOCUMENTS
1.1 Approve and sign all building or property documents including licences or leases	CFO (or nominated officer) and CE (or nominated officer)	SO 15.3
1.2 Contracting for Goods & Services[1]		SFIs Section 9
a) Agreements other than as specified below[2]:		
▪ up to £~~4,999~~1,499	Team managers, Ward sisters, equivalent staff member ~~Clinical Director/Divisional Operation Manager/Dept Head~~	
• from £~~5,000~~1,500 to £19,999	Operations Managers, Heads of Department, Chiefs of Service, Service Directors, Deputy Operations Directors, Matrons, equivalent staff member ~~DGM or Head of Corporate Department~~	
• from £20,000 to £149,999	DODs, DNDs, some Heads of Department ~~CFO or Nominated Deputy~~	
• from £150,000 to £249,000	CODs, Directors	
• from £~~150,~~250,000 to £~~500~~499,000	Executive Directors including the Board Secretary ~~CFO~~	
• £500,000 to £2,000,000	CE and CFO	
• over £2,000,000	Trust Board	
b) Pharmacy orders:		
▪ up to £10,000	Head of Pharmacy or Nominated Deputy	
▪ from £10,000 to £50,000	Head of Pharmacy	
▪ over £50,000	CFO	
c) Capital orders:[3]		
▪ up to ~~<~~£~~500~~499,999~~000~~	CFO, Director of Strategy and Major Projects or Nominated Deputy	
▪ ~~£500,000 to £1,000,000~~	~~CFO~~	
• from £~~1,000~~500,000 to £2,000,000	CE and CFO	
• over £2,000,000	Trust Board	

d) Non Pay Expenditure for which no specific budget has been set <£2,000,000	CE and CFO	

[1] For the avoidance of doubt, periodic payments under contractual arrangements that have received Board approval may be approved for payment in accordance with procedures agreed by the CFO notwithstanding that they may exceed the authority limits specified here.

[2] In any circumstances of uncertainty or which appear to fall outside the categories specified in this Scheme, the delegated authority limits specified in this section 1.2 (a) should be taken to apply

3 In accordance with approved capital expenditure programme. All capital orders must have a completed and authorised Capital Expenditure form signed by CFO/Deputy Director of Finance/

REPORT TO THE TRUST BOARD

Date	**2 June 2021**
Title	**Chair's key Issues from Quality and Safety Committee Meeting on 25.05.21**
Lead	**Dr Geraldine O'Sullivan – Non-Executive Director (Committee Chair)**
Purpose	**For Information and assurance**

1 Background/Context

The Quality and Safety Committee met on 25 May 2021. Papers for the meeting were made available to all Board members for information in the usual way. The meeting was quorate and was held on site and by MS Teams. The meeting was attended by Mrs Ines Grote (Public Governor) as observer via MS Teams.

2 Key Issues/Risks/Actions

Key issues to highlight to the Board were identified as follows:		
1	Quality and Safety – Current Performance	The Committee again noted the ongoing high rate of caesarean section deliveries. The explanation remains complex, in terms of case mix and patient choice. In order to inform monitoring and assurance however the Committee requested greater clarity in terms of benchmarking data and associated targets. The Committee has also requested additional information and regular reporting of Covid nosocomial infections through the IPR. The Committee has been informed that a thematic review is being carried out which will determine the classification of cases and information will be reported to the Committee once concluded. [Information available in the meantime, post-meeting, is as **attached**].
2	Corporate Risk Register – Clinical risks	The Committee reviewed the relevant extract from the Corporate Risk Register and noted the reduction of risk rating related to patients on the waiting list due to rigorous, proactive management of the waiting list. The Committee noted the ongoing risks relating to the Pharmacy Department. The capital and estates issues are recognised as difficult but there is a need to review our plan for a sustainable solution to the problems associated with the Department and its space constraints. The Committee requested that this should be discussed by the Management Board and report back.
3	Patient Experience, feedback and incidents	The Committee received a regular update in relation to incident reporting. The programme to cap-off outlets for Medical Air is underway with a final 45 nebulisers to be fitted. The Committee received a report with respect to the work undertaken by the Patient Experience Team concerning assessment against the Equality Delivery System (EDS2). This was seen as a very positive initiative meriting highlighting to the Board. The number of claims received by the Trust was also noted, which has fallen in the last couple of years

		2016/17 – 153 2017/18 – 150 2018/19 – 168 2019/20 – 158 2020/21 - 149
4	CQIA Update	The Committee receives regular updates on the process for Clinical Quality Impact Assessment, as a safeguard in the context of our cost improvement programme. The Committee was advised that it is hoped to extend the use of our Virtual Ward to monitor patients who are awaiting cardiac surgery – of whom there may be 20 patients at any given time. The Committee was impressed with this initiative not only in terms of its potential efficiency but also its innovation and patient benefit.
5	Draft Quality Report 2020/21	The Committee reviewed the draft Quality Report 2020/21. Recognising the constraints of the requirements relating to format and content, the Committee suggested that it would be helpful to prepare a summary particularly relating to our Quality Priorities, accessible to staff and public.
6	National Patient Safety Strategy	The Committee received a briefing with respect to planned actions in the Trust to implement the National Patient Safety Strategy, with particular focus to: - Implement a new Patient Safety Incident Response Framework (PSIRF) - Develop a framework for involving patients in patient safety - Strengthen Patient Safety education and training - Improve the quality of incident reporting - Enhance development of a Just Culture in the Trust. This will be a significant programme of work and the Committee will receive further reports on intended implementation plans.

3 Conclusions/Outcome/Next steps

The next Committee meeting is scheduled for 29 June 2021.

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

Potential Nosocomial infection

SARS-CoV2 Figures NNUH Trust March 2020 – April 2021

Criteria	Category
1st positive specimen date 15 or more days after admission	**HODA** (Hospital Onset Definite Associated)
1st positive specimen date 8–14 days after admission	**HOPA** (Hospital Onset Probable Associated)
1st positive specimen date 3–7 days after admission	**HOIA** (Hospital Onset Indeterminate associated)
1st positive specimen date <=2 days after admission	**Community Onset**

1st Positive specimen by NHSE criteria as above

Category	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
HODA	10	16	1	0	0	0	0	1	18	33	59	9	0	0
HOPA	7	10	2	0	0	0	0	0	16	31	56	9	1	0

Died within 28 days of specimen

Category	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
HODA	7	6	0	0	0	0	0	1	4	15	24	3	0	0
HOPA	4	5	0	0	0	0	0	0	6	17	19	2	0	0

Died within 28 days of specimen where Death Certificate has cause 1 / 2 as COVID-19

Category	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21
HODA	7	5	0	0	0	0	0	0	3	12	22	3	0	0
HOPA	4	3	0	0	0	0	0	0	5	14	18	2	0	0

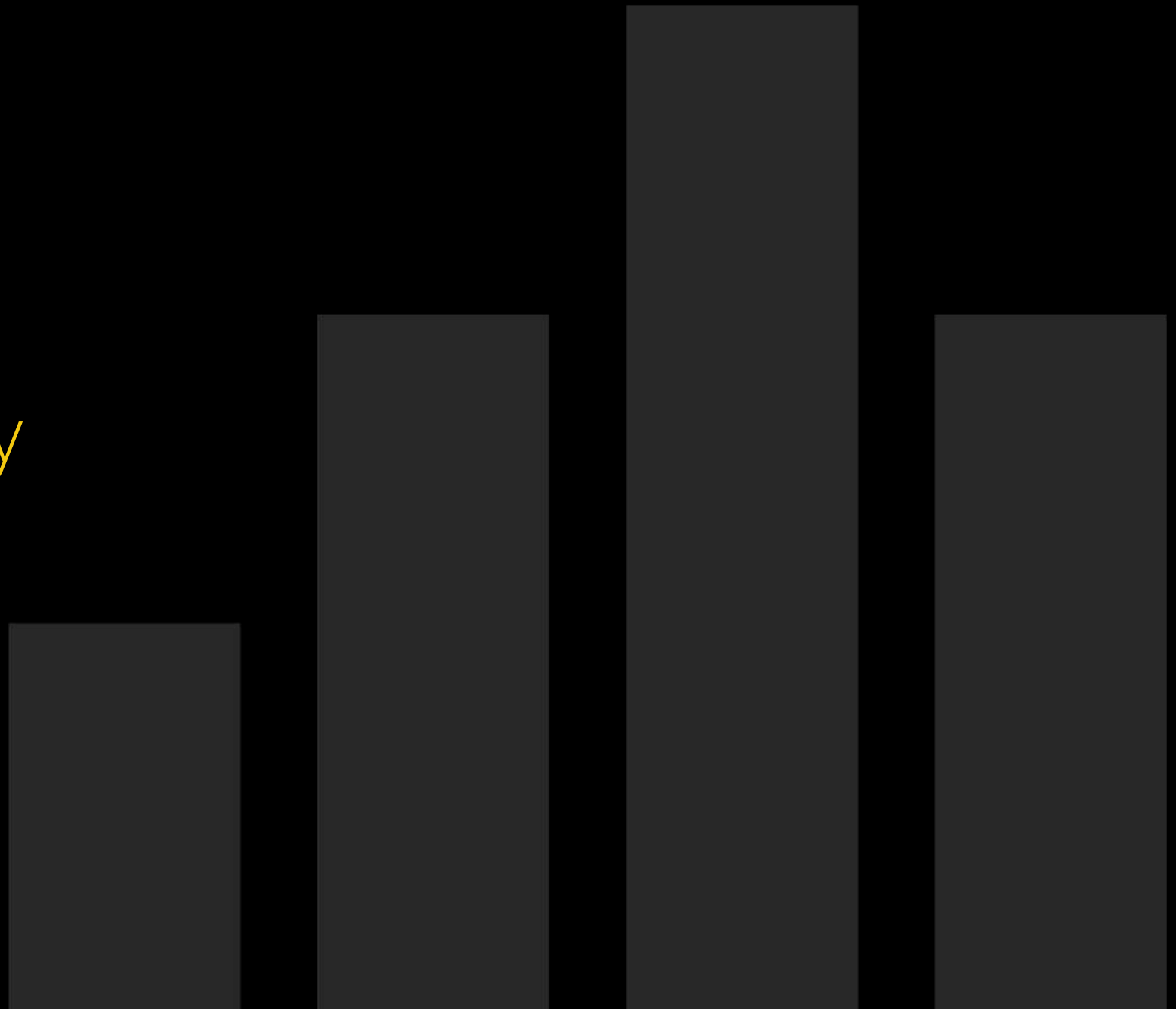
Microsoft | Power BI

Quality & Safety

View in Power BI

Last data refresh:
21/05/2021 07:30:21 UTC

Downloaded at:
21/05/2021 14:44:06 UTC



Quality Summary

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

NNUH Digital Health
business intelligence

Topic	Metric Name	Date	Result	Variation	Assurance
Children & Midwifery Safeguarding	Safeguarding Children	Apr 2021	24	Concern (High)	No Target
Children & Midwifery Safeguarding	Safeguarding Children and Midwifery	Apr 2021	30	Concern (High)	No Target
Complaints	Complaints - Acknowledgement	Apr 2021	100%	Improvement (High)	Unreliable
Maternity: Mothers	1:1 Care in Labour	Apr 2021	99.4%	Improvement (High)	No Target
Maternity: Mothers	Caesarean Deliveries	Apr 2021	42.5%	Concern (High)	No Target
Patient Safety	Incidents	Apr 2021	4,209	Concern (High)	No Target
Safer Staffing	Safe Staffing Fill Rates	Apr 2021	89.20%	Concern (Low)	Not capable
Saving Babies Lives	CTG Training and Human factors situational awareness compliance	Apr 2021	86%	Concern (Low)	Unreliable

SPC Variation Icons

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

SPC Assurance Icons

Capable | Not capable | Unreliable

Patient Safety

NNUH Digital Health
business intelligence

Serious Incidents

Apr 2021

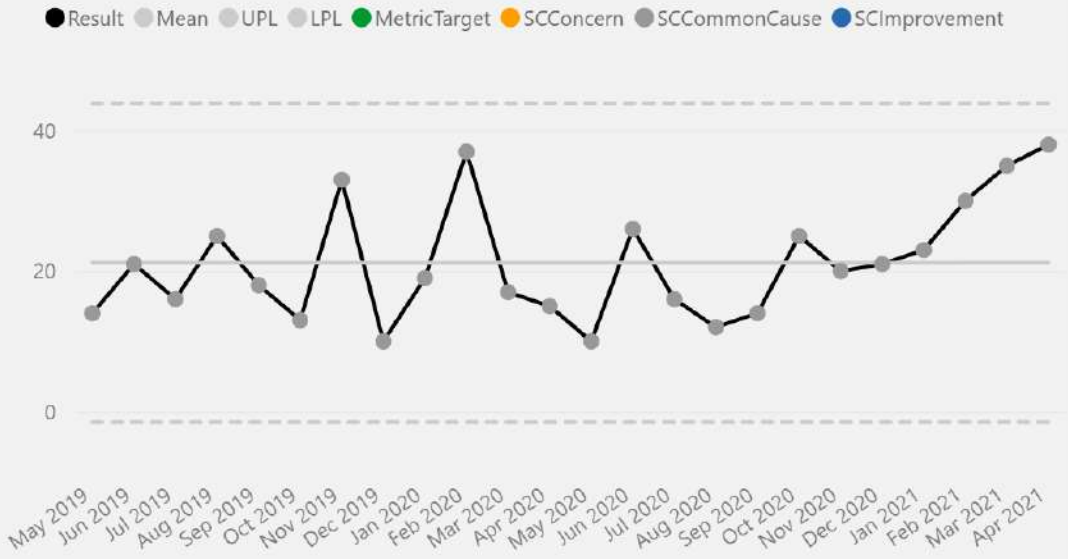
Variation	Assurance
	

38 Result	44 UPL
N/A Target	21 Mean
	-2 LPL

Analytical Commentary

Variation is Common Cause

Serious Incidents



Assurance Commentary

The number of Serious Incidents reported continue to show common cause variation however an increasing trend over the last 5 months is evident which is driven by the number of commissioning incidents, (delays to admit patients with mental health needs.) We have also reported 6 Wave 1 COVID cluster outbreaks in this month's data. 38 SI reported for April. Of these 2 void requests made for duplicate entries.
The high number of Datix incidents (98% of which are 'no or low' harm) includes the increasing number of 52 week breach patients.
Duty of Candour has seen improved compliance.

Improvement Actions

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

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Duty of Candour Compliance	Apr 2021	95%		Common Cause		Unreliable
Incidents	Apr 2021	4,209		Concern (High)		No Target

Pressure Ulcers

NNUH Digital Health
business intelligence

Hospital Acquired Pressure Ulcers per 1,000 bed days

Apr 2021

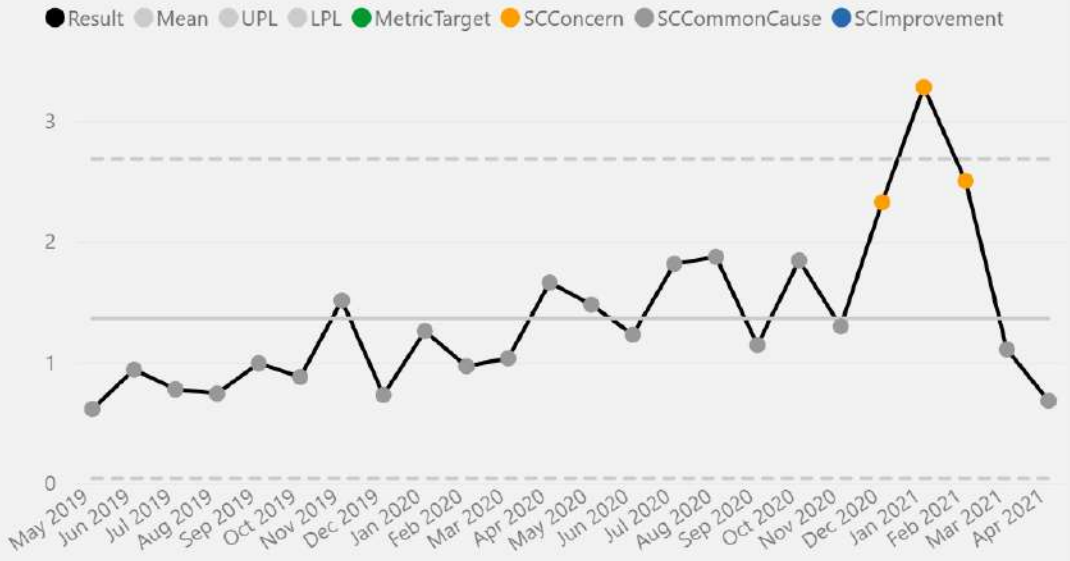
Variation | Assurance

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

Analytical Commentary

Variation is Common Cause

Hospital Acquired Pressure Ulcers per 1,000 bed days



Assurance Commentary

Hospital Aquired Pressure Ulcers have fallen back to Pre Covid levels with two data points below the median line which is encouraging .

Improvement Actions

The Pressure Ulcer Improvement Programme aims to achieve a 20% reduction in the number of hospital acquired pressure ulcers.Ward based QI projects are ongoing . Promoting 'healthy skin, monitoring 'pressure free' days. Education to improve grading and reporting of pressure damage. HCA's focussed education and support. Feedback : "educator was with 3 Mattishall HCAs undertaking a brilliant teaching session re diabetic foot care, pressure area care and fluid balance. They were totally engaged. It was lovely to see" Some wards achieving 100 pressure free days. Pilot of 'PurposeT' due in June.

Patient Falls

NNUH Digital Health
business intelligence

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

Apr 2021

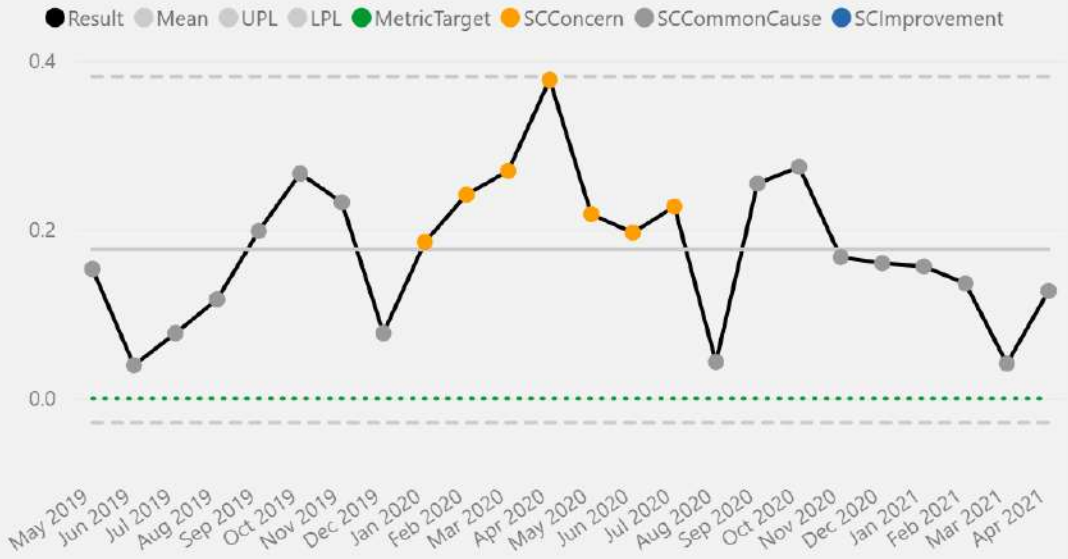
Variation | Assurance

0.1 Result	0.4 UPL
0.0 Target	0.2 Mean
	0.0 LPL

Analytical Commentary

Variation is Common Cause

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



Assurance Commentary

The number of inpatient falls is within the expected range and has reverted back to levels seen pre COVID. The rate of falls causing moderate harm or above has reduced over the last 4 months, however it is too early to say if this is an improving trend or sustained reduction.

Improvement Actions

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

Patient Experience

NNUH Digital Health
business intelligence

Friends & Family Score

Mar 2021

Variation	Assurance

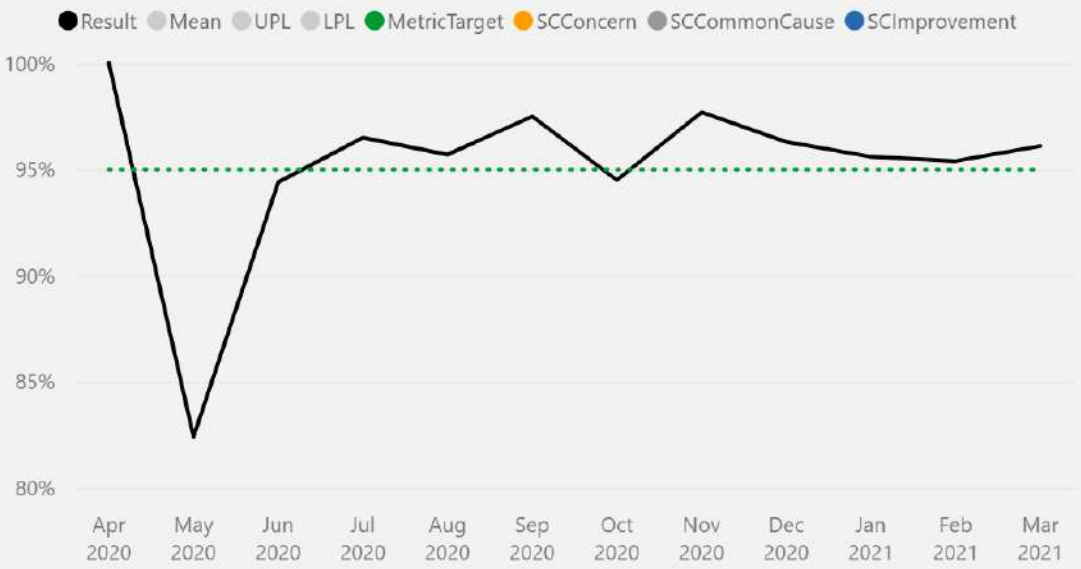
96.10% Result
95.00% Target

UPL
Mean
LPL

Analytical Commentary

Metric does not meet SPC criteria

Friends & Family Score



Assurance Commentary

FFT data transfer issues for IPR reporting- National (Unify) reporting achieved through manual submission, the same has not been possible for IPR. Currently working with IT to ensure BI have necessary access to retrieve the FFT data since going live on the 01st April with IMI Healthcare Comms- Envoy, the new provider. We will ensure the issues are resolved for June IPR.

Improvement Actions

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

Supplementary Metrics

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

Patient Concerns

NNUH Digital Health
business intelligence

PALS % Closed within 48hours

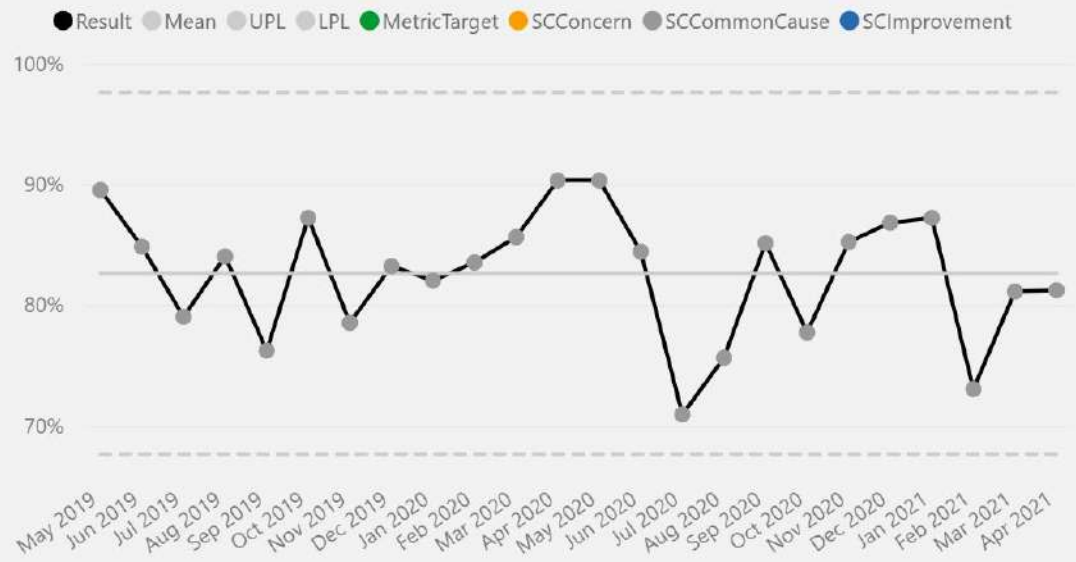
Apr 2021

Variation	Assurance
81.2% Result	97.6% UPL
N/A Target	82.6% Mean
	67.6% LPL

Analytical Commentary

Variation is Common Cause

PALS % Closed within 48hours



Assurance Commentary

PALS responsiveness to all contacts remains high.

This month total PALS matters received – 468 (565)
Concerns = 192,
Enquiries = 125,
Signposting = 99 (of which 38 are formal complaints)
Best Wishes = 52

Main Subjects
Communications, Appointment delays and cancellations, waiting times.

Improvement Actions

Divisions provide reports to PEEG covering their local actions.
77 colleagues (via 8 sessions) have attended 'Let's Resolve it' training, with ongoing sessions planned.
Dunston will be the pilot ward for a new QSIR project starting on the 1st June for 3 months, with an aim to see if the patient experience improves with staff who are 'Let's Resolve it' trained.
Month 1 - pt. survey, Month 2 - train the staff, Month 3 - follow up pt. survey.
Consider as part of new discharge process.

Supplementary Metrics

Metric Name	Date	Result	Variation	Assurance
PALS Enquiries	Apr 2021	468	Common Cause	No Target

Complaints

NNUH Digital Health
business intelligence

Complaints - Trust

Apr 2021

Variation | Assurance

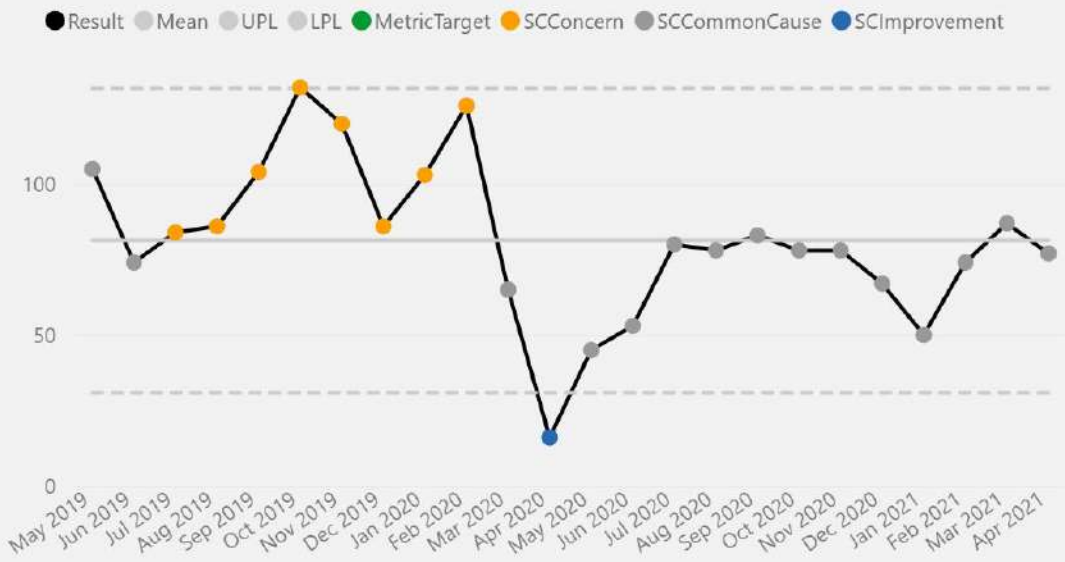
77 Result
N/A Target

132 UPL
81 Mean
31 LPL

Analytical Commentary

Variation is Common Cause

Complaints - Trust



Assurance Commentary

All targets met.

Improvement Actions

Supplementary Metrics

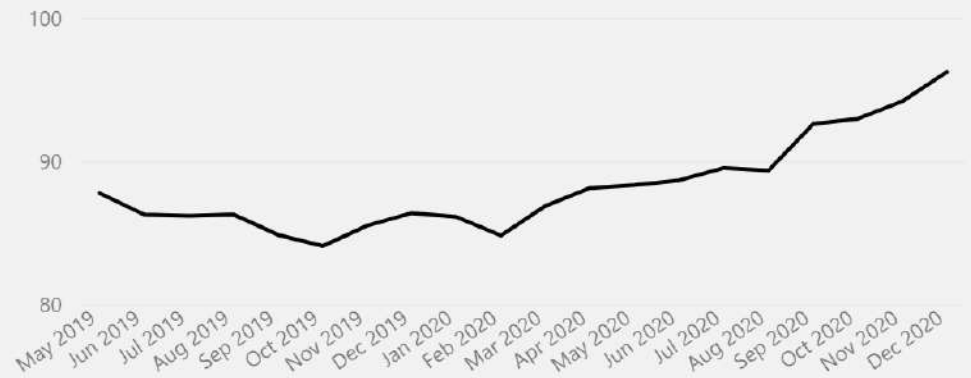
Metric Name	Date	Result		Variation		Assurance
Complaints - Acknowledgement	Apr 2021	100%		Improvement (High)		Unreliable
Complaints - Response Times - Trust	Apr 2021	97%		Not Applicable		Not Applicable
Post-investigation enquiries	Apr 2021	12		Common Cause		Capable

Mortality Rate

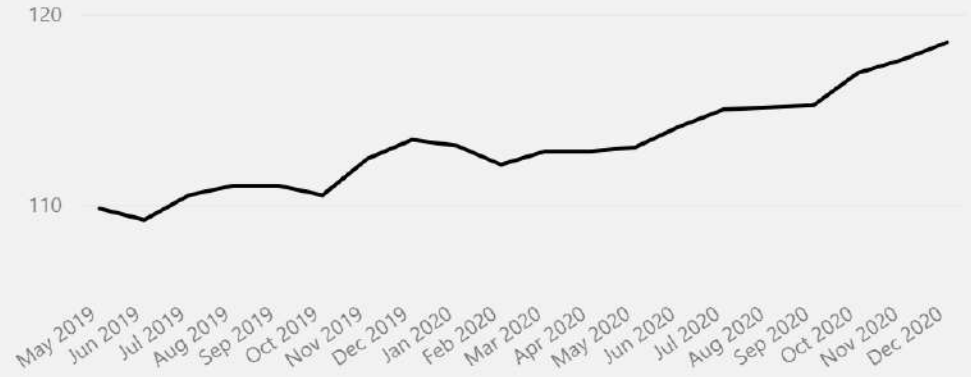
NNUH Digital Health
business intelligence

MetricName	Date	Result
HSMR	Dec 2020	96.24
SHMI	Dec 2020	119

HSMR



SHMI



Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Crude Mortality Rate	Mar 2021	4.30%		Common Cause		No Target

Assurance Commentary

An indepth review of has been completed with assistance from Dr Foster (Marianne Tankard) on SHMI and HSMR mortality data with covid peer organisations. The analysis did not show NNUH as an outlier during this period.

Improvement Actions

NNUH SHMI action plan in progress to address increased trend reported over recent months.

The SJR cohort review of Covid Deaths for the second wave is due to be completed in September.

Work continues with improvement groups which include #NOF pathway and palliative care.

Safer Staffing

NNUH Digital Health
business intelligence

Safe Staffing Fill Rates

Apr 2021

Variation	Assurance
L	F

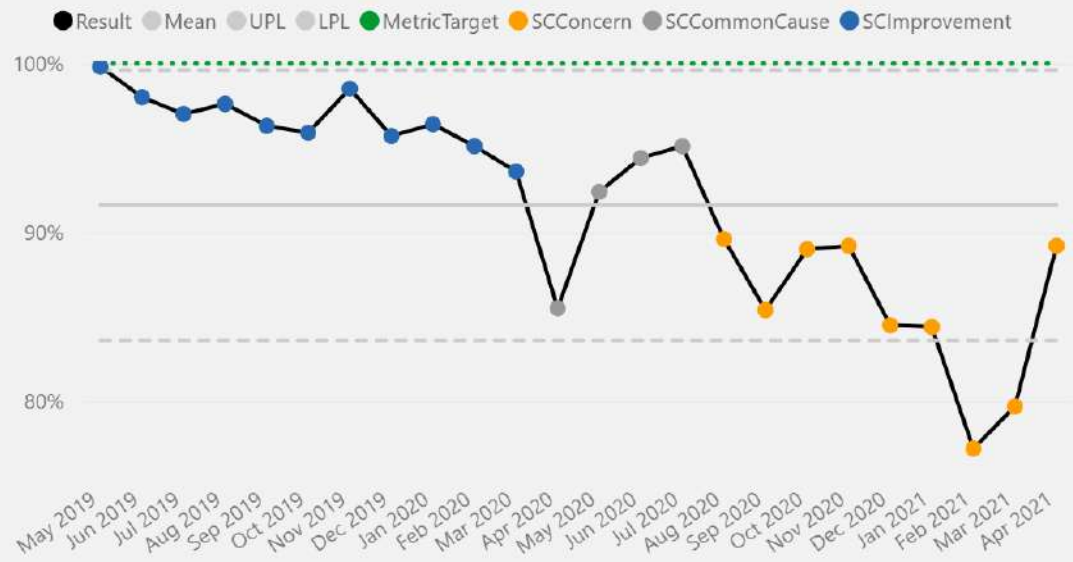
89.20% Result
100.00% Target

99.60% UPL
91.60% Mean
83.60% LPL

Analytical Commentary

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

Safe Staffing Fill Rates



Assurance Commentary

CHPPD increased by 0.3 to 8.5 with 4.6 being delivered by RN. However, maternity are now including babies in the midnight count.
Overall, ward nursing fill rates for RNs in April were 87.8% and 90.9% for unregistered staff. We saw an increase of 14.8% in HCA nights to 96% as well as an increase of 8.2% in RNs to 87.1%. April highlighted 888 nursing deployments, 303 of these were for night shifts and 38% of these were registered staff.
The number of shifts where actual number fell below planned on days was 22 /36 for Rn and 18/36 for HCA, this decreased to 16/36 on nights for RNs and 10/36 for HCAs.
Temporary staffing requests have also seen a decrease by 1,316 for RN and 1,109 for unregistered which includes a 7% increase in fill rate for RNs also. NHSi/Shelford group signed off validators for the establishment review to go ahead.

Improvement Actions

Nursing and Midwifery workforce portfolio launched with 13 projects to aid the improvement of the nursing workforce standards.
NHSe/i Shelford Tool trainers will be attending beginning of June to implement the acuity validation for children and young people. Red flags are in the process of being reviewed and discussed with divisions.
Establishment process commences 7th June for 20 days following discussion with ward sisters and matrons.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Safe Staffing CHPPD	Apr 2021	8.5		Common Cause		No Target

Infection Prevention & Control

NNUH Digital Health
business intelligence

MetricName	Date	Result	Target	Mean
C. difficile Cases Total	Apr 2021	9	35	6
CPE positive screens	Apr 2021	1	N/A	1
E. Coli trust apportioned	Apr 2021	2	N/A	4
HOHA C. difficile Cases	Apr 2021	0	0	1
Hospital Acquired MRSA bacteraemia	Apr 2021	0	0	0
Klebsiella trust apportioned	Apr 2021	1	N/A	2
MSSA HAI	Apr 2021	4	N/A	3
Pseudomonas trust apportioned	Apr 2021	2	N/A	1

Assurance Commentary

The Business Intelligence team have enhanced the daily screening emails to assist the areas in identifying patients who require screening and also those that may be overdue.

Hospital Acquired MRSA bacteraemia

E. Coli trust apportioned

C. difficile Cases Total

HOHA C. difficile Cases

MSSA HAI

Klebsiella trust apportioned

CPE positive screens

Pseudomonas trust apportioned

Improvement Actions

Supportive measures were declared on Edgefield ward on 19/04/21 following 2 cases of HAI C.difficile within 28 days.

These cases have been reported as different ribotypes. Work is also ongoing to promote compliance with day 0, 3 and 6 COVID screening.

Maternity: Mothers

NNUH Digital Health
business intelligence

Caesarean Deliveries

Apr 2021

Variation	Assurance
H	

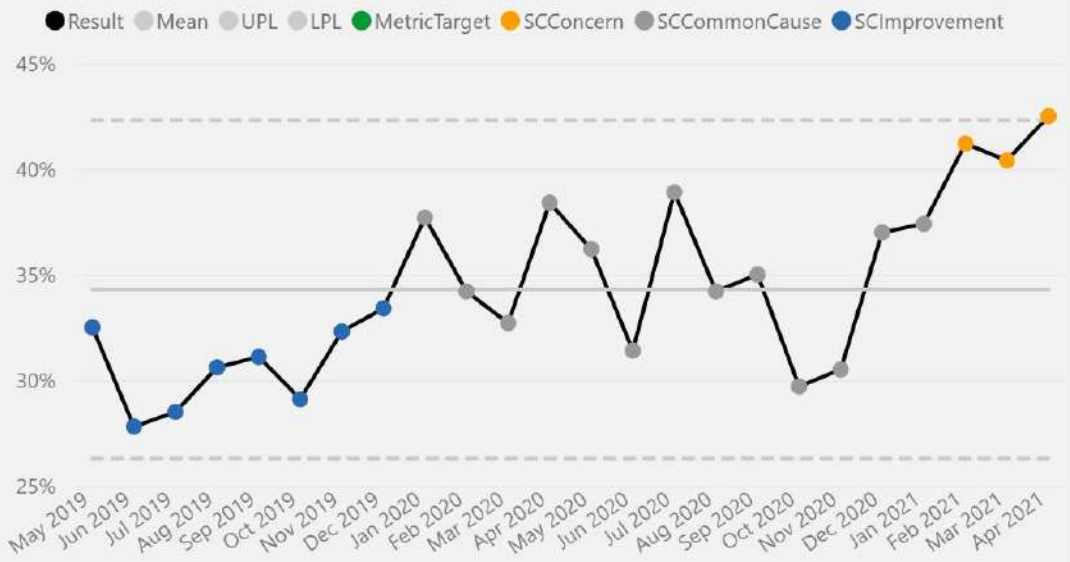
42.5% Result
N/A Target

42.3% UPL
34.3% Mean
26.3% LPL

Analytical Commentary

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

Caesarean Deliveries



Assurance Commentary

1:1 care in labour was 99.4%. Deliveries by Lower Segment Ceasarian Section (LSCS) were 42.5%.
There were two BBA's in April. Both were rapid deliveries at home. Paramedics in attendance for one delivery. One lady had to be transferred to NNUH due to a retained placenta.
Two women were transferred to other units to the an increase in number of inductions of labour vs acuity.

