Trust Board (public) - 8 June 2022

Wed 08 June 2022, 09:30 - 11:30

Boardroom and by MS Teams

Norfolk and Norwich University Hospitals NHS Foundation Trust

Agenda

Agenda

00 TB Agenda Public 8 June 2022.pdf (1 pages)

1. Apologies, Declarations of Interest and Chairman's Introduction

2. Experience of Care – maternity (inc National Drivers)

Information

02 MatVoices 08June2022 TRUST BOARD REPORT (09.21).pdf (2 pages)
02a MatVoices 08June2022 TB presentation (09.21).pdf (15 pages)

3. Minutes of the Board meeting held in public on 06.04.22

John Paul Garside

Approval

03 Unconfirmed TB Minutes 06.04.22 Public.pdf (8 pages)

4. Matters arising and update on actions

Discussion

5. Reflections on clinical visits

Discussion

6. Chief Executive's Update

Sam Higginson

Discussion

7. Reports for Information and Assurance:

7.1. Quality and Safety Committee (24.05.22)

Pamela Chrispin

Information & approval

07(a) Report on QS Comm 24.05.22.pdf (2 pages)

7.1.1. approval of Quality Account 2021/22

Approval

07a(i) Quality Account 2022 final draft.pdf (105 pages)

7.2. IPR – Quality, Safety and Patient Experience data

Information

07(b) Quality Safety IPR report 16.05.2022.pdf (19 pages)

7.3. Finance, Investments and Performance Committee (25.05.22)

Tom Spink

Information

07(c) Report on Finance Investments Performance Committee meeting on 25.05.22.pdf (2 pages)

7.3.1. inc Committee Annual Report

Information

07(c)(i) Aproved FIPC Annual Report 2021-2022.pdf (6 pages)

7.3.2. IPR – Performance and Productivity data

Chris Cobb

information

07(c)(ii) Performance and Activity IPR April 2022.pdf (39 pages)

7.3.3. Finance – Month 1 report

Roy Clarke

Information

07(ii) Public Board Cover Sheet - M1 Finance Report.pdf (2 pages)
07(ii)a Trust Finance Report M1 - Public Board.pdf (6 pages)

7.4. IPR – Workforce data

Paul Jones

Information

07(d) Workforce IPR April 2022.pdf (10 pages)

8. Staff Survey - Priority Improvement Actions

Paul Jones

Information

08 Trust Board Staff Survey - Priority Improvement Actions v.1.6.pdf (7 pages)

9. Questions from members of the public

10. Any other business

Date and Time of next Board meeting in public: The next Board meeting in public will be at 9.30am on Wednesday 3 August 2022 – Room UG55 A&B Quadram Building, Norwich Research Park

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MEETING OF THE TRUST BOARD IN PUBLIC
WEDNESDAY 8 JUNE 2022

A meeting of the Trust Board will take place at 9.30am on Wednesday 8 June 2022 in the NNUH Boardroom and by MS Teams

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AGENDA

	Item	Timing	Lead	Purpose
0	Clinical/Departmental Visits – see separate schedule	08.45-9.15		Information & Assurance
1	Apologies, Declarations of Interest and Chairman's Introduction	09.30-09.35	Chair	Information/ Discussion
2	Experience of Care – Maternity (inc National Drivers Review) Stephanie Pease – Divisional Midwifery Director Lisa Mastrullo – Quality Improvement Midwife Jenny Whatling - Chair, NNUH Maternity Voices Partnership (MVP)	09.35-10.05	NF	Information
3	Minutes of the Board meeting held in public on 06.04.22	10.05-10.15	Chair	Approval
4	Matters arising and update on actions		Chair	Discussion
5	Reflections on clinical visits		All	Discussion
6	Chief Executive's Update	10.15-10.25	CEO	Discussion
7	**Reports for Information and Assurance:**			Information, Assurance & Approval as specified
	(a) Quality and Safety Committee (24.05.22) - inc Quality Account 2021/22 – for approval (b) IPR – Quality, Safety and Patient Experience data	10.25-10.40	PC ED/NF	
	(c) Finance, Investments and Performance Committee (25.05.22) - inc Committee Annual Report (d) IPR – Performance and Productivity data (e) Finance – Month 1 report	10.40-11.00	TS CC RC	
	(f) IPR – Workforce data	11.00-11.20	PJ	
8	Staff Survey - Priority Improvement Actions		PJ	Discussion
9	Questions from members of the public	11.20-11.25	Chair	Discussion
10	Any other business	11.25-11.30	Chair	Discussion

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REPORT TO THE TRUST BOARD OF DIRECTORS

Date	**08 June 2022**
Title	**Experience of care – Maternity Services**
Author & Exec lead	**Stephanie Pease, Divisional Midwifery Director / Lisa Mastrullo Quality Improvement Lead Midwife** **Jenny Whatling, Chair, NNUH Maternity Voices Partnership (MVP)** **Professor Nancy Fontaine, Chief Nurse**
Purpose	**For Information/ Discussion**
Relevant Strategic Objective	**1. We will be a provider of high quality health and care services to our local population** **4. We will be a leader in the design and delivery of health and social care services in Norfolk**

Are there any quality, operational, workforce or financial implications of the decision requested by this report? If so explain where these are/will be addressed.	**Quality**	**Yes✓ No☐**	**Shares journey of improvement and engagement**
	Operational	**Yes☐ No☐**	
	Workforce	**Yes☐ No☐**	
	Financial	**Yes☐ No☐**	

1. Background/Context

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

1.2 Listening to Experiences of Care gives us the opportunity to learn about the things that we do well and consider where we can make improvements. It helps put patients at the heart of service development and improvements.

1.3 Today, the focus is on Maternity Services – sharing the journey of improvement and greater engagement with our Maternity Voices Partnership to ensure the voices of those who use and experience the service are amplified (especially the less well heard) and also that we work in collaboration to review feedback and co-produce improvements.

1.4 In particular the personal story of Jenny, Chair of the MVP will illustrate how the experiences of services users are central to and directly impacting how we work together as partners for improvement.

2. Key issues, risks and actions

2.1 The Final Ockenden report highlighted that service user voice is central to provision of quality care by listening to concerns and acting upon them. NNUH maternity services are committed to working closely with our MVP gain feedback and improve services

2.2 We have developed a feedback process to ensure the feedback given is actioned. This includes a bimonthly MVP feedback listening event on a particular theme. This is then discussed at a monthly meeting with maternity, MVP and PEEG to turn the feedback into actions and document on an action log. We then share the results at the next MVP meeting. 'COP Friday' will be utilised to share feedback with staff and formulate/delegate action owners.

2.3 The FFT and MVP survey have been merged via envoy to gain increased feedback which is more meaningful to improve our service

2.4 The Ockenden report outlined the need for true informed decision making. We have coproduced an informed decision-making tool which is presented in all maternity areas and online to ensure that women/birthing people are empowered to ask questions and receive the information they need to make informed decisions.

3. Conclusions/Outcome/Next steps

3.1 The experiences of services users are central to all Maternity service improvements and the underlying ethos of working with the MVP and service users to do this is demonstrable and outstanding.

3.2 Next steps for working together include:

- Outreach work to gain feedback from seldom heard voices and those where English is not the first language
- Recruitment of a second Vice Chair to enhance and expand the NNUH MVP and lead on volunteer outreach work to gain wider feedback
- Work to be started on improving the website and making is accessible for all

Recommendation:

The Board is recommended to:

- **note** the outstanding contribution of the MVP and Maternity Team in co-production and ensuring the voices of service users are embedded.
- provide any information/networking that would be helpful to our work.

Maternity Services National Driver Review

Stephanie Pease – Divisional Midwifery Director

Lisa Mastrullo – Quality Improvement Midwife

8th June 2022

National Drivers

2015

The Report of the Morecambe Bay Investigation

2016

Better Births – Improving outcomes of maternity services in England

Continuity of Carer

2020

Ockenden Report - Emerging findings and Recommendations from the independent review of maternity services at the Shrewsbury and Telford hospital NHS trust

2021

60 Supportive Steps To Safety

2022

Ockenden Report – Final

Findings, conclusions and essential actions from the independent t review of maternity services at the Shrewsbury and Telford hospital NHS trust

NNUH Response to National Drivers

Morecambe Bay	
Actions Outstanding	• Mandatory Training must be 90% and above (currently 89.7%)
Action Plan	• Mandatory training non compliance policy being produced for the three Trusts • IT system cleanse to ensure accuracy of compliance data • IT equipment for staff to complete mandatory training at home as result of staff feedback • Protected allocated time increased to ensure completion commencing - 1/4/22 • Mandatory training will be reviewed via the LMNS Quality and Safety Oversight Group
Deadline	July 2022

NNUH Response to National Drivers

Ockenden Report (Part 1)	
Actions outstanding	3 Actions IEA 3 & 7 • PROMPT - Multidisciplinary training 90% (Currently 86.4%) • CQC survey and action plan • Out of guidance SOP
Action Plan	• Implement new mandatory training non-compliance policy – across the 3 trusts • IT system cleanse of incorrect data to ensure accuracy • Nurse bank to add restrictions to bank contracts if PROMPT training not complete • CQC survey action plans underway • New birthing out of guidance policy in progress - First draft ready for maternity guidelines in June 2022
Deadline	July 2022

NNUH Response to National Drivers

60 Supportive Steps	
Actions Outstanding	8 actions Overlap with the other drivers and delays caused by external factors such as IT system updates, LMNS actions and awaiting guidelines meetings
Action Plan	Action owners to be chased and actions completed
Deadline	July 2022

Continuity of Carer Update

The Ockenden Final Report Letter states that until each trust has achieved safe sustainable staffing, this should be stopped until safe to continue

NNUH trust board is fully sighted on this and has confirmed its support for this decision