Improvement Actions

Learning continues to be shared with the teams.
Documentation around the circumstances of Born Before Arrival (BBA's) needs to be improved.
The LSCS rate has again increased this month. All units have seen an increase in the rate of LSCS during the COVID-19 pandemic. The Divisional Leadership Team will explore the drivers behind the increase.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
1:1 Care in Labour	Apr 2021	99.4%		Improvement (High)		No Target
3rd & 4th Degree Tears	Apr 2021	2.0%		Common Cause		Unreliable
Births Before Arrival	Apr 2021	2		Common Cause		No Target
Post Partum Haemorrhage ≥1500mls	Apr 2021	2.6%		Common Cause		No Target

Mothers Delivered
431

Babies Delivered
438

Maternity: Babies

NNUH Digital Health
business intelligence

Unplanned NICU ≥37 week Admissions (E3)

Apr 2021

Variation	Assurance
	

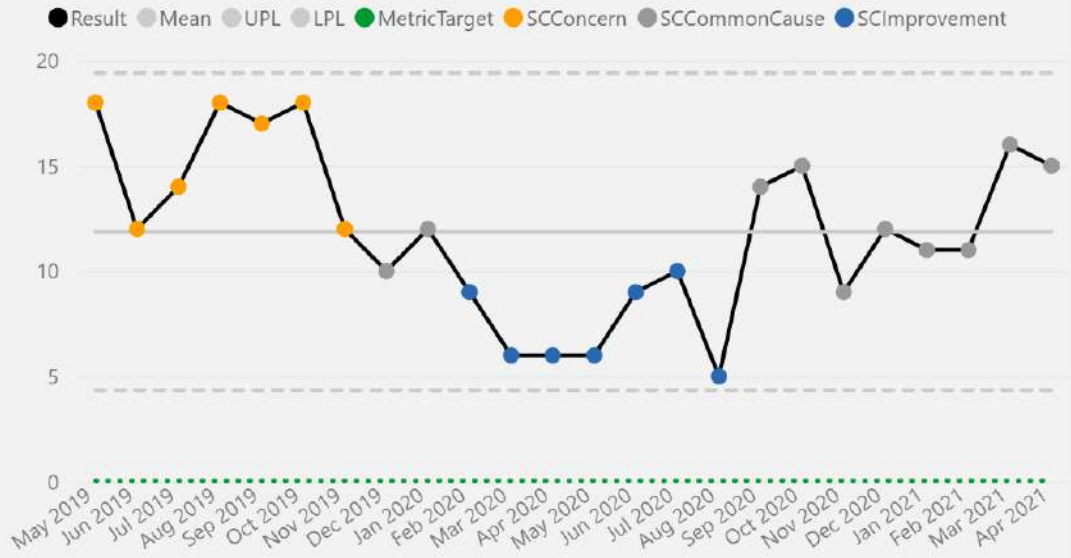
15 Result
0 Target

19 UPL
12 Mean
4 LPL

Analytical Commentary

Variation is Common Cause

Unplanned NICU ≥37 week Admissions (E3)



Assurance Commentary

There were 15 unanticipated admissions into NICU in April 2021. 6 were primigravidas and 9 were multigravidas. Of these, 4 were normal vaginal deliveries and 11 LSCS (5 elective, 6 emergency). 13 babies had respiratory distress of the newborn, 2 significant meconium, 2 metabolic acidosis which required cooling and both of these babies have a HIE grade 1.
We are awaiting a response to determine which of these are HSIB cases.
One round table meeting has taken place. All cases have a Datix and have been investigated. Care in 13 of these cases appears appropriate, 2 are still under review.

Improvement Actions

Concerns have again been identified within the maternity department that Datix's are not being completed and investigated in a timely manner.
A band 7 Maternity and Gynaecology Governance and Risk facilitator has commenced in post and is currently leading on Datix improvements.
A reminder of the importance of completing Datix's in a timely manner has been circulated.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Adjusted Still Births	Apr 2021	0		Not Applicable		No Target
Apgar score <7 @5, ≥37 weeks	Apr 2021	8		Common Cause		No Target
Early Neonatal Death	Apr 2021	0		Not Applicable		No Target
Mothers Transferred Out of Unit	Apr 2021	2		Not Applicable		No Target

Saving Babies Lives

NNUH Digital Health
business intelligence

Topic	Metric Name	Date	Result		Variation		Assurance
Smoking Awareness	Smoking Status at Delivery	Apr 2021	9.5%		Common Cause		Unreliable
Fetal Growth Restriction	Less Than 3rd centile born > 37+6 weeks	Apr 2021	2%		Common Cause		Unreliable
Fetal Growth Restriction	SGA detected Antenatally	Apr 2021	62%		Common Cause		No Target
Reducing Preterm Birth	Singleton Births Preterm	Apr 2021	7%		Common Cause		Unreliable
Reducing Preterm Birth	Singleton live births < 34 wks (AN corticosteroids within 7 days PN)	Apr 2021	56%		Common Cause		Unreliable
Effective Fetal Monitoring	CTG Training and Human factors situational awareness compliance	Apr 2021	86%		Concern (Low)		Unreliable

Assurance Commentary

Carbon Monoxide monitoring remains below target following recommencement in April 2021, most likely as staff continuting to be careful regarding C19.
Data pull for <30 weeks - 6 not 7 babies born, 100% compliance with Magnesium Sulphate.
Gap training at 77%.
Ongoing work regarding metrics to have changes made to numerators and denominators to ensure correct data is reported.

Improvement Actions

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

Adult Safeguarding

NNUH Digital Health
business intelligence

Safeguarding Adults

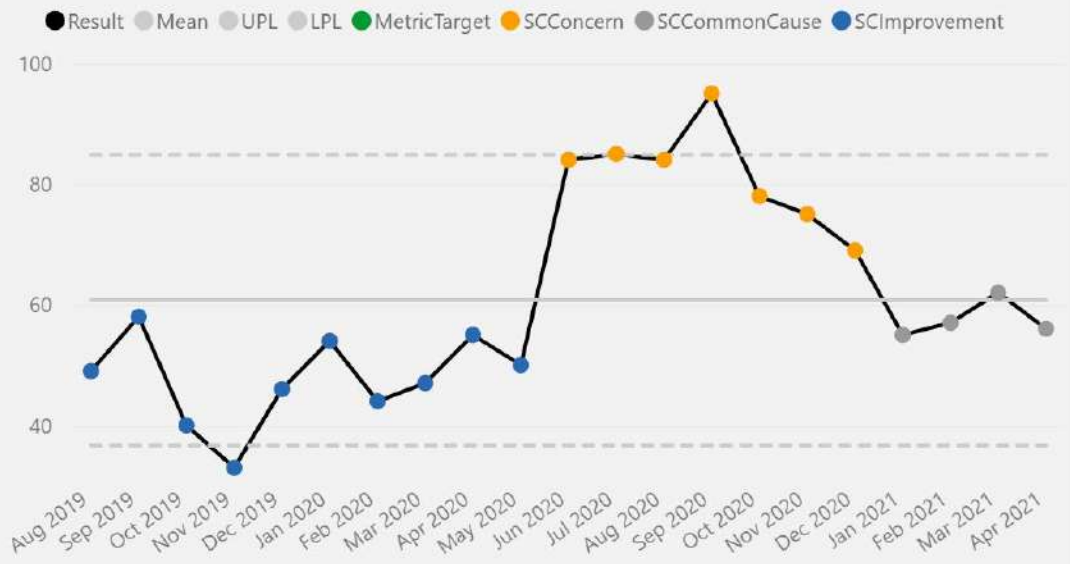
Apr 2021

Variation	Assurance
56 Result	85 UPL
N/A Target	61 Mean
	37 LPL

Analytical Commentary

Variation is Common Cause

Safeguarding Adults



Assurance Commentary

Safeguarding referrals continue to be raised by Teams across the Trust in line with predicted activity.

Improvement Actions

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

Children & Midwifery Safeguarding

NNUH Digital Health
business intelligence

Safeguarding Children and Midwife...

Apr 2021

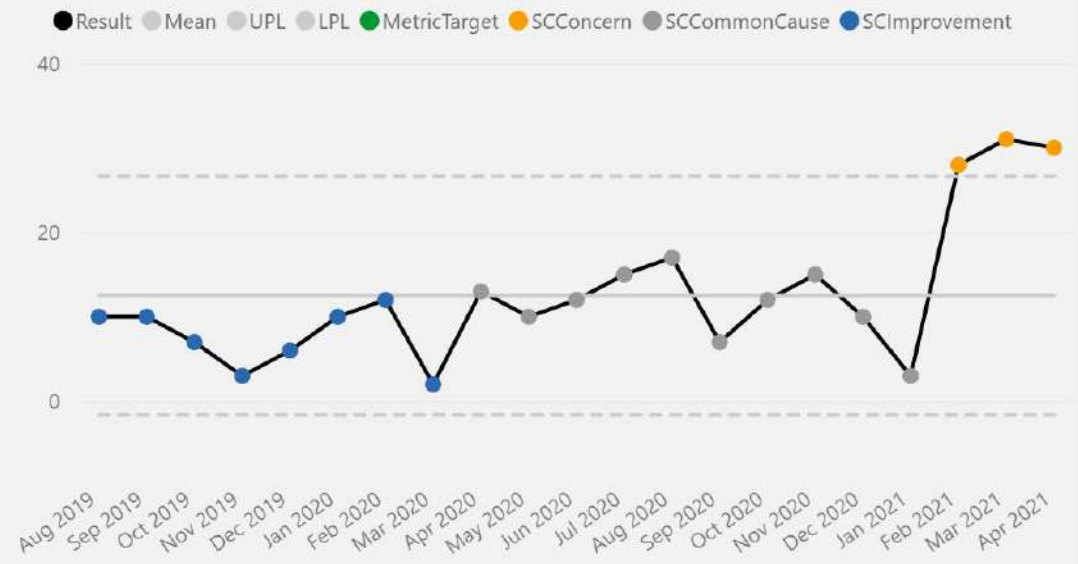
Variation	Assurance
H	

30 Result	27 UPL
N/A Target	13 Mean
	-2 LPL

Analytical Commentary

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

Safeguarding Children and Midwifery



Assurance Commentary

Numbers of safeguaridng referrals for Safeguarding Children and Midwifery are now being recorded on Datix as per Trust Policy.

Improvement Actions

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

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Safeguarding Children	Apr 2021	24		Concern (High)		No Target
Safeguarding Midwifery	Apr 2021	6		Not Applicable		No Target

REPORT TO THE TRUST BOARD	
Date	**2 June 2021**
Title	**Chair's Key Actions from Finance, Investments and Performance Committee meeting on 26 May 2021**
Lead	**Tom Spink – Non-Executive Director (Committee Chair)**
Purpose	**For Information and assurance**

1 Background/Context

The Finance, Investments and Performance Committee met on 26 May 2021. The meeting was quorate and attended by Mrs Jackie Hammond and Mr Richard Smith (Public Governors) as observers. Papers for the meetings were circulated to Board members for information in the usual way.

The Committee considered the usual extensive suite of information regarding operational and financial performance, relevant risks on the Risk Register and actions to improve the Use of Resources position. It is noteworthy that the Trust is able to build this year on the foundations of solid financial performance in 2020/21, resulting in a favourable Outturn variance of £14.7m relative to Plan.

The items below were identified by the Committee for specific reference to the Board.

2 Key Issues

The following issues were identified to highlight and escalate to the Board		
1	Elective Recovery Plan	The Committee reviewed in some detail the draft Elective Recovery Plan, aimed at improving the position with respect to waiting times for patients on the cancer pathways and those awaiting other elective care. This Plan is intended to meet the relevant elements of the Trust's Licence Undertakings and forms a separate agenda item for Board approval.
2	Electronic Patient Record SOC	The Committee reviewed again the Strategic Outline Case for the Electronic Patient Record. This has been under extensive scrutiny at regional level and repeated updating and revision. It is for consideration by the Board as a separate agenda item but comes with the recommendation of the Committee. It will be a major project but a significant step forward in developing efficiency and quality in the services of the Trust. Introducing a uniform record system will also facilitate transformation of services across the ICS.
3	Workforce CIP Opportunities	The Committee received a report from Mr Jones regarding Workforce-related CIP opportunities. This has been on the Committee's radar for some time and was welcomed. CIP workbooks are to be developed in relation to those ideas that do not already have them and, at the meeting on 30 June, the Committee will receive a further report providing dates for intended implementation of the ideas and schemes outlined. The Committee **agreed** that after this next report these workforce initiatives should be integrated with the broader CIP Programme for further development, monitoring and reporting.

4	PFI Contract Monitoring	The Committee was updated on ongoing work with the PFI provider to improve the position highlighted by Model Hospital, which shows that our estates costs are high. The Committee will continue to receive regular reports on this and benchmarking of the Soft FM contract.

3 Conclusions/Outcome/Next steps

The next Committee meeting is scheduled for 30 June 2021 and will consider the Emergency and Urgent Care Improvement Plan and future plans for the Surgical Division including theatre productivity.

Recommendation: The Board is recommended to:

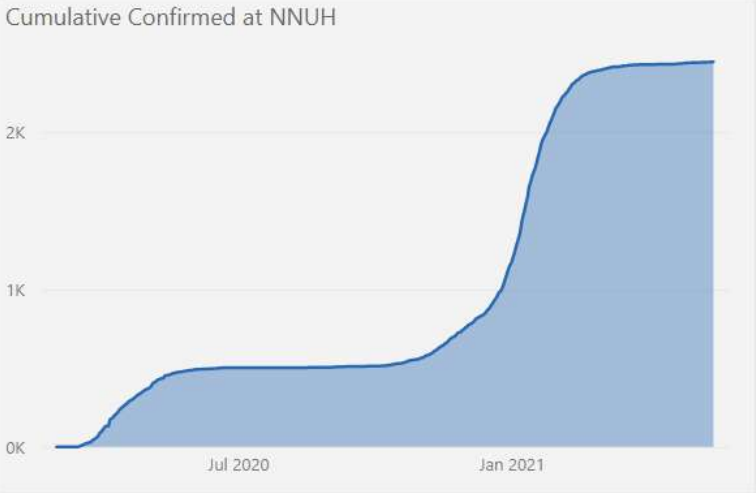
- **note** the work of its Finance, Investments and Performance Committee.

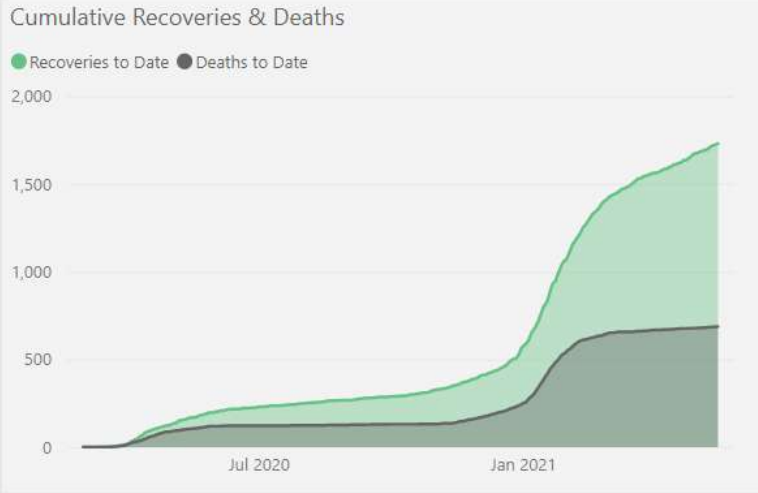
COVID-19 Update

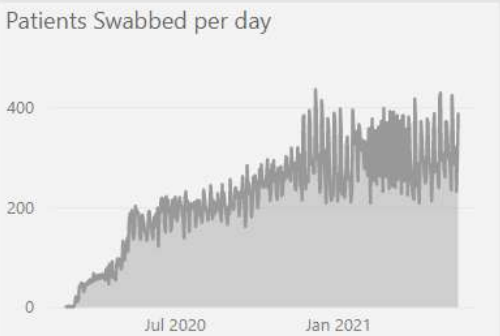
May 2021

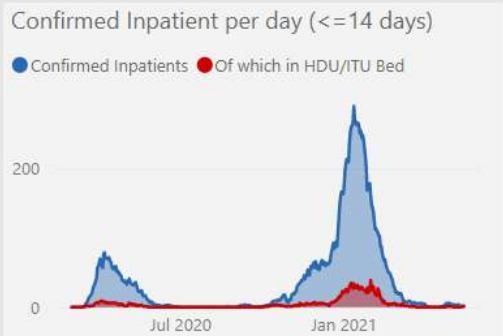
COVID-19 Report: Timeseries to 17th May 2021

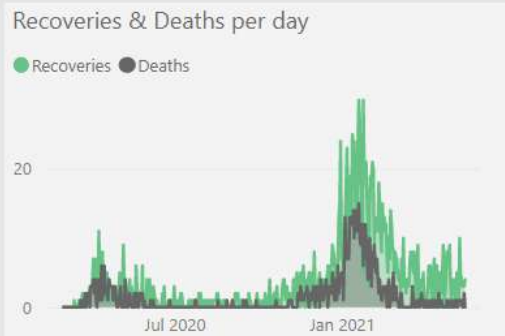
Cumulative	Total Swabs Taken	Patients Swabbed	Confirmed Cases	Recoveries	Deaths
01/03/20 - 17/05/21	101,110	38,790	2,445	1,730	687











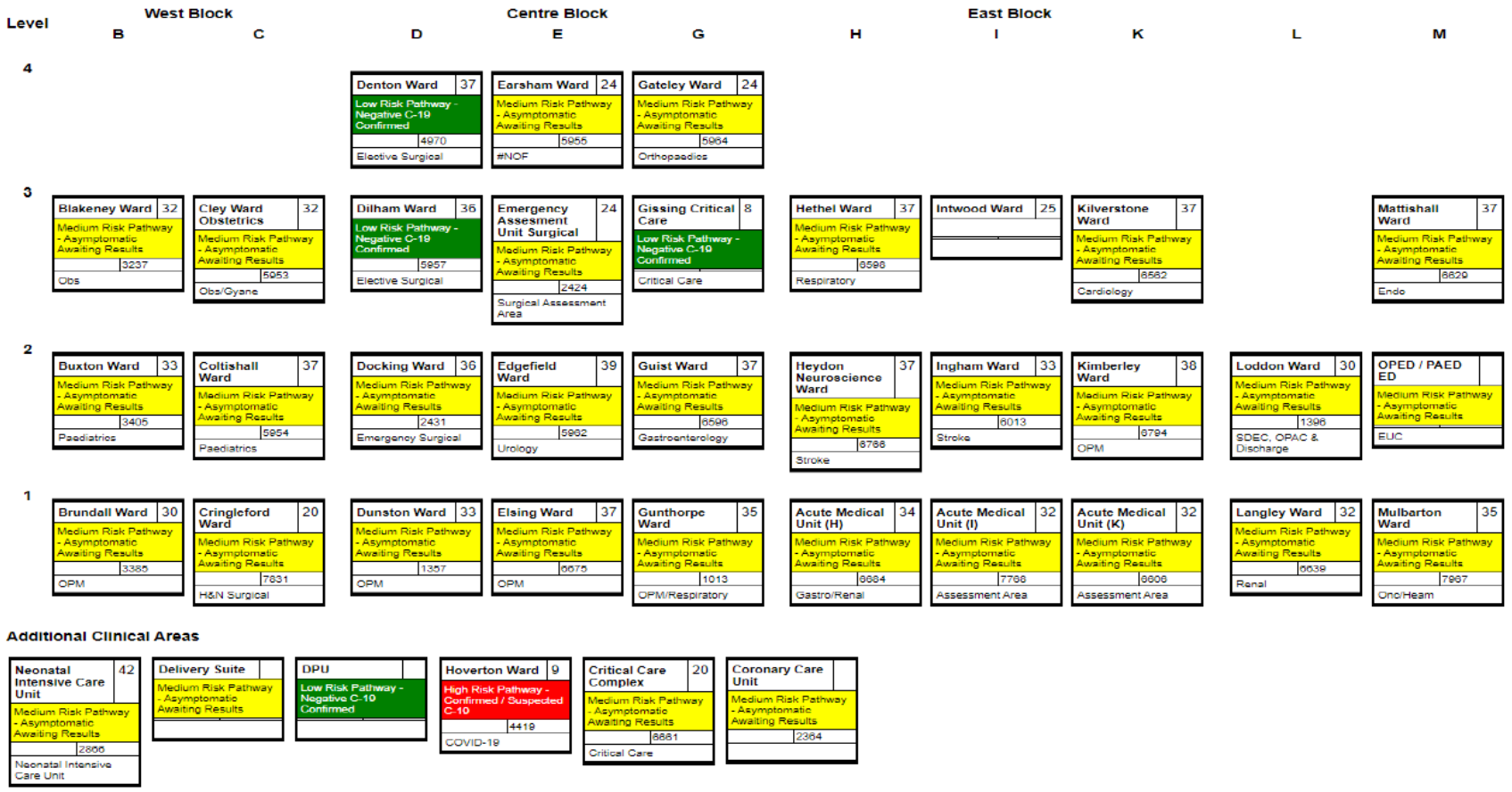
Commentary

Prevalence of COVID-19 within both the hospital and wider community has fallen during March and April 2021. The hospital is currently on Local COVID State 2 with any patients requiring isolation for COVID-19 being cared for within the Hoveton Isolation Unit.

The Trust has reiterated the need to remain vigilant to the potential of continued spread, identifying the need to maintain high levels of infection control standards, complying with government guidance of operating during COVID-19.

A COVID-19 wave 3 lessons learned survey is being sent to all staff members as well as to staff of partner organisations that supported the Trust throughout the pandemic. In addition, focused groups are currently being organised. The aim is to give staff a supportive environment and encourage an open and honest discussion in order to get a richer picture of staff experience during wave 3 of the pandemic. These exercises will be used to inform future emergency planning.

COVID-19 Report: Current Local Covid State



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

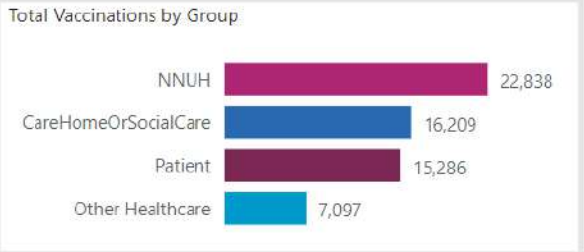
Key:
- High Risk Pathway - Confirmed / Suspected C-19
- Medium Risk Pathway - Asymptomatic Awaiting Results
- Low Risk Pathway - Negative C-19 Confirmed

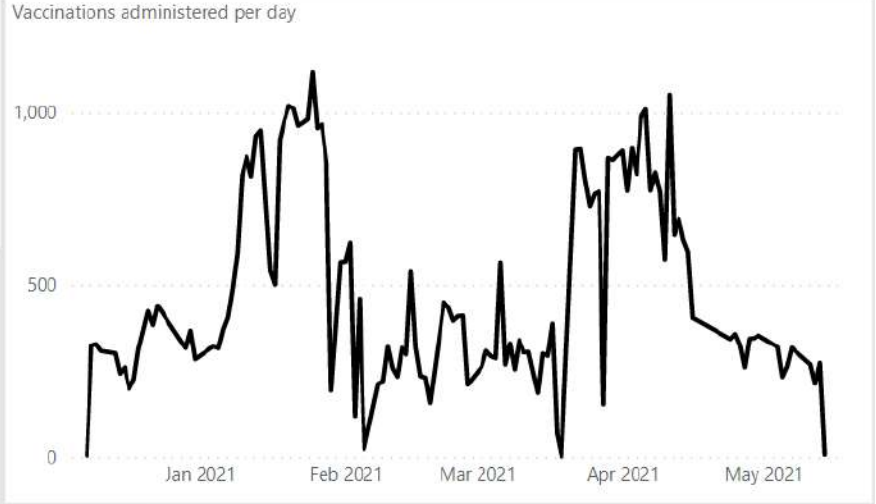
Commentary

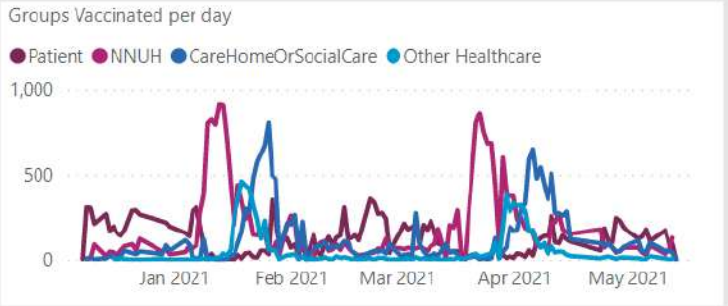
The Trust escalated through Local COVID States, with Local Covid State 5 triggered on 18th December 2020 which remained until 18th February 2021. De-escalation throughout February and March. The Trust is currently on Local COVID State 2 with 2 positive patients as of 17th May 2021 .

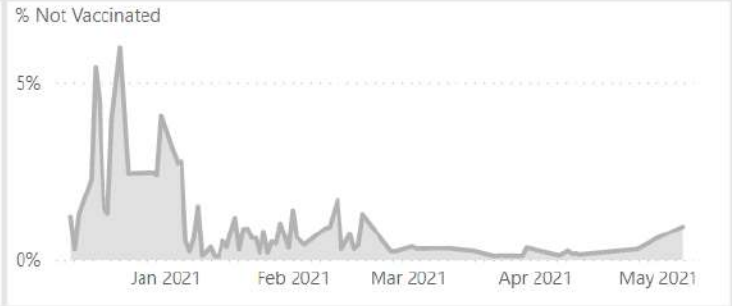
COVID-19 Report: Vaccination (As of 14th May)

Total Vaccinations	Patients	NNUH Staff	CareHome or SocialCare	Other Healthcare
61,430	15,286	22,838	16,209	7,097









The information shown is dependent on a daily extract from the National Immunisation Vaccination System (NIVS). Vaccinations up to and including 14/05/2021

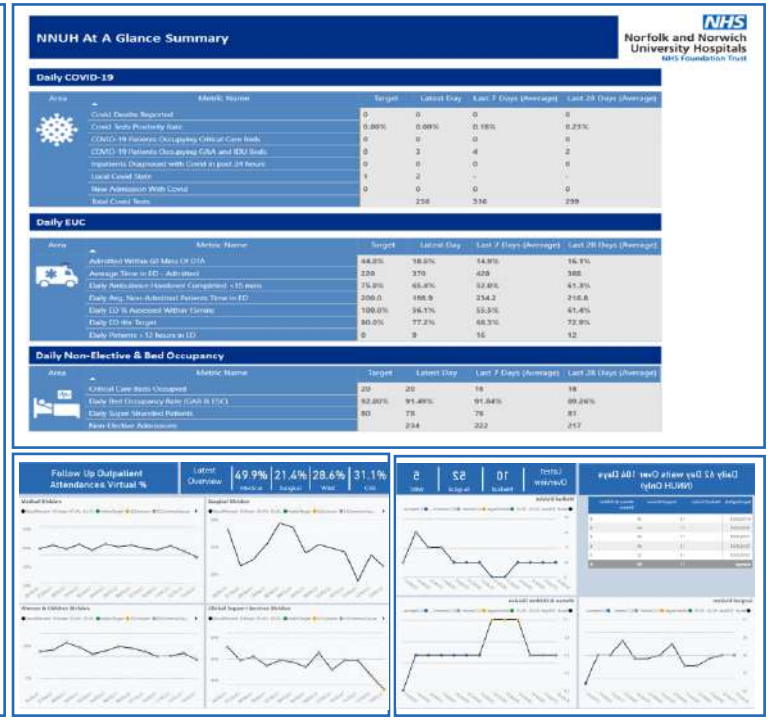
Commentary

The NNUH Vaccination hub became operational on the 8th December 2020 and has subsequently delivered over 60,000 vaccinations to Over 80's, Care Home Staff, Healthcare Staff and Social Care Staff.

Over 10,000 NNUH Staff (Including Substantive Bank & Sub-Contractors) have received both doses of vaccination. The team have adopted policy and operations in light of national guidance received for vaccinations of under 40's as well as pregnant individuals.

A scale-down of the vaccination programme is currently in progress to allow a return of 'BAU' use of the Alyhsam Suite.

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



Commentary

A 6 month operational blueprint was drafted in conjunction with the Trust's 18 month strategic objectives (Dec 2019). The management of delivery was agreed to be completed on a daily basis at the IMT Command & Control Meeting covering: COVID, EUC, Non-Electives, Elective Care, Efficiency, Finance and Estates. A number of targets and trajectories have been provided to create meaningful and realistic action plans to realise improved performance. Support in completing and complying with these trajectories has been, and continues to be provided by the wider IMT, corporate leads and divisions.

Integrated Performance Report:

Performance & Activity Domains

May 2021

Non-Elective Care Standards

Ref	KPI	Target	Baseline	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
1	4 hr Standard	95%	77.60%	78.51%	72.60%											
2	Initial Assessment <15 mins (ED)	85% (N)	45.40%	52.90%	61.00%											
3	Average Time in ED (Non-Admitted)<220 mins	<200 (L)	218	182	221											
4	Average Time in ED (Admitted)<220 mins	<200 (L)	421	314	373											
5	Admitted within 1hr of safe to leave	85% (N)	19.10%	9.50%	18.60%											
6	Total Time in ED <12hrs	100% (N)	94.00%	97.10%	97.80%											
7	Ambulance handovers </=15 mins (ED)	90% (N)	39.60%	56.80%	63.50%											
8	>21 LLOS Patients *based on 40% reduction on 2018 baseline	86 (N)*	106	83	93											
9	SDEC as % of emergency attendances	>30% (N)	20.79%	25.00%	20.95%											
10	14 - 20 LLOS Patients	TBC (N)* 110 (L)**	183	153	155											
11	Triage	<60min (L)	97.80%	98.10%	95.10%											

Performance – Ambulance Handovers <15 mins

Improvement Actions

1. Focus on handovers between midnight and 08:00.
2. Targeted focus on creating upstream capacity and expedited assessment and admission (if needed) in order to release capacity for offloading.
3. Emergency access standard trajectories in development

Analytical Commentary

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

Assurance Commentary

Improved performance on Ambulance Handovers in April 2021: 63.5% (4150) compared to 34.2% (3022) in April 2020.

Due to the rapid recovery following pressured days, the percentage of 15 minute handovers has remained higher than January which was the last month with a similar number of breaches and activity.

Performance – 15 Minute Handover % Trends EoE

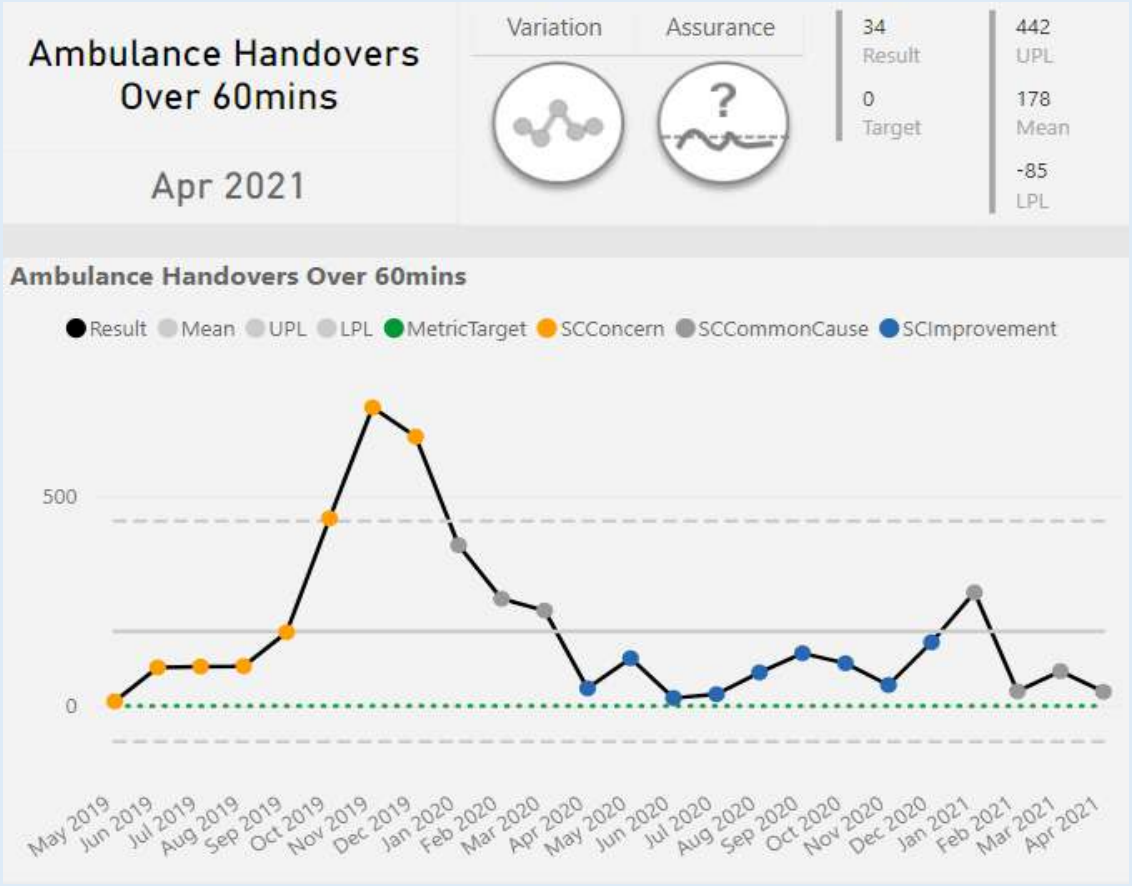
NNUH Digital Health
business intelligence

Hospital ED	April	May	June	July	August	September	October	November	December	January	February	March	April	April Total Transports
Addenbrookes Hospital	42.7%	43.8%	47.3%	48.2%	44.3%	41.9%	42.4%	43.0%	37.2%	38.3%	38.0%	43.2%	42.1%	2906
Basildon & Thurrock Hospital	39.1%	50.1%	57.4%	59.5%	62.8%	63.4%	58.3%	55.7%	41.4%	52.6%	68.0%	69.2%	68.4%	2555
Bedford Hospital South Wing	45.4%	52.4%	51.4%	50.1%	44.4%	44.2%	41.0%	40.7%	37.8%	33.1%	48.9%	60.3%	57.6%	1674
Broomfield Hospital	20.3%	28.9%	31.3%	32.8%	37.8%	37.9%	40.1%	41.0%	31.0%	33.2%	44.3%	50.1%	44.2%	2552
Colchester General Hospital	26.4%	29.1%	31.2%	32.6%	28.5%	28.6%	32.0%	30.9%	25.0%	19.3%	24.3%	20.8%	33.2%	3048
Hinchingbrooke Hospital	32.7%	36.4%	33.3%	34.4%	29.9%	26.7%	30.5%	34.0%	32.0%	27.6%	28.1%	27.8%	23.4%	1461
Ipswich Hospital	38.7%	42.7%	41.9%	44.5%	37.3%	41.3%	38.8%	40.2%	31.6%	29.2%	41.2%	44.1%	39.9%	2425
James Paget Hospital	55.9%	60.1%	54.0%	66.8%	50.7%	51.5%	44.0%	27.7%	21.4%	19.4%	33.5%	48.4%	44.8%	2026
Lister Hospital	20.7%	33.4%	32.5%	33.3%	31.2%	27.3%	26.5%	23.5%	20.1%	21.6%	26.6%	25.7%	22.0%	2395
Luton And Dunstable Hospital	16.2%	26.9%	42.5%	49.6%	47.6%	42.4%	47.2%	50.7%	41.5%	41.1%	48.1%	47.5%	47.9%	2691
Norfolk & Norwich University Hospital	34.1%	32.3%	37.9%	56.5%	51.1%	56.3%	62.3%	63.0%	51.2%	34.5%	52.7%	60.3%	63.5%	4150
Peterborough City Hospital	15.1%	16.1%	26.4%	49.5%	33.9%	27.1%	20.5%	17.2%	12.3%	11.0%	20.5%	18.1%	18.9%	2213
Princess Alexandra Hospital	37.6%	46.0%	41.9%	40.6%	33.4%	30.5%	32.2%	29.0%	22.2%	9.3%	11.7%	17.1%	30.1%	1751
Queen Elizabeth Hospital	52.2%	53.1%	56.7%	50.1%	41.1%	33.6%	39.4%	37.2%	33.6%	45.2%	55.2%	59.2%	58.9%	1986
Southend University Hospital	25.1%	25.2%	22.7%	28.2%	28.0%	27.3%	24.0%	22.1%	17.8%	22.0%	23.1%	21.4%	21.0%	2673
Watford General Hospital	26.2%	41.6%	37.9%	35.1%	35.2%	35.6%	33.0%	33.4%	15.3%	15.2%	30.8%	31.1%	40.7%	2806
West Suffolk Hospital	36.9%	43.9%	43.0%	48.4%	51.8%	47.1%	39.0%	43.4%	39.6%	38.5%	50.8%	50.6%	52.6%	1938

Comments

NNUH received the highest volume of ambulance transports into ED in the EoE Region in April 2021 with 4,150 arrivals (down slightly from 4,175 in March 21). 63.5% of ambulance handovers were completed within 15 minutes of arrival, with NNUH ranked 2nd best in the region for performance.

Performance – Ambulance Handovers >60 mins



Analytical Commentary

Variation is Common Cause

Assurance Commentary

Improved performance with 0.8% (34) ambulance handovers over 60 min. Average time from DTA to admission reduced from 199 min in March to 177 min in April. The average arrivals in April was 953 a week.

The focus has been on rapid recovery following pressured days and creating upstream capacity and time to first clinician in order to release capacity for offloading.

Improvement Actions

1. Safer, Better, Faster (SBF) has a number of work streams to reduce the time of patients in ED after a DTA and also redirect patients to the appropriate services, preventing the need of ED.
2. Targeted focus on creating upstream capacity and expedited assessment and admission (if needed) in order to release capacity for offloading.
3. Emergency access standard trajectories in development

Performance – ED Assessment Within 15 Mins

NNUH Digital Health business intelligence

ED % Assessed Within 15mins

April 2021

Variation | Assurance

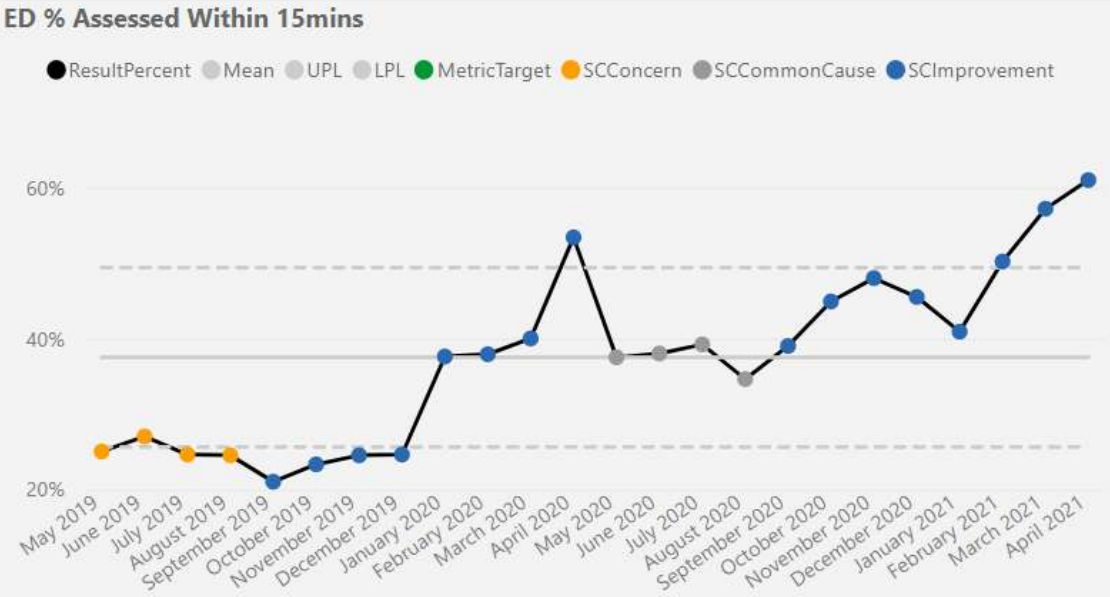
61.00% Result

N/A Target

49.40% UPL

37.50% Mean

25.60% LPL



Analytical Commentary

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

Assurance Commentary

There has been a continued improvement in performance ahead of trajectory.

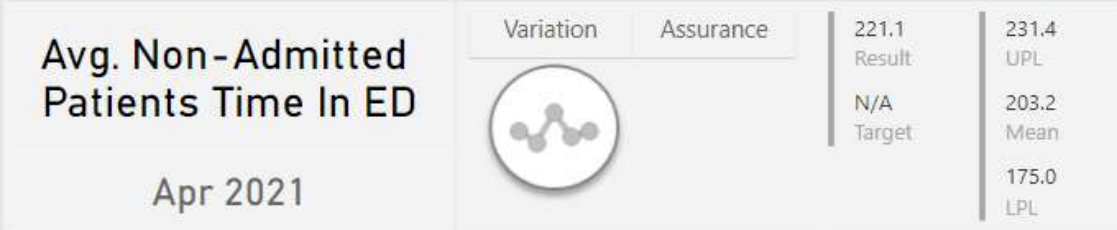
Education sessions are being carried out among further members of the ED nursing team. The new processes seem to be embedded and working.

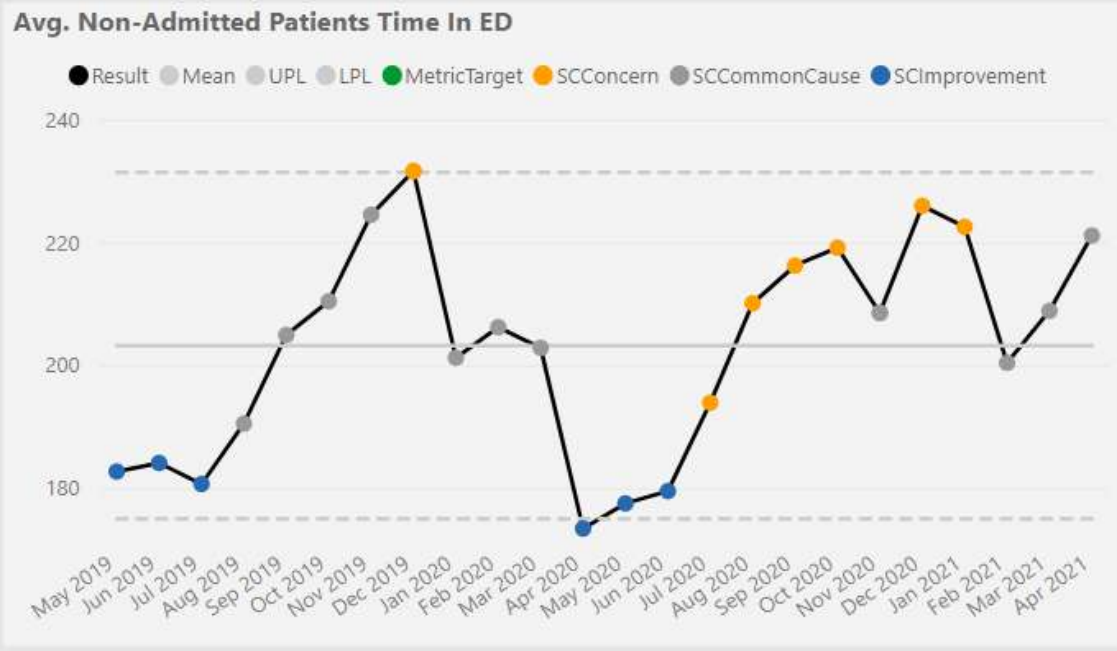
Performance against this quality standard continues to be monitored and actioned on a live basis and at each safety huddle in ED. In addition, oversight and delivery against the standard are in-place via both the SBF programme and IMT Command & Control meetings with supportive actions initiated as required.

Improvement Actions

1. Continued evaluation of improvement actions with ED Clinical Teams and EUC Leads.
2. Daily review of performance at IMT meetings and ED Operational Teams.
3. Ensure the non-walk-in assessments are captured properly and the same zero tolerance approach is followed.
4. Focus attention on Resus and RATs as areas with most variation.

Performance – Average non admitted patient time in ED





Improvement Actions

1. Development of a liaison role to co-ordinate the flow of patients.

Analytical Commentary

Variation is Common Cause

Assurance Commentary

The non-admitted time in ED has increased in line with attendances among walk-in patients. The re-opening of Cromer decreased the capacity of NNUH to see patients with minor injuries due to staff transferring back to Cromer from NNUH. Post-COVID attendances increased as a result of post-vaccination worries and vaccination side effect concerns.

Social distancing requirements meant separation of the location of the tests required which caused delays in diagnosis, particularly for X-ray.

Performance – Average Time DTA to Admission

NNUH Digital Health business intelligence

Monthly Admitted Within 60 Mins Of DTA

Apr 2021

Variation | Assurance

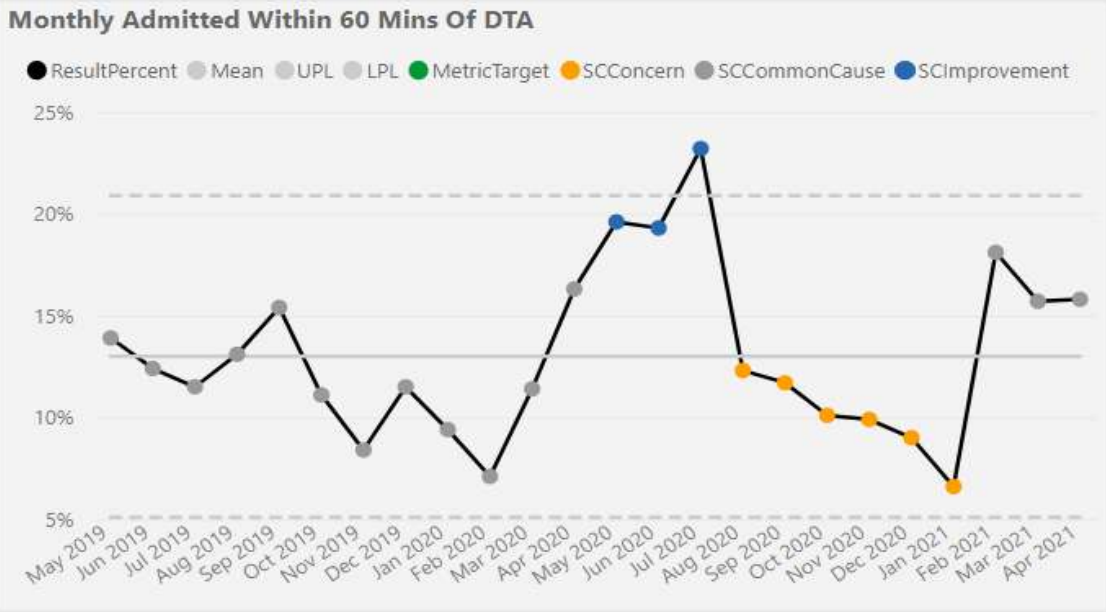
15.8% Result

N/A Target

20.9% UPL

13.0% Mean

5.1% LPL



Analytical Commentary

Variation is Common Cause

Assurance Commentary

The average time from DTA to admission during April was 177 minutes, a decrease from 199 minutes in March. However, performance remains a challenge as it is a long way off the new target of 85%.

Performance across all divisions has been co-ordinated daily through IMT. Actions have been taken to understand blockages and improve trial exercises.

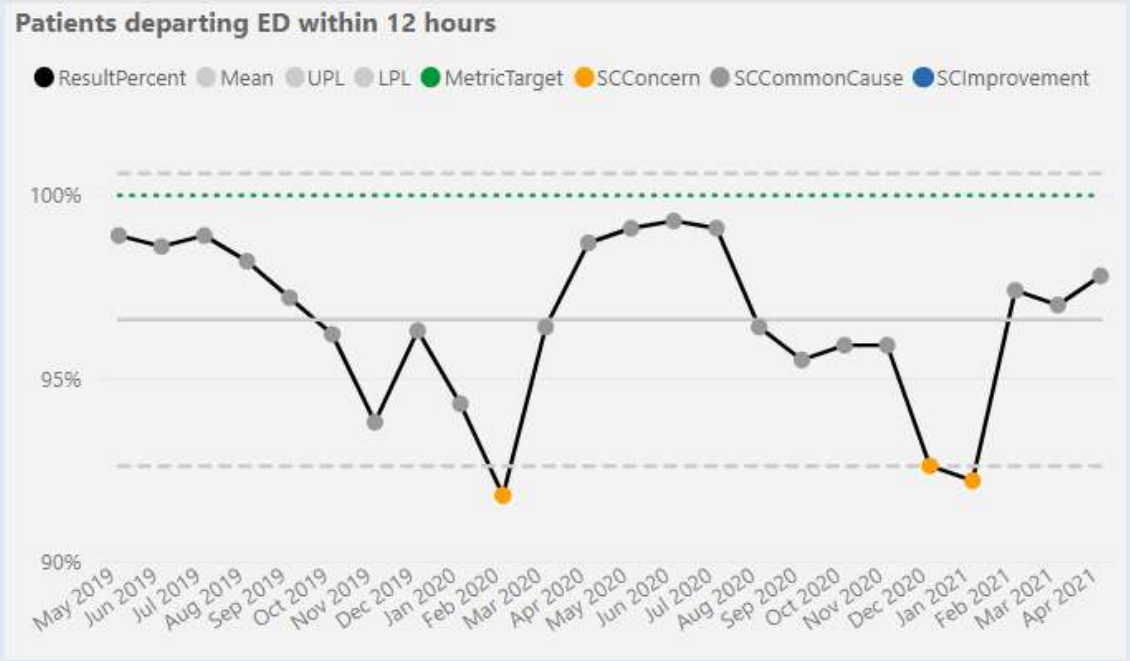
The main challenge is the need to fully re-configure the assessment unit functions and re-align them into acute assessment, SDEC, PAU and short stay. This is a large scale project which has interdependencies with the CSORT/STP D2A and Pre-Hospital programmes.

Improvement Actions

1. A series of flow events are scheduled for May (weekly tests of change).
2. Development of a ready-to-proceed timestamp within ED to identify the genuine delay from a patient being ready to moving to a ward.
3. Dedicated diagnostic work stream within the Safer, Better, Faster (SBF) programme as well as development of speciality review processes.
4. Expansion of Think 111 First appointments to ED and SDEC.
5. Re-configuration of the assessment unit.

Performance (New Metric) – Patients Departing ED within 12 hours

NNUH Digital Health business intelligence



Analytical Commentary

Variation is Common Cause

Assurance Commentary

The % of patients departing ED within 12 hours of arrival has been outlined as new quality standard for EUC (yet to be confirmed nationally). Although the performance is in line with the trajectory, there is no system resolution to enable ED to achieve 100% due to the continued mental health capacity issues.

Operational Safety Huddles are in place throughout the day and night to ensure escalation of patients in ED and longest waiting to Senior Leadership Teams including Executive On-Call. A number of patient cohorts fall into this category – overnight transportations, mental health patients, long DTA waits.

Improvement Actions

1. Best use of a dedicated ED group, responsible for the discharge lounge.
2. System 'pre-hospital' task and finish group initiatives (mental health programme).
3. NSFT in the process of establishing a transformation programme with a dedicated groups for UEC. The focus will be home-based/community care, alternative conveyancing and reducing delayed discharges to release capacity and prevent ED delays.

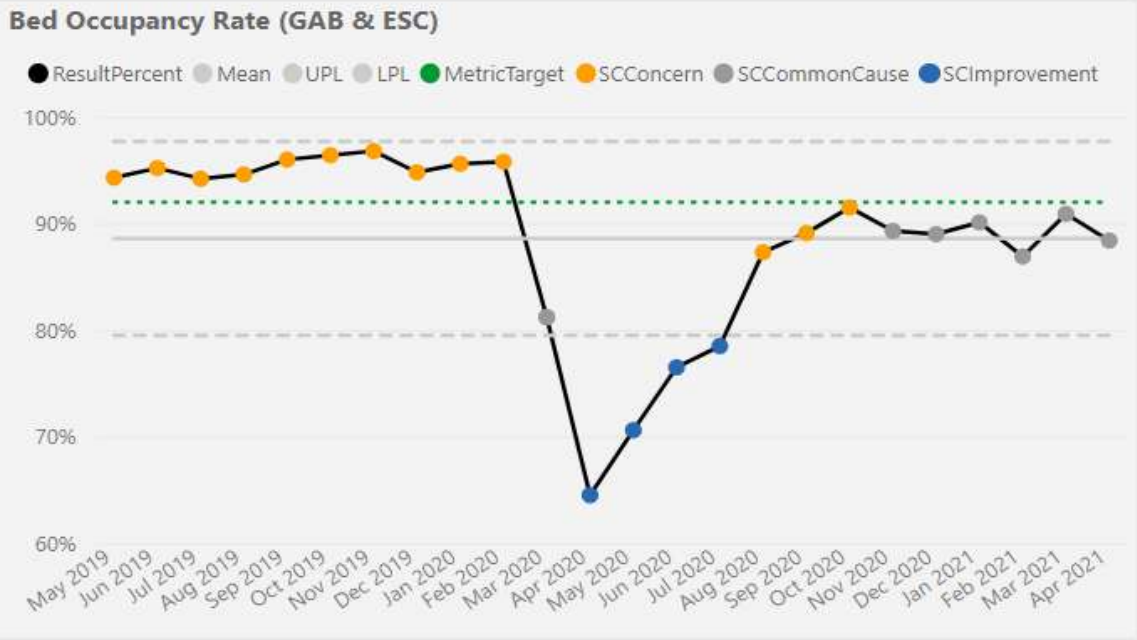
Performance – Bed Occupancy

NNUH Digital Health
business intelligence

Bed Occupancy Rate (GAB & ESC)

Apr 2021

Variation	Assurance		
		88.40% Result	97.70% UPL
		92.00% Target	88.60% Mean
			79.50% LPL



Analytical Commentary

Variation is Common Cause

Assurance Commentary

Bed occupancy rate in April in both General & Acute and Escalation beds is 88.4%.

Adherence to COVID-19 Infection Control Policy has ensured pathways (red, yellow and green) are maintained throughout the hospital. The number of red, yellow and green wards have been strategically placed to ensure a dynamic approach is taken to meet patients clinical pathways.

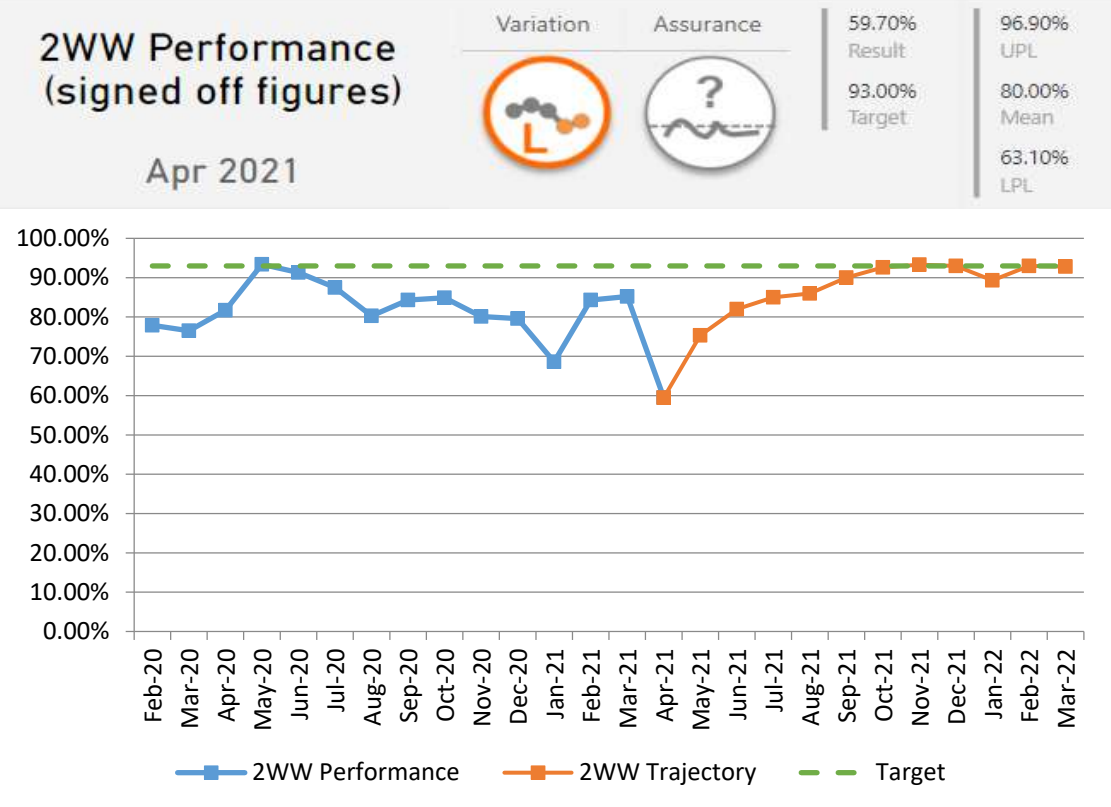
Improvement Actions

1. Dedicated group within the Safer, Better, Faster programme responsible for the discharge system.
2. Continued segregation and enhanced IP&C measures to reduce transmission of COVID-19.

Elective Care Standards

Ref	KPI	Target		Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
1	Cancer 2WW Performance	93% (N)	Actual	85.2%	59.5%											
			Trajectory		76.4%	75.3%	82.0%	85.0%	86.0%	90.0%	92.6%	93.3%	93.0%	89.3%	93.0%	92.8%
2	Cancer 2WW Backlog	38 (Feb 20)	Actual	47	264											
			Trajectory		264	353	225	131	93	77	48	23	27	76	41	22
3	Cancer 62 Day Performance	74% National Avg (Feb 20)	Actual	62.1%	63.0%											
			Trajectory		64.3%	67.0%	64.5%	66.3%	70.2%	74.3%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%
4	Cancer 62 Day Backlog	184 (Feb 20)	Actual	316	223											
			Trajectory		223	222	219	217	196	205	174	146	145	181	159	143
5	Cancer 62 Day Waits >104 Days	0	Actual	126	73											
			Trajectory		73	60	34	29	21	28	26	16	12	27	19	9
6	Cancer Faster Diagnosis Standard	75% (N)	Actual	83.5%	79.7%											
			Trajectory		75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%
7	Waiting List - Health Inequality Indicators	TBC	Ethnicity													
			IMD													
8	Activity Targets	70% (A) 75% (M) 80% (J) 85% J-S)	Actual													
			Trajectory		70%	75%	80%	85%	85%	85%						
9	Virtual Outpatients	25% (N)	Actual	44.2%	38.7%											
			Trajectory		37.5%	40.0%	40.0%	40.0%	40.0%	40.0%	40.0%	40.0%	40.0%	40.0%	40.0%	40.0%
10	PIFU	Implement in 3 specialties	Actual	28	28											
			Trajectory		3	3	3	3	3	3	0	0	0	0	0	0
11	Advice and Guidance	1000	Actual	1038	813											
			Trajectory		800	800	800	800	800	800	800	800	800	800	800	800
12	Achieve Upper Decile: Orthopaedics	Touchtime 85% (N) Cases 1.9 (N)	Touchtime	84.00%												
			Cases Per Session	1.7												
13	Achieve Upper Decile: Ophthalmology	Touchtime 85% (N) Cases 3.8 (N)	Touchtime	68.00%												
			Cases Per Session	3.5												

Performance – Cancer 2WW Performance



Improvement Actions

1. Continue to provision additional weekend Breast clinics to both reduce backlog and ensure catch up to book within 14 days.
2. Frequent reviews of 2WW protected slots with body site teams ensuring capacity is flexed to meet expected demand.
3. Reviews of referral pathways with STP and Cancer Alliance to ensure appropriate referrals seen and received.
4. Full system review of Dermatology service by 30th June.

Analytical Commentary

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

Assurance Commentary

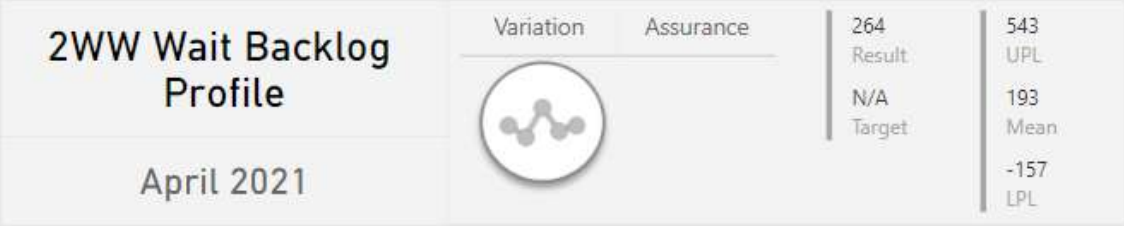
2WW referrals have increased in April, particularly in Breast which have had capacity issues. To support getting these back on track, additional one-stop clinics have been set up out-of-hours.

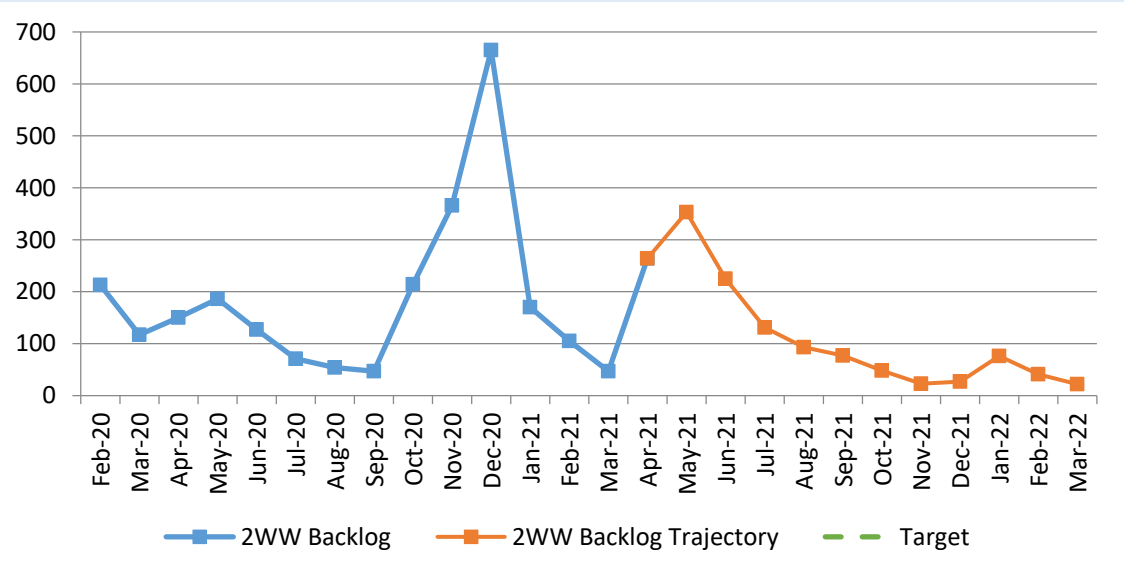
Divisions have been asked to flex clinic and direct access capacity to support the increase in 2ww referrals.

Patients are still receiving their diagnosis before 28 days in the majority of body sites.

Performance – Cancer 2WW Backlog Profile

NNUH Digital Health
business intelligence





Improvement Actions

1. Continue to provision additional weekend Breast clinics to both reduce backlog and ensure catch up to book within 14 days.
2. Frequent reviews of 2WW protected slots with body site teams ensuring capacity is flexed to meet expected demand.
3. Reviews of referral pathways with STP and Cancer Alliance to ensure appropriate referrals seen and received.
4. Full system review of Dermatology service by 30th June.

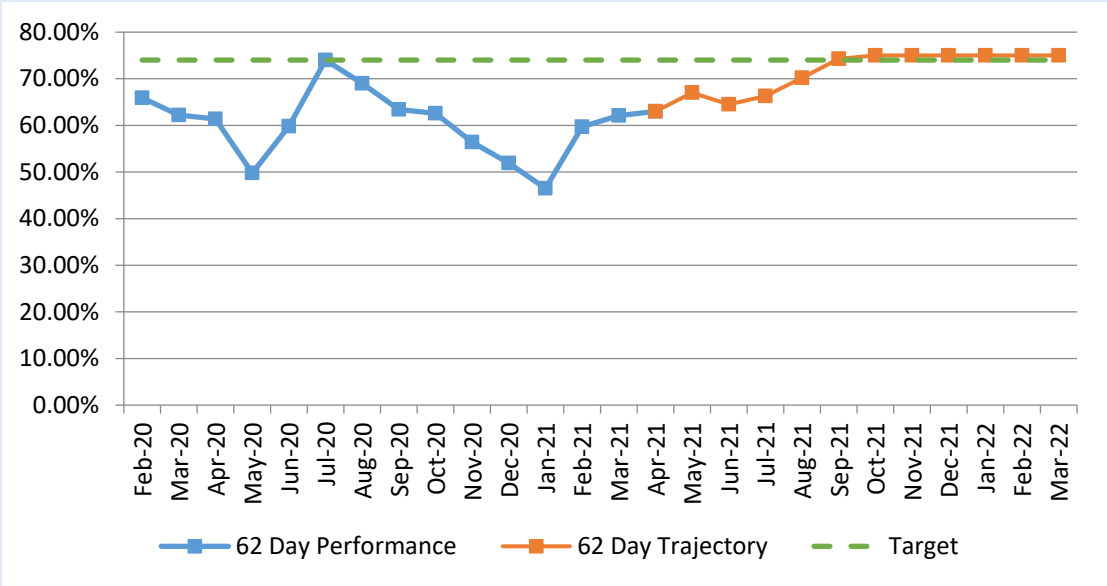
Analytical Commentary

Variation is Common Cause

Assurance Commentary

Two week wait Waiting List profile will increase in the coming months due to referral rates exceeding all previous levels. Additional funding is being agreed through the Cancer Alliance to reduce the wait for first attendance. Patients are still receiving their diagnosis before 28 days in the majority of body sites. Additional weekend sessions have been agreed to manage the increase in demand.

Performance – Cancer 62 Day Performance



Improvement Actions

1. The full focus on P2 patients in order to reduce numbers waiting >28 days for surgery and maintain this turnover will encompass many patients on a cancer 62-day pathway.
2. Improved diagnostics flow and efficiency of patients – additional diagnostic sessions to reduce delays, escalations to CSS triumvirate and review of histopathology capacity.
3. Focus on additional Urology in H1.

Analytical Commentary

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

Assurance Commentary

The number of patients waiting over 62 days continues to be above the 200 mark. This is due to focused work on the long waiting patients and additional referrals meaning patients are waiting in excess of 62 days before being removed from the pathway. Improvements in the longest waiting patients and increased capacity for two week wait will reduce this number in the coming months.

Performance – Cancer 62 Day Backlog Profile

NNUH Digital Health business intelligence

62 Day Backlog Profile

April 2021

Variation | Assurance

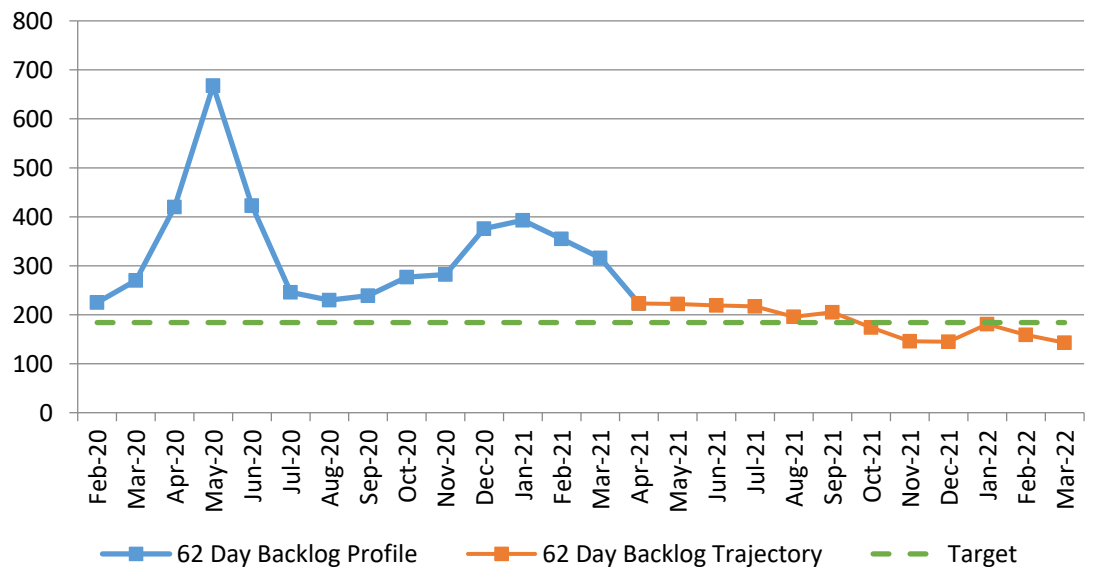
223 Result

N/A Target

439 UPL

269 Mean

100 LPL



Analytical Commentary

Variation is Common Cause

Assurance Commentary

The number of patients waiting over 62 days continues to be above the 200 mark. This is due to focused work on the long waiting patients and additional referrals meaning patients are waiting in excess of 62 days before being removed from the pathway.

Improvements in the longest waiting patients and increased capacity for two week wait will reduce this number in the coming months.

Improvement Actions

1. The full focus on P2 patients in order to reduce numbers waiting >28 days for surgery and maintain this turnover will encompass many patients on a cancer 62-day pathway.
2. Improved diagnostics flow and efficiency of patients – additional diagnostic sessions to reduce delays, escalations to CSS triumvirate and review of histopathology capacity.
3. Focus on additional Urology in H1.

Performance – Cancer 62 Day Waits over 104 Days

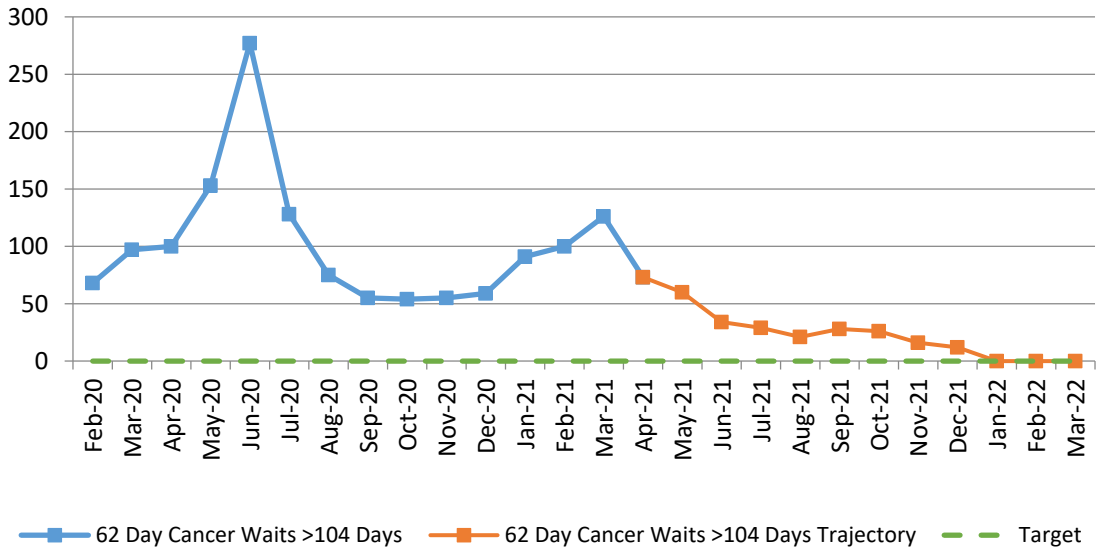
NNUH Digital Health business intelligence

62 Day waits over 104 Days

April 2021

Variation | Assurance

73.0 Result
N/A Target
146.9 UPL
73.6 Mean
0.3 LPL



Analytical Commentary

Variation is Common Cause

Assurance Commentary

Continued improvement in over 104 day waiters as additional Theatre activity comes online. Weekend Urology Robotic work has improved the position and will continue to help reduce the waits over the next 6 weeks.

Improvement Actions

1. The full focus on P2 patients in order to reduce numbers waiting >28 days for surgery and maintain this turnover will encompass many patients on a cancer 62-day pathway
2. Renewed focus on Cancer Red to Green process to improve engagement with senior teams.
3. Focus on additional Urology activity in H1.

Performance – Faster Diagnosis Standard

NNUH Digital Health business intelligence

Faster Diagnosis Performance

April 2021

Variation | Assurance

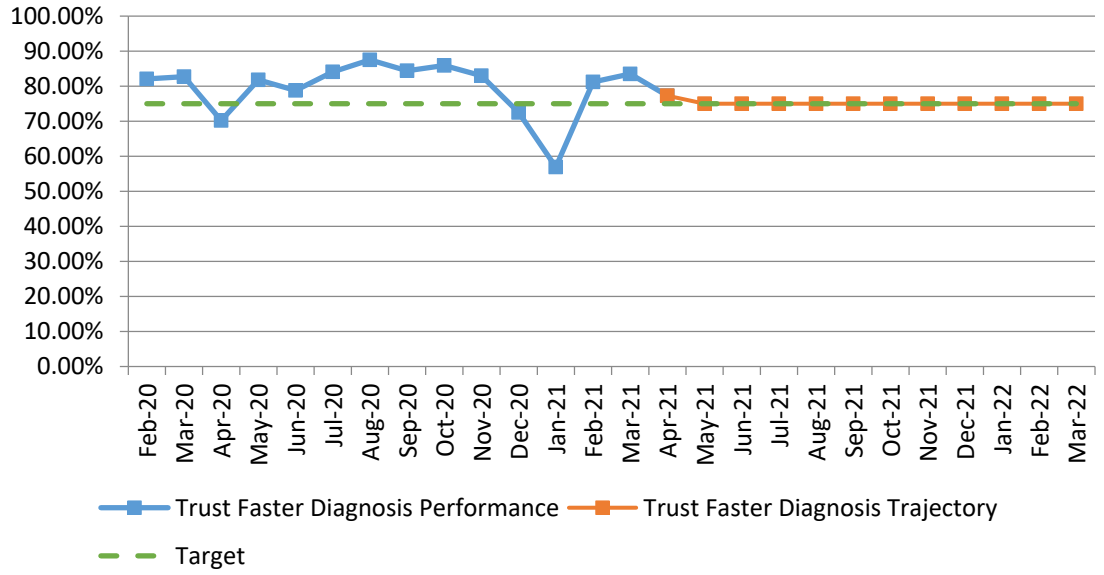
76.60% Result

N/A Target

98.00% UPL

81.60% Mean

65.20% LPL



Improvement Actions

1. Focus on ensuring all body sites have a data completeness rate of above 90%
2. Continued utilisation of Cancer Alliance funding for restoration of services to increase throughput prior to diagnosis.

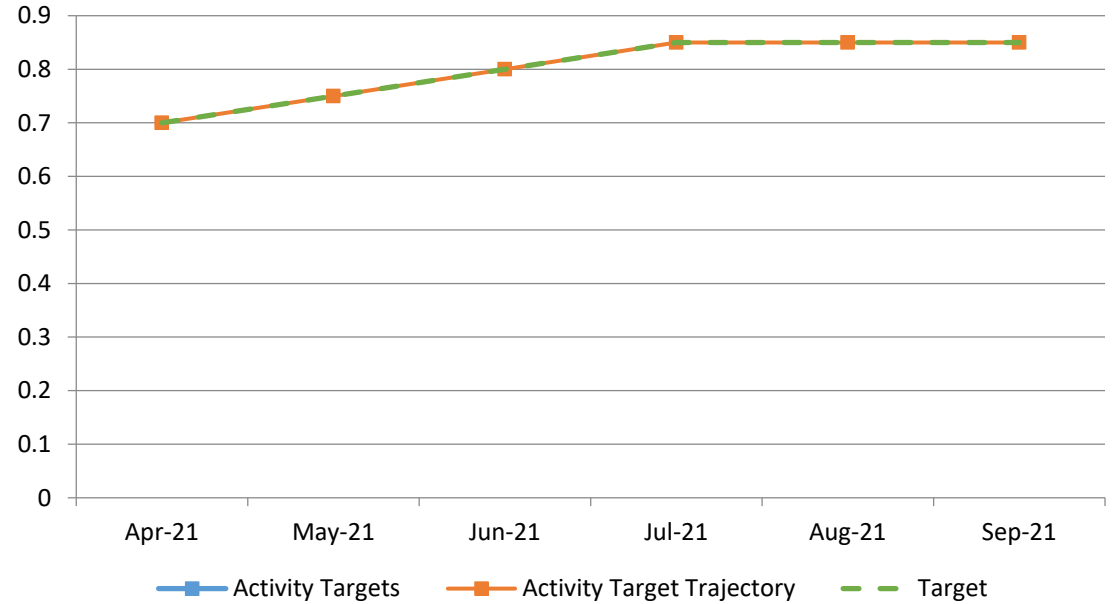
Analytical Commentary

Variation is Common Cause

Assurance Commentary

Compliance against FDS is generally above the 75% standard. Skin and Breast continue to deliver high Faster Diagnosis performance which accounts for the majority of patients on a FDS pathway. Continued focus on data completeness and implementation of timed pathways as they are released will ensure compliance against the standard.

Performance – H1 Activity Requirements



Improvement Actions

1. Efficiency measures to increase productivity.
2. Use of out-of-hours and weekends.
3. Maximise use of IS.
4. Engage with system on transformation of key pathways.