Ockenden Assurance Visit – May 2022

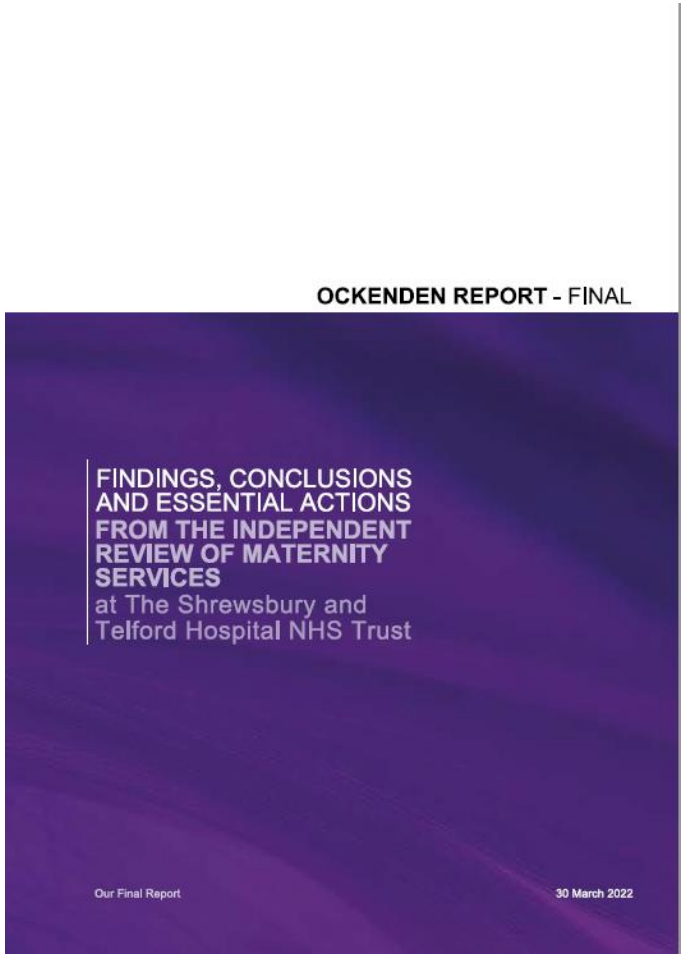
Visit from NHS England team to ensure the Ockenden evidence submitted in 2021 is embedded in practice. Full feedback expected shortly but immediate feedback themes were shared.

Achievements - Welcoming staff who took pride in their work, open door policies, staff well supported with incidents, engagement of MVP, improvements made since last visit

Challenges - Staff awareness of the safety champions and roles, clarification of reporting to board, obstetric staffing,

Reflections on the Final Ockenden Report

- 1486 families letters/responses have been used for this report.
- 1592 incidents of harm/ significant harm to mothers and babies from 2000 to 2019.
- Sadly 201 babies died and there were 12 maternal deaths



The report detailed avoidable failings across the whole service with four pillars of recurrent themes:

Safe staffing levels	**A well-trained workforce**
Learning from incidents	**Listening to families**

The 15 Immediate and Essential Actions

The report has produced 15 immediate and essential actions which are a 'Must do' for trusts across the country

Workforce planning and sustainability	Safe staffing	Escalation and accountability	Clinical governance --Leadership	Clinical governance Incident - investigation and complaints
Learning from deaths	Multi-disciplinary training	Complex antenatal care	Preterm birth	Labour and birth
Obstetric anaesthesia	Postnatal Care	Bereavement care	Neonatal care	Supporting families

Final Report - NNUH Commitment

The report was a harrowing read and maternity services at the NNUH are committed to providing safe care for women and birthing people

We will continue to learn from our incidents and be open and honest with staff and service users

We are committed to listening to our service - users and working closely with our MVP to improve services

Gain oversight from the Trust Board with regular reporting via Quality and Safety Committee, Hospital Management Board and the Trust Board

Continually review staffing levels, recruitment trajectory and retention. Improve our MT performance for a safe and effective workforce

Ockenden Final IEA's - Current position

15 Immediate and Essential Actions - 88 Actions Overall

Actions	Number
Red actions - Not started	13
Amber actions - Further action required	26
Green actions - On track	10
Blue actions - Complete	34
Grey actions (Awaiting national input)	2
Black actions – N/A to trust	3

The Next Steps

- RAG rate our current position
- Identify action owners
- Complete the 'Quick wins'
- Develop a business case where significant funding required
- Fortnightly meetings with the Ockenden MDT to review and progress the action plans and achieve compliance with the 15 immediate and essential actions

Final Message From Donna Ockenden

Remember that this report contains immediate and essential actions which are not a

'Would like or would be nice'

The actions are a MUST DO and despite no deadline being set these must be achieved to ensure a safe maternity service

THANK YOU FOR LISTENING!

ANY QUESTIONS?

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MINUTES OF TRUST BOARD MEETING IN PUBLIC

HELD ON 6 APRIL 2022

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
	Prof N Fontaine	- Chief Nurse
	Mr J Foster	- Non-Executive Director
	Prof C ffrench-Constant	- Non-Executive Director
	Mrs J Hannam	- Non-Executive Director
	Mr S Higginson	- Chief Executive
	Mr P Jones	- Chief People Officer
	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 V Rant	- Assistant to Board Secretary
	Members of the public and press	
	Mrs E Betts	- Public Governor
	Mr C Hinds	- Public Governors
	Mrs C Stubbs	- Staff Governor

22/013 **APOLOGIES, DECLARATIONS OF INTEREST AND CHAIRMAN'S INTRODUCTION**

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

22/014 **EXPERIENCE OF CARE – PATIENT/FAMILY REFLECTIONS**

The Board received a report concerning the Trust's Family Liaison Service and the experience of a family member, Nikki, who had used the Service during a relative's stay in hospital.

Professor Fontaine explained that evidence from feedback and complaints highlighted issues of poor communication with families during the pandemic. A number of initiatives were introduced to mitigate the impact of the pandemic:

- local visiting protocol introduced to enable visiting for patients at end of life, with dementia or other vulnerable people;
- iPads provided on wards to enable patients to use Skype;
- use of PALS messages to loved-ones with 2,228 messages delivered;
- virtual visiting enabled for Chaplaincy;
- Relatives Liaison Team established with a dedicated phone line in Wave 1 and 2 of the pandemic.

The CCG granted funding for a temporary Family Liaison Service in the acute Trusts and this was used to establish Family Liaison Officers on the wards to assist

communication with families/carers. Feedback from ward staff indicates that this has been a valuable resource, helping to de-escalate frustration of patients/relatives in not being able to speak to someone. Professor Fontaine indicated that in light of the increasing acuity and dependency of patients, the ward clerks and nurses have less capacity to perform this function. Ms Higson explained that other Trusts are looking to recruit to these posts substantively and this remains under review.

Non-Executives asked about the boundaries for communication of medical information to a patient's relatives and it was explained that medical updates are only provided by the medical and nursing teams. The Family Liaison Officers are however able to highlight to the medical teams when a patient's next of kin has requested an update so that this can be processed more swiftly.

Non-Executives asked what was available to inform patients about the arrangements that could be called upon while in hospital, to help keep their relatives informed. Ms Higson explained that our website has been updated with information about the Family Liaison Officers and we are reviewing information that is available to patients before and during their stay. Non-Executives asked how this information would be made available for non-English speaking patients/relatives and it was confirmed that different routes of accessibility are being implemented via the website and patient information leaflets/communications.

22/015 **MINUTES OF PREVIOUS MEETING HELD ON 2 FEBRUARY 2022**

The minutes of the meeting held on 2 February 2022 were agreed as a true record and approved for signing by the Chairman.

22/016 **MATTERS ARISING**

The Board reviewed the Action Points arising from its meeting held on 2 February 2022 as follows:

21/047 (21/037 Aug '21) Freedom to Speak-Up training – carried forward. We understand that the suite of 3 national e-learning videos regarding Speak-up (with the third aimed specifically at Board members) may be completed on 12 April 2022. Details to be circulated as soon as available nationally. **Action: Mr Garside/Mr Jones**

22/008 – Research update - Professor Denton will work with the R&D team to identify an appropriate Research Story to present to the Board in due course.
Action: Professor Denton

22/009 – North Western link road - The Trust was informed that the Council is undertaking further work around the carbon impact of the scheme and this would be shared. The Trust is awaiting this information. **Action: Mr Hackwell**

22/017 **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 reported that there has been an increase in Covid in the community and the number of patients in hospital with Covid has risen. The number of patients requiring emergency care is also high and we are seeing patients with higher frailty/acuity. The Trust is focussing on treatment of long waiting elective patients but the number of Covid and emergency patients is causing significant additional pressure on beds.

Due to congestion in the hospital, ambulance handover performance has been adversely affected, with over 60% of ambulances delayed beyond the 15-minute handover target. This is a real challenge and reflects a series of influences – mental

health demand, availability of alternatives to hospital, discharge delays in health and social care. We are working with system partners to try to find solutions to each of these.

The results of the Staff Survey have been published and indicate a decrease in staff satisfaction which reflects a national trend. This appears to reflect the impact on staff from the pandemic. A number of underlying local issues have been identified at NNUH including matters concerning facilities and travel. We want NNUH to be a place where people want to work and we are looking at what can be done to address staff concerns as quickly as possible.

The Personalised Outpatient Programme is a significant change to the way that patients will access follow-up appointments. The Trust has been selected for involvement as part of a national innovation pilot and the Board will be kept updated as this develops.

We are also continuing development of our Virtual Ward to enable appropriate patients to be monitored at home freeing-up hospital beds for other patients.

Mr Higginson reflected on the recent publication of the second Ockenden Report. All NHS Trusts will be working to implement actions to address recommendations from the report to ensure we are doing the best we can for maternity services. The Board will be updated at its meeting in June, on the work to address the findings and recommendations of the Ockenden Reports. **Action: Prof Fontaine**

22/018 **REPORTS FOR INFORMATION AND ASSURANCE**

(a) People and Culture Committee (28.03.22)

The Board received a report concerning the People & Culture Committee meeting on 28 March 2022.

Mrs Hannam reported that the Committee had reviewed the draft People & Culture Strategy. Staff engagement regarding the Strategy is being undertaken to ensure that the right objectives are identified and so that the Strategy enhances our work to support our PRIDE values.

The Staff Survey results were reviewed and the Committee noted that proposed actions are to be developed to improve the experience of our staff.

The Committee had considered metrics regarding the gender pay gap. It was noted that this is hugely influenced by the gender profile in the medical workforce and this is changing nationally, with more women reaching senior medical roles. An area for further focus concerns the clinical excellence awards scheme for doctors, which can operate to favour those following a traditional 'male-pattern' career. The scheme is under review nationally to avoid disadvantaging those who work part time or take career breaks.

The Committee has completed its annual assessment and updating changes have been made to its Terms of Reference. On the recommendation of the Committee, the Board **approved** the updated Terms of Reference for its People & Culture Committee.