Analytical Commentary

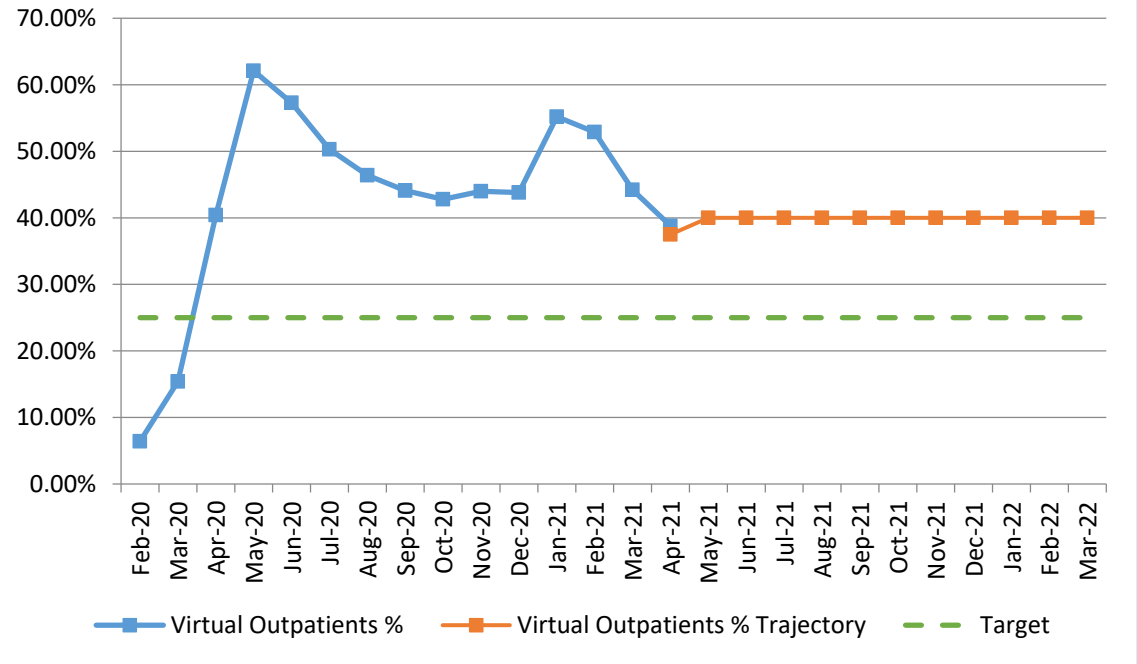
N/A

Assurance Commentary

The activity threshold level is set against a baseline value of all elective activity delivered in 2019/20. For April it is set at 70%, rising by 5% in subsequent months to 85% from July through to September 2021.

The Trust met the 70% requirement in April 2021. However, the measure of success will be judged at system level and the currency will be ''value'', not ''volume''.

Performance – Remote Outpatients



Improvement Actions

1. Ongoing transformation initiatives to review National best practice models for delivering remote care in each speciality.
2. Dedicated programme and project manager now in place
3. Enhanced and renewed focus on outpatient remote activity via daily IMT meetings with executive oversight. Supportive actions and plans initiated to ensure remote performance is embedded as part of normal practice.
4. Repeat review re potential gaps in hardware underway via Divisional leads.
5. Linked into regional community of practice for VC shared learning

Analytical Commentary

N/A

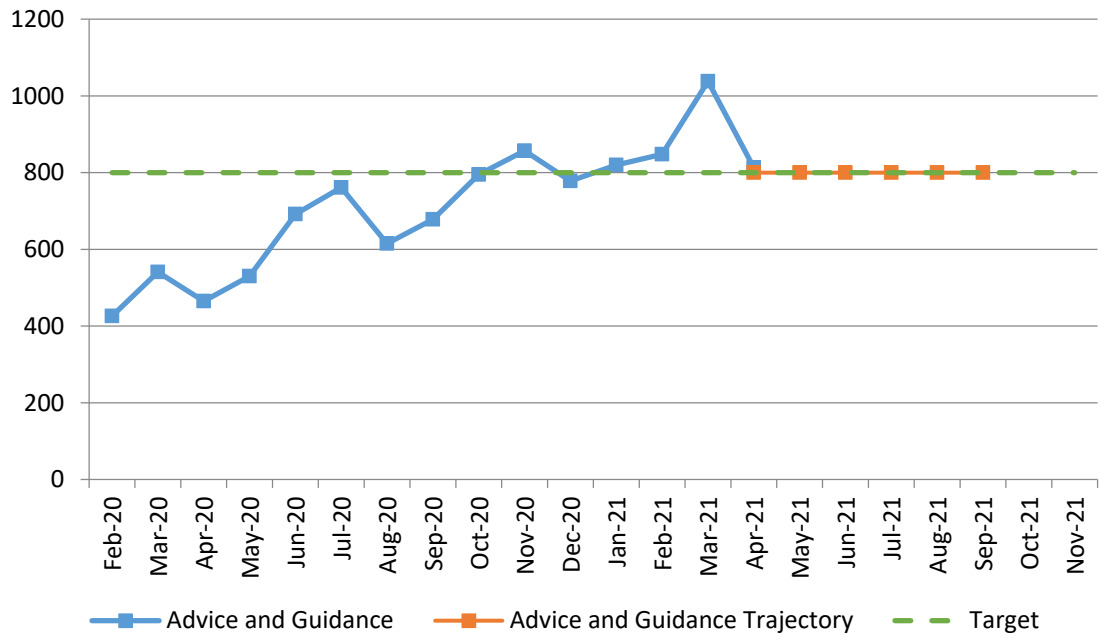
Assurance Commentary

The Trust delivered 38.8% of outpatient appointments remotely during April (down from 44%). The number of outpatient attendances continues to increase with an increasing number of face to face appointments. These are largely for clinical reasons and 'catching up' with patients who have previously had a number of virtual appointments during COVID.

The overall number of outpatient appointments delivered remotely (Telephone and Video) decreased from 27,792 to 23,617 in April.

NHS Planning Guidance for 21-22 reiterated the need for providers to embed transformation initiatives avoiding outpatient attendances of low clinical value. The guidance highlighted that at least 25% should be delivered remotely and 40% where appointments do not involve a procedure. Internally, the Trust has a target of 50% virtual appointments.

Performance – Advice & Guidance



Analytical Commentary

N/A

Assurance Commentary

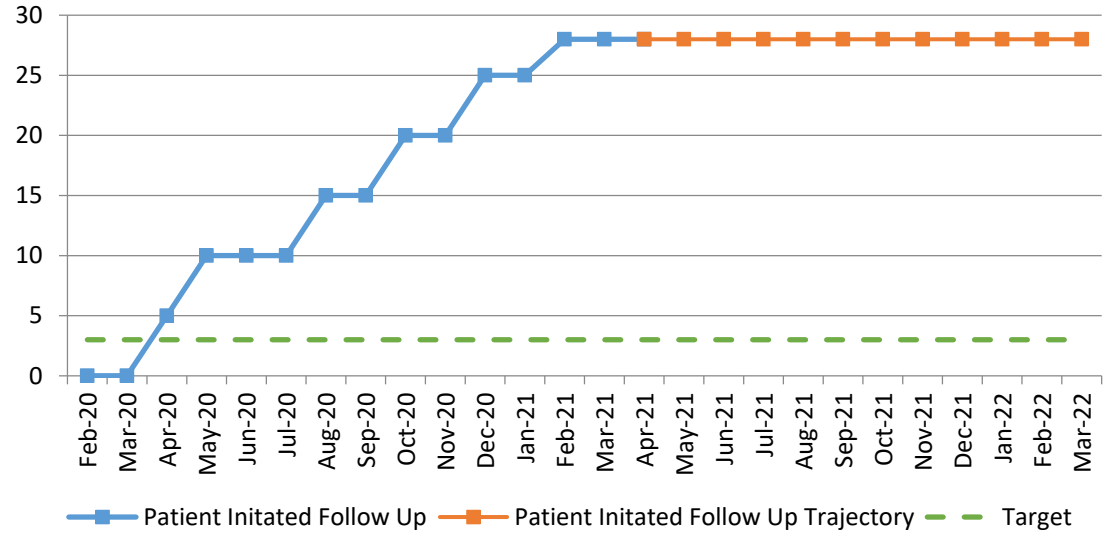
Covid has seen a 100% improvement in A&G activity. Levels.

Following the restoration of services and where face to face outpatient appointments are reinstated where necessary, there will be additional monitoring of advice and guidance requests.

Improvement Actions

1. Continued monitoring by speciality and division
2. Exploring best practice and use of A&G across N&W System with Primary Care

Performance – Patient Initiated Follow Up (PIFU)



Analytical Commentary

N/A

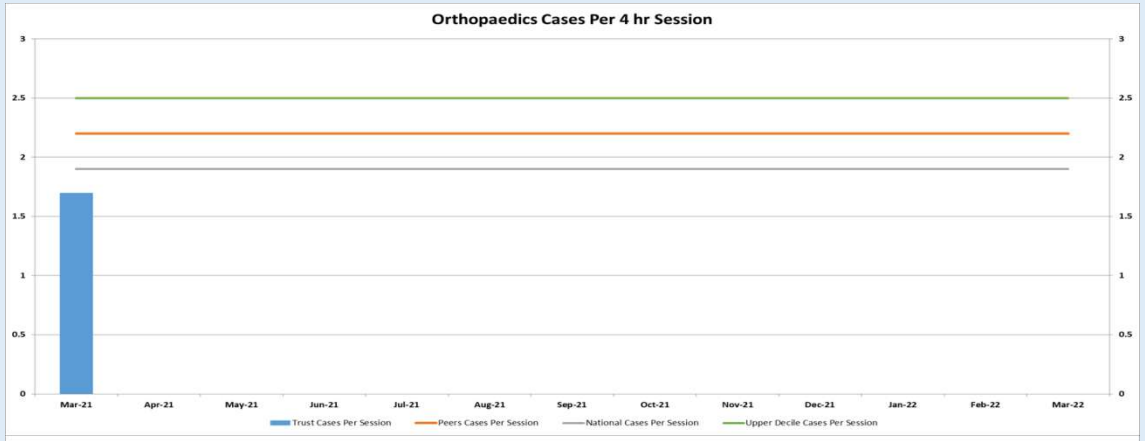
Assurance Commentary

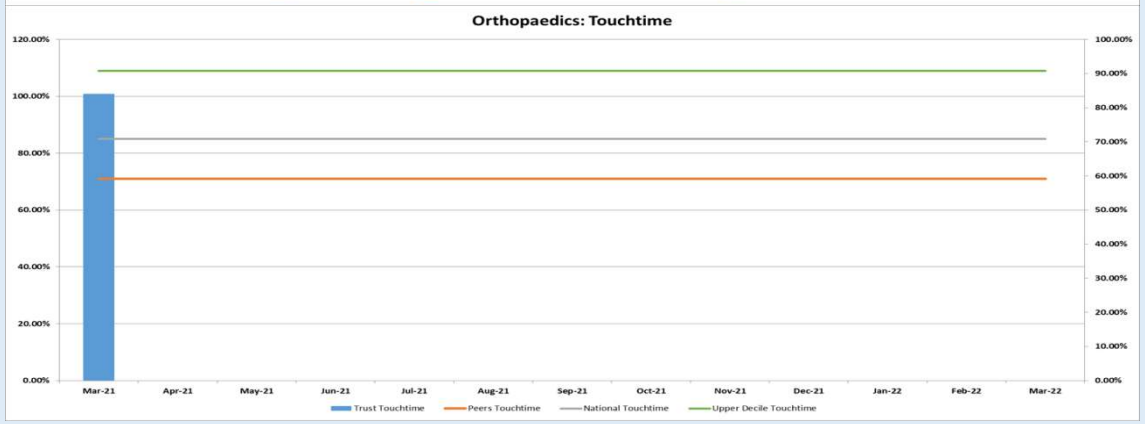
Currently well ahead of target. The Trust's outpatient Transformation Programme has supported all specialties to identify pathways /patients that would benefit from being placed upon a PIFU list. These patients are selected clinically. Triggers, timelines and access back to the service are agreed.

Improvement Actions

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

Performance – Model Hospital Orthopaedics





Improvement Actions

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

Analytical Commentary

N/A

Assurance Commentary

Model Hospital provides hospital-provider level-benchmarking against peer and national activity and performance.

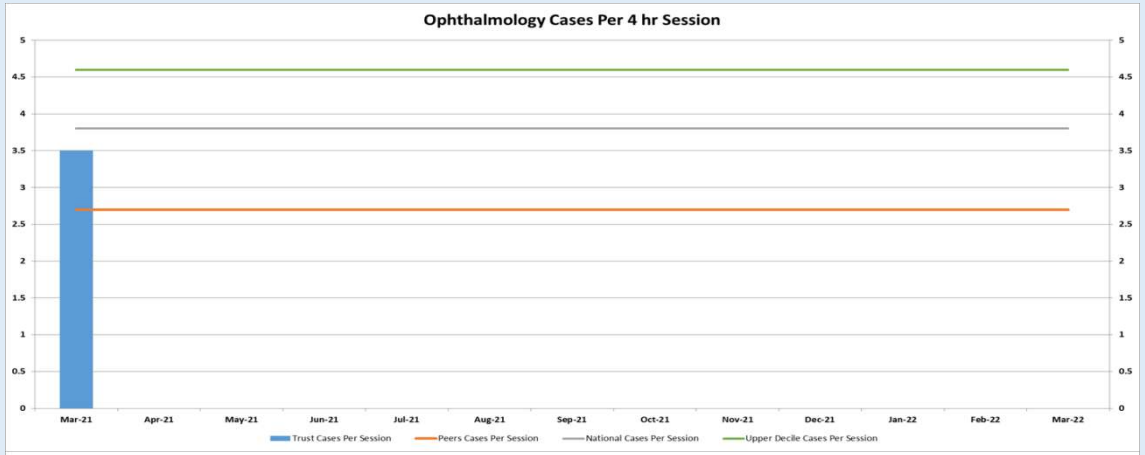
The Trust will use Model Hospital data to increase efficiency in 2 key areas:

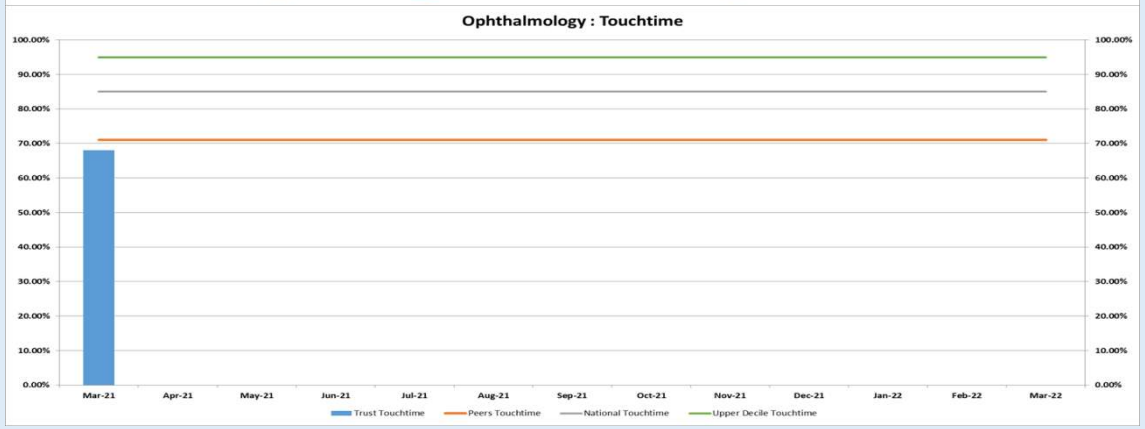
1) Theatre touch time
2) Cases per list

using upper decile levels of efficiency in March 2021.

There was capacity to treat an additional 48 patients (using touch time indicators) and the average number of cases per 4-hour session gave an opportunity for the Trust to increase from 1.7 to 2.1 (the peer Trusts' median).

Performance – Model Hospital Ophthalmology





Improvement Actions

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

Analytical Commentary

N/A

Assurance Commentary

Model Hospital provides hospital-provider level-benchmarking against peer and national activity and performance.

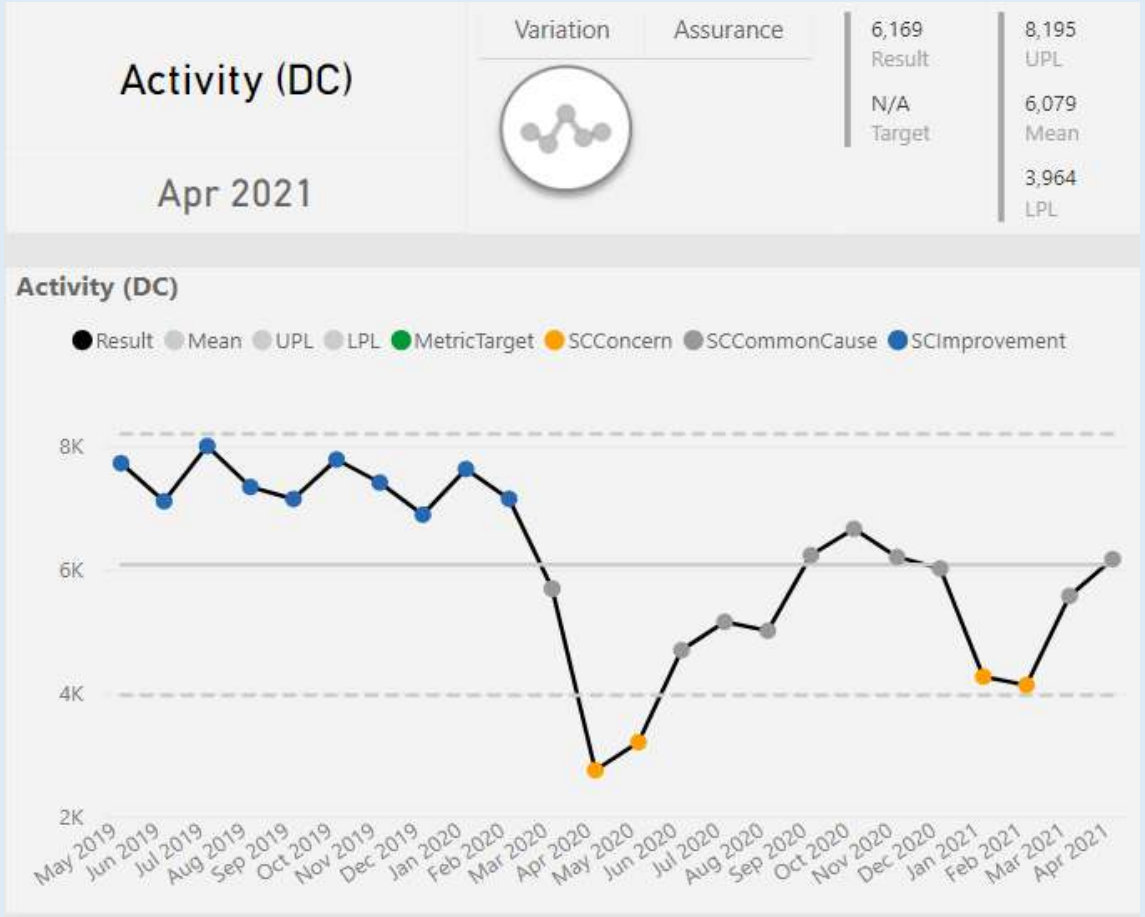
The Trust will use Model Hospital data to increase efficiency in 2 key areas:

1) Theatre touch time
2) Cases per list

using upper decile levels of efficiency in March 2021.

There was capacity to treat an additional 82 patients (using touch time indicators) and the average number of cases per 4-hour session gave an opportunity for the Trust to increase from 3.5 to 3.8 (the peer Trusts' median).

Activity – Day case



Improvement Actions

1. Continued focus on P2 activity and long waiting patients.
2. Additional lists at weekends.
3. Extended use of Vanguard for Plastics and Dermatology to facilitate increase in activity.

Analytical Commentary

Variation is Common Cause

Assurance Commentary

From April 2021 activity numbers now include acute service integration (ASI) and independent sector (IS).

For NNUH, there were 6,162 day cases in April 2021, exceeding the internal plan of 5,163. Notable areas of over performance include Gastro, Clinical Oncology and Ophthalmology. Activity also exceeded the NHSE compliance target of 5,002 (70% of April 2019 activity adjusted for working days), with over performance in medicine, but surgical specialties such as Ophthalmology and Oral were below plan.

Numbers reflect actual activity for ASI at Queen Elizabeth Hospital, 191 cases against internal plan of 218 and NHSE Compliance plan of 210. ASI at James Paget Hospital is estimated using March 2021 as a proxy at 124 cases compared to internal plan of 126 and NHSE compliance of 103. There was no activity for Independent sector in April 2021.

Activity – Elective Inpatient

NNUH Digital Health
business intelligence

Activity (IP)

Apr 2021

Variation | Assurance

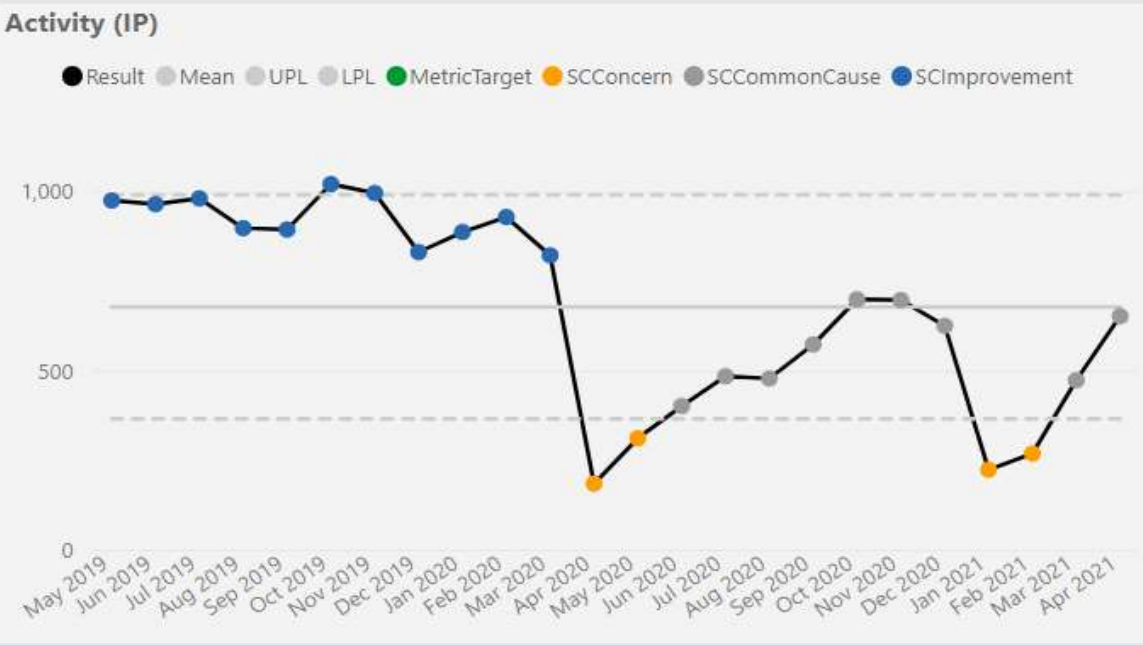
652 Result

N/A Target

991 UPL

678 Mean

365 LPL



Improvement Actions

1. Focus remains on P2. Patients and long waiters.
2. Use of Independent Sector (IS).
3. Maintain Green pathways.
4. Additional lists at weekends.
5. Review of length and utilisation of theatre lists.

Analytical Commentary

Variation is Common Cause

Assurance Commentary

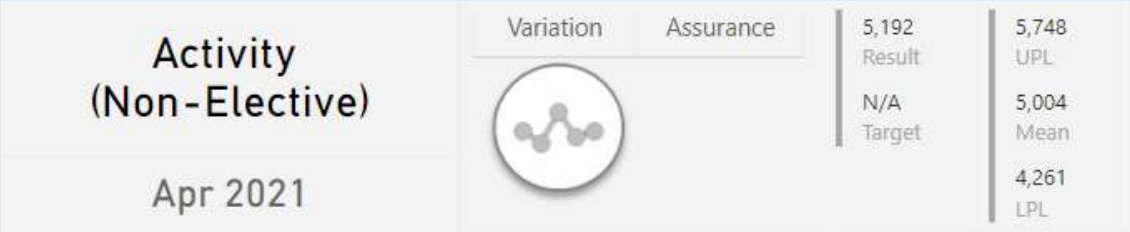
From April 2021 activity numbers now include acute service integration (ASI) and independent sector (IS).

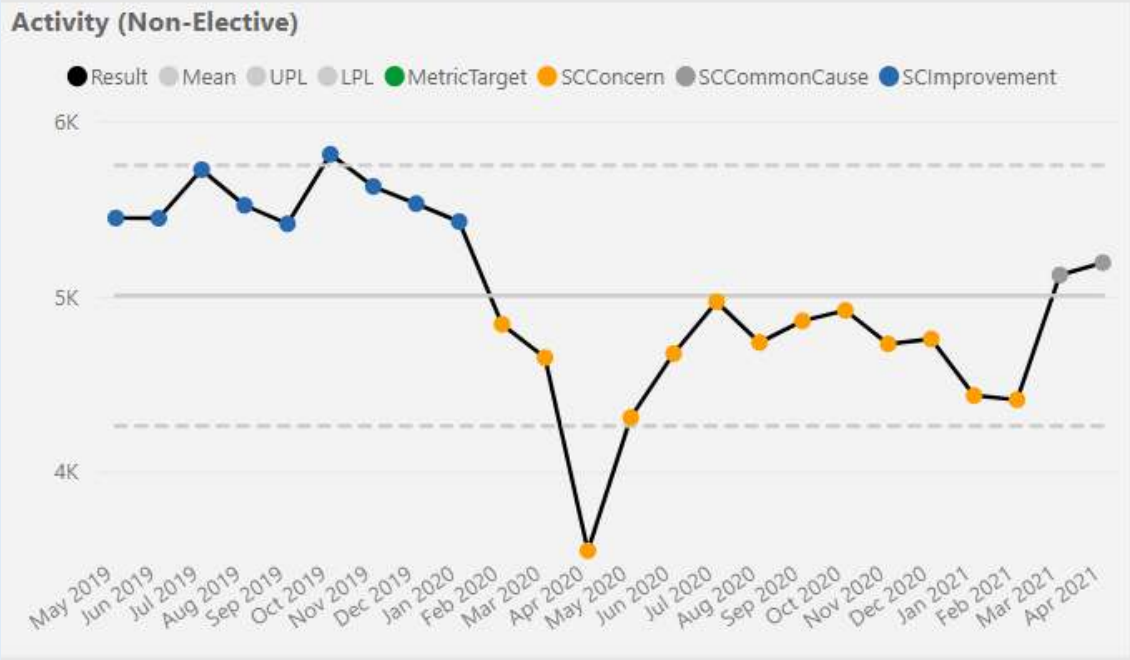
For NNUH, there were 644 elective inpatient discharges in April 2021, exceeding the internal plan of 537. Surgical specialties such as Urology and General surgery over performed, as well as Gynaecology.

Activity fell short of the NHSE compliance target of 668 (70% of April 2019 activity adjusted for working days), with under performance across medicine and surgery, particularly T&O/spinal and ENT. Gynaecology over performed, however.

Numbers reflect actual activity for ASI at Queen Elizabeth Hospital, 56 cases against internal plan of 36 and NHSE Compliance plan of 34. ASI at James Paget Hospital is estimated using March 2021 as a proxy at 17 cases compared to internal plan of 16 and NHSE compliance of 25. There was no activity for Independent sector in April 2021.

Activity – Non-Elective Discharges





Improvement Actions

1. STP blueprint to be implemented by October to enable patients on pathway 1 to 3 (community support required) to be discharged from hospital in a timely manner.

Analytical Commentary

Variation is Common Cause

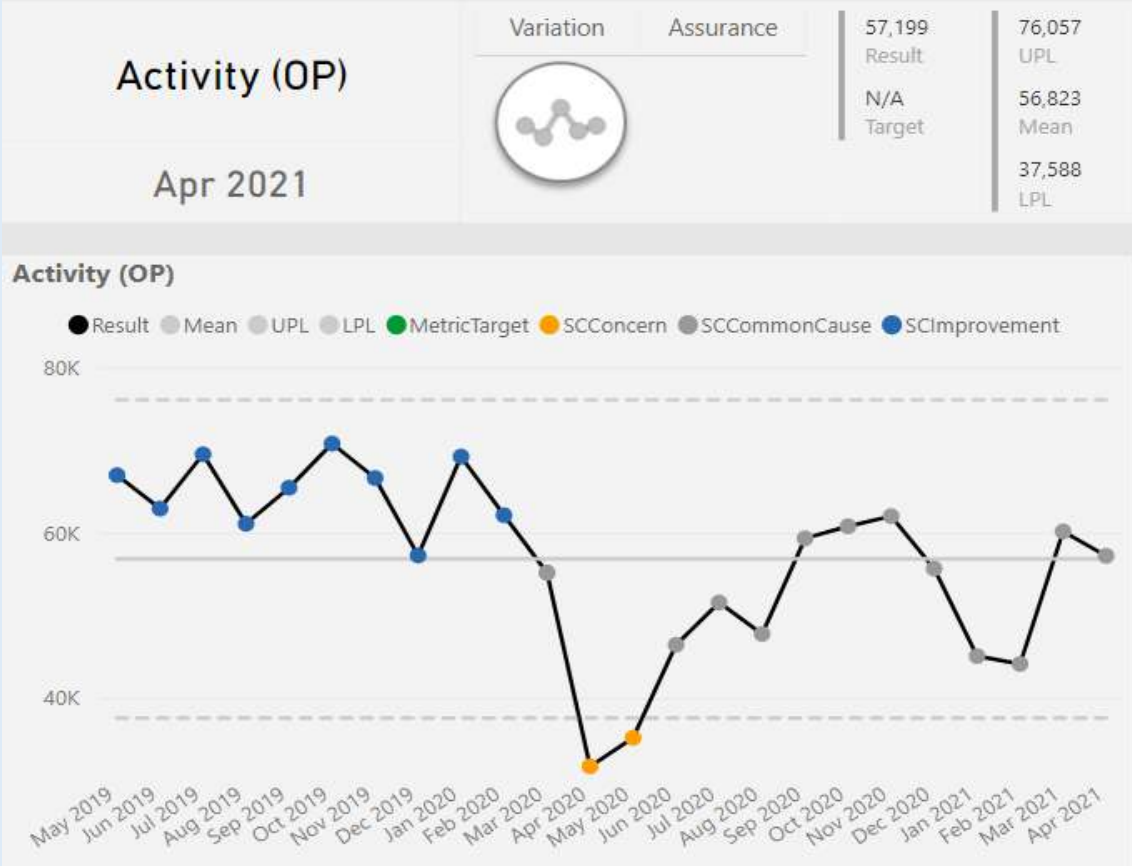
Assurance Commentary

From April 2021 activity numbers now include acute service integration (ASI)

For NNUH, there were 5,203 non-elective discharges (including maternity) in April 2021, exceeding the internal plan of 4,756. Women & Children were over plan, due to over performance in paediatric medicine, whilst surgical specialties such as ENT and plastics were below plan.

Numbers reflect actual activity for ASI at Queen Elizabeth Hospital, 44 cases against internal plan of 83. ASI at James Paget Hospital is estimated using March 2021 as a proxy at 5 cases compared to internal plan of 5.

Activity – Outpatient



Improvement Actions

1. Increase virtual outputs where appropriate.
2. Review clinic utilisation and bookings within divisions.
3. Review new and follow up numbers in clinics and revise.
4. Move patients onto PIFU where appropriate.

Analytical Commentary

Variation is Common Cause

Assurance Commentary

From April 2021 activity numbers now include acute service integration (ASI) and independent sector (IS).

There were 13,451 new consultant led appointments at NNUH in April 2021, which 20% were telephone/video, and exceeding the internal plan of 12,820. Surgical specialties such as ENT and Ophthalmology over performed, as well as gynaecology.

There were 35,972 follow up consultant led appointments at NNUH in April 2021, of which 43% were telephone/video, and exceeding the internal plan of 31,705. The majority of specialities over performed, with the notable exceptions of general surgery, T&O and plastics.

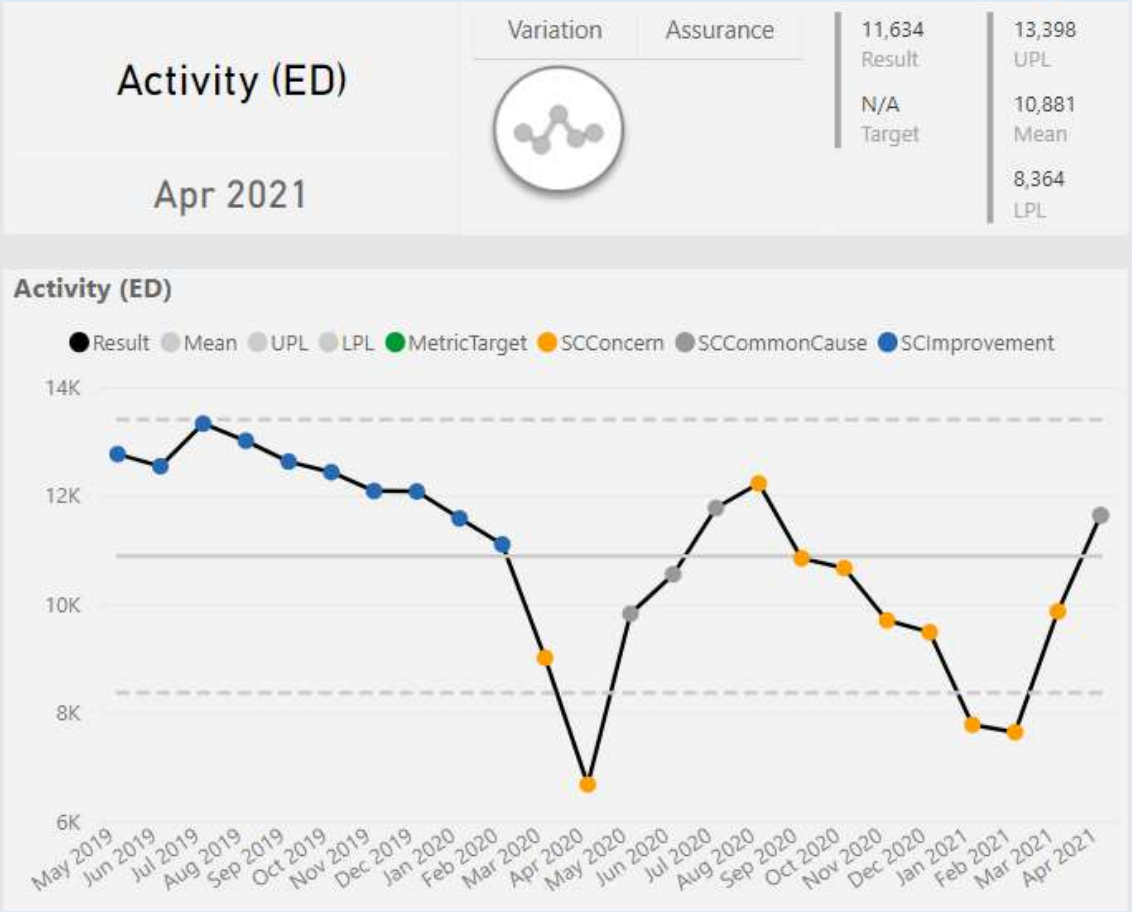
There were 7,581 non consultant led appointments at NNUH in April 2021, of which 59% were telephone/video, falling short of the internal plan of 7,871. Underperformance was seen in clinical oncology, T&O and paediatrics.

There were 10,513 outpatient procedures at NNUH in April 2021, exceeding the NHSE compliance target of 8,862 (70% of April 2019 activity adjusted for working days). Cardiology and urology saw significant over performance.

There were 46,491 outpatient appointments (excluding procedures) at NNUH in April 2021, exceeding the NHSE compliance target of 35,177 (70% of April 2019 adjusted for working days). Most specialties over performed, with the notable exceptions of Ophthalmology and Oral Surgery

Numbers reflect actual activity for ASI at Queen Elizabeth Hospital, 975 appointments against internal plan of 947 and NHSE Compliance plan of 760. ASI at James Paget Hospital is estimated using March 2021 as a proxy at 3,449 appointments compared to internal plan of 1,794 and NHSE compliance of 1,744. There was no activity for Independent sector in April 2021.

Activity – ED Attendances



Analytical Commentary

Variation is Common Cause

Assurance Commentary

There were 11,634 A&E attendances in April 2021, exceeding the internal plan of 11,229. 954 (8.2%) were at Cromer MIU, whilst 1,425 (12.2%) were for children (CHED).

Improvement Actions

1. Safer, Better, Faster (SBF) looking at Pre-Hospital pathways to direct patients to the relevant services and bypass ED.

Norfolk and Norwich University Hospitals NHS Foundation Trust

Finance Report
April 2021

25 May 2021

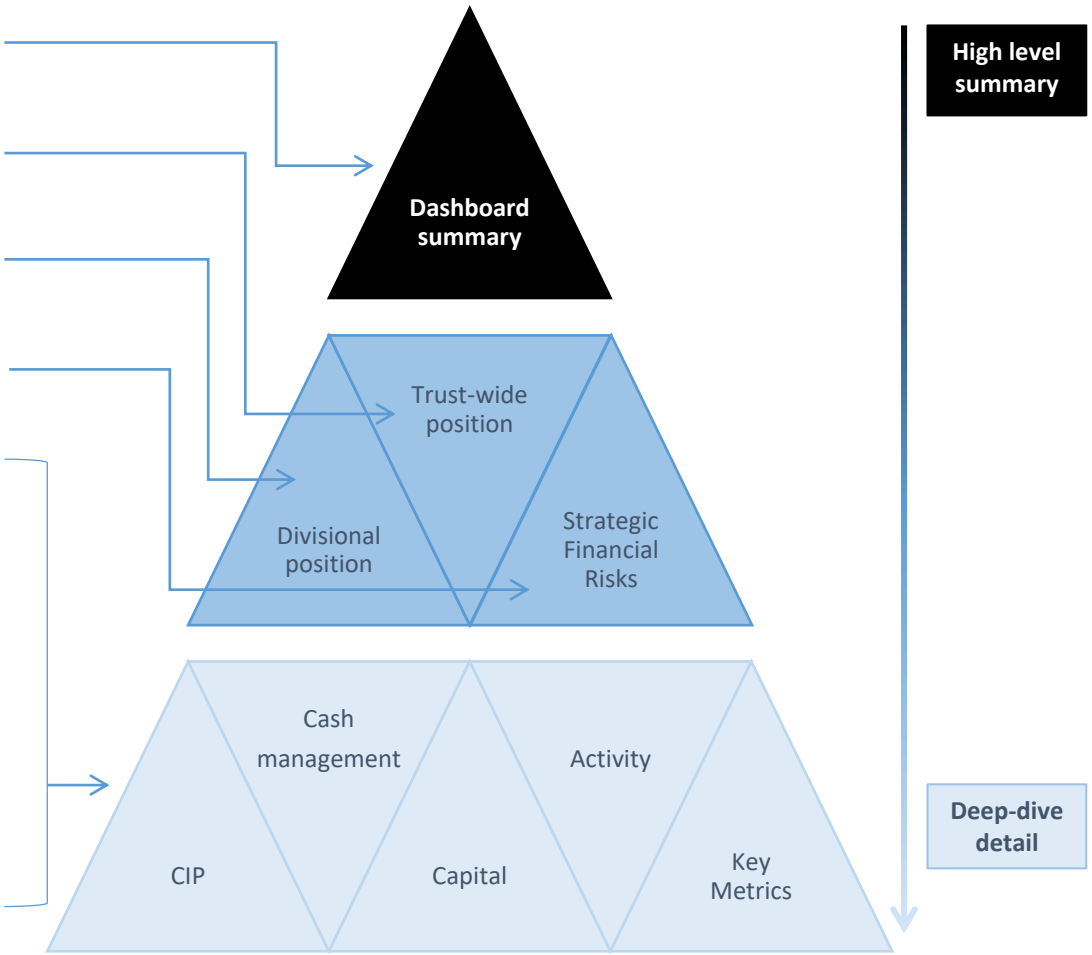
Roy Clarke, Chief Finance Officer

Norfolk and Norwich University Hospitals NHS Foundation Trust

Contents

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

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



Norfolk and Norwich University Hospitals NHS Foundation Trust

1.1 Executive Dashboard

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

The Trust operational plan position at Cycle 4 is:

- **A 2021/22 deficit of £55.2m, comprising a breakeven position for H1 and a £55.0m deficit for H2.**
- **An underlying full year deficit of £110.1m, requiring improvement through further management action.**

For the month of April 2021, the position on a control total basis is a surplus of £1.5m. This is a £0.7m favourable variance to the planned £0.9m surplus for the month. The favourable variance of £0.7m is made up of an underspend in Pay of £0.3m and clinical & non clinical supplies of £0.7m offset by reduced income of £0.3m.

Forecast Outturn (H1):
Forecast outturn remains on plan at breakeven. This has been risk assessed as an Upside Forecast Outturn of a £6.4m surplus, based on current run rates and committed expenditure. This is £6.4m favourable to the breakeven plan. However, assuming expenditure increases to planned levels for the remaining months, would result in a risk adjusted forecast outturn of breakeven being nil variance to the operational plan.

Management action is required to ensure expenditure run rate in key recovery areas increases to planned levels via grip and control measures, further CIP identification and completion of cycle 4 outstanding actions.

Activity:
New activity targets have been set by NHSE for Half 1 of 2021/22, targets being 70% of 2019/20 activity levels in April, increasing by 5% each month until July when the target is 85% and this will remain the target until September. Targets for H2 are not yet known. The Trust has devised its own internal plan, submitting a draft plan in early May in which overall the targets are met and exceeded across some points of delivery – over performance in Day Case and Outpatient attendances mainly outweighing the expected under performance in the harder to achieve areas of Elective inpatient and Outpatient Procedures. With this in mind recognition around benefits from the Elective Recovery Fund are treated prudently.

Cash at 30 April 2021 is £60m. The closing balance is high for the following main reasons: cumulative operational underspends in 2020/21, and exceptional capital creditors, accruals and levels of general debt. These are timing differences and expected to settle to normal levels during the first half year. The cash position at 30 September is forecast to be £40.7m.

Capital: As at 30th April the Trust has underspent its plan by £1.2m. Key drivers of the YTD variance are underspends on NNMC of £0.3m, theatres reconfiguration of £0.2m, Network Hardware Refresh of £0.1m and EDMS of £0.1m. The remaining £0.5m comprises small underspends on various projects.

	YTD			April21 - September21			
	Actual £m	Plan £m	Variance £m	FOT £m	Plan £m	Variance £m	RAG
Clinical Income	47.3	47.0	0.2	282.3	282.3	0.0	
Other Income	16.6	17.1	(0.5)	108.3	108.3	0.0	
Pay	(35.8)	(36.2)	0.3	(217.3)	(217.3)	0.0	
Non Pay	(15.7)	(16.4)	0.8	(108.1)	(108.1)	0.0	
Net Drugs Cost	(6.2)	(6.0)	(0.2)	(36.0)	(36.0)	0.0	
Non Opex	(4.7)	(4.7)	0.0	(29.2)	(29.2)	0.0	
Surplus / (Deficit)	1.5	0.9	0.7	0.0	0.0	0.0	
COVID (Out of System) Expenditure	1.0	0.0	1.0	1.0	0.0	1.0	
COVID (Out of System) Income	(1.0)	0.0	(1.0)	(1.0)	0.0	(1.0)	
Reported Surplus / (Deficit)	1.5	0.9	0.7	(0.0)	0.0	(0.0)	
Headline Surplus / (Deficit)*	1.8	1.7	0.0	2.2	2.2	(0.0)	
Cash at Bank (before support funding)	60.0	59.3	0.7	40.7	40.7	0.0	
Capital Programme	15.5	16.6	(1.2)	52.4	52.4	0.1	
CIP	0.2	0.3	(0.1)	3.5	3.5	0.0	
Inpatients** (000's)	12.0	10.5	1.6	70.4	70.4	0.0	
Outpatients** (000's)	57.0	51.8	5.2	345.3	345.3	0.0	
A&E** (000's)	11.6	11.3	0.3	82.0	82.0	0.0	

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

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

Norfolk and Norwich University Hospitals NHS Foundation Trust

1.2 Executive Dashboard

Risks

As part of FY21/22 annual planning, a detailed refresh of the Financial Risk Register has been performed, resulting in 16 key strategic and operational risks.

Strategic Financial Risks	Extreme (15-25)	High (8-14)	Moderate (4-6)	Low (1-3)
Total This Month	7	6	3	0
Total Last Month	5	8	4	0
Overall Trend	↑	↓	↓	↔

Divisional Performance

The Medicine division is the only overspent division in April 2021 as a result of increased drug expenditure although this is offset by additional income centrally managed in the 'other' division. The CSS division is underspent mostly through vacancies. All other divisions are broadly on plan.

Both the Medicine and Surgery Divisions are overspent for pay and recovery plans have been requested.

The Medicine division is showing an adverse position to plan of £0.7m, this is as a result of increased expenditure on high cost drugs. The NHSEI commissioned drugs are offset by additional income centrally managed in the 'other' division. The CSS Division is showing a favourable position of £0.6m, mostly relating to vacancies against their establishment. Surgery, Women's & Children's, Emergency & Urgent care and corporate are all c. on plan for Month 1.

As actual activity is significantly lower than prior year and the reduced expenditure is not proportional to this, all divisions are RAG rated either amber or red.

'Other' shows a favourable position of £0.8m as a result of the funding for the additional cost & volume drugs usage in the Medicine Division.

YTD Divisional Performance Excl. COVID	Medicine		Emergency & Urgent Care		Surgery		Women's & Children's		CSS		Corporate Incl. COVID		Other		Total	
	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m
YTD Surplus / (Deficit)	(18.9)	(0.7)	(2.3)	0.0	(12.3)	(0.0)	(4.6)	(0.0)	(7.6)	0.6	(8.9)	0.1	56.2	0.8	1.5	0.7
Apr-Sep FOT	(108.0)	0.0	(13.8)	0.0	(75.1)	0.0	(27.6)	0.0	(49.4)	0.0	(59.2)	0.0	333.2	0.0	0.0	0.0
Inpatients*	7.4	0.8	0.0	0.0	2.8	0.3	1.8	0.5	0.0	0.0	-	-	-	-	12.0	1.6
Outpatients*	22.1	1.8	0.0	0.0	25.5	1.6	5.9	1.4	3.5	0.4	-	-	-	-	57.0	5.2
A&E*	0.0	0.0	11.6	0.3	0.0	0.0	0.0	0.0	0.0	0.0	-	-	-	-	11.6	0.3
CIP RAG																
FINANCE RAG**																
PAF RAG**																

**Activity variance against H1 Draft Activity plans*

*** Prior Quarter PAF Rating*

Cost Improvement Programme

YTD the Trust has delivered £0.25m of CIPs against a target of £0.33m, an adverse variance of £0.08m. RAG adjusted forecast CIP delivery is £14.4m which is favourable by £1.8 to the risk adjusted plan of £12.6 however adverse by 12.0m to the total plan of £26.4m.

YTD the Trust has delivered £0.25m of CIPs against a target of £0.33m, an adverse variance of £0.08m, comprised of:

- A planning variance of nil; and
- A performance variance of £0.08m. This has arisen through adverse performance in pay initiatives and additional in month expenditure for the voice recognition roll out.

FY20/21 CIP Plan - Divisional Breakdown	FY20/21 Indicative Target £m	FY20/21 FIP Board Approved £m	FYE FY20/21 £m	Gap £m	FY20/21 RAG Adj. Forecast Delivery £m	Gap £m
Medicine	7.2	5.6	2.4	0.9	7.8	0.6
Emergency & Urgent Care	1.1	1.1	0.3	0.3	1.4	0.3
Surgery	7.8	2.4	1.5	(4.0)	3.3	(4.5)
Women's & Children's	2.7	0.5	0.2	(2.0)	0.7	(2.0)
CSS	4.1	0.7	0.5	(2.9)	1.1	(3.0)
Corporate	3.5	0.0	0.2	(3.3)	0.2	(3.3)
Total	26.4	10.3	5.2	(10.9)	14.4	(12.0)

FY21/22 CIP Plan Development

As at 17 May 2021, the programme consists of £10.3m of Gateway 2 approved schemes; £5.2m of FYE of FY20/21 schemes; £9.4m of Gateway 1 approved schemes, which are being reviewed and developed to be progressed or removed from the programme; and £1.2m of schemes within the CIP development pipeline (Gateway 0).

Norfolk and Norwich University Hospitals NHS Foundation Trust

2.1 Financial Performance – April 2021 & Year To Date

For the month of April 2021, the position on a control total basis is a surplus of £1.5m. This is a £0.7m favourable variance to the planned £0.9m surplus for the month. The favourable variance of £0.7m is made up of an underspend in Pay of £0.3m and clinical & non clinical supplies of £0.7m offset by reduced income of £0.3m.

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

Other Income:
There is a £0.4m adverse variance to plan for April 2021. This relates to a number of small variances including reduced Education & Training and ASI both matched by reduced expenditure.

Pay:
Including COVID, there is a £0.3m favourable position against plan for April 2021. This comprises of a £0.2 adverse variance for In System COVID and an operational variance of £0.5m favourable relating to net vacancies against establishment in CSS & Corporate.

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

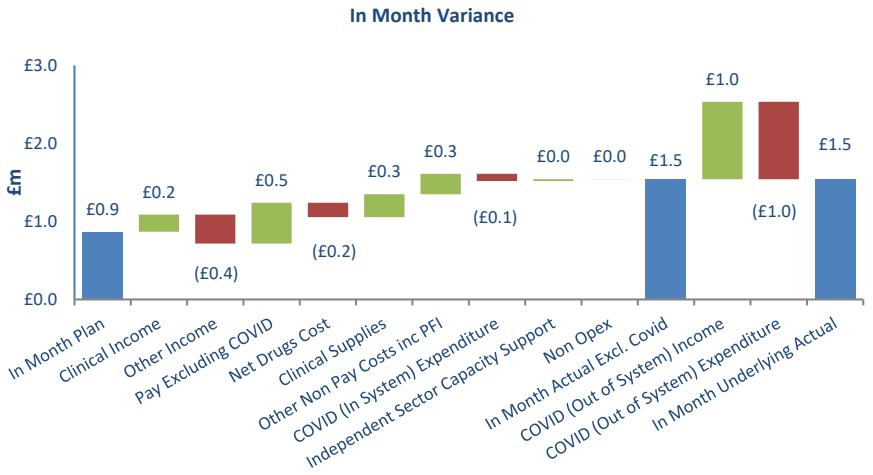
Non Pay:
There is a £0.6m favourable variance in April 2021. £0.3m of this relates to clinical supplies as a result of the activity case mix across CSS & Surgery. A further £0.3m is due to a number of small variances including offsetting cost savings against the reduced other income.

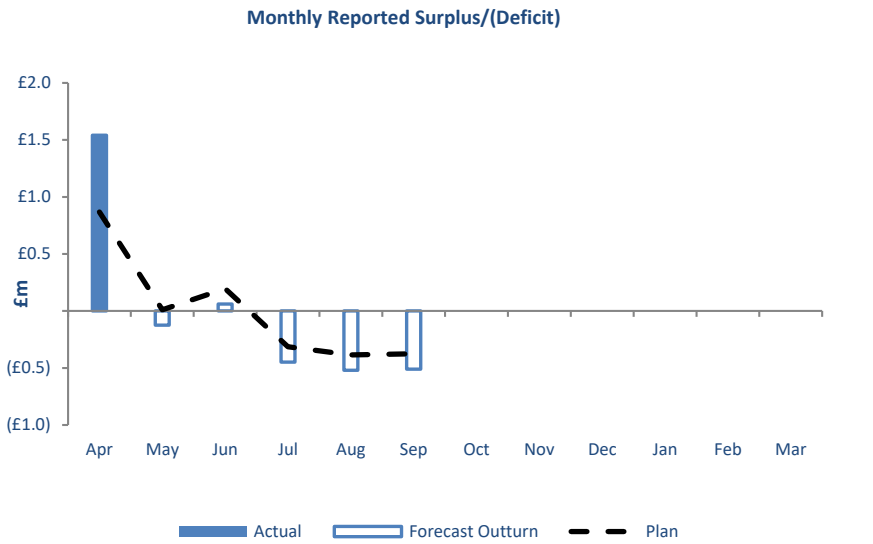
In System COVID 19 Expenditure:
There is a small adverse variance of £0.1m for April 2021

Independent Sector Capacity Support:
There is no spend against a nil plan for Apr. Costs are forecast to increase from May.

Non Operating Expenditure:
Non operating expenditure is on plan for April 2021

Out of System COVID 19 Expenditure:
The COVID-19 expenditure in month is £1.0m, with offsetting income of £1.0m and therefore an in month breakeven position.





Norfolk and Norwich University Hospitals NHS Foundation Trust

2.2 Forecast Outturn H1

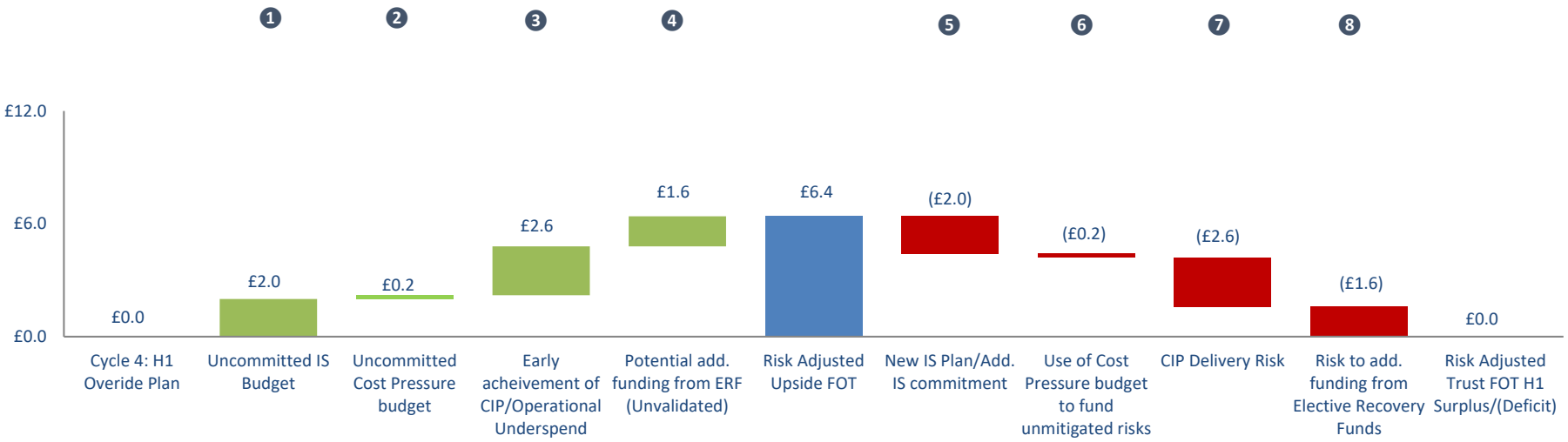
Forecast outturn remains on plan at breakeven. This has been risk assessed as an Upside Forecast Outturn of a £6.4m surplus, based on current run rates and committed expenditure. This is £6.4m favourable to the breakeven plan. However, assuming expenditure increases to planned levels for the remaining months, would result in a risk adjusted forecast outturn of breakeven being nil variance to the operational plan.

1. **Independent Sector Capacity Support:** Currently budget is under committed by £2.0m
2. **Cost Pressure Budget:** Uncommitted Cost Pressure budget remains unused - £0.2m
3. **CIP Delivery/Operational Expenditure:** Additional Delivery of CIP/Operational Underspends - £2.6m
4. **Elective Recovery Funds (ERF):** Potential £1.6m of additional income from Elective Recovery Funds based on prior year case mix assumptions and April activity delivered

This results in a risk adjusted upside forecast outturn of a £6.4m surplus, £6.4m favourable to the operational plan of breakeven

5. **Independent Sector Capacity Support:** Revised IS expenditure plan/additional IS commitment – (£2.0m)
6. **Cost Pressure Budget:** Use of cost pressure reserve to support unmitigated cost pressures – (£0.2m)
7. **CIP Delivery/Operational Expenditure:** Divisional CIP Risk/Operational Expenditure run rate – (£2.6m)
8. **Elective Recovery Funds:** Recognition of ERF is high risk due to 1) high level of uncertainty over case mix and work complete under ERF at this stage, 2) confidence in whole system performance and 3) system distribution of planned ERF not yet agreed

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



Norfolk and Norwich University Hospitals NHS Foundation Trust

2.3 Underlying Plan Analysis

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

1. **Cycle 4 H1 Plan:** Breakeven

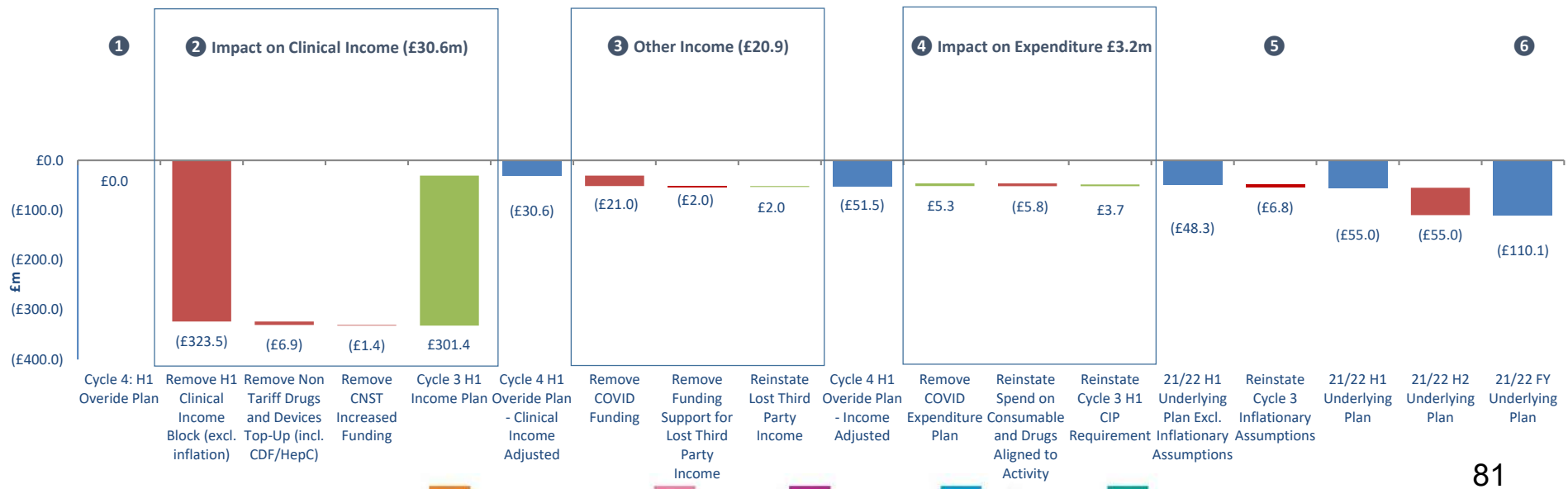
2. **Impact on Clinical Income** – The underlying plan included £301.3m of clinical income across commissioning contracts, including non tariff drugs. This has been replaced by £331.9m of system allocated block funding. **Reverting back to the underlying plan is a £30.6m adverse movement.**

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

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

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

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



Norfolk and Norwich University Hospitals NHS Foundation Trust

3.1 Divisional Performance - Summary

The Medicine division is the only overspent division in April 2021 as a result of increased drug expenditure although this is offset by additional income centrally managed in the 'other' division. The CSS division is underspent mostly through vacancies. All other divisions are broadly on plan.

The below commentary is against the year to date position:

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

Medicine:

Net expenditure of £18.9m, (£0.7m) adverse position against plan. Pay has an adverse variance of (£0.1m) driven by expenditure on WLI sessions for Trust recovery and internal locum junior doctors. Non Pay of (£0.6m), predominantly as a result of an increase in expenditure on specialised commissioned high cost drugs, which is offset by an increase in drugs income.

Emergency:

Net expenditure of £2.3m, nil variance against plan.

Surgery:

Net expenditure of £12.3m, £nil variance against plan. Case mix during the period has impacted clinical supplies usage seeing a favourable Non-Pay position of £0.3m against plan. Day Case & Elective activity are both trending above the Division's internally submitted activity plan, although it remains below the NHSEI recovery trajectory. The Division is £0.2m overspent on Pay due to reliance upon premium medical pay expenditure in the period & ongoing overspends on junior doctors.

Women's & Children's:

Net expenditure of £4.6m, nil variance against plan. Pay is on plan although there are underspends still showing within Paediatric nursing which is being offset by increased locum expenditure. Drugs spend continues to be high and is overspent in month by £0.1m, additional income has been recognised in month within the top up block agreement.

Clinical Support:

Net expenditure of £7.6m, £0.6m favourable variance against plan. £0.4m of this is within Pay due to a number of vacancies across the division (notably within Therapies and Cellular Pathology), and £0.2m underspends in clinical supplies, due to activity and current case mix IRU, and across the laboratories

Corporate:

Net expenditure of £8.9m including in system COVID expenditure of £0.5m, £0.1m favourable against plan including in system COVID.

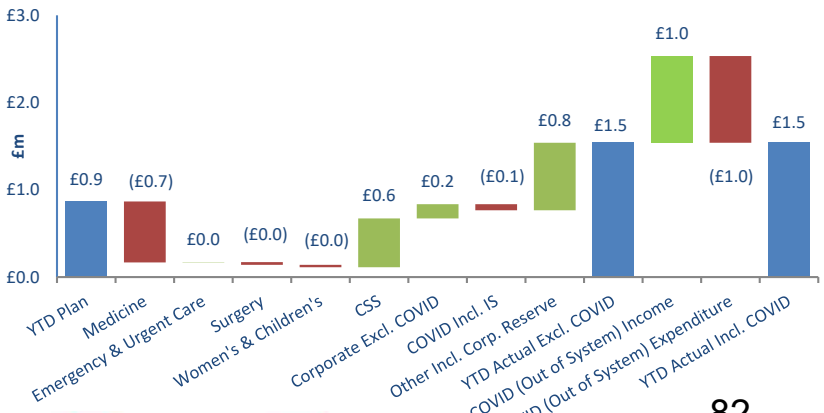
Other:

Other includes Clinical Income block and Top up funding along with R&D and the Trust Reserves. Net favourable variance of £0.8m mostly being £0.6m from additional income relating to cost & volume drugs income recognised based on usage.

YTD Divisional Performance Excl. COVID	Medicine		Emergency & Urgent Care		Surgery		Women's & Children's		CSS		Corporate Incl. COVID		Other		Total	
	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m	Act. £m	Var. £m
Clinical Income	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	47.3	0.2	47.3	0.2
Other Income	0.2	0.0	0.1	0.1	0.4	(0.1)	0.1	0.0	1.1	(0.0)	0.5	(0.2)	14.2	(0.3)	16.6	(0.5)
Pay	(10.1)	(0.1)	(2.2)	(0.0)	(10.2)	(0.2)	(4.0)	0.0	(5.9)	0.4	(3.1)	(0.1)	(0.4)	0.4	(35.8)	0.3
Non Pay	(2.8)	0.1	(0.2)	(0.0)	(1.7)	0.2	(0.3)	0.0	(2.6)	0.2	(6.3)	0.4	(1.7)	(0.2)	(15.7)	0.8
Net Drugs Cost	(6.3)	(0.7)	(0.0)	(0.0)	(0.8)	0.0	(0.5)	(0.1)	(0.2)	(0.0)	(0.0)	(0.0)	1.6	0.6	(6.2)	(0.2)
Non Opex	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	(4.7)	0.0	(4.7)	0.0
YTD Surplus / (Deficit)	(18.9)	(0.7)	(2.3)	0.0	(12.3)	(0.0)	(4.6)	(0.0)	(7.6)	0.6	(8.9)	0.1	56.2	0.8	1.5	0.7
Apr-Sep FOT	(108.0)	0.0	(13.8)	0.0	(75.1)	0.0	(27.6)	0.0	(49.4)	0.0	(59.2)	0.0	333.2	0.0	0.0	0.0
CIP	0.1	(0.0)	0.1	0.0	0.1	(0.0)	0.0	(0.0)	0.0	(0.0)	0.0	0.0	(0.1)	(0.0)	0.2	(0.1)
Inpatients*	7.4	0.8	0.0	0.0	2.8	0.3	1.8	0.5	0.0	0.0	-	-	-	-	12.0	1.6
Outpatients*	22.1	1.8	0.0	0.0	25.5	1.6	5.9	1.4	3.5	0.4	-	-	-	-	57.0	5.2
A&E*	0.0	0.0	11.6	0.3	0.0	0.0	0.0	0.0	0.0	0.0	-	-	-	-	11.6	0.3
CIP RAG																
FINANCE RAG**																
PAF RAG**																

*Activity variance against H1 Draft Activity plans

** Prior Quarter PAF Rating



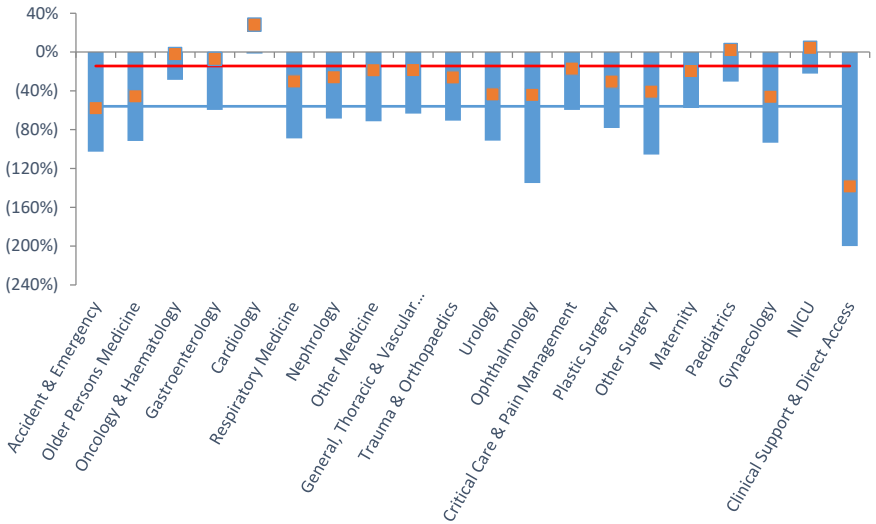
Norfolk and Norwich University Hospitals NHS Foundation Trust

3.2 Divisional Performance - Service Line Reporting 2020/21

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

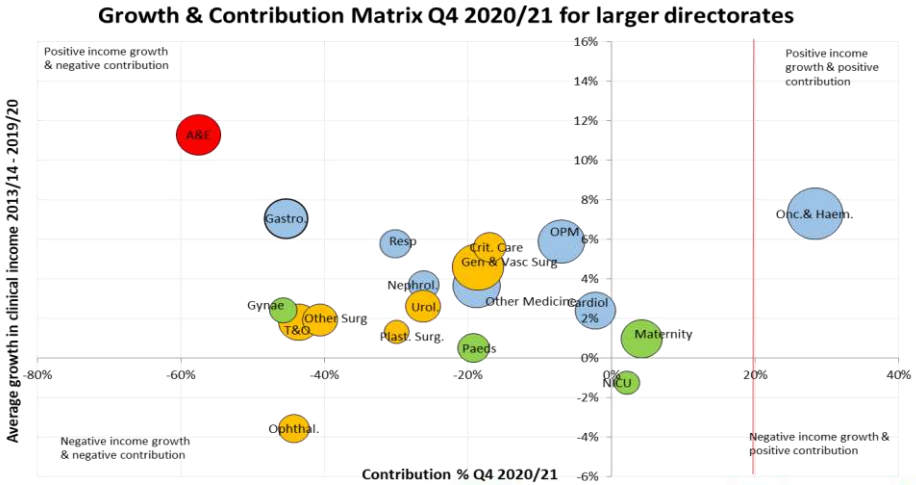
The impact of Covid in the New Year was a fall in activity and PBR-based income of 10-15% in Q4 compared to Q3, with Surgery most affected. This level of activity and income was 20% below 2019/20 levels, whilst costs increased, resulting in negative levels of contribution throughout 2020/21 as follows:

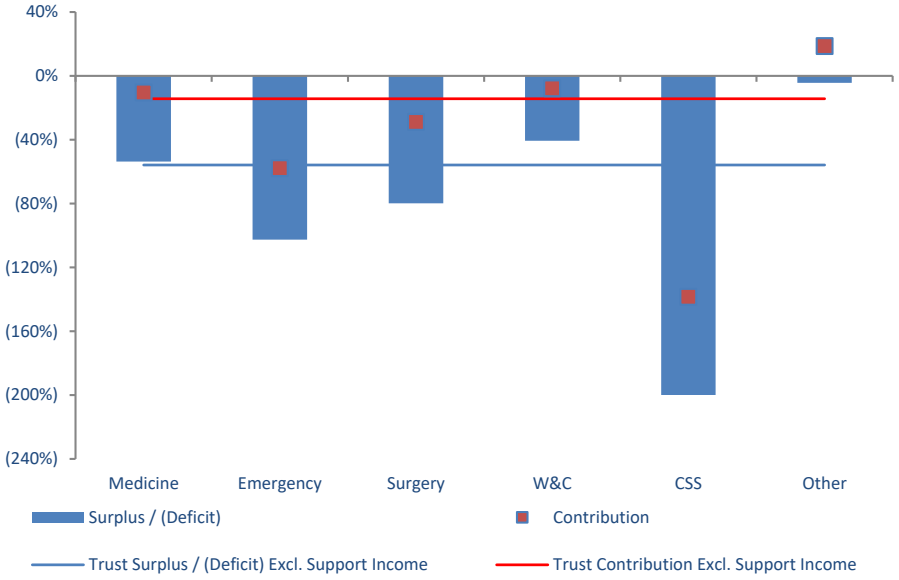
Division	% of 'PbR' Income	19/20	Q1 20/21	Q2 20/21	Q3 20/21	Q4 20/21	20/21 Contribution
Medicine	6.4%	14%	(26%)	(4%)	1%	(16%)	(10%)
Emergency	47.0%	(35%)	(92%)	(35%)	(52%)	(58%)	(58%)
Surgery	27.4%	6%	(77%)	(29%)	(13%)	(13%)	(29%)
Women & Children's	18.9%	5%	(25%)	(5%)	1%	(5%)	(8%)
Clinical Support	0.4%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



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

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





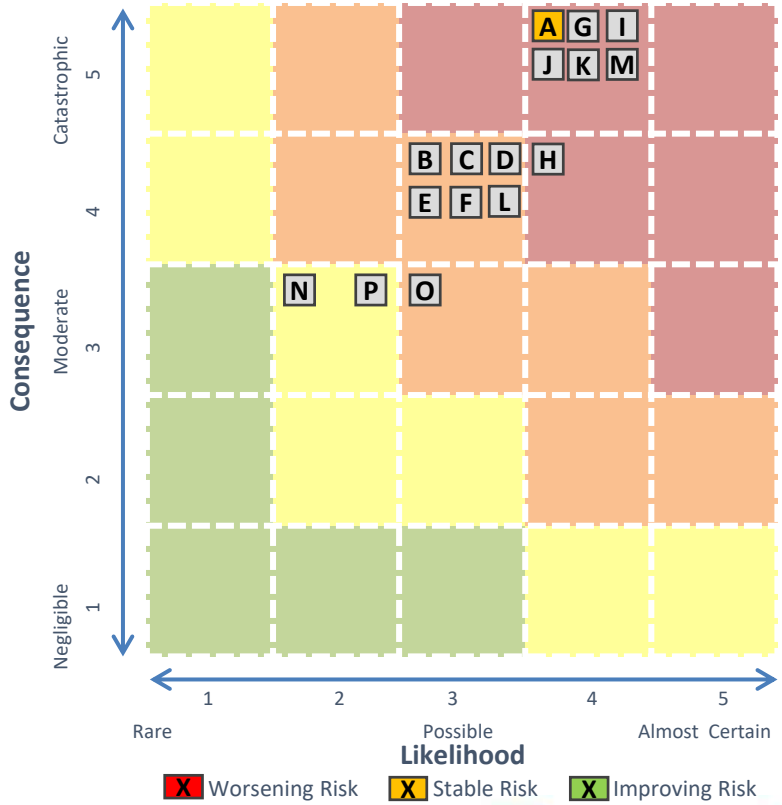
Norfolk and Norwich University Hospitals NHS Foundation Trust

4. Strategic Financial Risks

A detailed refresh of the Financial Risk Register has been performed, resulting in 16 key strategic and operational risks.

As part of FY21/22 annual planning, a detailed refresh of the Financial Risk Register has been performed, resulting in 16 key strategic and operational risks.

The Finance Directorate continues to formally review the Financial Risk Register, on a monthly basis, reviewing the risks and adding new risks which have been identified across the finance portfolio. As part of the monthly review of Financial Risk Register, 15 new risks have been identified and one remains unchanged.



	ID	Description	Risk Score	Prior Month
A	624	IF the Trust does not have a detailed financial strategy in place to deliver financial sustainability THEN the Trust will fail to achieve its strategic and operational priorities.	20	20
B	1534	IF the Trust is unable to generate the FY21/22 planned activity and case mix, THEN the income generated may be lower than planned levels.	12	New
C	1535	IF the Trust is unable to deliver the FY21/22 required activity levels per the national recovery framework, THEN additional funding available through the Elective Recovery Fund may not be available to invest back in recovering activity.	12	New
D	1536	IF the Trust's capacity plan does not reflect the available clinical space and workforce effective hours, THEN there is a risk that activity assumptions underpinning the FY21/22 plan are not valid, potentially leading to lower levels of income or higher levels of costs than planned through the use of third party capacity.	12	New
E	1539	IF the Trust does not deliver forecast activity growth levels within the identified cost envelope or IF there is a change in case mix to less profitable procedures, THEN this will lead to lower income as a proportion of cost levels driving a higher deficit than planned.	12	New
F	1540	IF the Trust creates additional capacity at additional cost to the Trust in order to reduce the waiting list, and does not secure the financial resources for this, THEN this will create additional cost pressures which will need to be mitigated through additional efficiency delivery, or the Trust will incur a higher deficit than planned.	12	New
G	1532	IF the Trust fails to control expenditure in line with the plan, including mitigation of identified but unfunded cost pressures, THEN the Trust will fail to deliver to plan, negatively impacting the I&E and cash position and increasing the distress funding requirement.	20	New
H	1533	IF the Trust enacts service developments or changes that result in an increase in cost that is not mitigated by a corresponding increase in the value of the Trust's income contracts, THEN the financial position will be negatively impacted.	16	New
I	1527	IF the efficiency requirement is not identified and delivered on an annual basis THEN the Trust is at risk of significantly failing its I&E and cash plans, alongside delivery of the Trust's Financial Strategy.	20	New
J	1529	IF the Trust does not deliver the financial improvements within its own control, THEN the access to technical solutions, including FRF, may no longer be available.	20	New
K	1526	IF the Trust is unable to manage its financial performance in line with the Operational Plan, THEN there is a risk that the Trust will require additional distress funding to meet its financial obligations.	20	New
L	1528	IF the Trust cannot secure sufficient emergency capital PDC to support the delivery of the capital programme, THEN the planned capital programme will be delayed, negatively impacting the ability to deliver planned activity levels and increasing costs leading to additional pressure to financial performance.	12	New
M	1548	IF additional or revised regulatory requirements do not align with the framework utilised in developing the Financial Strategy THEN additional financial pressures may arise, negatively impacting the Trust's ability to deliver sustainable financial improvement.	20	New
N	1549	IF cost inflation rates are higher than the levels assumed within the financial plan, THEN this will create additional cost pressures which will need to be mitigated through additional efficiency delivery.	6	New
O	1550	IF NHS funding is further restrained, for example as a result of wider government economic policy, THEN future income levels will be reduced and require reduction in the cost base to avoid deterioration of the deficit.	9	New
P	1551	IF there is material supply chain or economic disruption from Brexit, THEN costs may increase or activity delivery may be reduced.	6	New

Norfolk and Norwich University Hospitals NHS Foundation Trust

5. Cash

Cash at 30 April 2021 is £60.0m. The closing balance is high for the following main reasons: cumulative operational underspends in 2020/21, and exceptional capital creditors, accruals and levels of general debt. These are timing differences and expected to settle to normal levels during the first half year. The cash position at 30 September is forecast to be £40.7m.

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

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

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

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

The twelve month rolling cash flow forecast before revenue funding support shows the cash balance reducing during the second half year to negative funds of £6.6m at end March 2022, thus revenue support would be required .