(b) IPR - Workforce

Mr Jones reported that the mandatory training 10-point action plan has been implemented and compliance is now over 90%. Resumption of face-to-face training has been challenging in light of operational pressures but E-learning has been expanded. Staff are permitted to complete their training prior to starting in post and learning can be transferred across from other NHS organisations.

Appraisal compliance continues on an upward trajectory and is above average for our peer group. The new Personal Development Review appraisal is being rolled out and will align with our Corporate Strategy.

The staff sickness absence rate has increased to 6.3% and this is thought to be due to the increased prevalence of Covid in the community.

The number of vacancies has reduced and there are currently 570 candidates at the 'under offer' stage of recruitment. 77 overseas nurses are in post and a further 36 will be joining in April and May. A protocol has been established to allow staff to move laterally between jobs within the Trust. Line managers have been encouraged to reduce shortlisting and interview timeframes to reduce the time to hire. The 48-hour target to make an offer to candidates is being achieved, with most offers made within 1.4 days.

(c) Quality and Safety Committee (29.03.22)

The Board received a report concerning the Quality & Safety Committee meeting on 29 March 2022.

Dr Chrispin reported that the Committee had reviewed pressure in the emergency pathway, pressures in ED and ambulance handover. It was clear that increased system focus on reducing delayed transfers of care would have a beneficial result in improved emergency care performance.

The Committee received assurance from the Surgery Division that actions are being implemented to address the risk of inadequate capacity in the Ophthalmology Department and to reduce the residual risk score to 8 by 2025.

The Maternity Team are reporting regularly to the Quality & Safety Committee and there has been significant assurance that the team are identifying challenges and addressing risks.

Mr White noted the reduction in pressure ulcers and thanked the nursing team on behalf of the Board for their work in this significant achievement.

(d) IPR – Quality, Safety and Patient Experience

Professor Fontaine highlighted that a high number of reported incidents is a positive indication of an embedded safety culture. A significant number of our incidents are categorised as no or low harm events and this is also good evidence of reporting aimed to optimise learning.

The number of patient falls has been an area of concern. A Quality Improvement Programme is underway and will use the same methodology for improvement as was used successfully for reducing the frequency of pressure ulcers. A number of improvement innovations are being evaluated including luminous bands and yellow socks/blankets to help identify 'at risk' patients.

Professor Denton reported that HSMR is within the expected range and the SHMI is above the expected range but falls within the expected range when adjusted for palliative care. Non-Executives indicated that it would be helpful to include an upper range on the mortality data chart. **Action: Professor Denton**

A report on mortality will be scheduled for a future Board meeting, in conjunction with the Quality & Safety Committee Work Programme.

Action: Mr Garside/Professor Denton

(e) Audit Committee (30.03.22)

The Board received a report concerning the Audit Committee meeting on 30 March 2022.

Although there were a number of adverse Internal Audit opinions issued during the year, there has been good progress on implementation of Internal Audit recommendations. This will have a positive impact on the Head of Internal Audit Opinion for 2021/22.

The Committee commended introduction of the Divisional Annual Governance Statements (AGS) which provide an opportunity for the Divisions to reflect on governance and to identify weaknesses/strengths to drive improvement. The Divisional AGS's will be used to support preparation of the Chief Executive's Annual Governance Statement.

The current Risk Management Strategy is under review. On the recommendation of the Audit Committee, the Board **approved** extension of the term of the Risk Management Strategy to October 2022.

Non-Executives asked about mitigations being put in place to reduce cyber security risks. Mr Foster explained that the Trust had been audited against new protocols which had been introduced in the DSPT framework. The position has been reviewed by the Committee and the Digital Health Team are working to implement recommendations swiftly in order to meet the submission deadline of the DSPT in June.

On the recommendation of the Committee, the Board **approved** the updated terms of reference for its Audit Committee.

Mr Foster reported that the Committee reviewed planning for year-end preparation of the Trust's Annual Report and Accounts. Following a report from Mr Clarke, and consistent with the recommendation of the Audit Committee, the Board **approved** preparation of the Financial Statements on a Going Concern basis and inclusion of an associated statement in the accounts (2021/22).

(f) Finance, Investments and Performance Committee (30.03.22)

The Board received a report concerning the Finance, Investments & Performance Committee meeting on 30 March 2022.

Mr Spink reported that the Committee recognised the extreme pressure on the Hospital due to the high number of patients awaiting discharge. The Committee acknowledged the efforts of our staff working under challenging conditions.

The elective programme has been maintained to limit the risk to long waiting patients and progress is being made to clear the number of patients waiting longer than 104 weeks.

The Committee was assured that a dedicated workforce lead will be identified to work with the three acute Trusts to address the workforce challenge for the forthcoming Diagnostic & Assessment Centres.

The Committee was assured by the cycle 3 Financial Plan for 2022/23. The financial position at month 11 is favourable and CIP delivery is £3m ahead of plan.

A review is underway to consider whether the remit of the Committee is too extensive and whether a sub-committee should be established for overseeing capital investments, business cases and innovation/transformation.

(g) IPR – Finance, Performance and Productivity

Mr Cobb informed the Board that the number of patients in hospital without a 'criteria to reside' remains high. The resulting congestion is significantly impacting our non-elective care pathways. The number and complexity of patients requiring non-elective care has been high and it is challenging to try to ensure that patients are treated in the right place for their condition. We are continuing to look at what we can do differently as services and pathways continue to be complicated by Covid but recent changes to the testing regime are expected to ease some pressures. We continue to focus on reducing ambulance delays wherever possible.

The elective recovery programme is ahead of trajectory, in reducing the number of patients waiting 104 weeks to zero by the end of June. The number of patients waiting over 52 weeks has been reduced from 11,300 to 10,300 in February.

Mr Higginson highlighted the work of our teams managing the waiting lists. Many patients are understandably frustrated at the length of wait and our staff are thanked for their work in managing this liaison as sympathetically as possible.

(i) Finance Report – Month 11

Mr Clarke reported the financial position in the year to date is a surplus of £9.7m (£8.2m better than plan) and we are forecasting a year end outturn surplus of £9.1m. The Capital Plan is underspent by £5.4m due to schemes missing planned milestones. CIP performance is ahead of plan with £14.1m CIPs delivered against the plan of £11.1m.

Mr Higginson reflected that this will be the second consecutive financial year that we have achieved our financial plan and our teams and financial colleagues were thanked for their efforts towards this significant improvement.

(j) Use of Resources Update and Financial Governance Review Actions

The Board was updated with regard to the Use of Resources position, as reviewed through the Finance, Investments & Performance Committee.

22/019 **TRUST CORPORATE STRATEGY 2022-2027**

The Board received the draft Corporate Strategy for 2022 to 2027 – *Caring with PRIDE*.

Mr Hackwell reported that engagement in developing our Strategy was at an unprecedented level. Over 600 feedback comments were received with over 50% from staff and this has been used to inform development of the Strategy. The Vision statement has been shortened and five Strategic Commitments identified for focus over the next five years:

1. Together, we will develop services so that everyone has the best experience of care and treatment.
2. Together, we will support each other to be the best we can be, to be valued and proud of our hospital for all.
3. Together, we will join up services to improve the health and wellbeing of our diverse communities.
4. Together, we will provide nationally recognised, clinically led services that are high quality, safe and based on evidence and research.
5. Together, we will use public money to maximum effect.

A launch programme will commence following publication of the Strategy, in order to engage stakeholders in our plans for the next five years. The Strategy will be published digitally with access via links and key messages can be extracted and displayed as posters for those who do not have access via digital routes.

Non-Executives welcomed the increased level of engagement and evidence that feedback contributions had been included. The Strategy also highlights the services provided by the Trust in the wider community. The Strategy's defined vision and aspirations for collaboration will be helpful in future liaison with partners on the Norwich Research Park.

Mr Higginson indicated that we will be aiming to introduce links to the Strategy in the annual appraisal process, in order that staff objectives align with our Strategic Commitments.

Board members commended the inclusive approach taken and **approved** the Trust's 5-year *Caring with PRIDE Strategy* (2022-27).

22/020 **QUESTIONS FROM MEMBERS OF THE PUBLIC**

- Mrs Betts (Public Governor) reflected that despite the apparent operational pressures, it was good to hear of a number of positive developments and that things are moving in the right direction.
- Mr Hind (Public Governor) congratulated Michelle Frost (Specialist Biomedical Scientist) on the Anti-Spiking Campaign and Emily Wells (CNIO) for achieving national recognition for digital work including the Virtual Ward.

22/021 **ANY OTHER BUSINESS**

There was no other business.

22/022 **DATE AND TIME OF NEXT MEETING**

The next meeting of the Trust Board in public will be at 9.30am on Wednesday 8 June 2022 in the Boardroom of the Norfolk and Norwich University Hospital (location TBC).

Signed by the Interim Chairman: …… Date: ……
Confirmed and approved by the Board for signature on 8 June 2022 [TBC]

Decisions Taken:

22/018(a) – People & Culture Committee ToRs	On the recommendation of the Committee, the Board **approved** the updated terms of reference for its People & Culture Committee.
22/018(e)(i) – Risk Management Strategy	On the recommendation of the Committee, the Board **approved** extension of the term of the Risk Management Strategy to October 2022.
22/018(e)(ii) – Audit Committee ToRs	On the recommendation of the Committee, the Board **approved** the updated terms of reference for its Audit Committee.
22/018(e)(iii) – Going Concern	Consistent with the recommendation of the Audit Committee, the Board **approved** preparation of the Financial Statements on a Going Concern basis and inclusion of an associated statement in the accounts (2021/22)
22/019 – *Caring with PRIDE* Strategy (2022-27)	Board members commended the inclusive approach taken and **approved** the Trust's 5-year Caring with PRIDE Strategy (2022-27)

Action Points Arising:

	Action
Carried forward	
21/047 (21/037 Aug '21) Freedom to Speak-Up training – carried forward.	We understand that the suite of 3 national e-learning videos regarding Speak-up (with the third aimed specifically at Board members) may be completed on 12 April 2022. Details to be circulated as soon as available nationally. **Action: Mr Garside/Mr Jones**
22/008 – Research update	Professor Denton will work with the R&D team to identify an appropriate Research Story to present to the Board in due course. **Action: Professor Denton**
22/009 – North Western link road	The Trust was informed that the Council is undertaking further work around the carbon impact of the scheme and this would be shared. The Trust is awaiting this information. **Action: Mr Hackwell**
Actions from 6 April '22	
22/017 – Ockenden Report Follow-up	The Board will be updated at its meeting in June, on the work to address the findings and recommendations of the Ockenden Reports. **Action: Prof Fontaine**
22/018 – mortality reporting - IPR	Professor Denton reported that HSMR is within the expected range and the SHMI is above the expected range but falls within the expected range when adjusted for palliative care. Non-Executives indicated that it would be helpful to include an upper range on the mortality data chart. **Action: Professor Denton**
22/018(d) – mortality reporting	A report on mortality will be scheduled for a future Board meeting, in conjunction with the Quality & Safety Committee Work Programme. **Action: Mr Garside/Professor Denton**

REPORT TO TRUST BOARD

Date	**8 June 2022**
Title	**Chair's key Issues report from Quality and Safety Committee Meeting on 24.05.22**
Author & Exec Lead	**John Paul Garside on behalf of Dr Pam Chrispin – Non-Executive Director (Committee Chair)**
Purpose	**For Information and approval as specified**

The Quality and Safety Committee met on 24 May 2022. Papers for the meeting were made available to all Board members for information in the usual way via Admin Control. The meeting was quorate and was attended by Ms Jackie Hammond (Public Governor) as observer and Ms Rosemary Moore (Patient Panel Chair).

In addition to consideration of the usual suite of information and reports concerning quality and safety in the Trust, the Committee identified the following matters to highlight to the Board:

0	Clinical Visit	The meeting began with a visit to the Clinical Sterile Supplies Department. This is a key element of the Trust's infrastructure for ensuring safe and efficient care; it ensures timely delivery of correctly assembled, sterile instruments and procedure packs for use in every operation and invasive procedure undertaken in the Trust.
1	Mental Health and Complex Care Board	The increased level of need for mental health support has been reported nationally in the aftermath of the pandemic. The Committee discussed concerns about the number of patients with mental health difficulties who self-present or are brought to this hospital for mental health support, in the absence of readily accessible specialist services elsewhere.
2	Medical staffing data	The Committee receives regular information regarding nurse staffing levels and requested a report concerning medical staffing. The information received highlighted areas of particular vacancies in the medical workforce. This is an important part of the full picture around performance and quality. The Committee requested that a follow-up report should be provided to the People & Culture Committee, indicating steps to be taken to address 'hard to fill' vacancies.
3	Waiting list harm	The Committee receives regular reports regarding our approach to monitoring patients who are waiting for treatment, in order to ensure that they are prioritised appropriately and that monitoring is in place to minimise the risk of harm. The Trust's systems have been commended as robust. Reducing waiting times is a quality and safety issue and the Committee noted the importance of completing the Norfolk & Norwich Orthopaedic Centre and Paediatric Theatres Complex.
4	Quality Account 2021/22	The Committee reviewed the Trust's draft Quality Account (as **attached**) and made a number of suggestions for revision. An Easy Read and accessible summary version will be prepared. In the meantime, the Committee recommends the Quality Account 2021/22 to the Board for approval.
5	Maternity update	The Committee receives regular updates regarding actions in the Maternity Department to enhance quality and safety and to implement the recommendations of national reports into maternity services. The Committee was updated on a recent external assurance visit and the Board will receive a maternity presentation elsewhere on its Agenda.

Conclusions/Outcome/Next steps: The next Committee meeting is scheduled for 28 June 2022 and will review matters including Falls Prevention, Research Oversight, safer staffing and Divisional focus on Clinical Support Services

Recommendations: The Board is recommended to:

- **note** the work of its Quality & Safety Committee
- **approve** the draft Quality Account 2021/22.

Norfolk and Norwich University Hospitals
NHS Foundation Trust

NNUH Annual Quality Account 2021-2022

Quality Account 2021/22 – Contents

Foreword

This report has been designed to provide assurance to our patients, the public and commissioners that the quality of care at Norfolk & Norwich University Hospitals NHS Foundation Trust (NNUH) meets the expected standard. It provides a review of the Trust's quality improvement activities and achievements during 2021/22 and identifies improvement opportunities the Trust will focus on.

This report also identifies and explains the Trust's quality priorities for 2022/2023.

Please note that where the abbreviation NNUH is utilised, or 'the Trust' this refers to the Norfolk & Norwich University Hospitals NHS Foundation Trust.

This document will be available in an Easy Read version.

If you would like this document in another language, large print or brail, please email q-s.team@nnuh.nhs.uk.

***Text written in blue is to highlight mandatory wording as per the requirements set by NHS England and NHS Improvement.**

Part 1 - Chief Executive's Statement on Quality

Welcome to the Norfolk and Norwich University Hospitals NHS Foundation Trust's Quality Account for 2021/22. This document provides an overview of all the activity that has been taking place within our Trust on the quality agenda over the past year.

It is hard to believe that it has been two years since the start of the Covid-19 pandemic and the first national lockdown. I want to thank all of our colleagues and volunteers for their incredible dedication, resilience, team work, compassion and hard work during an extremely challenging and difficult time for the NHS and the communities we serve.

We, as an NHS Trust and the wider health and care system, are continually working to restore services impacted by the pandemic and manage constraints brought on by the continued presence of COVID-19 but these are not without their own challenges. Whilst patient safety and care, as well as, the welfare of our staff is ever the primary importance, progression on some of our quality priorities and improvements have been affected.

December saw the election results of our five public governor seats; two governors were newly elected and three were existing re-elected governors. Also appointed were two new staff governors, one for Nursing and Midwifery and one for Admin and Clerical. Governors have an important role in representing the interests of the members (public and staff), partner organisations and the community we serve, in monitoring how services are developed and how the organisation is managed. Congratulations and a warm welcome to them all.

The NHS staff survey results were published in March and this year's results reflect the arduous period the NHS has encountered. As a Trust we are disappointed about our staff's experience of working for us, therefore, we are developing a three-year improvement plan to turn around our results and are determined to make our hospitals a better place to work. We will need to work together, both internally and with the wider healthcare system, to make transformational changes to the way in which we work, care for patients and each other.

Despite the pressures we all have been under and multiple changes to services, we have also been able to make some great improvements that we must recognise and take pride in. We have accelerated many programmes of work in very short timeframes from redesigning services, opening new centres, introducing virtual consultations and the Virtual Ward, being involved in ground-breaking research, and playing our part in the Covid-19 vaccination programme.

We are delighted to announce that the National Institute for Health Research (NIHR) have awarded researchers from NNUH and UEA £1.25m to further develop a pioneering device that monitors dizziness and diagnoses its causes. The award is to fund a large-scale project that will involve the participation of ten hospitals across the UK. By the end of the project, it is hoped to have a device that can automatically identify some of the most common causes of dizziness.

In October, the North Norfolk Macmillan Centre at Cromer Hospital was officially opened. It marks the culmination of many years of hard work and planning between our hospital, the Norfolk & Norwich Hospitals Charity, Macmillan Cancer Support and local patients, plus the Cromer Community and Hospital Friends, who funded the equipment. We'd like to say thank you to our charity partners and the local community for all the support we have received in making this cancer centre come to fruition in the teeth of a pandemic. It's a remarkable achievement by all concerned and will benefit patients in North Norfolk for years to come

There have been several reports in the media around maternal care particularly the Ockenden reports. Our Trust has been working hard to learn from these reports and improve maternity care at NNUH. A recent National Maternity Survey, coordinated by the CQC, saw the maternity service receive a score of 9.4 out of 10 for treating patients with respect and dignity and 9 out of 10 of respondents had confidence and trust in staff. A wonderful achievement.

Also, our hospital will be home to one of two Maternal Medicine Centres (MMCs) of excellence in the East of England for those who are pregnant with pre-existing medical conditions. NHS England has an ambitious aim to reduce maternal deaths by 50% by 2025. To help achieve this goal, they have supported the establishment of a national Maternal Medicine Network with a 'hub and spoke model' in each region. With existing established maternal medicine service, our Norwich hospital was in an ideal position to provide a regional networked service.

In addition, as part of the National Strategy, NHS England are funding training of 12 Consultant Physicians in Obstetric Medicine. Mark Andrews, our established Renal and Obstetric Physician, was the first person to be accepted for this training and currently remains the only person in the country to have completed the program and be awarded the prestigious Diploma in Obstetric Medicine. He will be leading on this service with the existing Maternal Medicine team led by Fran Harlow, Obstetric Consultant. This is a great opportunity to improve the level of care for those who are pregnant with serious conditions in our region, and I look forward to seeing how the centre and improvements progress over the coming year.

We cannot forget that NNUH is not the only heath care provider in Norfolk & Waveney and that our patients can use a range of services across the system. Together we are looking at ways to join up our services for patient safety and experience. Just a highlight of some achievements so far has been the co-design and implementation of the Consent Policy and Clinical Harm Review Process at the three acute hospitals; James Paget University Hospital NHS Foundation Trust, The Queen Elizabeth Hospital

Kings Lynn NHS Foundation Trust and us. We are working in partnership with our partners at Norfolk and Suffolk NHS Foundation Trust, East of England Ambulance Service NHS Trust and Norfolk and Waveney CCG to support people experiencing a mental health crisis with a dedicated mental health response car staff by a paramedic and a specialist mental health practitioner.

This year again has also seen numerous members of staff and departments internationally, nationally, and locally recognised for their hard work and dedication; such a wonderful achievement and congratulations to you all.

One such team is the specialist In-patient Diabetes Services Team from Elsie Bertram Diabetes Centre who have won the Royal College of Physicians (RCP) 2021 Excellence in Patient Care Quality Improvement Award. NNUH's specialist diabetes in-patient team had been shortlisted for their 18-month programme aimed at helping the thousands of patients with diabetes who are treated at the hospital. This is a wonderful achievement, especially through the pandemic, and I know the team are not resting on their laurels and are using this accolade to look further and expand their support to patients with diabetes.

As we look ahead to 2022/23, in addition to continuing to work on elective recovery and the demands of COVID-19, we will be launching our new five-year strategy for the Trust and celebrating 250 years of our Norfolk and Norwich Hospital.

I confirm, that to the best of my knowledge the information contained within this report reflects a true, accurate and balanced picture of our performance.

Sam Higginson
Chief Executive

Good News Story

New technology launches to speed up sepsis diagnosis for hospital patients

The combined Microbiology departments at the Eastern Pathology Alliance have launched onsite blood culture machines across Norfolk's three acute hospitals to diagnose sepsis more quickly.