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

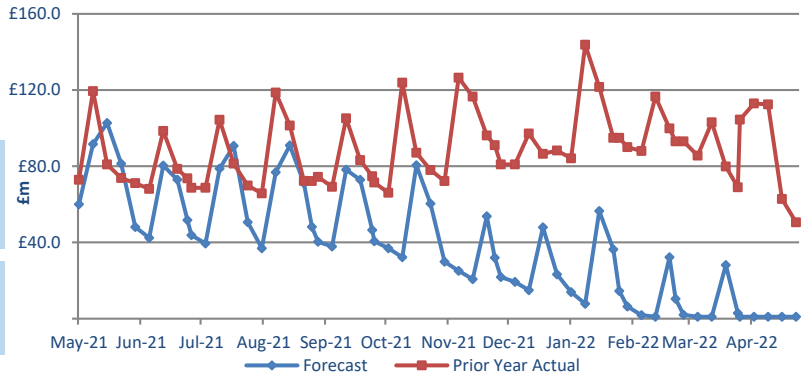
The availability of funding has been properly considered and guidance issued by NHSE/I in March 2021 stated that 'where providers do require supplementary revenue cash support providers will be able to apply for revenue cash support from DHSC via the NHSE/I capital and Cash team. Therefore should the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

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

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

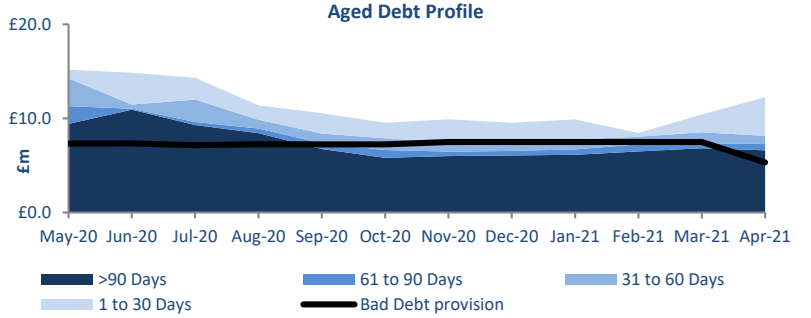
Aged Debt - Debtors at April 2021 are £11.6m, of which £6.9m is over 90 days. Of the NHS debt greater than 90 days, £1.4m is JPUH, no change from the prior month. Of the Non NHS debt greater than 90 days £2.1m relates to TPW, £0.5m relates to Big C and £0.9m relates to private/overseas patients. The Trust continues to focus on resolving these debts.

Weekly Closing Cash (£m)



Debtors by Type	Total Debt			Debt > 90 days		
	Feb-21 £m	Mar-21 £m	Apr-21 £m	Feb-21 £m	Mar-21 £m	Apr-21 £m
NHS	4.18	4.20	3.91	1.97	1.70	1.81
Non NHS	6.24	8.07	7.68	4.88	4.92	5.09
Total	10.42	12.27	11.59	6.84	6.62	6.90

Aged Debt Profile



Norfolk and Norwich University Hospitals NHS Foundation Trust

6.1 Activity (Income PbR)

New activity targets have been set by NHSE for Half 1 of 2021/22, targets being 70% of 2019/20 activity levels in April, increasing by 5% each month until July when the target is 85% and this will remain the target until September. Targets for H2 are not yet known. The Trust has devised its own internal plan, submitting a draft plan in early May in which overall the targets are met and exceeded across some points of delivery – over performance in Day Case and Outpatient attendances mainly outweighing the expected under performance in the harder to achieve areas of Elective inpatient and Outpatient Procedures. With this in mind recognition around benefits from the Elective Recovery Fund are treated prudently.

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

Whilst block funding remains in place, activity expectations have been set by NHSE/I, with targets for April being 70% of 2019/20 activity levels – across Elective (including Day Case) and Outpatients areas. In the event that these targets are exceeded there is potential for additional funding through the Elective Recovery Fund (see below). It is important however to note that performance is calculated on value of activity , not activity count and case-mix will therefore be significant.

Performance v 2021/22 Base Plan

Despite being block funded, full contract monitoring processing and reporting will still be completed so that true levels of activity and income can be understood – i.e. had the Trust been paid on a Payment by Results (PbR) basis. Currently these figures are based on a mixture of the 2021/22 Consultation Tariffs and in the absence of negotiations with Commissioners, some assumptions around locally agreed pricing.

A clinical income 'Base Plan' for 2021/22 has been derived from the 2020/21 draft annual plan, with some known changes reflected. A tariff inflator assumption of +1.4% has been used and demographic growth assumptions of +0.54% (based on expected population increase from ONS stats).

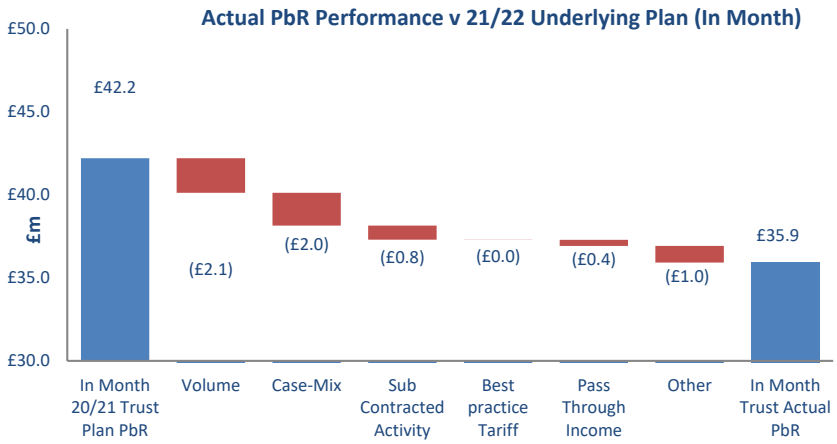
It must be noted that the figures on this and the next slide relate to NNUH activity only, and do not include any activity undertaken in the Independent Sector, nor Acute Service Integration.

The graph opposite shows that 'actual' performance would fall short of the 21/22 base plan, but there are signs of activity levels recovering to what could be considered normal. The financial variance for April 2021 is estimated at -£6.3m, this compares to an average monthly variance in 2020/21 of £11.5m shortfall. The variance of the 'best' month in 2020/21 (October) was -£8.9m.

Financial performance is currently very difficult to estimate in light of the potential case-mix changes that are likely. The prioritisation of urgent and cancer work means that the case-mix currently is likely to be quite different to what was seen in 2019/20 for example. This must be considered when thinking about potential benefits from the Elective Recovery Fund also.

Elective Recovery Fund

NHSE/I have introduced the Elective Recovery Fund (ERF) for the first half of 2021/22. A financial adjustment will be made in the event that 2019/20 activity targets are exceeded. In the event that the activity levels exceed the targets 100% of the financial value of that activity will be paid above block funding levels. In the event that activity levels exceed 85%, the value above 85% will be paid at 120%. Unlike the proposed Elective Incentive Scheme in 2020/21 no downside financial adjustment will be made in the event of under performance. It must be noted that any adjustment is calculated on overall system performance and there is no guarantee NNUH will received funds if over perform. It is important to note that the ERF achievement is calculated as a financial value of the activity, with specific methodology used to price that activity (it is different to standard National Tariff rules). The case-mix of the activity therefore is very significant in the calculations – for example it is quite possible that activity targets could be exceeded but the financial value of that activity does not exceed 2019/20 levels and no additional funding will be received.



Norfolk and Norwich University Hospitals NHS Foundation Trust

6.2 Activity - POD

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

Day Case & Elective Inpatient Spells

Provisional figures for April indicated that Day Case activity levels will exceed both NHSE expectations, and the Trust's recovery plan. This is the result of strong performance across many Medical Specialties, but it has to be noted that many Surgical Specialties have not met the NHSE expectations, Ophthalmology and Oral Surgery being most notable. Surgical Division has however exceeded the Trust's recovery plan for Day Case spells.

The number of Elective Inpatient spells however does remain much lower than that seen in 2019/20, with the NHSE compliance targets not being met. This is mainly small variance across many specialties, although T&O and ENT are notable negative variances.

In terms of the Trust's recovery plan for Elective Inpatient activity it is notable that Medical Specialties have fallen below planned levels, but Surgical Division have exceed the plan.

Outpatient Activity

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

Appointments with a procedure are expected to be 79% of 2019/20 levels. New attendances, without a procedure are expected to be 82% of 2019/20 levels and Follow Up 99%.

Strong performances seen in Cardiology and Urology. ENT is still finding it challenging to reach previous levels of outpatient procedures. Oral Surgery is an area in which it is also notable that activity levels are falling well short of NHSE expectations,.

The Trust's recovery plan is expected to be exceeded across all points of delivery.

Non Elective Spells (Including Maternity)

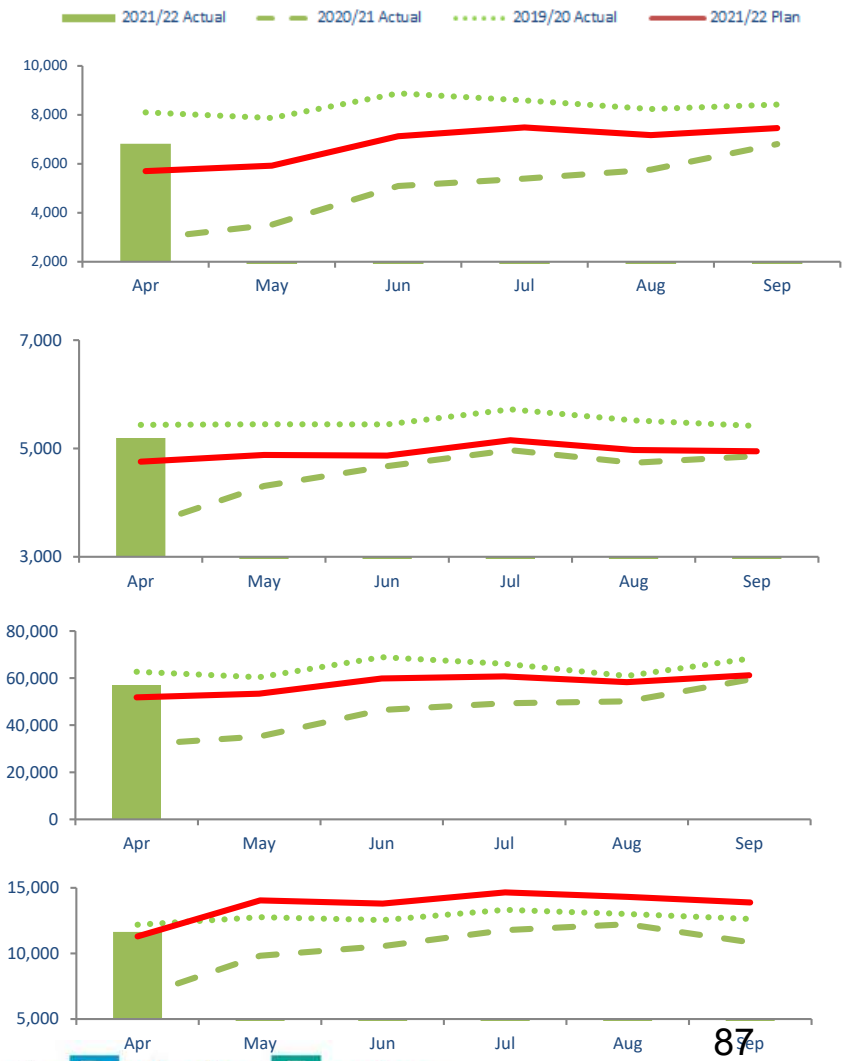
It can be seen from the graph opposite that non elective activity has increased from that seen in 2020/21. Whilst the graph indicates that activity levels are just below that in 2019/20 it should be noted that there was a change in recording of the Emergency Assessment Unit (Surgical) – EAUS – from December 2019, which results in c. 500 spells no longer being recorded as non-elective activity.

When comparing non-elective spell count in April 2021 to that seen in 2019/20 it is noticeable that both Medical and Women & Children divisions have seen greater number of cases in 2021 than in 2019. Once the EAUS change in recording is considered Surgical Specialties are seeing similar levels of activity.

A&E (Emergency Department

A&E activity levels in April 2021 are much more comparable to pre-COVID levels than what we have seen in the last 12 months. Activity levels in April were in excess of 90% of the average number of attendances in the first half of 2019/20.

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



Norfolk and Norwich University Hospitals NHS Foundation Trust

7. CIP

Year to date the Trust has delivered £0.7m of CIPs against a target of £0.8m, an adverse variance of £0.1m, comprised of: a planning variance of nil; and a performance variance of £0.1m. This has arisen through adverse performance in pay initiatives and additional in month expenditure for the voice recognition roll out. The risk adjusted forecast outturn CIP delivery is currently £14.4m against a CIP target of £26.4m presenting a significant risk to achievement of the target.

FY21/22 CIP Performance:

YTD the Trust has delivered £0.7m of CIPs against a target of £0.8m, an adverse variance of £0.1m, comprised of:

- A planning variance of nil; and
- A performance variance of £0.08m. This has arisen through adverse performance in pay initiatives and additional in month expenditure for the voice recognition roll out. It is anticipated that these variances will reduce in the remaining months of Q1.

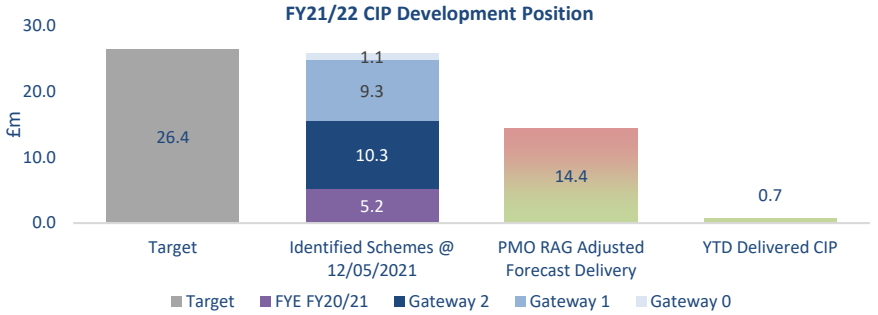
The risk adjusted forecast outturn CIP delivery for FY21/22 is currently calculated as £14.4m based on the latest forecast financial performance of Gateway 2 schemes, progress against milestone delivery and performance against quality and performance indicators.

FY21/22 CIP Plan Development

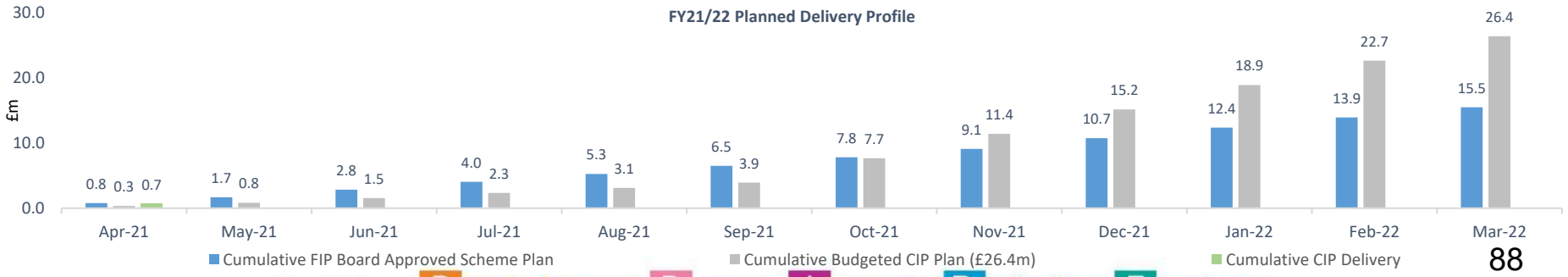
Due to the significant planning risk surrounding the efficiency programme as the Trust continues to develop plans, a CIP hedge of £13.8m has been offset against the £26.4m programme within the annual plan (Cycle 4).

As at 17 May 2021, the programme consists of £10.3m of Gateway 2 approved schemes; £5.2m of FYE of FY20/21 schemes; £9.4m of Gateway 1 approved schemes, which are being reviewed and developed to be progressed or removed from the programme; and £1.2m of schemes within the CIP development pipeline (Gateway 0).

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



FY20/21 CIP Plan - Divisional Breakdown	FY20/21 Indicative Target £m	FY20/21 FIP Board Approved £m	FYE FY20/21 £m	Gap £m	FY20/21 RAG Adj. Forecast Delivery £m	Gap £m
Medicine	7.2	5.6	2.4	0.9	7.8	0.6
Emergency & Urgent Care	1.1	1.1	0.3	0.3	1.4	0.3
Surgery	7.8	2.4	1.5	(4.0)	3.3	(4.5)
Women's & Children's	2.7	0.5	0.2	(2.0)	0.7	(2.0)
CSS	4.1	0.7	0.5	(2.9)	1.1	(3.0)
Corporate	3.5	0.0	0.2	(3.3)	0.2	(3.3)
Total	26.4	10.3	5.2	(10.9)	14.4	(12.0)



Norfolk and Norwich University Hospitals NHS Foundation Trust

8.1 Capital

Introduction and Background

This summary provides an update on the delivery of the Trust's capital plan as at 30 April 2021. The Trust's capital programme was approved by the Trust Board via cycle 4 of the financial planning process, totalling £52.4m.

A number of minor variations resulting from 2020/21 year-end adjustments were incorporated into the Trust's capital programme as part of cycle 4 budget setting.

Year to date performance – 30th April 2021

YTD Plan £'000	YTD Actual £'000	YTD Variance £'000	FY Plan £'000	FY OT £'000	FY Variance £'000
16,645	15,465	(1,180)	52,372	52,433	61

The Trust has underspent Plan by £1.2m YTD. Key drivers of the YTD variance are underspends on NNMC of £0.3m, theatres reconfiguration of £0.2m, Network Hardware Refresh of £0.1m and EDMS of £0.1m. The remaining £0.5m comprises small underspends on various projects.

Forecast Outturn

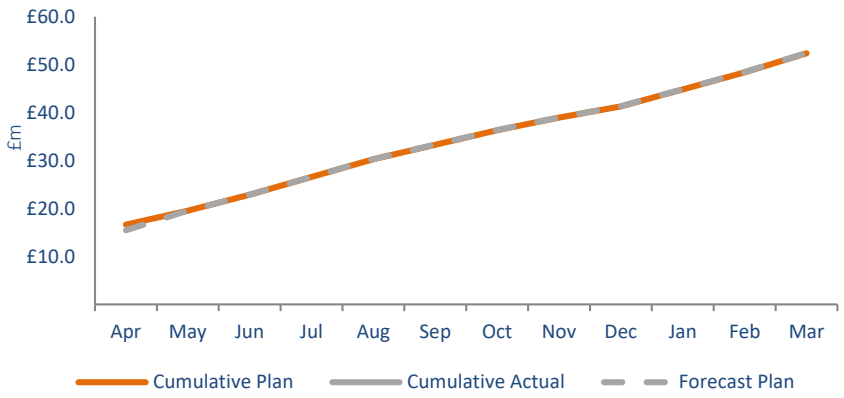
The current forecast is to deliver an outturn of £52.433m, against a plan of £52.372m. The difference of £0.061m is as a result of the Trust receiving a revised MOU for the Diagnostic and Assessment Centres, which is centrally funded and does not impact the Trust's allocation of system CDEL.

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

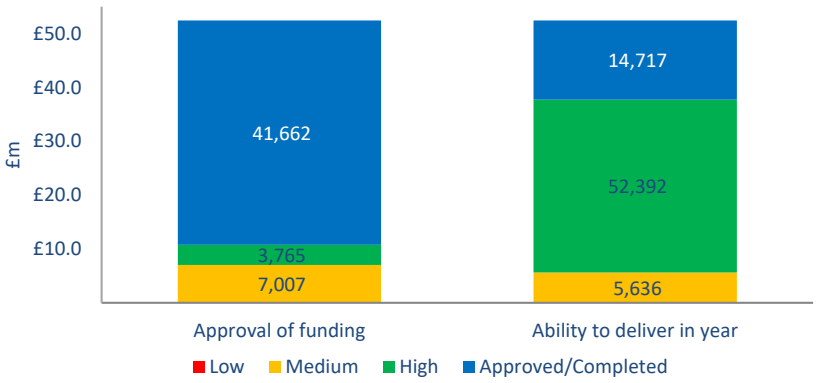
- An assessment based on approval of funding - £41.7m has been approved, which includes internally generated funding and the distress PDC already secured. £3.8m is yet to be approved for Digital Aspirant and is risk rated high as the Trust has agreed the LOA. The remaining £7m is yet to be approved and risk rated a medium. This includes £6.3m of distress funding and £0.7m of DAC PDC for the FBC development.
- An assessment based on the ability to deliver the projects – at present, all bar two schemes (investment in elective infrastructure and the electricity upgrade), have a high deliverability rating.

Programme leads have reviewed each scheme within the plan and assessed delivery, which is reflected in the charts to the right. Based on their assessments, there is high confidence of the forecast plan as being deliverable. However, given the 2020/21 performance, the Finance team will be implementing a new forecast process. This will encompass a check and challenge review as part of Q1 close-down. So far three schemes have been completed, being the PFI lifecycle capitalisation of £14.7m, £0.01m for Ward Block MTX Variations and £0.03m for planting around the Isolation Unit/Ward Block.

Plan v Actual



Confidence Rating



Norfolk and Norwich University Hospitals NHS Foundation Trust

9.1 Statement of Comprehensive Income

For the month of April 2021, the position is a surplus of £1.5m on a control total basis. This is a £0.7m favourable variance to plan of £0.9m surplus for the month. The favourable variance of £0.7m is made up of an underspend in pay of £0.7m & clinical supplies of £0.5m offset by reduced other income of £0.5m. £1.0m of out of system COVID expenditure is offset by £1.0m of income. The headline surplus which includes donated income of £0.4m and donated asset depreciation of £0.1m is £1.8m.

	In Month Month 1 - April 2022			Year to Date			Forecast Outturn April 2021 - September 2021		
	Actual £m	Trust Plan £m	Variance £m	Actual £m	Trust Plan £m	Variance £m	FOT £m	Trust Plan £m	Variance £m
Clinical Income	47.3	47.0	0.2	47.3	47.0	0.2	282.3	282.3	0.0
NT Drugs Income	1.6	0.9	0.6	1.6	0.9	0.6	5.6	5.6	0.0
Total Clinical Income	**48.8**	**48.0**	**0.9**	**48.8**	**48.0**	**0.9**	**287.8**	**287.8**	**0.0**
Other Income Incl. Non NHS Clinical Income	16.6	17.1	(0.5)	16.6	17.1	(0.5)	108.3	108.3	0.0
Total Operating Income	**65.4**	**65.0**	**0.4**	**65.4**	**65.0**	**0.4**	**396.2**	**396.2**	**0.0**
Medical Staff	(11.4)	(10.6)	(0.8)	(11.4)	(10.6)	(0.8)	(63.6)	(63.6)	0.0
Nursing	(13.8)	(14.0)	0.1	(13.8)	(14.0)	0.1	(83.1)	(83.1)	0.0
A&C	(4.1)	(4.4)	0.3	(4.1)	(4.4)	0.3	(26.1)	(26.1)	0.0
Other Staffing Groups	(6.3)	(6.4)	0.1	(6.3)	(6.4)	0.1	(38.1)	(38.1)	0.0
Other Employee Expenses	(0.2)	(0.9)	0.6	(0.2)	(0.9)	0.6	(6.4)	(6.4)	0.0
Total Employee Expenses	**(35.8)**	**(36.2)**	**0.3**	**(35.8)**	**(36.2)**	**0.3**	**(217.3)**	**(217.3)**	**0.0**
Drugs Costs	(7.8)	(6.9)	(0.8)	(7.8)	(6.9)	(0.8)	(41.6)	(41.6)	0.0
Clinical Supplies	(5.6)	(6.2)	0.6	(5.6)	(6.2)	0.6	(40.3)	(40.3)	0.0
Non Clinical Supplies	(7.9)	(8.0)	0.1	(7.9)	(8.0)	0.1	(54.4)	(54.4)	0.0
PFI	(2.2)	(2.2)	0.0	(2.2)	(2.2)	0.0	(13.4)	(13.4)	0.0
Total Expenditure Excl. Employee Expenses	**(23.4)**	**(23.4)**	**(0.1)**	**(23.4)**	**(23.4)**	**(0.1)**	**(149.6)**	**(149.6)**	**0.0**
Total Operating Expenditure	**(59.2)**	**(59.5)**	**0.3**	**(59.2)**	**(59.5)**	**0.3**	**(366.9)**	**(366.9)**	**0.0**
Total Operating Surplus/(Deficit)	**6.2**	**5.5**	**0.7**	**6.2**	**5.5**	**0.7**	**29.2**	**29.2**	**0.0**
Total Non Operating Expenditure	(4.7)	(4.7)	0.0	(4.7)	(4.7)	0.0	(29.2)	(29.2)	0.0
Total Surplus/(Deficit)	**1.5**	**0.9**	**0.7**	**1.5**	**0.9**	**0.7**	**0.0**	**0.0**	**0.0**
COVID (Out of System) Income	1.0	0.0	1.0	1.0	0.0	1.0	1.0	0.0	1.0
COVID (Out of System) Expenditure	(1.0)	0.0	(1.0)	(1.0)	0.0	(1.0)	(1.0)	0.0	(1.0)
Total Surplus / (Deficit)	**1.5**	**0.9**	**0.7**	**1.5**	**0.9**	**0.7**	**(0.0)**	**0.0**	**(0.0)**
Control Total Adjustments									
Donated Income & Equipment	0.4	0.9	(0.6)	0.4	0.9	(0.6)	2.7	2.7	0.0
Donated Assets Dep'n	(0.1)	(0.1)	(0.0)	(0.1)	(0.1)	(0.0)	(0.5)	(0.5)	0.0
Headline Surplus / (Deficit) (Excl. COVID)	**1.8**	**1.7**	**0.0**	**1.8**	**1.7**	**0.0**	**2.2**	**2.2**	**0.0**

Norfolk and Norwich University Hospitals NHS Foundation Trust

9.2 Pay Expenditure

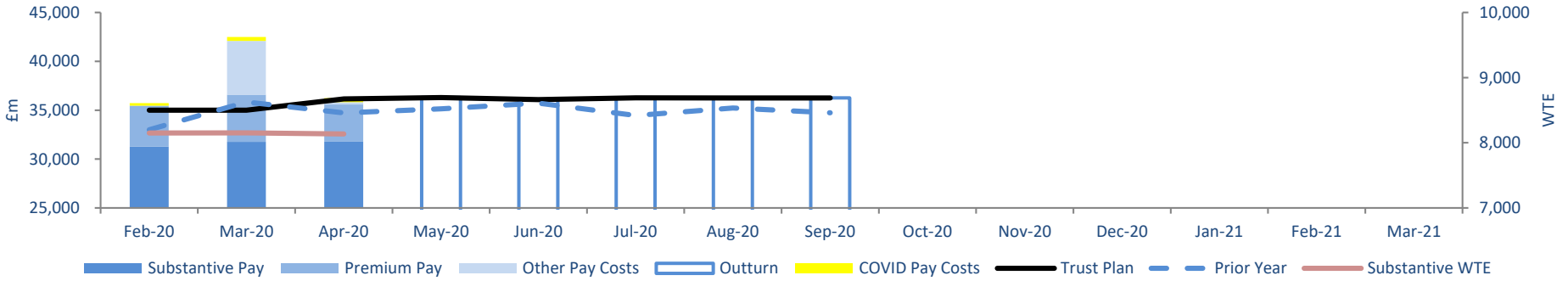
Year to date expenditure is £35.8m, a favourable position to plan of £0.3m. Predominantly as a result of vacancies against establishment in CSS.

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

Substantive WTE	Feb-21 WTE	Mar-21 WTE	Apr-21 WTE	May-21 WTE	Jun-21 WTE	Jul-21 WTE	Aug-21 WTE	Sep-21 WTE	Mar-22 WTE
A&C	1,566	1,566	1,563						
Medical	1,707	1,706	1,181						
Nursing			3,694						
Other			1,699						
Total	**8,151**		**8,136**						

Premium Source (Excl. Out of System COVID) YTD			Total Trust Total £m	Total Trust *Premium Cost* £m*
Medical	**Source**	Internal Locum	1.0	*0.2*
		External Locum	0.1	*0.1*
		WLI/NAG	0.3	*0.2*
		Total	**1.5**	***0.4***
Nursing	**Source**	Bank	1.3	*0.0*
		Overtime	0.4	*0.1*
		Agency	0.1	*0.0*
		Total	**1.8**	***0.1***
A&C & Other	**Source**	Bank	0.2	*0.0*
		Overtime	0.1	*0.0*
		Agency	0.2	*0.1*
		Total	**0.6**	***0.1***
Total	**Source**	Bank/Internal Locum	2.5	*0.2*
		Overtime	0.5	*0.2*
		Agency/External Locum	0.5	*0.2*
		WLI/NAG	0.3	*0.2*
		Total	**3.8**	***0.7***

** Incremental cost of premium staff over substantive staff*



Norfolk and Norwich University Hospitals NHS Foundation Trust

9.3 Statement of Financial Position

Property, plant and equipment
The key items are capital expenditure of £1.1m offset in part by depreciation of £1.7m, together with a £14.7m transfer from trade and other receivables relating to the capitalisation of a lifecycle maintenance prepayment.

Trade and Other Receivables – non current
This balance is £15.7m lower than the opening balance, with the key item being a transfer of £14.7m to PPE for the capitalisation of a lifecycle maintenance prepayment.

Trade and Other Receivables - current
This balance is £7.7m higher than the opening balance. The key items are £4.9m of income accruals and £1.6m of prepayments.

Cash
This is £9.0m lower than the opening balance. The key reasons are a reduction in capital creditors and capital accruals of £5.3m, and other working capital movements particularly accruals of £4.9m.

Trade and other payables
This is £9.5m lower than the opening balance. The key reason is the settlement of 1 of 2 credit notes (totalling £8m of £15.3m) raised to N&W CCG relating to repatriation of COVID unspent funds and a regional true-up of resources.

Borrowings
The £0.4m decrease in non-current borrowings relates to capital repayment for the PFI contract and Fuji PACS finance lease.

Deferred Income
This balance is £5.2m higher than the opening balance, £5.4m of which relates to Education funding received in advance of costs.

Total Taxpayers' and Others' Equity
This balance is £1.8m higher than the opening balance, this reflects the £1.5m surplus to date on a control total basis in addition to £0.3m of donated asset additions.

April 2021	Actual Mar-21 £m	Actual Apr-21 £m	Movement £m	Prior Month £m
Property, plant and equipment	349.0	363.1	14.1	349.0
Trade and other receivables	62.5	46.8	(15.7)	62.5
Total non-current assets	**411.5**	**409.9**	**(1.6)**	**411.5**
Inventories	13.1	13.1	0.0	13.1
Trade and other receivables	31.3	39.0	7.7	31.3
Cash and cash equivalents	68.9	59.9	(9.0)	68.9
Total Current assets	**113.3**	**112.0**	**(1.3)**	**113.3**
Trade and other payables	(114.3)	(104.8)	9.5	(114.3)
Borrowings - PFI & Finance Lease	(5.0)	(5.0)	0.0	(5.0)
Provisions	(0.5)	(0.3)	0.2	(0.5)
Deferred Income	(15.8)	(22.0)	(6.2)	(15.8)
Total current liabilities	**(135.6)**	**(132.1)**	**3.5**	**(135.6)**
Total assets less current liabilities	**389.2**	**389.8**	**0.6**	**389.2**
Borrowings - PFI & Finance Lease	(182.4)	(182.0)	0.4	(182.4)
Borrowings - Revenue Support	0.0	0.0	0.0	0.0
Provisions	(4.8)	(5.0)	(0.2)	(4.8)
Deferred Income	(5.3)	(4.3)	1.0	(5.3)
Total non-current liabilities	**(192.5)**	**(191.3)**	**1.2**	**(192.5)**
Total assets employed	**196.7**	**198.5**	**1.8**	**196.7**
Financed by				
Public dividend capital	290.7	290.7	0.0	290.7
Retained Earnings (Accumulated Losses)	(121.1)	(119.2)	1.9	(121.1)
Revaluation reserve	27.1	27.0	(0.1)	27.1
Total Taxpayers' and others' equity	**196.7**	**198.5**	**1.8**	**196.7**

REPORT TO THE TRUST BOARD

Date	**2 June 2021**
Title	**Chair's Key Issues from People and Culture Committee Meeting on 24.05.21**
Lead	**Professor David Richardson (Committee Chair)**
Purpose	**For Information, assurance and approval as specified**

1 Background/Context

The People and Culture Committee held its latest meeting on 24 May 2021. Papers for the meeting were circulated to Board members for information in the usual way. The meeting was quorate and was held in person and via MS Teams; it was attended by Mrs Janey Bevington and Mr Peter Bush (Public Governors) as observers.

2 Key Issues/Risks/Actions

The following items were identified to highlight to the Board:		
1	Review of Misconduct Policies	The Committee received a report regarding the Trust's Misconduct Policy – in light of findings of a national review of such policies following the suicide of an NHS employee in 2016. The **attached** report explains the background and revisions made. The Policy has been developed in collaboration with staff representatives, HR colleagues and the Lead FTSU Guardian. It incorporates 'Just Learning' principles and includes safeguards aimed to ensure that investigations are conducted in a timely fashion and in accordance with good practice and procedures. The Policy is **recommended** by the Committee to the Board for approval. The full draft Policy has been uploaded to the Resource Centre for ease of reference.
2	Modern Slavery Act Statement	The Committee reviewed and agreed the Trust's Slavery Act Statement, which was then incorporated in the draft Annual Report 2020/21 approved by the Board.
3	Gender Pay Gap Report	The Committee received a report regarding the gender gap in the Trust – being the difference in the average pay between all men and women in a workforce. The Trust is required to publish an annual review of any gender pay gap. The Committee was informed that a gender pay gap is discernible in the data however: *"The staff group/ banding analysis indicates that for all the AfC bands (1 to 9) there is no significant pay gap. In fact, for seven of the twelve AfC pay bands, the pay gap is in favour of females. Also, for the other five AfC pay bands, the pay gap in favour of men is small.* *Further analysis suggests that the gender pay gap can be attributed to the medical roles, which includes the overwhelming majority of the highest earning roles within NNUH. In these roles, there are disproportionately more men than women, in an organisation where 79.4% of the*

		workforce is female. Such is the disproportionality, relative to the pay rates for all staff groups; the gender pay gap is magnified." The Trust currently employs 499 medical consultants, a proportion of whom receive Clinical Excellence Awards, and this area is primarily responsible for the gender pay gap. The Committee was informed that over the past ten years there has been significant growth in the percentage of women in medical roles and, as these doctors grow in seniority, this should see the gender pay gap diminish with time. This analysis is helpful in identifying the target area on which to focus actions and attention.
4	Draft People & Culture Strategy	The Committee received a timeline for production of the Trust's People & Culture Strategy. The aim is for this to be available for review by the Board and People & Culture Committee by October 2021 and this will be factored into the Board's Annual Programme accordingly.
5	Committee Annual Report (2020/21)	The Committee reviewed its draft Annual Report and this was **agreed** for presentation to the Board (as **attached**). Recognising the constraints and priorities arising from the global pandemic, the Committee considers that it has achieved its Purpose so far as possible during 2020/21. Particular progress was noted in the realms of Freedom to Speak Up and Equality Diversity and Inclusivity. There are a number of key items for inclusion in the Committee Work Programme for the year ahead, to include: - implementation of relevant actions under the National People Plan - concordance with the requirements of the Operating Planning Guidance - development of the Trust's People and Culture Strategy - workforce planning and the Trust's Strategic Objectives with respect to education & training of staff and healthcare professionals.
6	Committee Terms of Reference	In light of its annual review, the Committee reviewed its Terms of Reference and **agreed to recommend** these to the Board for approval (as **attached**). The Committee considered whether it wished to propose substantive revision to its membership but decided against against this. The ToRs already include provision for attendance by divisional deputies if Chiefs of Division cannot attend and this is to be encouraged.
7	Role of the Staff Wellbeing Guardian	At its meeting in February 2021 the Board ratified the proposal that the Chair of People & Culture Committee should be the nominated Board level staff Wellbeing Guardian to fulfil the role required by the National People Plan (the People Plan recommends that the Wellbeing Guardian should be a NED). Since that time, national guidance has been issued with respect to the role – it is more extensive than expected. To ensure appropriate 'check and challenge' there may be an advantage to separation of the roles of Wellbeing Guardian and Chair of P&C.

3 Conclusions/Outcome/Next steps

The next meeting of the Committee is scheduled for 26 July.

Recommendation:

The Board is recommended to:

- **note** the work of its People and Culture Committee;
- **approve** the Trust's new Misconduct Policy;
- **receive** the Committee's Annual Report;
- **approve** the Committee's updated Terms of Reference.

REPORT TO TRUST BOARD	
Date	Wednesday 2nd June 2021
Title	NHS England & Improvement Guidance Recommendations relating to the management and oversight of local investigation and disciplinary procedures.
Author & Exec lead	Amy Knights, Head of HR Corporate Development, for Paul Jones, Chief People Officer
Purpose	To provide an overview of the guidance issued to Trust Chairs and Chief Executives, with an update summary of our organisational response, including revisions to our Misconduct Policy.

Background

In May 2018, the Chair of NHS Improvement wrote to NHS Chairs and Chief Executives to share the outcomes of a piece of work they had undertaken in response to a very tragic event that occurred at a London NHS trust three years previously. An individual subject to a disciplinary procedure committed suicide following their dismissal.

This triggered an independent inquiry with the findings reported to the board of the employing Trust and to NHS Improvement in August 2018. The report concluded that, in addition to serious procedural errors the individual had been treated very poorly, to the extent that their mental health was severely impacted. The report recommendations were accepted by the Trust, in full.

Subsequently, NHS Improvement established a 'task and finish' Advisory Group to consider to what extent the failings identified in this case were more widespread across the NHS, and what learning could be applied. The analysis highlighted several key themes included: poor framing of the allegations; inconsistency in the fair application of local policies; lack of adherence to best practice guidance; variation in the quality of investigations; shortcomings in the management of conflicts of interest; insufficient consideration of the health and wellbeing of individuals; and an over-reliance on the immediate application of formal procedures, rather than consideration of alternative responses to concerns.

Lessons Learned on the management of local investigations was issued to all NHS organisations, based on the Advisory Group's recommendations. The request was to review the guidance and assess our own procedures and make adjustments where required. The seven identified recommendations were as follows:

NHS England and Improvement identified Guidance/ Recommendations relating to the management and oversight of local investigation and disciplinary procedures
1. Adhering to best practice a) The development and application of local investigation and disciplinary procedures should be informed and underpinned by the provisions of current best practice, principally that which is detailed in the Acas 'code of practice on disciplinary and grievance procedures' and other non-statutory Acas guidance; the GMC's 'principles of a good investigation'; and the NMC's 'best practice guidance on local investigations'. b) All measures should be taken to ensure that complete independence and objectivity is maintained at every stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are acknowledged and appropriately mitigated (this may require the sourcing of independent external advice and expertise).