Sepsis is a serious life-threatening condition that can occur in patients in the community or in hospital with vulnerable patients and patients with chronic health conditions most at risk.

The blood culture samples of hospital patients with suspected sepsis across Norfolk used to be sent to the Microbiology lab at Norwich Research Park.

However, new machines – the BioMerieux BACT/ Alert Virtuo – have been installed in the laboratories at the JPUH, NNUH and the Queen Elizabeth Hospital, significantly reducing the time it takes to provide information to help clinical staff treat patients.

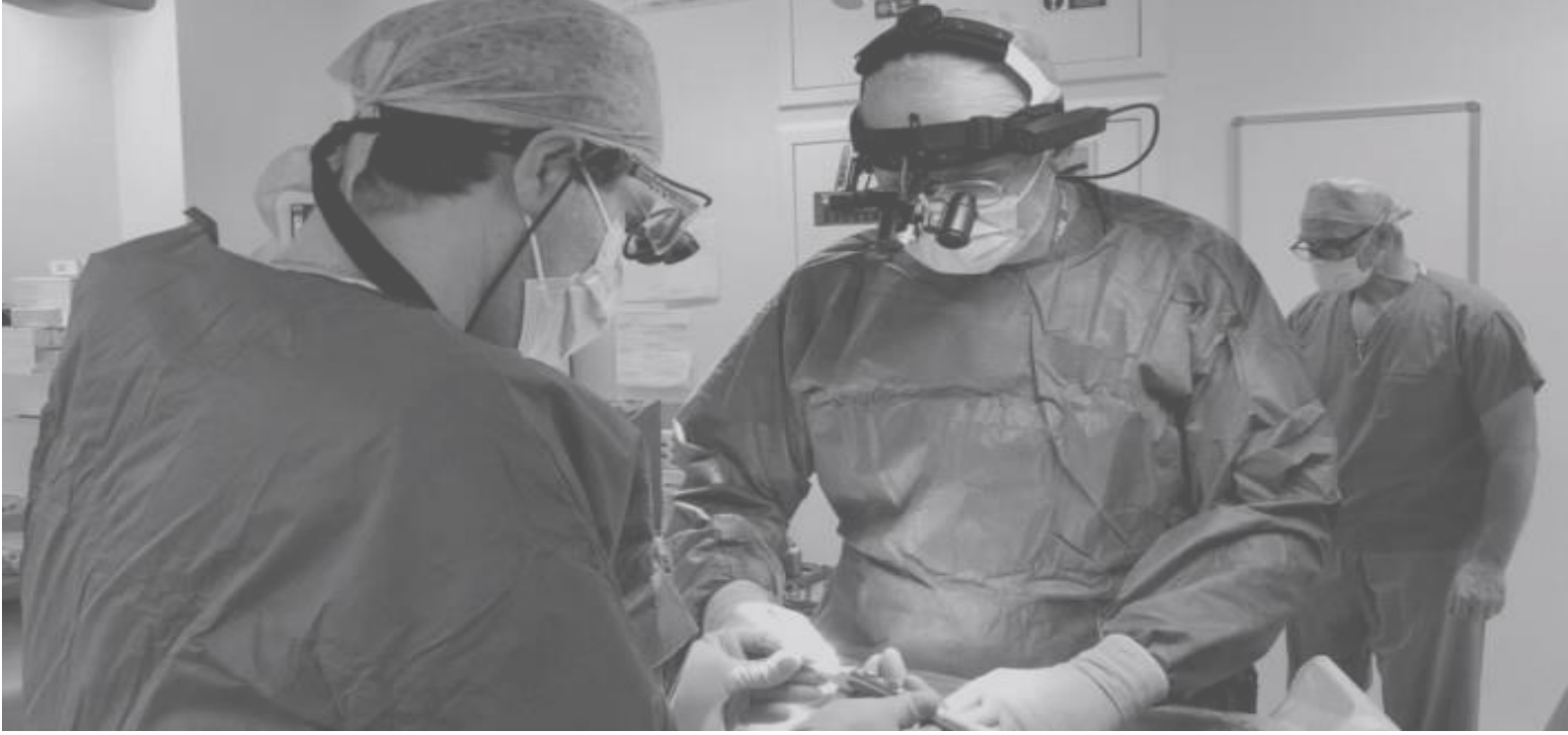
If sepsis is suspected, a patient's blood is collected and mixed with a sterile culture media to encourage the bug to grow so it can be identified by scientists Microbiology labs.

The new machines are part of the EPA Microbiology network service at the three hospitals and will process hundreds of blood samples each week that will be reviewed more quickly and patients with positive samples can be treated with more focused antibiotics at an earlier stage. Once a blood culture sample is collected it can be delivered to the onsite lab straight away and fed into the fully automated system immediately day or night.

The benefits include:

- Optimal growth and reduced loss of fastidious organisms
- Prompt results and further work available sooner due to decreased transport delay
- Negative results released sooner, meaning patients will be discharged more promptly
- Increased bed space
- Reduced unnecessary antibiotic usage and associated antibiotic resistance development
- Better patients outcomes, decrease in costs
- Improved adherence to National guidelines

Part 2 – Priorities for improvement and statements of assurance from the board



Good news story

First AR neuromodulation spinal surgery in the world takes place at NNUH

The first neuromodulation AR surgery in the world has taken place at our hospital.

Nick Steele, Spinal Consultant, and team used the latest video technology and augmented reality (AR) goggles and were assisted by a neurosurgical colleague in Wales providing extra support with a complex spinal cord stimulation procedure.

The operation took place with technical support on hand by Rods and Cones in Belgium, which meant we were the first Neuromodulation team to use the Boston Scientific augmented reality goggles worldwide. The technology provides remote support or teaching without the need for a supporting surgeon to travel a long distance to be physically present in the operating room.

Ann-Katrin Fritz, Consultant in Neuromodulation and Pain Management, said: "*When procedures are complicated, this technology allows us to have another specialist available in another part of the UK and someone very experienced in that procedure. It is the next best thing to having someone scrubbed up at the table in the theatre and there are a lot of advantages to this.*

"Having that extra support if we do have an expected difficult case improves patient safety and the chances of the procedure being a success.

"The patient was fascinated and very grateful for the surgery to happen in this way. It is great that we can treat these patients at the hospital and not send them to other centres in Oxford or London."

Part 2.1 - Priorities for improvement

Due to the pandemic and service demands, performance of the fourteen quality improvement priorities set out for 2021/22 in the 2020/21 Quality Account has been mixed; a number of priorities were met, had significant improvement or sustainable results demonstrated over the year. The fourteen priorities were:

Patient Safety:

- **Safe 1:** Appropriate Antibiotic Prescribing for UTI in adults aged 16 + (Target for 2021/22 met)
- **Safe 3:** Recording of NEWS2 Score, escalation time and response times for unplanned critical care admissions. (Target for 2021/22 met)
- **Safe 4**: Screening and Treatment of Iron Deficiency anaemia in patients listed for major elective blood loss surgery.
- **Safe 5:** Treatment of Community Acquired pneumonia (CAP) in line with BTS Care Bundle (Target for 2021/22 met)
- **Safe 6:** Rapid rule out protocol for ED patients with suspected acute myocardial infarction
- **Safe 7:** All pregnant women will have a discussion regarding preferred place of birth and a risk assessment of their choice at each scheduled Antenatal appointment.

Clinical Effectiveness:

- **Effective 1:** Adherence to Evidence Based intervention Clinical Criteria (Target for 2021/22 met)
- **UoR9.1.1:** The implementation of a robust discharge to assess process and earlier more efficient discharge planning.
- **UoR8.1.3:** Same Day Emergency Care focus on frailty service
- **UoR9.1:** The implementation of a robust discharge to assess process and earlier more efficient discharge planning.

- **UoR9.1.3:** Reconfiguration the ED footprint and patient journey processes through the department with a focus on improved triage processes and the management of ambulatory majors.

Experience:

- **Experience 1:** Shared Decision Making; Cardiology (Target for 2021/22 met)
- **Experience 3:** Patient experience of redesigned processes (described in effectiveness section)
- **Experience 4:** Improving patient centred transfers of care

The Board of Directors has chosen to refresh the quality priorities to align to the new Trust Strategy 'Caring with PRIDE' 2022-2026 published in April 2022. Eleven new priorities are being introduced:

Patient Safety:

- Improve surveillance of patients who have delayed surgical treatment - (Harm review process)
- Safe record keeping and results management – 1-3 years
- Improving Emergency Pathways – 1-2 years
- Provide personalised safe care to women, people, babies and their families – 1-2 years

Clinical Effectiveness:

- Reduce waiting list backlog (Personalised Outpatient Programme)
- Improve COPD pathway 1-2 years
- Improve Orthopaedic pathways and outcomes

Patient Experience:

- Shared Decision Making and Personalised Care – 1-3 years
- Improving equity of access and experience to services 1-2 years
- Introduce the Home First model (Discharge to Assess) 1-2 years

Staff Experience:

- Improve Staff Experience 1-3 years

Due to the pandemic CQUINs for 2020/21 which were suspended nationally, and as we were heavily focussed on the pandemic response, we agreed that these would be adopted as the Quality Priorities for 2020/21 which were rolled over into 2021/22. Data for the discontinued priorities is still collected, monitored and reported internally at the relevant Trust groups e.g. evidence group and Quality Programme Board.