2. Applying a rigorous decision-making methodology

a) Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology should be applied that provides for full and careful consideration of context and prevailing factors when determining next steps.

b) In all decision-making that relates to the application of sanctions, the principle of plurality should be adopted, such that important decisions which have potentially serious consequences are very well informed, reviewed from multiple perspectives, and never taken by one person alone.

3. Ensuring people are fully trained and competent to carry out their role

Individuals should not be appointed as case managers, case investigators or panel members unless they have received related up to date training and, through such training, are able to demonstrate the aptitude and competencies (in areas such as awareness of relevant aspects of best practice and principles of natural justice, and appreciation of race and cultural considerations) required to undertake these roles.

4. Assigning sufficient resources

Before commencing investigation and disciplinary procedures, appointed case managers, case investigators and other individuals charged with specific responsibilities should be provided with the resources that will fully support the timely and thorough completion of these procedures. Within the overall context of 'resourcing', the extent to which individuals charged with such responsibilities (especially members of disciplinary panels) are truly independent should also be considered

5. Decisions relating to the implementation of suspensions/exclusions

Any decision to suspend/exclude an individual should not be taken by one person alone, or by anyone who has an identified or perceived conflict of interest. Except where immediate safety or security issues prevail, any decision to suspend/exclude should be a measure of last resort that is proportionate, timebound and only applied when there is full justification for doing so. The continued suspension/exclusion of any individual should be subject to appropriate senior-level oversight and sanction.

6. Safeguarding people's health and wellbeing

a) Concern for the health and welfare of people involved in investigation and disciplinary procedures should be paramount and continually assessed. Appropriate professional occupational health assessments and intervention should be made available to any person who either requests or is identified as requiring such support.

b) A communication plan should be established with people who are the subject of an investigation or disciplinary procedure, with the plan forming part of the associated terms of reference. The underlying principle should be that all communication, in whatever form it takes, is timely; comprehensive; unambiguous; sensitive; and compassionate.

c) Where a person who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a 'never event' which therefore is the subject of an immediate independent investigation commissioned and received by the board. Further, prompt action should be taken in response to the identified harm and its causes.

7. Board-level oversight

Mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Associated data collation

and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt.

NHSI wrote to all NHS organisations requesting that by 30 June 2021, they should have reviewed all disciplinary policies and procedures against the guidance recommendations and specifically asked that:

- Disciplinary Policy is reviewed and discussed at a public Board or equivalent and
- Updated Policy is made available on our organisation's public website.

NNUH Misconduct Policy

In September 2018, a new Misconduct Policy was launched, which was written and agreed in partnership with staff side representatives, and replaced the Disciplinary Policy. The key changes included:

- Inclusion of 'Know your Staff' principles our compassionate approach to people management
- A new Fast track process
- Suspension decision making
- Accreditation/ training for key roles
- Explicit reference to MHPS
- A new Investigation Toolkit and template letters
- Clarity of roles/ expectations:
  - Role of the Commissioning Manager
  - Role of the Investigating Officer
  - Panels

Specific action taken in response to NHSE/I guidance recommendations

A Misconduct Review group was formed earlier this year, with colleagues from HR, Staff side and our Freedom to Speak Up Guardian. Members have discussed and fully considered the guidance recommendations and have agreed amendments to the Misconduct Policy (attached), which were approved by the Pay & Conditions of Service (PACS) Group and approved by the People & Culture Committee. The main changes include:

- Inclusion of Just Learning principles
- Inclusion of a 'Review of Events' process to be undertaken prior to a decision to progress a formal investigation
- Suspension considerations have been strengthened in the revised policy, along with a requirement to carry out a suspension risk assessment, prior to any suspension decision.
- Where a suspension extends over 28 days it will be escalated to the triumvirate/ Head of Department and will also be reported to the Workforce & Education Board.
- Progress of formal Misconduct cases will be reported on a monthly basis to the Workforce & Education Board. This will highlight the number and length of suspensions, length of formal investigations and highlight where a case is be escalated to the Divisional Management Triumvirate/ Head of Department (for Corporate Departments). This would consider if any further management intervention or review is required.
- Strengthened employee health and wellbeing considerations, to be made during misconduct processes.
- A lesson learned review will be completed by the Commissioning Manager and submitted to the Divisional Management Triumvirate/ Head of Department (for Corporate Departments) to consider any further management intervention required to address any systemic lessons learnt.
- Provide clarity on the responsibilities of key roles and levels of decision making.

The revised Misconduct Policy will be published on the NNUH website before 30 June 2021. The Misconduct Review Group will continue to meet to develop policy supporting materials (which will be available on the Staff Hub page), and ensure the delivery for key roles. It is recognised that the inclusion of the Just Learning principles is an organisational development and it may take time to truly embed this approach as part of our normal way of working across the organisation.

Recommendations:

The Trust Board is recommended to approve the Misconduct Policy revisions and confirm assurance that the actions for the NHSE/I recommendations have been adopted.

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

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

PEOPLE AND CULTURE COMMITTEE ANNUAL REPORT 2020/21

1. Introduction

The People and Culture Committee is established under Board delegation, in accordance with Standing Orders and with approved Terms of Reference. The Committee's Terms of Reference were last reviewed and approved by the Board in February 2020. They are available to public and staff through the Trust intranet and website.

This Annual Report has been prepared in satisfaction of the requirement in the Terms of Reference that the Committee should generate an Annual Report including *"reporting on the work of the Committee, member attendance and the results of its annual review of performance and function".*

In accordance with the Trust's Organisational Framework for Governance, the Audit Committee will consider the work of the other Board Assurance Committees, as part of its overview of the systems and processes of integrated governance. At its meeting in May 2021 the Audit Committee is accordingly scheduled to receive the Annual Reports of the Quality & Safety Committee, People & Culture Committee and Finance, Investments Committee, for information.

2. Committee Membership and Meetings

2.1 Membership

Membership of the Committee consists of three Non-Executive Directors, Chief Executive, Chief People Officer, Chief Operating Officer, Chief Nurse, Medical Director and Chiefs of Division.

2.2 Meetings

During 2020/21 six meetings of the People and Culture Committee were held and attendance was as set out in the table below.

	28.05.20	18.06.20	24.07.20	26.10.20	25.01.21	29.03.21
Board members						
Prof David Richardson (Chair and Non-Executive Director)	✓	✓	✓	✓	✓	✓
Mr Chris Cobb (Chief Operating Officer)	X	X	X	X	X	X
Prof Erika Denton (Medical Director)	✓	✓	✓	✓	✓	✓

	28.05.20	18.06.20	24.07.20	26.10.20	25.01.21	29.03.21
Ms Sandra Dinneen (Non-Executive Director)	✓	X	✓	✓	✓	✓
Prof Nancy Fontaine (Chief Nurse)	X	✓	✓	✓	X	✓
Mrs Joanna Hannam (Non-Executive Director)	✓	X	✓	✓	✓	✓
Mr Sam Higginson (Chief Executive)	X	✓	✓	✓	✓	X
Mr Paul Jones (Chief People Officer)	✓	✓	✓	✓	✓	✓
Divisional members						
Dr Richard Goodwin (CoD - Clinical Support Services)	✓	X	X	X	*	X
Dr Tim Gilbert (CoD – Medicine and Emergency Services)	X	X	✓	✓	*	✓
Dr Caroline Kavanagh (AMD - Emergency and Urgent Care)	✓	X	X	✓	*	✓
Dr Tim Leary (CoD - Surgery)	✓	✓	X	X	*	**
Mr Jo Nieto (CoD - Women and Children)	✓	X	X	X	*	**

* Attendance was not expected due to acute operational position

** Attendance was via deputies

The Terms of Reference stipulate that to be quorate, meetings of the Committee must be attended by at least 3 members of the Committee, with at least 1 Non-Executive Director and 2 Executive Directors. Each meeting held in 2020/21 has therefore been quorate. It must however be noted that attendance at this Committee has been less consistent than that for the other Board committees. The Terms of Reference specify that members will be required to attend 75% of Committee meetings in any one year. There are a number of members who have not met this threshold and there may be a number of reasons for this.

The People & Culture Committee is unique amongst the Board Assurance Committees in having members who are not members of the Board. This was intended to convey a role-modelling message of inclusion - but the level of non-attendance creates a risk that it may perceived that the remit of this committee is seen as less important than finance, performance or quality.

Attendance by non-members:
In addition to Committee members, meetings of the Committee have been routinely attended by Ms Frances Dawson (Lead Freedom to Speak-Up Guardian), Ms Sarah Pask (Head of Organisational Learning and Development), Professor Diane DeBell and Mrs Carol Edwards (Link Governor Observers). The work of the Committee is supported by the Board Secretary and his Assistant.

Other Directors and officers of the Trust have attended meetings when required. To mitigate the impact of the pandemic 'lockdown' restrictions on attendance at the hospital, the majority of meetings during 2020/21 (May, June, January & March) have been attended remotely by the Trust Chairman.

2.3 Reporting

In common with other Board committees, the papers for the People and Culture Committee are circulated to all Board members for information in advance of its meetings, via the Diligent Board system.

In accordance with its Terms of Reference, a report from each Committee meeting has been made to the Board of Directors, as below:

P&C Committee meeting	Corresponding Report to Board
28 May 2020	3 June 2020
18 June 2020	24 June 2020
24 July 2020	5 August 2020
26 October 2020	4 November 2020
25 January 2021	3 February 2021
29 March 2021	7 April 2021

3. Committee Work Programme & Annual Review

3.1 Annual Review of Committee Effectiveness

In accordance with its Terms of Reference, the Committee reviewed its performance and satisfaction of its Terms of Reference. This involved:

- Questionnaire feedback from Committee members;
- Review of evidence of performance against ToRs;
- Look-back at reports received in the last year.

During 2020/21 the work of the Committee has obviously been influenced by the pandemic, and its reporting schedule has reflected Covid-related risks and priorities - consistent with national guidance to avoid distraction from the operational response to the pandemic. In addition to giving appropriate focus to our pandemic response, this year the Committee has also sought to support and obtain assurance with regard to other areas of Trust activity and achievement of broader Strategic Objectives, where possible. This has involved focus on topics including:

- Regional Covid surge centre mobilisation (April '20)
- Support of staff during the pandemic and in restoration of services (May & July '20 & Jan '21);
- Actions in response to the Staff Survey (May & October '20 & Jan & March '21);

- Workforce disparities exacerbated by the pandemic (June ’20);
- Lessons learned from the pandemic (July ’20);
- Leadership Strategy (July ’20);
- Freedom to Speak-Up (July October ’20 & Jan ‘21);
- Health & Safety (July ’20)
- Equality Diversity Inclusion (July ’20);
- Education (Jan ’21)
- Flu vaccination (October ’20);
- Gap Analysis on the National People Plan and priorities for NNUH (October ’20, Jan & March ’21);
- Workforce Cost Improvement Programme.

The Committee noted the feedback from the Board Questionnaire – with 10 out of 15 responses agreeing or strongly agreeing that the Committee effectively performs its role, as below. This suggests that there is some room for improvement to enhance the valuable role of the Committee.

3	COMMITTEE STRUCTURE	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
3.5	**People & Culture Committee:** 3.5.1 Communication to the full Board on the activities of the People and Culture Committee is adequate and appropriate			3	9	3
	3.5.2 The People and Culture Committee effectively performs its role.			5	7	3

As part of its self-assessment, the Committee discussed the option of whether to set itself objectives and agreed that this would not be helpful at this time – the Trust already has a series of clear priorities and objectives.

The outcome of the review and member feedback was that there was clear evidence of the Committee acting in accordance with its Terms of Reference. However there are other themes apparent:

- the ability to engage with the Committee in the last year has been adversely affected by the pandemic;
- there is debate about the Membership and whether this should be bigger or smaller;
- whether focus of the Committee is correctly positioned between engagement with staff and gaining assurance for the Board.

At its meeting in May ’21 the Committee is scheduled to review its Terms of Reference in order to agree any recommendations for change to be made to the Board.

3.2 Work Programme

In accordance with its established practice, the Committee has an agreed annual cycle of business and a Work Programme of reports to be received at future meetings. In this way the Committee ensures that all aspects of its Terms of Reference are fulfilled and there is clear advance notice to those who are responsible for producing reports of the timetable for them to do so.

The Committee review confirmed that there is evidence of the Committee receiving reports in accordance with its Terms of Reference. It is however also clear that the disruption to the regular reporting cycle this year has been such that in a number of areas duties specified in the Terms of Reference were undeliverable. In part this was due to the need to focus on the most pressing operational matters, but areas 'squeezed out' this year have included focus on education, workforce planning and development of our People & Culture Strategy.

In May 2021 the Committee is scheduled to review its Work Programme for 2021/22, which will pick-up items that could not be covered during 2020/21.

4. Conclusion

The Terms of Reference for the People and Culture Committee specify that its **Purpose** is to:

i) provide assurance to the Board that the Trust has appropriate and effective strategies and plans relating to workforce, education, organisational development and culture, so as to enable the Trust to meet its Strategic Objectives;

ii) assist the Board in establishing ambitious but realistic goals and targets in relation to workforce, education, organisational development and culture and obtain assurance on implementation of the plans to achieve those goals and targets;

iii) act as a link to staff, stakeholders and strategic partners and provide a forum for discussion and consideration of best practice reports, guidance and initiatives relating to workforce, education, organisational development and culture, to enable the Trust to continue its progress towards being a provider of outstanding care to patients and an employer and education provider of choice.

Recognising the constraints and priorities arising from the global pandemic, the Committee considers that it has achieved this Purpose so far as possible during 2020/21. The Committee considers that the Audit Committee and Board are accordingly entitled to take assurance from the work of the People and Culture Committee as part of the Trust's system of integrated governance.

Based on its consideration of reports and information through the course of 2021/21, the Committee considers that **the most significant risks** relating to the domains of People and Culture are:

	Area of significant risk and concern (People & Culture Committee remit)	Cross-referencing
1	**Service demands exceed the number of available and affordable staff (especially in specialist areas)** (*IF the Trust is unable to afford, recruit or retain sufficient numbers of appropriately trained staff THEN this may have an adverse impact on quality, staff experience and may result in premium pay costs)*	**CRR:1293, 1002, 654, 890, 931 & 1096** **BAF 5.3**
2	**Potential deficit in staff health & well-being, motivation, engagement & resilience may impact on quality of care, performance and efficiency** *(IF staff feel unwell, tired, disillusioned, disrespected, disappointed and demotivated THEN recruitment, retention and resilience will suffer, staff will not perform at their best and will not identify the Trust as a good place to work or to be cared for)*	**CRR: 1411** **BAF 1.4**
3	**We do not train sufficient staff to meet our current & future needs** *(IF we do not adequately plan and anticipate our future workforce needs and educate sufficient specialist staff THEN we will be unable to maintain and develop services for patients and will incur additional costs in seeking to attract staff educated elsewhere)*	**CRR:** **BAF 1.5, 2.4, 3.2 & 5.3**
4	**Sub-optimal workforce, leadership and management processes and practices** *(IF leadership and line management practices do not follow best practice and are not adequately supported by operational policies, processes and structures THEN efficiency, performance and staff experience will suffer and staff will not be supported to realise their potential)*	**CRR:** **BAF: 4.4, 5.4**
5	**Very significant underlying financial deficit and relatively immature culture and processes of delivering long-term sustainable cost improvement** *(IF the Trust does not develop a culture of optimised workforce practices, business planning, financial management, operational efficiency and long term cost improvement THEN it will fail to comply with financial regulatory requirements and achievement of sustainable high quality clinical services)*	**CRR: 624 & 1034** **BAF: 5.1, 5.2, 5.3 & 5.4**

These matters will inform the focus of the Committee in the year ahead.

PEOPLE AND CULTURE COMMITTEE

TERMS OF REFERENCE

1 CONSTITUTION AND PURPOSE

1.1 As part of the Trust's Governance Structure, a committee of the Board of Directors has been established to be known as the People and Culture Committee (hereafter *'the People and Culture Committee'* or '*the Committee'*).

1.2 The **Purpose** of the Committee is to:

i) provide assurance to the Board that the Trust has appropriate and effective strategies and plans relating to workforce, education, organisational development and culture, so as to enable the Trust to meet its Strategic Objectives;

ii) assist the Board in establishing ambitious but realistic goals and targets in relation to workforce, education, organisational development and culture and obtain assurance on implementation of the plans to achieve those goals and targets;

iii) act as a link to staff, stakeholders and strategic partners and provide a forum for discussion and consideration of best practice reports, guidance and initiatives relating to workforce (including health and well-being), education, organisational development and culture, to enable the Trust to continue its progress towards being a provider of outstanding care to patients and an employer and education provider of choice.

2 AUTHORITY

2.1 The Committee has no executive powers other than those specified in these Terms of Reference or as requested by the Trust Board. The Committee is authorised to investigate any activity within its Terms of Reference and all Trust staff are expected to co-operate with the Committee to facilitate satisfaction of its duties.

2.2 The Committee has authority to establish sub groups or working groups as it considers appropriate, efficient and necessary. Such reporting committees or working groups are listed at section 9 below and responsibility for overseeing the work of such committees rests with the Committee.

2.3 The Committee has authority for approval and monitoring implementation of policies relevant to its Terms of Reference, as specified at section 10.

3 MEMBERSHIP

3.1 Membership of the Committee shall comprise:

- Three Non–Executive Directors
- Chief Executive
- Chief People Officer
- Chief Operating Officer
- Chief Nurse
- Medical Director
- Chiefs of Division

3.2 The Committee will review its membership annually to ensure that it meets the requirements of the Trust. Members will be required to attend 75% of Committee meetings in any one year.

4. MEETINGS, ATTENDANCE AND QUORUM

4.1 Only members of the Committee are entitled to be present at its meetings. The Committee may however invite non-members to attend its meetings as it considers necessary, at the discretion of the Chair, and typically the following will be invited to attend meetings of the Committee as relevant Agenda items apply:

- Head of Organisational Development and Learning
- Director of Postgraduate Medical Education
- Lead for Non-Medical Education
- Lead Freedom to Speak-Up Guardian
- Guardian of Safe Junior Doctors Working Hours
- Responsible Officer for Medical Appraisal

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

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

4.4 Meetings of the Committee shall be Chaired by one of the Non-Executive Director members, with another acting as deputy in his/her absence. Responsibility for calling meetings of the Committee shall rest with the Committee Chair.

4.5 Meetings of the Committee shall be scheduled to take place at least quarterly and otherwise at a frequency sufficient to enable the Committee to satisfy its Purpose.

4.6 To be quorate at least 3 members of the Committee must be present with at least 1 Non-Executive Director and 2 Executive Directors.

4.7 If any member is unable to attend a meeting of Committee they may arrange for a substitute to attend in their place, with the agreement of the Committee Chair, and their substitute shall be counted for the purposes of quoracy.

4.8 A record of Action Points arising from meetings of the Committee shall be made and circulated to its members. Formal minutes must be kept as an account of the meeting together with agreed actions and decisions.

5 SUPPORT ARRANGEMENTS

5.1 The Board Secretary will arrange for appropriate administrative support to be provided to the Committee.

5.2 The Committee shall operate as follows:

- The Committee will routinely meet monthly unless agreed otherwise.
- The Committee will establish an annual work programme, summarising those items and reports that it expects to consider at forthcoming meetings.
- Agendas for forthcoming meetings will be based on the Work Programme, reviewed by the Committee and agreed with the Committee Chair.
- Papers for the meeting should be submitted to the Committee secretary a minimum of 6 working days prior to the meeting. Papers on other matters will be put on the agenda only with the prior agreement of the Chair.

- Papers will be sent out by the Committee secretary at least 4 days before each meeting.
- To facilitate oversight by the Board of Directors of matters relating to people and culture, papers for meetings of the Committee will be circulated for information to those members of the Board who are not members of the Committee.
- Minutes will be prepared after each meeting of this Committee within 14 days and circulated to members of the Committee and others as necessary once confirmed by the Chair of the Committee. A record of action points arising from meetings of the Committee shall be made and circulated to its members with the minutes.
- Following each meeting of the Committee, the Chair of the Committee shall make a report to the next meeting of the Board of Directors highlighting any issues that require its particular attention, or require it to take action.
- The Terms of Reference of the Committee will be reviewed annually and will only be changed with the approval of the Trust Board.

6 DECLARATIONS OF INTEREST

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

7 DUTIES

In furtherance of its Purpose, particular duties of the Committee shall be to provide assurance to the Board in relation to:

7.1 obtain assurance on behalf of the Board that the Trust has appropriate and effective strategies and plans relating to workforce, education, organisational development and culture, so as to enable the Trust to meet its Strategic Objectives;

7.1.1 oversee development and monitoring of strategies and plans in relation to **Workforce** including:

a) workforce planning – to ensure that the Trust has sufficient and appropriately trained staff in the short, medium and long term to provide high quality care and services;

b) strategies to promote and protect staff Health & Wellbeing;

c) plans regarding staff recruitment, retention and remuneration;

d) succession planning and talent management;

e) staff appraisal and performance management.

7.1.2 oversee development and monitoring of strategies and plans in relation to **Education** including:

a) undergraduate and postgraduate education of healthcare professionals – both medical and non-medical;

b) professional development of non-clinical staff;

c) opportunities for development of new or innovative roles to promote cost-effectiveness and quality improvement in delivery of the Trust's services;

d) recognising the interrelationship between research and education and the benefits of developing clinical academic and joint posts with strategic partners.

7.1.3 oversee development and monitoring of strategies and plans in relation to **Organisational Development and Culture** including:

a) strengthening the organisational culture in accordance with the Trust's PRIDE values – notable for the hallmarks of People-focus; Respect; Integrity; Dedication and Excellence;

b) promotion of a culture in which Staff recommend the Trust:
i) as a place to work and deliver care and
ii) as a place for patients to receive care;

c) ensuring that staff feel free to speak-up, able to raise suggestions or concerns about the Trust, to enhance economy or efficiency in the Trust, the quality or safety of its services or workplace relations;

d) developing leaders and leadership within the Trust and the wider health and social care system;

e) plans to develop and maintain a motivated, engaged and resilient workforce;

f) arrangements for staff empowerment and responsibility through appropriate delegation of responsibilities within a robust performance and accountability framework.

7.2 assist the Board in establishing ambitious but realistic goals and targets in relation to workforce, education, organisational development and culture and obtain assurance on the effective implementation of the plans to achieve those goals and targets;

7.2.1 establish and keep under review appropriate metrics regarding to the remit of the Committee in order to obtain assurance on behalf of the Board of Directors, including but not limited to:
- rates of sickness and absence;
- rates of vacancy and recruitment 'time to hire';
- equality, diversity and inclusion;
- job-planning, appraisal and mandatory training;
- staff satisfaction feedback (including survey and exit feedback results);
. rates of premium pay spending and compliance with workforce budgets;

7.2.2 receive reports on Divisional performance relating to the remit of the Committee, undertaking more detailed reviews as indicated.

7.2.3 promote innovation and improvement in the Trust's management of its workforce to enhance economy, efficiency, patient experience and outcomes;

7.3 act as a link to staff, stakeholders and strategic partners and provide a forum for discussion and consideration of best practice reports, guidance and initiatives relating to workforce, education and organisational development and culture, to enable the Trust to continue its progress towards being a provider of outstanding care to patients and an employer and education provider of choice.

7.3.1 receive and review reports relevant to the remit of the Committee, including those produced from time to time by or relating to:
- junior doctors surveys
- Guardian of Safe Junior Doctors Working Hours
- Health Education England (HEE)
- GMC
- undergraduate satisfaction surveys
- national Staff Survey
- Freedom to Speak Up feedback

7.3.2 consider best practice arrangements for enhancing staff engagement and communication;

7.4 review risks and mitigation related to the Trust's workforce and review reports or extracts from the Board Assurance Framework and Corporate Risk Register as relevant to the remit of the Committee;

7.5 consider matters referred to it by the Board or otherwise as relevant to its duties, provide appropriate recommendations to the Board and otherwise report back as required and appropriate;

7.6 oversee work of those reporting groups identified at section 10 below, approving their Terms of Reference and receiving such reports as the Committee considers appropriate;

7.7 undertake an annual review of Committee effectiveness and satisfaction of these Terms of Reference.

8 PROCESS FOR MONITORING COMMITTEE EFFECTIVENESS

8.1 The Committee shall submit an Annual Report to the Trust Board, reporting on the work of the Committee, member attendance and the results of its annual review of performance and function.

8.2 The Committee will carry out an annual review of its performance and function in satisfaction of these Terms of Reference and report to the Board on any consequent recommendations for change.

9 REPORTING COMMITTEES

9.1 The following committees or working groups have been established to report to the Committee:
- Nil currently

10 ASSOCIATED POLICIES

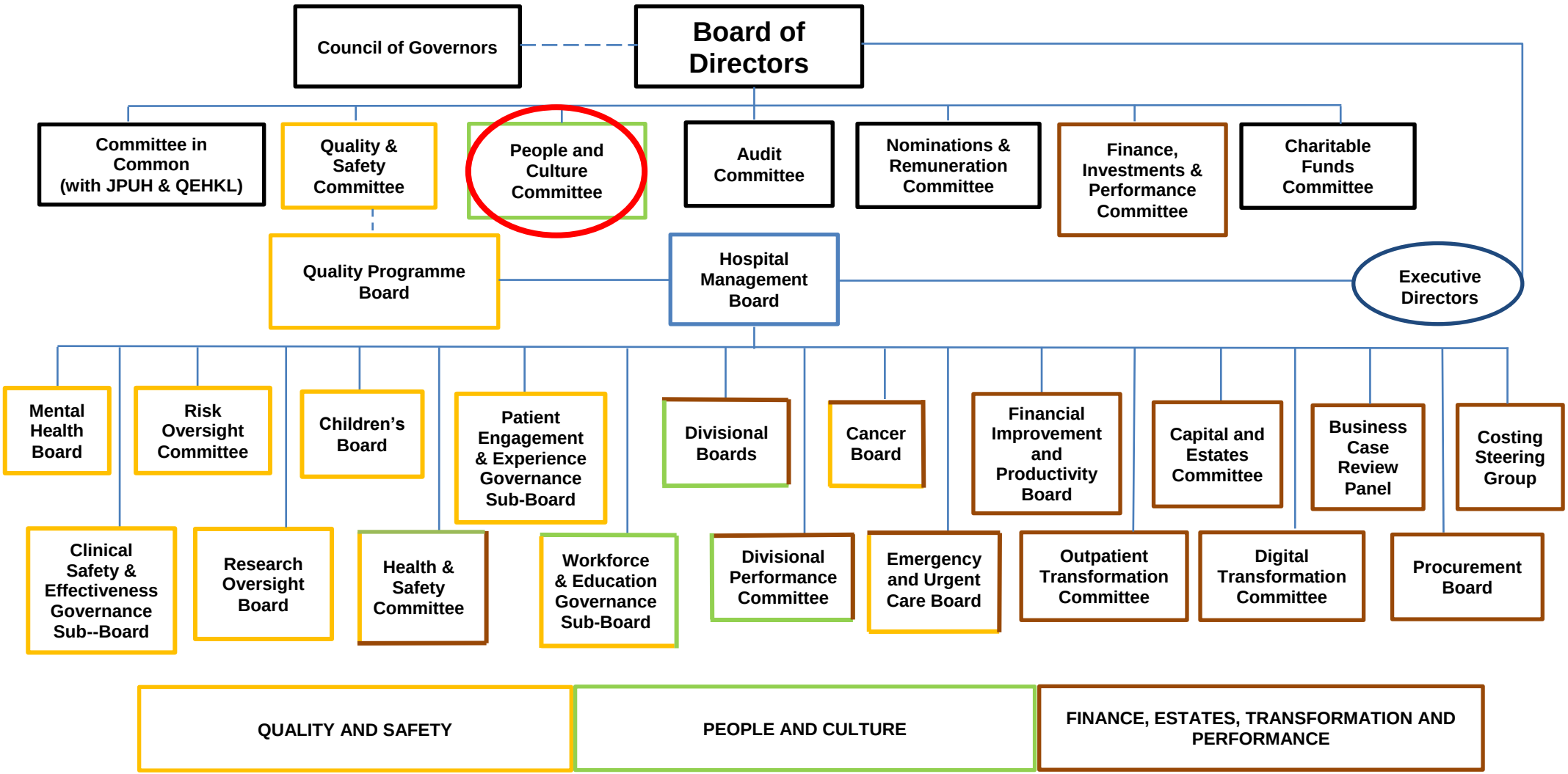
10.1 The Committee has delegated authority to approve and oversee implementation of the following polices:
- Nil currently

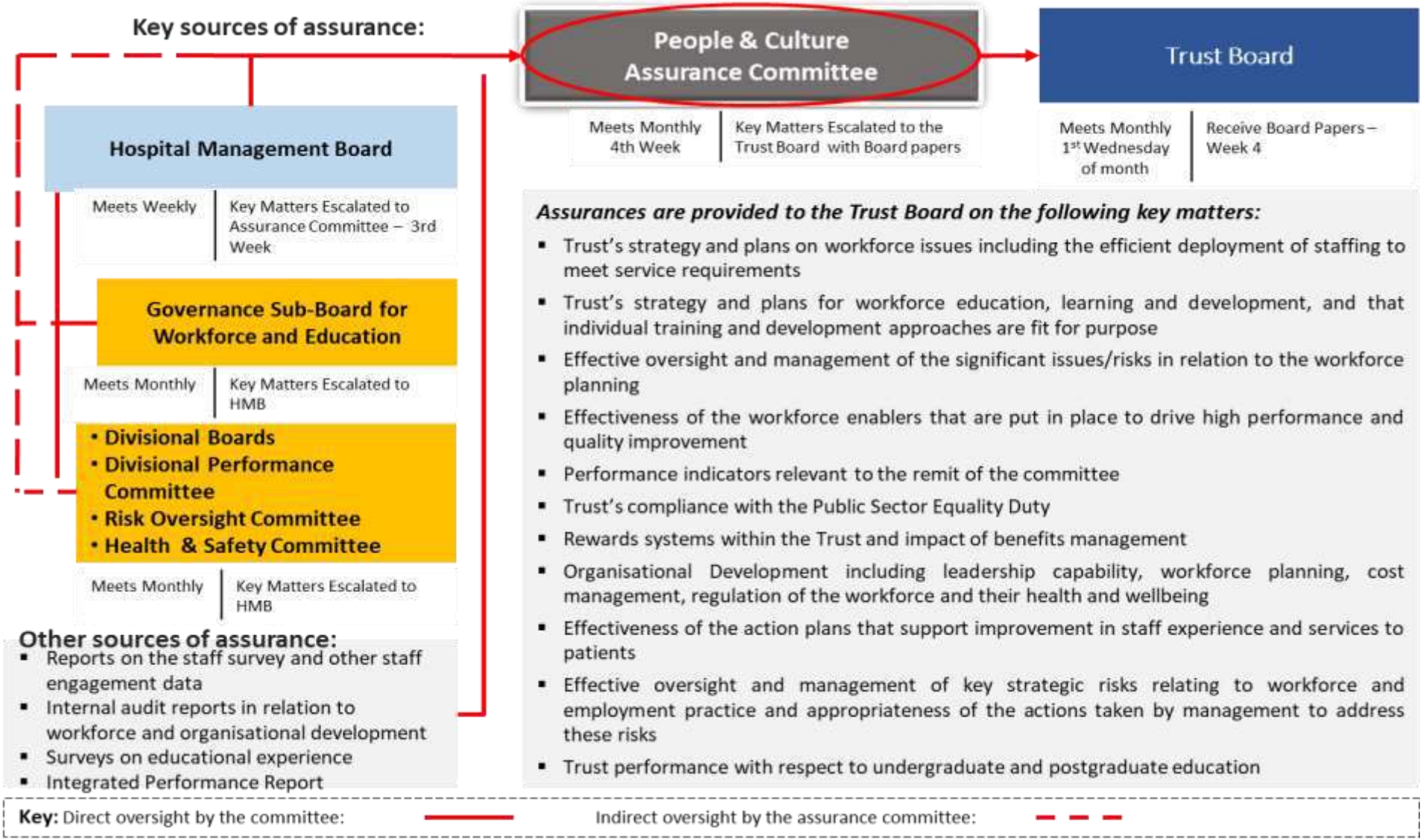
Date approved by the Board of Directors: ~~5 February 2020~~02 June 2021

Annual Review date: May 2022 ~~31 March~~

Board of Directors and Management Board Reporting and Accountability Structure

Norfolk and Norwich University Hospitals NHS Foundation Trust




Key sources of assurance:
People & Culture Assurance Committee
Trust Board
Meets Monthly 4th Week
Key Matters Escalated to the Trust Board with Board papers
Meets Monthly 1st Wednesday of month
Receive Board Papers – Week 4
Hospital Management Board
Meets Weekly
Key Matters Escalated to Assurance Committee – 3rd Week
Governance Sub-Board for Workforce and Education
Meets Monthly
Key Matters Escalated to HMB
• Divisional Boards
• Divisional Performance Committee
• Risk Oversight Committee
• Health & Safety Committee
Meets Monthly
Key Matters Escalated to HMB
Other sources of assurance:
▪ Reports on the staff survey and other staff engagement data
▪ Internal audit reports in relation to workforce and organisational development
▪ Surveys on educational experience
▪ Integrated Performance Report
Assurances are provided to the Trust Board on the following key matters:
▪ Trust's strategy and plans on workforce issues including the efficient deployment of staffing to meet service requirements
▪ Trust's strategy and plans for workforce education, learning and development, and that individual training and development approaches are fit for purpose
▪ Effective oversight and management of the significant issues/risks in relation to the workforce planning
▪ Effectiveness of the workforce enablers that are put in place to drive high performance and quality improvement
▪ Performance indicators relevant to the remit of the committee
▪ Trust's compliance with the Public Sector Equality Duty
▪ Rewards systems within the Trust and impact of benefits management
▪ Organisational Development including leadership capability, workforce planning, cost management, regulation of the workforce and their health and wellbeing
▪ Effectiveness of the action plans that support improvement in staff experience and services to patients
▪ Effective oversight and management of key strategic risks relating to workforce and employment practice and appropriateness of the actions taken by management to address these risks
▪ Trust performance with respect to undergraduate and postgraduate education
Key: Direct oversight by the committee:
Indirect oversight by the assurance committee:

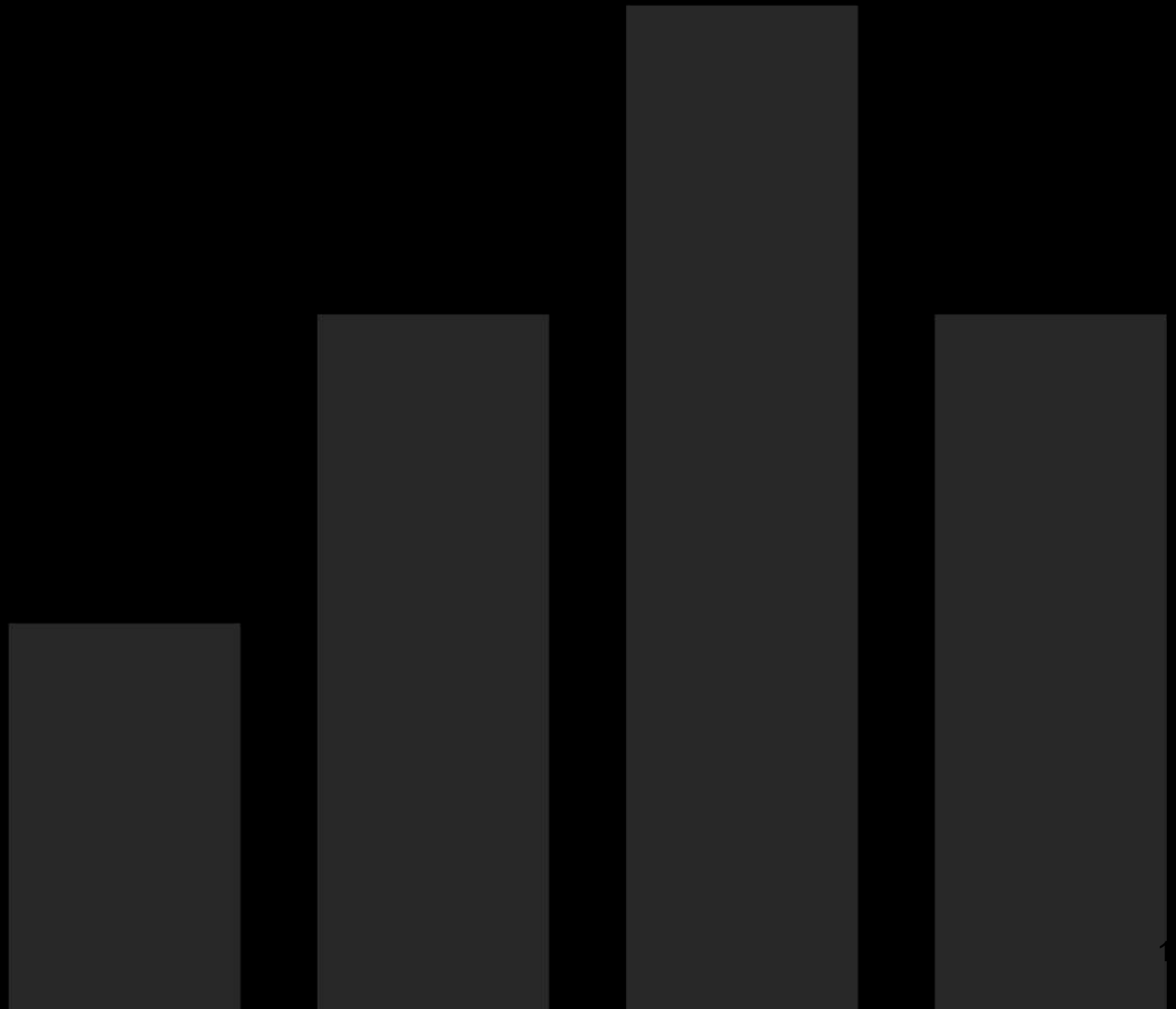
Microsoft | Power BI

Workforce

View in Power BI

Last data refresh:
21/05/2021 07:30:35 UTC

Downloaded at:
21/05/2021 09:01:04 UTC



Workforce Summary

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

NNUH Digital Health
business intelligence

Topic	Metric Name	Date	Result	Variation	Assurance
Recruitment (Non-Medical)	Time to Hire - Total	Apr 2021	53.9	Improvement (Low)	Unreliable
Staff in Post	Actual Substantive Headcount (WTE)	Apr 2021	8,203	Improvement (High)	No Target

SPC Variation Icons

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

SPC Assurance Icons

Capable | Not capable | Unreliable

Mandatory Training

NNUH Digital Health
business intelligence

Mandatory Training

Apr 2021

Variation | Assurance

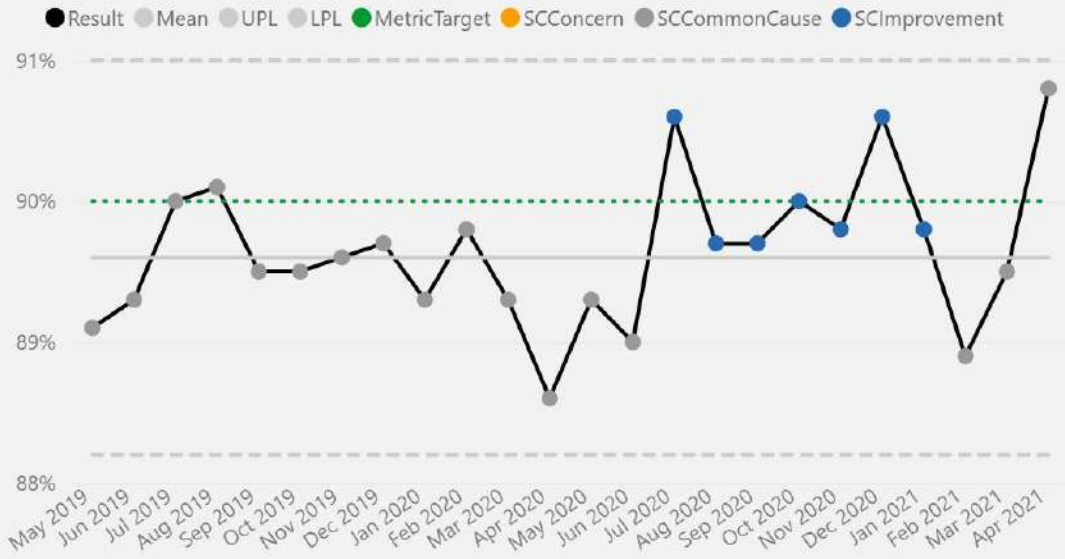
90.8% Result
90.0% Target

91.0% UPL
89.6% Mean
88.2% LPL

Analytical Commentary

Variation is Common Cause

Mandatory Training



Assurance Commentary

As at the end of April, the compliance rate was 90.8%.