New Quality Priorities for 2022/2023

Patient Safety

Improve surveillance of patients who have delayed surgical treatment - (Harm review process)	
Rationale	Prolonged waiting times for elective care with increased risk of harm whilst waiting • Strategic commitment 1 • Corporate Risk Register - 1 score 20 • Risk Register: 363, 513, 694, 908, 948, 1299, 1407, 1410, 1599, 1504, 1636, 1637, 1670, 1826, 1856, 1877 • Business Assurance Framework: 1.3
How we will do this	• P codes assigned to all on waiting list • Embed robust harm review process • Identify higher risk pathways and reprioritise the to come in date • Identify themes from harm review of those identified as experiencing moderate or above harm
Proposed measurement and monitoring	• Reviews Due (in the past and in the future) • Reviews completed (on time and not on time/breaching target) • Performance % = [Reviews Completed On Time]/[Reviews Due] • Upgrades and downgrades at review (e.g. P3 to P2 = upgrade) • Emergency admissions whilst on waiting list • Deaths whilst on waiting list (related to index condition) • Analysis of moderate and above harm incidents Monitored via Elective Clinical Harm Group and system Clinical Harm and Prioritisation Group reporting to Elective Recovery Board Progress reported via Quality Programme Board
Executive Lead and Delivery Leads	Medical Director Deputy Chief Operations Officer Elective Deputy Chief Nurse Elective Recovery Associate Medical Director

Safe record keeping and results management – 1 - 3 years	
Rationale	Documentation and management of results a theme from Structured Judgement Review and Serious Incidents Quality of discharge information a theme from patient complaints and feedback from primary care partners • Strategic commitment 1, 3 & 5.
How we will do this	Implement an enterprise electronic health record by 2024. Write guidance, learn from best practise from other hospitals Define and process map clinical processes and define the future state in preparation for Electronic Patient Record. Set up and resource an ICE filing Task and Finish group Implement a Standard Operating Procedure (SOP) for filing results Improve quality of electronic discharge letters – timeliness and completeness of letters
Proposed measurement and monitoring	• Safety incidents related to results management • % Electronic Discharge Letter (EDL) completed at time of discharge • Audit compliance with ICE filing SOP in Q3/4 Power BI dashboard and digital health quality reporting into Clinical Safety and Effectiveness Sub-Board Committee. Monitored via EDL task and finish group Monitored via ICE filing Task and Finish group Progress reported via Quality Programme Board
Executive Lead and Delivery Leads	Medical Director Chief Clinical Information Officer Deputy Medical Director Associate Medical Director Primary Care

Improving Emergency Pathways – 1-2 years	
Rationale	Increasing numbers of people requiring unplanned care • Strategic Commitment 1, 3 • Corporate Risk Register 5 – score 20 • Risk Register: 717, 965, 1002, 1256, 1381, 1510, 1511, 1609 & 1689 • Business Assurance Framework:1.2
How we will do this	• Safer Better Faster programme • Reconfigure Emergency Department (ED) footprint to make flow through dept more efficient • Establish an Urgent Treatment Centre at Cromer and NNUH

	• Maximise efficient use of Same Day Emergency Care (SDEC)
Proposed measurement and monitoring	• Ambulance handover times • Time to initial assessment • Admissions within 1 hour of being clinically ready to proceed • Total time in ED • Average time in ED • 4 hour standard • SDEC activity levels • Virtual Ward activity • Average Length of Stay • Pathway zero No Criteria to Reside (NC2R) • Discharge to assess 1-3 NC2R patients • GP streaming activity • Discharges before 12 noon Monitored via Emergency and Urgent Care Improvement Board Progress reported via Quality Programme Board
Executive Lead and Delivery Leads	Chief Operations Officer (COO) Deputy COO– Urgent and Emergency Care Chief Of Division (COD) Medicine COD Surgery, Emergency and critical care Operations Director – Transformation and Integration

Provide personalised safe care to women, people, babies and their families – 1-2 years	
Rationale	Maternity services are experiencing high levels of scrutiny Several published reports that highlight maternity safety concerns CQC State of Care report 2021 – ongoing quality concern that Maternity Improvements are too slow • Strategic commitment 1.

How we will do this	• Assess our services against the recommendations from national reports:
	  o Ockenden
	  o East Kent
	  o Nottingham
	• Develop robust safety assurance processes
	• Create a maternity metrics dashboard

Proposed measurement and monitoring	• Delivery method and location (excluding C section) • Place of birth risk assessment • 1:1 care in labour

	• Maternal mortality • 3rd & 4th degree tear • Post-Partum Haemorrhage at or >1.5l • Unplanned admission to critical care complex • Mothers transferred out of unit • Readmissions within 30 days • At risk groups (>45yrs, black Asian and minority ethnic group, Vulnerable groups) • Perinatal Mortality • Stillbirth and early neonatal death <6days • Unplanned admission to NICU at 37/40+ • Seizures, therapeutic cooling, Hypoxic Ischemic Encephalopathy grade 3. • Unit closures. Monitored via Maternity Safety Board Progress reported via Quality Programme Board
Executive Lead and Delivery Leads	Chief Nurse Director of Midwifery Service Director Obstetrics

Clinical Effectiveness

Reduce waiting list backlog (Personalised Outpatient Programme)	
Rationale	NHS target to reduce outpatient follow-ups by a minimum of 25% against 2019/20 activity levels by March 2023 to release time for new appointments and additional procedure lists • Strategic commitment 1 • Corporate Risk Register 1 • Risk Register: 363, 513, 694, 908, 948, 1299, 1407, 1410, 1599, 1504, 1636, 1637, 1670, 1826, 1856, 1877 • Business Assurance Framework: 1.3
How we will do this	• Introduction of a Personalised Outpatient Programme • Implement 2 new IT systems: o Infinity – a referral task management platform linked to the Patient Administration system o DrDoctor – a cloud based platform for 2 way communication between the hospital and patients
Proposed measurement	• Number of Follow up appointments

and monitoring	• Number of new appointments • Impact on waiting list • Patient feedback Monitored via Personalised Outpatient Programme Board Progress reported via Quality Programme Board
Executive Lead and Delivery Leads	Chief Operations Officer Operations Director – Transformation and Integration

Improve Chronic Obstructive Pulmonary Disease (COPD) pathway 1-2 years.	
Rationale	Current COPD pathway is secondary care focussed and a significant number of patients attend ED or are admitted with exacerbation of COPD who could be managed effectively in the community. • Strategic commitment 3 • Corporate Risk Register 5 score 20 • Risk Register: 717, 965, 1002, 1256, 1381, 1510, 1511, 1609 & 1689 • Business Assurance Framework:1.2 • COPD National Action plan Feb 2021.
How we will do this	• Analysis of Getting It Right First Time (GIRFT) and Right Care data to identify pathway issues • Reduce unnecessary inpatient stays • Increasing the number of planning discussions for end of life • Implement Shared Decision Making • Increase use of Virtual Ward • Explore community model to include pulmonary rehab and alternate pathways • Engage and work with system partners to redesign pathway to a more self-managed community supported model • Adopt and embed best practice care bundle and COPD national action plan
Proposed measurement and monitoring	• Reasons for admission and specialties admitted into • Length of stay • Readmission rates • Audit of readmission cases to identify themes • Increase personalised ceiling of care plans (ReSPECT) • Mortality data • Preferred place of death • National audit

	Monitored through Medical Divisional Board Progress reported via Quality Programme Board
Executive Lead and Delivery Leads	Operational Lead Respiratory Respiratory Matron Medical Lead (to be confirmed)

Improve Orthopaedic pathways and outcomes	
Rationale	Prolonged waiting times for elective care with increased risk of harm whilst waiting. Trauma and Orthopaedics is the specialty with the largest waiting list. • Strategic commitment 1, 4 • Corporate Risk Register - 1 score 20 • Risk Register: 363, 513, 694, 908, 948, 1299, 1407, 1410, 1599, 1504, 1636, 1637, 1670, 1826, 1856, 1877 • Business Assurance Framework: 1.3
How we will do this	Provide a dedicated orthopaedic centre comprising of two new laminar theatres and a dedicated bed base.
Proposed measurement and monitoring	• Progress against project plan • Recovery of the Orthopaedic elective backlog towards 18 Week compliance • Reduction in orthopaedic cancellations for wider Trust pressures • Reduction in length of stay for Hips and Knees surgery • Increase in Day Case procedures • Elective hip and knee outcomes via National audit Monitored via Project Steering Group Progress reported via Quality Programme Board
Executive Lead and Delivery Leads	Director of Strategy Project Manager Deputy Director of Operations within Surgery

Patient Experience

Shared Decision Making and Personalised Care – 1-3 years	
Rationale	Achieving high quality shared decision-making conversations to support patients to make informed decisions based on available evidence, knowledge of risks, benefits, consequences and the options available to them and their preference • Strategic commitment 1 • Commissioning for Quality and Innovation (CQUIN) • Compliance with NICE guidance and General Medical Counsel guidance on Shared Decision Making and consent

How we will do this	• Focus on the following areas for 2022/23: Primary immune deficiencies, Bone marrow transplant, Palliative chemotherapy, Cardiology COPD
Proposed measurement and monitoring	• Measure level of patient satisfaction with SDM conversations as measured by patient scores on internationally validated patient questionnaires Progress reported via Quality Programme Board
Executive Lead and Delivery Leads	Medical Director Deputy Medical Director Associate Director Patient Engagement and Experience

Improving equity of access and experience to services 1-2 years	
Rationale	Equality Delivery System 2 (EDS2) Core 20 plus 5 Reducing health inequalities • By working with seldom heard groups we will ensure that everyone has equitable care • Strategic commitment 1, 3
How we will do this	• Using EDS2 data as a baseline to inform required improvement work • Conduct Patient and community survey • Programme of Community engagement • Set up a community reference group • Set up robust governance structure
Proposed measurement and monitoring	• EDS2 data Monitored via Patient Engagement Experience Group and Equality and Diversity Group Progress reported via Quality Programme Board
Executive Lead and Delivery Leads	Chief Nurse Associate Director Patient Engagement and Experience

Introduce the Home First model (Discharge to Assess (D2A)) 1-2 years	
Rationale	Increasing numbers of patient medically fit for discharge without criteria to reside Enhanced therapy and rehab input with this model of care which supports improved experience and outcomes for patients • Strategic commitment 1 • Corporate Risk Register - 6 – Score 20 • Risk Register: 1371 & 1173 • Business Assurance Framework:1.3

How we will do this	• Establish a dedicated Home first Unit with the right skills and experience to rehabilitate patients whilst waiting an ongoing care placement • Roll out and embed SAFER (Senior review, All patients, Flow, Early discharge, Review)
Proposed measurement and monitoring	• Average length of stay • Pathway zero No Criteria to Reside (NC2R) • D2A 1-3 NC2R patients • GP streaming activity • Discharges before 12 noon Monitored via Emergency and Urgent Care Improvement Board Progress reported via Quality Programme Board
Executive Lead and Delivery Leads	Chief Nurse Chief Of Division Clinical Support Services Divisional Director Clinical Support Services

Staff Experience

Improve Staff Experience 1-2 years	
Rationale	Staff Survey 2021 results indicate all 7 People Promise Themes and Staff Engagement, and morale theme are below the national average (of 126 acute trusts). Trusts with higher levels of staff engagement deliver services of higher quality and perform better financially, as rated by the Care Quality Commission. They have higher patient satisfaction scores and lower staff absenteeism. They have consistently lower patient mortality rates than other trusts. Strategic Commitment 2. Corporate Risk Register: 10, 12 – Score 20 Business Assurance Framework - 2.2, 4.4, 5.4
How we will do this	We need to make transformational, sustained improvement into how our staff feel about working at NNUH. Year one priorities: • Improve staff facilities across the Trust following investment • Improve quality of appraisal, with new Personal Development Review (PDR) process. This will include a health and wellbeing discussion and career conversation. • Recruitment to establishment. • Reform Dignity at Work Policy Please see the full breakdown of these priorities below:

Improve staff facilities following investment	
Rationale	Staff survey results indicate widespread dissatisfaction regarding staff facilities/rest areas Survey also shows high levels of staff burnout and fatigue Supports NHS People Promise commitment of "We are safe and healthy" Strategic commitment 2
How we will do this	• 1M of investment has been agreed for improvements • Establishment of a joint decision making council to enable staff to play a part in identifying what will make the biggest impact • Communication to staff of the group's purpose and how to enable their voice to heard • Programme of improvements to be identified, scoped and costed • Ensuring key stakeholder engagement to ensure projects are achievable and potential barriers identified • Communication plan to ensure staff are kept informed and able to contribute
Proposed measurement and monitoring	Programme of improvements in place with timescales for completion Annual staff survey results, Pulse surveys and feedback from trades unions and staff networks Monitored as part of People Promise commitments, Workforce and Education Sub-Board (WESB) and People and Culture Board
Executive Lead and Delivery Leads	Chief People Officer Head of Facilities/Estates
Improve quality of appraisal with new Personal Development Review (PDR) process	
Rationale	Staff survey results indicate that current process did not help them to do their job better, nor set high quality objectives. Appraisal is a key part of staff engagement and building a good relationship with your line manager. Trusts with higher levels of staff engagement deliver higher quality services, perform better financially and have higher patient satisfaction scores and lower staff absence. Supports all seven of the People Promise Commitments Strategic commitment 2
How we will do this	• Revised PDR process to be implemented, aligned to People Promise and organisational strategic commitments • Programme of line manager training and supporting materials to be in place • PDRs to be delivered on a "cascade" basis during a 6 month period, starting with the most senior posts • Divisions to agree and implement a detailed plan to deliver and

	monitor against Key Performance Indicators (KPIs) • Health and wellbeing and career conversations to form a key part of PDR, with appropriate signposting to wider resources and support within the organisation to enable meaningful discussion
Proposed measurement and monitoring	Organisational and divisional compliance to be monitored via Patient Assurance Framework (PAF) Divisional support provided by Business Partnering team to enable divisions to identify areas of concern and action plan Sample quality testing of completed PDR forms Annual staff survey and quarterly Pulse survey results Monitored as part of People Promise commitments, WESB and People and Culture Board
Executive Lead and Delivery Leads	Chief People Officer Director of HR and Head of Corporate HR Management
Recruitment to Establishment	
Rationale	Current vacancy factor of 18.8% and turnover of 14.2% Reliance on bank and agency to ensure staffing levels are maintained Staff survey results show high levels of burnout, fatigue and that staff feel there are not enough staff to enable them to do their job properly. Supports “We are a Team” and wider People Promise Commitments Strategic commitment 2
How we will do this	• Reduction in each stage of time to hire process to meet 55 days by end June 2022 • Line manager education and support regarding recruitment best practice through Licenced to Lead Programme and bespoke training packages • Review of each step of the pre-employment checks and opportunities to streamline • Internal recruitment processes streamlined to facilitate faster internal moves • Continued international nursing recruitment programme • Large-scale Healthcare Assistant (HCA) recruitment programme and enhanced support to increase retention • Increased access to flexible working opportunities and bank to permanent • Updated and best practice candidate attraction via advertising and website with greater opportunities for candidates to learn more about the role prior to application
Proposed measurement	Time to hire to be at 55 days by end June 2022 Turnover to reduce to 10% by end March 2023

and monitoring	Vacancy factor to reduce to 8% by end March 2023 Monitored as part of People Promise Commitments, WESB, Integrated Performance Report (IPR) and People and Culture Board
Executive Lead and Delivery Leads	Chief People Officer Director of HR
Reform Dignity at Work Policy	
Rationale	Staff survey results show an increase in the number of staff reporting they feel bullied at work This is also reflected within Speak Up complaints, together with concerns regarding the length of time investigations can take and the impact onto staff. Supports “We are safe and healthy” and wider People Promise Commitments Strategic commitment 2
How we will do this	• External review of current Communicating with PRIDE and Dignity at Work processes • Workstream established to review key findings and consider potential changes to policy and supporting processes • Revised policy to be drafted and agreed with trades unions • Each division to identify “heatmap” of areas for concern from staff survey results, with Chief of Division (CoD) as Senior Responsible Owner (SRO) for action plans to improve • Training for line managers in managing conflict as part of the Licensed to Lead programme • Introduction of trained mediators to enable faster resolution • Launch and delivery of Health and Wellbeing Framework
Proposed measurement and monitoring	• Reduction in the number of formal complaints raised and investigated via an increase in the number of informal resolutions • Divisional monitoring of action plans against heatmaps supported by HR Business Partners and in partnership with Speak Up Guardian and Trades Unions • Reduction in the number of complaints made via the Speak Up Guardian that relate to poor behaviours • Monitored as part of People Promise commitments, WESB and People and Culture Board
Executive Lead and Delivery Leads	Chief People Officer Director of HR and Head of HR Corporate Development

Good News Story

Leisa Freeman, Honorary Consultant in Cardiology, awarded honorary fellowship of the RCOG

Leisa Freeman, Honorary Consultant Cardiologist, has been awarded an honorary fellowship from the Royal College of Obstetricians and Gynaecologists (RCOG) for her contribution to women's health and in particular maternal cardiology.

Leisa, who retired last October, established an adult congenital heart service at our hospital in 1993.

NHS England in 2018 approved NNUH as a Specialist Congenital Cardiac Centre, one of only four in England.

Leisa established annual courses for heart conditions and pregnancy aimed at trainee cardiologists, obstetricians and obstetric anaesthetists and was a speaker at national and international pregnancy and heart disease meetings.

Together with Katherine Stanley, former Maternal Medicine Lead, in 1997 Leisa started a joint service to look after pregnant women with congenital heart conditions. The service rapidly expanded to look after patients with congenital and acquired heart conditions from across the East of England.

The demand for the service saw the joint Obstetric Cardiology Clinic occurring every other week with Obstetricians Fran Harlow, Alasdair Mckelvey and Jon Lartey.

"*It is a great honour to receive this Fellowship which is rarely awarded to healthcare professionals working outside women's health*," said Leisa.

"*I'm proud of having established a new service which is continuing after my retirement under the lead of Cathy Head, Consultant Cardiologist, who recently set up the UK Maternal Cardiology Society*."

Pictured from left: Eddie Morris, President of RCOG; Fran Harlow, Maternal Medicine Lead; Leisa Freeman, Honorary Consultant Cardiologist; Alasdair Mckelvey, Obstetrician and regional EoE representative on council RCOG

Part 2.2 - Board Assurance Statements

Review of services

During 2021/2022 the Norfolk and Norwich University Hospitals NHS Foundation Trust provided and/or sub-contracted 80 relevant health services.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has reviewed all the data available to them on the quality of care in 80 of these relevant health services.

Due to the Covid-19 pandemic funding for services, both clinical and non-clinical, have block funding with levels of funding dictated by NHS England and Improvement. Therefore, we are unable to indicate the percentage of income generated from the provision of relevant health services by the Norfolk and Norwich University Hospitals NHS Foundation Trust for 2021/2022.

Information on participation in national clinical audits (NCA) and national confidential enquiries (NCE)

During 2021/22 58 Quality Account national clinical audits and 4 Quality Account national confidential enquiries covered relevant health services that Norfolk and Norwich University Hospitals NHS Foundation provides.

During that period Norfolk & Norwich University Hospitals NHS Foundation participated in 100% national clinical audits and 100% national confidential enquiries of the Quality Account national clinical audits and national confidential enquiries that it was mandated to participate in. We did not participate in the National Respiratory Audit for National Outpatient Management of Pulmonary Embolism the pressures of the pandemic on the Respiratory Department.

Data collection was suspended in a few Quality Account national audits due to the Covid-19 pandemic. We participated in other National Audits which fall outside of the Quality Account recommended list.

The national Quality Account clinical audits and national confidential enquiries that Norfolk and Norwich University Hospitals NHS Foundation participated in during 2021/22 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

[NB. The data collection period for some of these audits is still in progress. Final figures are not yet available for all audits and these participation rates may increase or decrease.]

National Clinical Audit (alphabetical order)	Eligible Y/N	Took part Y/N	Participation Rate Cases Submitted	Completed/ In-progress/ Ongoing
Case Mix Programme	Y	Y	1586/1586 (100%)	Ongoing
Child Health Clinical Outcome Review Programme (NCE)	Y	Y	Transition from child to adult health services: 4/7 (57%)	In progress
Chronic Kidney Disease registry	Y	Y	857/857 (100%)	Ongoing
Cleft Registry and Audit NEtwork Database	N	n/a	n/a	n/a
Elective Surgery (National PROMs Programme)	Y	Y	Hips 454/460 (98.7%) Knees 314/318 (98.74%)	Ongoing
Emergency Medicine QIPs				
a. Pain in Children (care in Emergency Departments)	Y	Y	56/56 (100%)	Ongoing
b. Severe sepsis and septic shock (care in Emergency Departments)	Y	n/a	This did not run in 2021/22	n/a
Falls and Fragility Fracture Audit Programme				
a. Fracture Liaison Service Database	N	n/a	No Fracture Liaison Service	n/a
b. National Audit of Inpatient Falls	Y	Y	1/36 (3%)	Ongoing
c. National Hip Fracture Database	Y	Y	759/759 (100%)	Ongoing
Inflammatory Bowel Disease Audit	Y	Y	11/11 100%	Ongoing
Learning Disabilities Mortality Review Programme (NCE)	Y	Y	4/4 (100%) of applicable cases submitted 13 cases were not submitted due to National Data Opt-Out	Ongoing
Maternal and Newborn Infant Clinical Outcome Review Programme (NCE)	Y	Y	47/47 (100%) Maternal deaths x1 Late Fetal Loss:	Ongoing