Improvement Actions

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

Non-Medical Appraisals

NNUH Digital Health
business intelligence

Non-Medical Appraisal

Apr 2021

Variation

Assurance

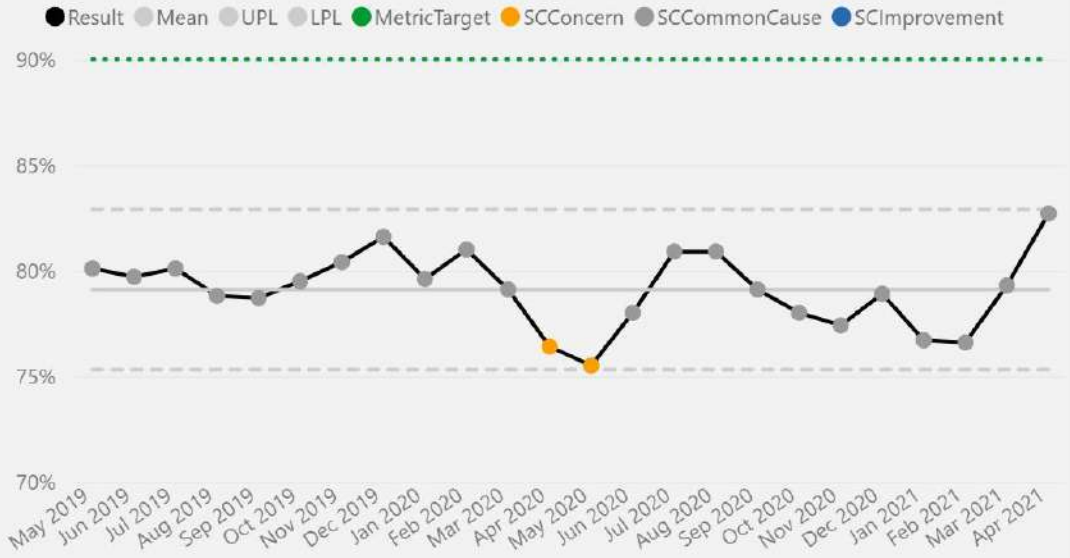
82.7% Result
90.0% Target

82.9% UPL
79.1% Mean
75.3% LPL

Analytical Commentary

Variation is Common Cause

Non-Medical Appraisal



Assurance Commentary

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

82.7% of eligible staff (Non-Medical appraisals) had an appraisal during the last 12 months; this is our highest reported compliance rate.

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

Improvement Actions

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

Sickness Absence

NNUH Digital Health
business intelligence

Monthly Sickness Absence %

Apr 2021

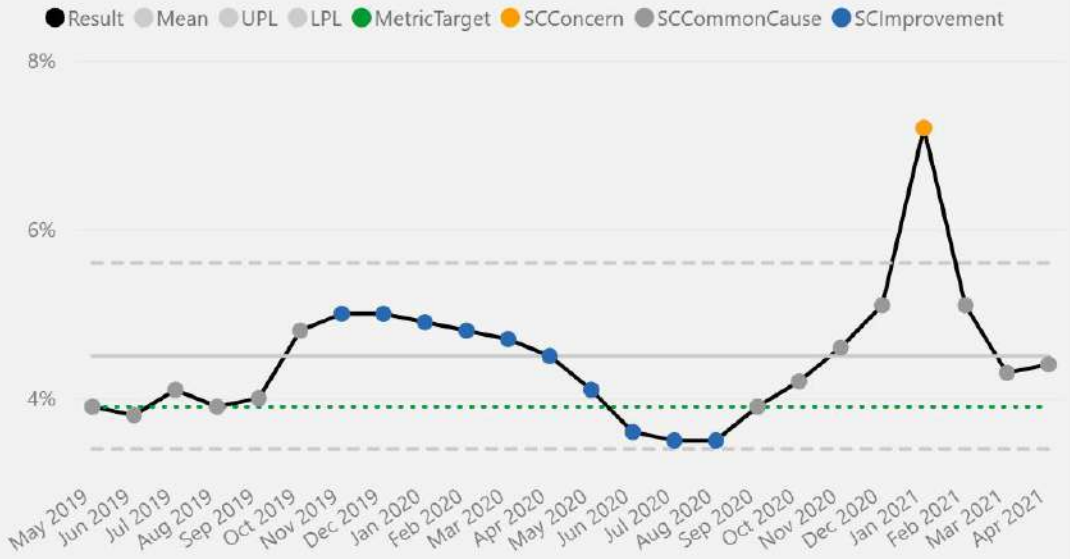
Variation	Assurance
	

4.4% Result	5.6% UPL
3.9% Target	4.5% Mean
	3.4% LPL

Analytical Commentary

Variation is Common Cause

Monthly Sickness Absence %



Assurance Commentary

The Operating Plan for 2020/21 has set a challenging 12 month rolling average target of 3.9% for sickness. As at 30 April 2021, that rate is 4.41%. The monthly absence figure for April is 4.36%.

All figures since March 2019 include Covid related sickness absence. Had Covid sickness been excluded the 12-month rolling average rate would be 3.67%.

The Trust was the best performing for attendance management in the Region and the System during the pandemic. At the peak, NNUH reported at 4.48%, in comparison to 6.3% for the East of England and 6.2% nationally. In relation to the local Acute Hospital's, the absence figures were QEH 8.9% and JPUH 8%. The most recent data collated by the STP indicates that our absence is lower at 4.4% in comparison to QEH at 6.3% and JPUH at 4.9%

Improvement Actions

Mar-2020 – Covid impact on sickness absence

Jul-2020 - HMB Paper highlighting interventions focused on minimising and preventing long term sickness absences

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

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

Staff Turnover

NNUH Digital Health
business intelligence

Monthly Turnover

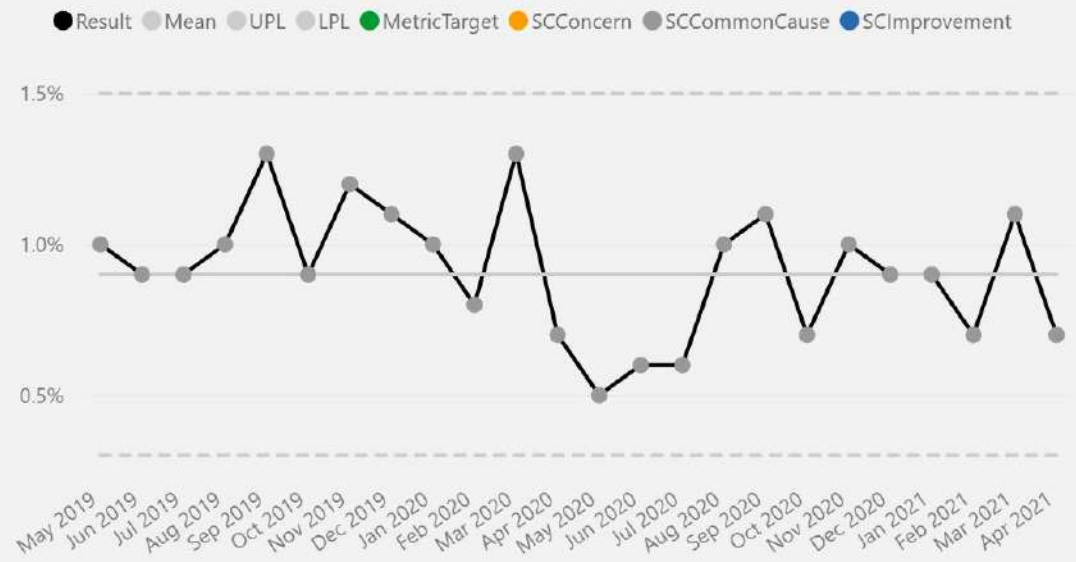
Apr 2021

Variation	Assurance
0.7% Result	1.5% UPL
N/A Target	0.9% Mean
	0.3% LPL

Analytical Commentary

Variation is Common Cause

Monthly Turnover



Assurance Commentary

The monthly turnover rate for April 2021 is 0.74% - a decrease from March (1.09%) but higher than April 2020 (0.69%). The actual number of leavers for April 2021 is 52.6 WTE compared to 77.9 WTE for March 2021.

The 12-month average turnover rate is 10.0%, the rate has stabilised after 12 consecutive monthly reductions, from the peak of 12.4% (March 2020).

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

Improvement Actions

May 2021 - The turnover for the Trust has stabilised. The pandemic will have impacted on the Trust turnover and a retention plan will be developed for the Trust which will be actioned and monitored at the Recruitment and Resourcing Improvement Group.

Staff in Post

NNUH Digital Health
business intelligence

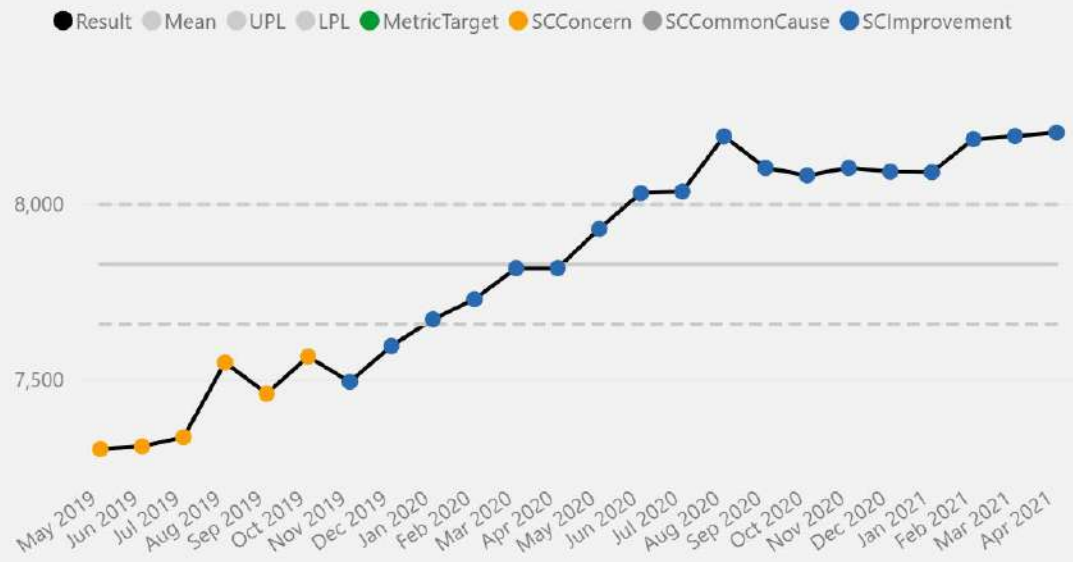
Actual Substantive Headcount (WTE)

Apr 2021

Variation | Assurance

8,203 Result	7,998 UPL
N/A Target	7,828 Mean
	7,658 LPL

Actual Substantive Headcount (WTE)



Improvement Actions

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

Analytical Commentary

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

Assurance Commentary

Since April 2020 there has been an increase of 4.8%, 373.6 WTE (7,730.2 staff in post 31-Mar-20)

Since April 2019 there has been an increase of 12.9%, 926.3 WTE (7,177.5 staff in post 31-Mar-19)

Since April 2018 there has been an increase of 19.4%, 1,316.8 WTE (6,787.1 staff in post 31-Mar-18)

Since April 2017 there has been an increase of 25.7%, 1,656.3 WTE (6,447.6 staff in post 31-Mar-17)

Vacancies

NNUH Digital Health
business intelligence

Variance: Headcount (WTE)

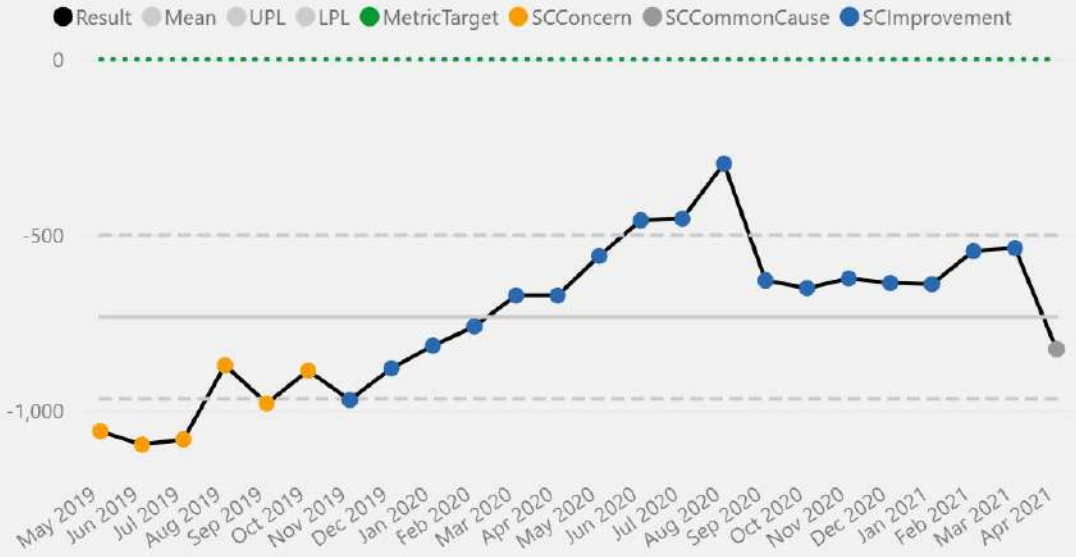
Apr 2021

Variation	Assurance
	

-825 Result
0 Target

-501 UPL
-734 Mean
-966 LPL

Variance: Headcount (WTE)



Improvement Actions

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

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

May 2021 – Due to varying recruitment and retention strategies reduced figure, only 33.6% of the identified hard to fill posts are now required to be actively recruited to.

Analytical Commentary

Variation is Common Cause

Assurance Commentary

Due to the Nursing & Midwifery Establishment Triangulation and Rebasing exercise, there is an increased vacancy position for Registered Nursing with an additional 55 FTE and Unregistered with an additional 76 FTE. This has been made effective in May's Divisional budget. Recruitment actions will be agreed and monitored at the Recruitment and Resourcing Improvement Group.

Since April 2020 there has been an increase of 4.8%, 373.6 WTE (7,730.2 staff in post 31-Mar-20)

Since April 2019 there has been an increase of 12.9%, 926.3 WTE (7,177.5 staff in post 31-Mar-19)

Since April 2018 there has been an increase of 19.4%, 1,316.8 WTE (6,787.1 staff in post 31-Mar-18)

Since April 2017 there has been an increase of 25.7%, 1,656.3 WTE (6,447.6 staff in post 31-Mar-17)

Recruitment (Non-Medical)

NNUH Digital Health
business intelligence

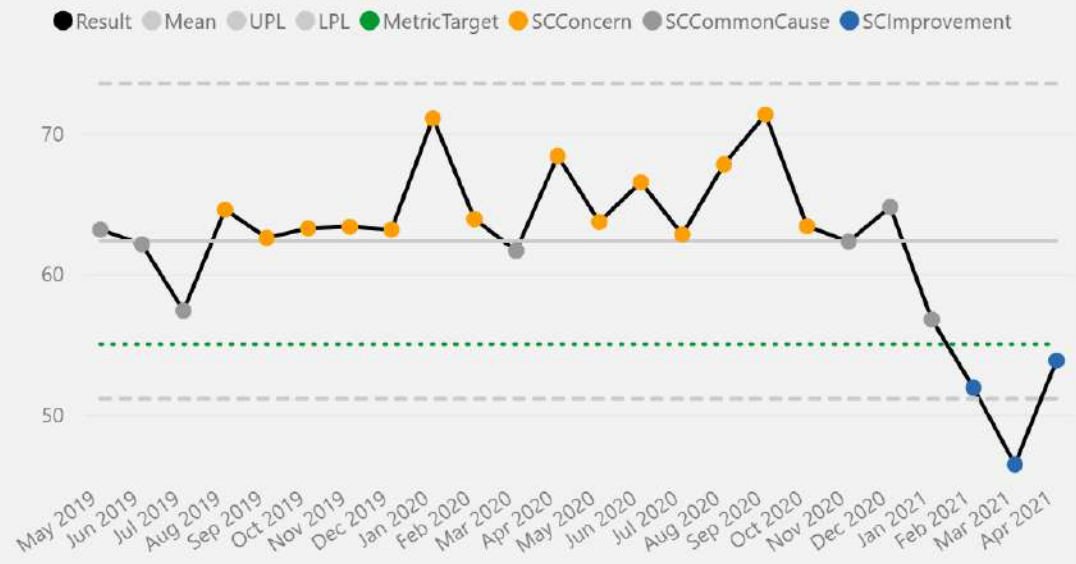
Time to Hire - Total

Apr 2021

Variation	Assurance
L	?

53.9 Result	73.6 UPL
55.0 Target	62.4 Mean
	51.1 LPL

Time to Hire - Total



Analytical Commentary

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

Assurance Commentary

There is an ambitious time to hire target of 55 days with time with manager set at 15 days. The performance committees include a focus on time to hire and supportive measures to enable improvements.

For April 21 the time to hire figure is 53.9 days, an increase from March (46.4 days) but still below the target. Particular actions have been agreed in Divisions where intervention is felt to be required.

Improvement Actions

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

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

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Time to Hire - Time with Manager	Apr 2021	17.9		Common Cause		No Target

REPORT TO THE TRUST BOARD OF DIRECTORS

Date	**2 June 2021**
Title	**Quality Priorities 2020/21, situation report and recommendations for 2021/22**
Author & Exec lead	**Karen Kemp, Associate Director Quality & Safety on behalf of Professor Nancy Fontaine, Chief Nurse**
Purpose	**For agreement**

EXECUTIVE SUMMARY

This paper gives an update on the progress against the quality priorities agreed for 2020/21 and makes recommendations for priorities for 2021/22.

A total of 14 priorities were identified over the domains of Safety (n=6), Effectiveness (n=5) and Patient Experience (n=3) for 2020/21. Progress YTD at end May 2021 is contained in appendix 1.

Throughout 2020 and into 2021 the NHS acute sector faced unprecedented disruption and challenge as a consequence of the global Covid-19 pandemic. Trusts were instructed to suspend all routine activity and to focus on business continuity and pandemic response. However, work has continued to progress the quality priorities as far as practicably possible with reporting and governance through Evidence Group and Quality Programme Board.

As at end of February 2021, 1 priority had been met in its entirety (Experience 2), 10 had progress made but work is ongoing and the remaining 3 had yet to be started. At the end of May 2021, another priority has been met (Safe 2).

It is proposed therefore to continue the 12 priorities form 2020/21 into 2021/22 with the addition of two new ones to replace the completed experience and safety priorities.

1. Background/context

The Trust agreed the organisational quality priorities for 2020/21 at the beginning of 2020. These priorities cover the domains of Safety, Effectiveness and Experience and form part of the Annual Quality Report which is a statutory requirement as set out in the Health Act 2009 and supporting regulations.

The progress to date against the 2020/21 priorities can be found in Appendix 1. This is the status of the priorities up to end of May 2021.

2. Discussion

The focus of the Quality Priorities through the governance of Evidence Group and Quality Programme Board (QPB) has ensured that continued attention is given to their achievement.

Despite operational pressures, one of the experience priorities regarding age appropriate patient and family feedback had been achieved by the end February. It was therefore proposed a new experience priority be agreed which will aim to improve patient centred transfers of care. Full details of this priority can be found in Appendix 2. This proposed priority has been shared with the commissioners and they are very supportive of this area of improvement as it links with system work in this area. This priority has already been endorsed by the Quality and Safety Committee in March 2021.

As at end May 2021, one of the Safe priorities regarding Cirrhosis and Fibrosis Tests for alcohol dependent patients has also been achieved. Following discussion at QPB in May, a new priority focussing on Maternity services has been identified. Full details of this priority can be found in Appendix 3.

3. Next Steps

Continue monitoring of Quality Priorities through Evidence Group and Quality Programme Board.

Recommendation:

The Board is recommended to:

- **acknowledge** progress to date with the achievement of the Quality Priorities 2020/21;
- **agree** the continuance of the existing priorities into 2021/22;
- **endorse** the new recommended patient experience and safe priorities.

Appendix 1. Progress against Quality Priorities 2020/21.

Quality Domain – Safe

Safe 1.	**Appropriate Antibiotic Prescribing for UTI in adults aged 16 +**
	Achieving 60% of all antibiotic prescriptions for UTI in patients aged 16+ years that meet NICE guidance for diagnosis and treatment.
Progress	Audit results for each category 1. Documented diagnosis of specific UTI based on clinical signs and symptoms / total number of patients (30) **56.6%** (36.6% were unable to be consulted as lethargic/confused* and only 2 were not documented 0.6%) 2. Diagnosis excludes use of urine dipstick in people aged 65+ years and in all Catheter Associated UTI (CAUTI); / total number of patients (30) **= 30/30 =100%** 3. Empirical antibiotic regimen prescribed following NICE / local guidelines; / total number of patients (30) **70%** (17% were antibiotics based on culture result and 13% were not compliant with any of the above) 4. Urine sample sent to microbiology as per NICE requirement;/ total number of patients (30)= **87%** sent (6% sample collection was not feasible (bedpans, incontinence) 6% did not send a sample). 5. For diagnosis of CAUTI, documented review of urinary catheter use is made in clinical record:/ total number of patients with CAUTI **100%**

Safe 2.	**Cirrhosis and Fibrosis Tests for alcohol dependent patients**				
	Achieving 35% of all unique inpatients (with at least one night stay) with a primary or secondary diagnosis of alcohol dependence who have an order or referral for a test to diagnose cirrhosis or advanced liver fibrosis.				
Progress	Results	**Q1**	**Q2**	**Q3**	**Q4**
	A) Number of unique patients discharged in period with primary or secondary coding of 'alcohol dependence'	179	200	198	177
	B) Number of patients excluded from initial cohort (due to having relevant blood test or fibroscan requested in previous 12 months)	153	174	176	151
	CQUIN denominator (A-B)	26	26	22	26
	CQUIN numerator (number of patients in denominator cohort who have a referral / order for a Fibroscan or relevant blood test)	24	25	21	26

	Percentage of patients in the denominator meeting CQUIN requirements (numerator/denominator).	**92.31%**	**96.15%**	**95.45%**	**100%**
	Achieved.				

Safe 3.	**Recording of NEWS2 Score, escalation time and response times for unplanned critical care admissions**
	Achieving 60% of all unplanned critical care unit admissions from non- critical care wards of patients aged 18+, having a NEWS2 score, time of escalation (T0) and time of clinical response (T1)
Progress	Admission data reviewed from Metavision indicates 98 admissions from to CCC from ward areas between 01/01/2021 to 29/03/2021. 37 admissions met the 3 audit criteria therefore achieved 37%. The Recognise and Respond team will be launched June 1st and a Band 7 Quality Assurance and Education Lead has been appointed with the responsibility to drive audit and improvement against this standard.

Safe 4.	**Screening and Treatment of Iron Deficiency anaemia in patients listed for major elective blood loss surgery**
	Ensuring that 60% of major elective blood loss surgery patients are treated in line with NICE Guideline NG24.
Progress	The person who was leading has now left the Trust. A new Clinical lead has been agreed to take this forward.

Safe 5.	**Treatment of Community Acquired pneumonia in line with BTS Care Bundle**
	Achieving 70% of patients with confirmed community acquired pneumonia to be managed in concordance with relevant steps of BTS CAP Care Bundle.

Progress

Criterion Number	**Criterion**	**%standard Met 1st audit**	**% Standard Met 2nd audit**
1	Chest x-ray completed within 4 hours	100%	100%
2	Symptoms present on admission	No data	100%
3	Antibiotics within 4 hours	77.8%	92%
4	Microbial Investigations	41%	54%

	5	CURB-65	38.9%	78%
	6	O2 Prescribed	81%	76%
	A further audit is being carried out in Q1 of this year.			

Safe 6.	**Rapid rule out protocol for ED patients with suspected acute myocardial infarction**
	Achieving 60% of Emergency Department (ED) admissions with suspected acute myocardial infarction for whom two high sensitivity troponin tests have been carried out in line with NICE recommendations.
Progress	An audit on symphony involving ACPs was due to be completed but this has been delayed due to the lead for this recommendation currently being on compassionate leave. Agreed that Nurse Consultant will provide support to the clinical lead. This work and the baseline audit will also feed into Same Day Emergency Care (SDEC) pathways.

Quality Domain - Effective

Effective 1.	**Adherence to Evidence Based intervention Clinical Criteria**
	Achieving 80% of Phase 1, Category 2 procedures from the evidence based interventions (EBI) statutory guidance of November 2018 meeting the required criteria for delivery.
Progress	This has been picked up as part of clinical prioritisation work. Introduced as patients waiting significantly longer for treatment due to loss of elective care. P1 to P6 prioritisation. P5 and P6 have been created for patients who choose to postpone treatment but remain active on the waiting list. Review process: • Stage 1 is administration validation, to check the accuracy of the list; patients are called or sent a letter to identify what the next step should be. • Stage 2 to assess if a clinical review is required. Assessment will look at whether a patient meets EBI criteria. • Stage 3 is a full clinical review. There is a shared decision making conversation with the patient and clinician, however the patient still needs to meet the criteria of EBI (they are waiting for 1 of the 17 criteria listed). 420 reviews have been conducted and all are compliant. But this is just for the admitted patient's waiting list and is still work in progress.

UoR 9.1.1.	The implementation of a robust discharge to assess process and earlier more efficient discharge planning.
	Reducing bed occupancy levels to a maximum of 92% through a reduction and improvements in long of stay, delayed transfers of care and admission avoidance in line with NHS England Operational Planning and Contracting Guidance for 2020/21.
Progress	The Trust has made reductions in the number of patients with a 21+ day long length of stay (LLoS) compared to a 2018/19 baseline of 120.4 patients set by NHSE. The Trust has met the objective throughout 2020 of achieving a 36% reduction on this baseline to 86 patients. However, during the COVID-19 pandemic there was an increased acuity of patients and due to isolation requirements, length of stay increased above this target. Following Winter 2020/21 and as covid prevalence has reduced, an improved position of LLoS in March 2021 has been realised. In conjunction with this, work has been ongoing to improve our discharge processes. The STP blueprint on Discharge to Assess (D2A) is due to be implemented in October 2021. A number of enabling actions and exercises are ongoing to ensure this implementation is as effective as possible. Renewed Monitoring processes of discharge and long length of stay have been implemented. This includes producing and refreshing trajectories for both reduction in both Stranded and Super Stranded Patients (14-20 and 21+ LLoS) have been produced and will be monitored through the Safer Better Faster (SBF) Emergency Pathways Improvement Programme. LoS holds a key part of the IMT with daily review of length of stay data for both our elective and non-elective patients. IMT has specifically maintained rigour in encouraging our uptake of the Virtual Ward to both improve the patient experience and safety by ensuring they are not kept in hospital for longer than required to, and for the benefit of additional bed capacity for new admissions. In conjunction with the above reviews of data, emphasis during April and May 2021 has been placed upon embedding Criteria to Reside (C2R) into our daily patient management as part of the DHSC Discharge Policy. This is also being monitored and driven by SBF. DTOCs are no longer monitored by NHSE although internal monitoring and escalation of patients who have been on the discharge list awaiting community support for more than 48 hours remains in place.

UoR: 8.1.3	Same Day Emergency Care focus on frailty service
	Ensuring that Same Day Emergency Care (SDEC) service is delivered for 12 hours per day 7 days a week. In addition providing an acute frailty service for at least 70 hours a week based upon NHS England Operational Planning and Contracting Guidance for 2020/21 and the NHS Long Term Plan.
Progress	A system bid secured to continue the locum and to have SpR extra hours to expand the operating hours for Frailty SDEC. Consultant Outreach initiative commenced and expanding access to the 'silver' admission avoidance phone support service. Baseline data was collected via Prism work and also Think 111 First as part of the Front Door Services work stream. The use of the silver phone for OPAC/OPED services

	ensures the trust is compliant in providing an acute frailty service for at least 70 hours a week. Combined SDEC service is in place as of January 2021. Initial pathways for SDEC have been agreed supported by EUC, Medicine and Surgery teams with additional scoping sessions to expand criteria and pathways being conducted by clinical leadership teams. Work with all divisions is ongoing to ensure all SDEC activity is captured correctly as ongoing monitoring mechanisms are in place via the IMT and due to be implemented with the Safer, Better, Faster Programme. Work is ongoing through the SBF Programme to expand the 'silver phone' service and principles to Surgical SDEC services. This project work will dove-tail with implementation of additional 111 First Booked slots for urgent and emergency care pathways across SDEC areas.

UoR 9.1	The implementation of a robust discharge to assess process and earlier more efficient discharge planning.
	Reduce face to face outpatients by 20% and introduce patient initiated follow up, enabling capacity to be released back to elective activity. Achieving a reduction of a third of face to face outpatient attendances by 2023/2024 in line with NHS England Operational Planning and Contracting Guidance for 2020/21
Progress	A clear 'shift' to Virtual Outpatient attendances was witnessed from March 2020 with sustained levels of attendances delivered from this point (>40% virtual consistently). The transformation steering group has been initiated in March 2021 to ensure initiatives such as remote outpatients are embedded across the organisation and provided the correct level of corporate and divisional support. Within the 21-22 Operational Planning Guidance it reiterates the need to embed outpatient transformation citing that where an outpatient appointment is clinically necessary that at list 25% should be delivered remotely (c 40% of outpatient appointments that do not involve a procedure). As with above, this is closely monitored through daily IMT meetings and will be measured as part of the Safer Efficient and Transformative (SET) Elective Care Improvement Programme.

UoR 9.1.3	Redesign the ED footprint and patient journey processes through the department with a focus on improved triage processes and the management of ambulatory majors
	Achieving an improvement in the 4 hour ED standard of patients treated, admitted or transferred with a focus on front-door clinical streaming and patient flow through the department. Focus on avoiding ambulance handover delays at hospital as per NHS England Operational Planning and Contracting Guidance for 2020/21.
Progress	The move of combined SDEC to Loddon ward has helped to release some space and estate to EUC to redesign footprint and patient journey in 2021. The 'Optimising Patient Flow Through ED' work stream led by Rachael Cocker has retained an objective of reviewing the ED footprint, patient journey and processes through the department A number of sub projects to capture this with clear objectives and KPI's have been established. A robust governance structure and reporting both internally via the ODG and HMB will take place with escalations of issues or blockers to progress.

	Recruitment programme and remodel of ED has also led to a reduction in delays overnight for waits to be seen. However, this remains under continued review. ED footprint and patient journey processes have been reviewed and re-designed as part of the SBF work during Summer 2020. Continuous improvement processes including (PDSA cycles) are in place. Improved time to initial assessment and triage can be viewed within data and reporting.

Quality domain – Experience

Experience 1	**Shared Decision Making**
	Patient satisfaction with shared decision making conversations at key decision points early stage lung cancer; palliative chemotherapy; localised prostate cancer; adjuvant use of chemotherapy for colorectal cancer. Patient satisfaction with shared decision making conversations at relating to: ablation for atrial fibrillation and aortic stenosis; cardiac surgery (CABG vs PCI);
Progress	**Cancer Pathways** 92 questionnaires were sent out and 44 responses received. • Responses were mostly positive. Patients agreed they had been part of decision making process. • 90% comments positive. • The issues highlighted were regarding surveillance and also access to face to face appointments. The negative comments centred on not being fully informed of all treatment options when Surveillance was recommended, and not having 'face to face' communication. These were mainly from the Prostate and Early Lung cancer patients. The individual comments are being sent to the clinical teams for further evaluation **Cardiology pathways** Data has been collected for the Ablation patients. Responses received for 96 patients over a 6 month period.

	• Positive feelings about staff • *"Everyone was friendly, kind, thoughtful and professional"* • *"Nursing and Medical team in EP suite excellent, friendly and professional"* • Excellent Service • *"All round exceptional care. Thank you so much."* • *"Could not wish for better treatment."* • Pre-assessment informative • "Pre-op assessment by phone was excellent." • "My pre-assessment call explained my procedure fully and my questions were all answered in a very friendly and informative manner. Thank you." • Lack of information post procedure • *"When I left I was not fully aware of what had been completed"* • *"I was discharged with only the discharge letter and physicians report. It was only when I phoned the Arrhythmia specialist nurse that I received a full and proper account of the outcome of my procedure."* • *"It would have been nice to have spoken to the doctor who done the procedure, just so he could tell me how it went. I left not really knowing if it had all gone to plan."* • Missed phone appointments • *"Friday phone appt not kept by hospital which was quite stressful."* • *"I was due a post-op call 4 days afterwards that did not happen."* Next area of focus is Aortic Stenosis and CABG v PCI pathways.

Experience 2.	Age appropriate patient and family feedback
	Mechanisms in place across the Trust to ensure that children and young people are always asked about their experience of the services they use.
Progress	Tops and pants has been embedded for younger children, with changes having been made as result of feedback/learning. New simplified questions regarding experience for 12 – 16 year olds. VCREATE being used successfully in NICU. Youth Forum has been developed, which is a board of young people who give their input. The Youth Forum were involved on the interview panel for a recent band 7 post in ED and contact has been made with the UEA so that the Youth Forum is involved in future interviews with recently qualified staff. A job description has been approved for a Youth Worker, funding is still required for this post. Funding opportunities are being explored for this post. Chief Nurse asked for an external press release once the Youth Worker in place **Achieved.**

Experience 3.	Patient experience of redesigned processes (described in effectiveness section)
	UoR 9.1.1: Discharge processes UoR 9.1 Virtual OP appointments
Progress	**Discharge Process:** Concerns raised regarding whether patients received too many request for feedback from different angles, i.e. surveys / phone calls. Need to create a 'joined up' approach. A whole new programme needs to be created to review all discharge processes in line with patient experience element, including virtual ward. Patient experience monitoring is already in place regarding D2A / OTs being moved out into the community. 2 patient panel members are involved in the piece of work. Decision to close this recommendation and develop into a much wider piece of work. **Virtual Outpatient Appointments:** Evidence is being collected automatically from virtual consultations via a pop up at the end of the consultation. New provider has been used from March 2021therefore need to gather evidence from this provider. Positive results so far with 94.2% of patients stating that they feel able to communicate what want to and 92.7% of patients stating that their needs were met. Any glitches with the system have been recorded and acted on. A report from patients and any areas which require improvement is fed back to the divisions for them to review as part of their clinical governance meetings. This is where the drive for improvements needs to be owned. Any Corporate improvements are fed through Outpatients Transformation Committee. The committee is very engaged with the process.

Appendix 2. New Patient Experience Priority for 2021/22

Experience 2	**Improving patient centred transfers of care**
Rationale	• There is continued reporting of incidents, including SIs, Complaints and PALS concerns related to transfers of care eg; from ward to discharge suite, between departments e.g ED / AMU to base ward, from hospital to care/nursing home, maternity transfers between providers, shared care for paediatrics, mental health shared care, discharge etc. • Issues with transfers of care cross cut experience of care as well as safety domains • Builds on the 20/21 quality priorities for patient experience around shared decision-making and involvement as a partner in care
Aim	• Desired outcome – patients and families are involved and (as far as possible) proactive partners in the transfer of care - they feel part of the decision making process, are fully informed and engaged in the process of planning and implementing their transfer of care. • Patients and families report high levels of satisfaction with communication and involvement in shared decision-making to ensure smooth transition / transfer of care experience.
Progress	Quarter 1 – Each Division to identify up to 2 pathways, services, areas to instigate an improvement in patient-centred transfers of care through: • A deep dive to analyse incidents, including SIs, complaints and PALS concerns and any other feedback related to transfers of care, using data to drive improvement focus and establish baseline measurement. • Identification of patient representatives to work as partners within the improvement project team • Identification of unique measurement for each pathway. Overarching measurement for all pathways to include: ○ Reduction in negative feedback related to transfers of care especially related to communication, caring, feeling involved – seen via Complaints/PALS/feedback ○ Improved scores in national and local patient surveys for communication, caring and feeling involved ○ Improved scores for staff surveys patient experience and safety domains? Quarter 2 - Initial identification and presentation of improvement plans to Evidence Group and Quality Programme Board Quarter 3 &4 – Commence improvement work using Life QI system to track progress, reporting to evidence group and QPB

Appendix 3. Proposed New Safe Priority for 2021/22.

Safe 2	All pregnant women will have a discussion regarding preferred place of birth and a risk assessment of their choice at each scheduled Antenatal appointment.
Rationale	Links to Amber rated Ockenden Recommendation 5. Risk Assessment Throughout Pregnancy. Staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway: • All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional • Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.
Aim	Achieving 95% of all women at scheduled antenatal appointments will have a documented discussion on preferred place of birth with an associated risk assessment recorded in the patient record.
Progress	Reporting will be via E3 system. By end of Q1 review current processes to establish baseline measurement. Review E3 workflow for documented review and discussion of intended place of birth at every contact. Identify risk assessment tool. Quarter 2 - Initial identification and presentation of improvement plans to Evidence Group and Quality Programme Board. Commence improvement work. Quarter 3 &4 – Continue improvement work using Life QI system to track progress, reporting to evidence group and QPB.