			x1 Terminations: x9 Stillbirths: x12 Early Neonatal Deaths: 19 Late Neonatal Deaths (includes. Transfers in): x5	
Medical and Surgical Clinical Outcome Review Programme (NCE)	Y	Y	Epilepsy Study: 3/5 (60%)	In progress
Mental Health Clinical Outcome Review Programme	N	n/a	n/a	n/a
National Adult Diabetes Audit				
a. National Diabetes Core Audit	Y	Y	Data collection for the 2021/22 audit closes in June. Anticipated will be 100%	In Progress
b. National Pregnancy in Diabetes Audit	Y	Y	54/54 (100%)	Completed
c. National Diabetes Footcare Audit	Y	Y	180/180 (100%)	Ongoing
d. National Inpatient Diabetes Audit, including National Diabetes In-patient Audit – Harms	Y	Y	38/38 (100%)	Completed
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme				
a. Paediatric Asthma Secondary Care	Y	Y	4/55 (7%)	Completed
b. Adult Asthma Secondary Care	Y	Y	133/133 (100%)	Ongoing
c. Chronic Obstructive Pulmonary Disease Secondary Care	Y	Y	432/432 (100%)	Ongoing
d. Pulmonary Rehabilitation-Organisational and Clinical Audit	N	N	n/a	n/a
National Audit of Breast Cancer in Older Patients	Y	Y	252/252 (100%)	Ongoing
National Audit of Cardiac Rehabilitation	Y	Y	3185/3365 (95%)	Ongoing
National Audit of Cardiovascular Disease Prevention	N	N	n/a	n/a
National Audit of Care at the End of Life	Y	Y	40/40 (100%)	
National Audit of Dementia	Y	n/a	As a result of the pandemic, the planned audit activity for the National Audit of Dementia was suspended.	n/a
National Audit of Pulmonary	N	n/a	n/a	n/a

Hypertension				
National Audit of Seizures and Epilepsies in Children and Young People (Epilepsy 12)	Y	Y	12/29 (41.4%)	Ongoing
National Cardiac Arrest Audit	Y	Y	72/72 (100%)	Ongoing
National Cardiac Audit Programme				
a. National Audit of Cardiac Rhythm Management	Y	Y	Electrophysiology 661/669 (99%) Pacemaker 1362/1362 (100%)	Ongoing
b. Myocardial Ischaemia National Audit Project	Y	Y	976/998 (98%)	Ongoing
c. National Adult Cardiac Surgery Audit	N	N	n/a	n/a
d. National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty)	Y	Y	1579/1592 (99%)	Ongoing
e. National Heart Failure Audit			404/405 (100%)	Ongoing
f. National Congenital Heart Disease	N	N	n/a	N/a
National Child Mortality Database	Y	Y	11/11 (100%) All child deaths are registered as required via the Child Deaths Overview Panel (CDOP) and the national database takes its data direct from the CDOPs.	Ongoing
National Clinical Audit of Psychosis	N	n/a	n/a	n/a
National Comparative Audit of Blood Transfusion				
a. 2021 Audit of Patient Blood Management & NICE Guidelines	Y	Y	25/25 (100%)	Completed
b. 2021 Audit of the perioperative management of anaemia in children undergoing elective surgery	Y	n/a	This audit did not run in 2021/22	n/a
National Early Inflammatory Arthritis Audit	Y	Y	30 Percentage not available due to data requirements	Ongoing
National Emergency Laparotomy Audit	Y	Y	291/291 (100%)	Ongoing
National Gastro-intestinal Cancer Programme				

a. National Oesophago-gastric Cancer	Y	Y	202/202 (100%)	Ongoing
b. National Bowel Cancer Audit	Y	Y	438/438 (100%)	Ongoing
National Joint Registry	Y	Y	725/725 (100%)	Ongoing
National Lung Cancer Audit	Y	Y	345/345 (100%)	Ongoing
National Maternity and Perinatal Audit	Y	Y	100% All births are registered as required and data is taken directly by NHS Digital	Ongoing
National Neonatal Audit Programme	Y	Y	1126/1126 (100%)	Ongoing
National Paediatric Diabetes Audit	Y	Y	313/313 (100%)	Complete
National Perinatal Mortality Review Tool	Y	Y	37/37 (100%)	Ongoing
National Prostate Cancer Audit	Y	Y	398/398 (100%)	Ongoing
National Vascular Registry	Y	Y	78 abdominal aortic aneurysm 40 carotid endarterectomy. *(anticipated >95% case ascertainment)*	Ongoing
Neurosurgical National Audit Programme	N	n/a	n/a	n/a
Out-of-Hospital Cardiac Arrest Outcomes Registry	N	n/a	n/a	n/a
Paediatric Intensive Care Audit	N	n/a	n/a	n/a
Prescribing Observatory for Mental Health	N	n/a	n/a	n/a
a. Prescribing for depression in adult mental health services	N	n/a	n/a	n/a
b. Prescribing for substance misuse: alcohol detoxification	N	n/a	n/a	n/a
Respiratory Audits				
a. National Outpatient Management of Pulmonary Embolism	Y	N	No data was submitted due to the pressures of the pandemic on the department.	n/a
Sentinel Stroke National Audit Programme	Y	Y	919/919 (100%)	Ongoing
Serious Hazards of Transfusion	Y	Y	21/21 (100%)	Ongoing
Society for Acute Medicine Benchmarking Audit	Y	Y	95/95 (100%)	Complete

Transurethral REsection and Single instillation mitomycin C Evaluation in bladder Cancer Treatment	Y	Y	55/55 (100%)	Ongoing
Trauma Audit & Research Network	Y	Y	617/735 (83.9%)	Ongoing
UK Cystic Fibrosis Registry	Y	Y	Paediatrics 51/51 (100%) and where required all had an annual review Adults x 86/89 (97%)	Ongoing
Urology Audits				
a. Cytoreductive Radical Nephrectomy Audit	Y	N	n/a	Audit did not run in 2021/22.
b. Management of the Lower Ureter in Nephroureterectomy Audit (BAUS Lower NU Audit)	Y	Y	1/57 (1%) BAUS confirmed Consultants at Norfolk and Norwich participated in the Cytoreductive Radical Nephrectomy Audit, but did not submit the required follow-up data to the Lower NU audit	Ongoing

The reports of published national clinical audits or confidential enquiries were reviewed by the provider in 2021/22. These are reported to through department's local governance teams and the Clinical Effectiveness Operational Group. Some examples of actions undertaken following review are given below. The number of published reports was reduced in the year 2021/2022 due to the Covid-19 pandemic.

Audit Name	Key Successes	Key concerns	Key actions
National Audit of Cardiac Rehabilitation	Retained certification for National Audit of Cardiac Rehabilitation (NACR)/British Association for Cardiovascular Prevention and	National figures demonstrated a drop in participation rates of patients from more deprived areas. There was	Key actions included: review of deprivation data from NACR; ensuring new components of the Cardiac Rehabilitation

	Rehabilitation (BACPR) standards.	significant shift away from group-based Cardiac Rehabilitation (CR) to home-based CR. There are concerns about the quality of home-based CR. Redeployment or suspension of service during Covid-19 impacted teams.	Programme, such as virtual programme, aligns with BACPR national standards; ensuring staff training maintained; and working with Community Teams.
National Joint Registry (NJR)	The national audit report demonstrated that the Trust achieved a case ascertainment rate of 96% and was at expected levels in regard to hip revision rate and 90 day mortality rate for both hip and knee replacement surgery. The Trust was highlighted to have a better-than-expected knee revision rate.	No key concerns identified	No key actions required
National Bowel Cancer Audit (NBOCA)	The audit report demonstrates that the Trust has one of the largest volumes of resections in the country, with the best observed and adjusted 90-day mortality rate in the East of England Network. The rates of unplanned readmissions, emergency surgery, and adequate lymph node count for the Trust were better than the national average, and the Trust was a positive outlier in terms of 18 month unclosed ileostomy rate (19%), which is a determinant of quality of life and risk of Renal injury.	No key concerns identified.	No key actions required

National Audit of Breast Cancer in Older Patients (NABCOP)	The national audit report demonstrated that the Trust's performance against all key indicators was above or at expected levels.	No key concerns identified	No key actions required
British Association of Urological Surgeons (BAUS) Renal Colic National Audit	The audit demonstrated the Trust has a high primary extracorporeal shock wave lithotripsy (ESWL) rate for ureteric stones and a lower than national average stent rate which is good.	The results found computed tomography of kidneys, ureters and bladder (CTKUB) was only achieved within 24hrs in 85% of cases compared with 91% nationally.	As a result of the audit the Fast Track Renal Protocol with Radiology and the Emergency Department (ED) was reviewed and updated.
National Cystic Fibrosis Registry	The report confirmed that the Paediatric Cystic Fibrosis (CF) service met the national standards, was performing well and was not a significant outlier in any of the clinical outcome measures.	No key concerns identified.	The report was discussed in detail in the Joint Adult and Paediatric Cystic Fibrosis multidisciplinary team (MDT) meeting. Staff continue to ensure that regular cough swabs/sputum are sent and where applicable referral to bronchoscopy made. Dieticians continue to counsel patients regarding weight/BMI where applicable.
Learning Disability Mortality Review Programme (LeDeR Programme) Audit (National)	Changes to clinical audit parameters were made based on LeDeR findings. Reduced mortality was demonstrated. Improvements were noted in weight monitoring, bowel monitoring, pain recognition, timely best interest decision-making and appropriate balance of carer input. Good liaison with Clinical Commissioning Groups	Information governance arrangements were preventing notification to LeDeR.	An action plan was formulated to standardise the notification monitoring within the team. Policies and processes were updated to reflect findings. There were improvements in Structured Judgement Review process, and more

	was demonstrated.		alignment with LeDeR.
National Trauma Audit and Research Network (TARN)	The Trust was praised by the Trauma Network, who use the TARN data for their reviews, for stepping up during the second wave of the pandemic and developing the pathway for secondary transfers. Recognition was also given for the introduction of the revised Trauma Policy, Trauma Team Leader/Trauma Team Member training during the pandemic and the introduction of rehabilitation prescriptions. Our case ascertainment of 83.9% for 2021 was higher than the 80% required by TARN for reliable reporting. This was reflected in the Clinical Report 3 which cites that “the data in the report should be viewed with confidence”.	The Trauma Network have submitted their feedback from the peer review and the overall outcome is that performance has decreased	In response to the Peer Review report and published TARN reports actions taken have included TXA training and additional information displayed in ED. Audit of time to Computerised Tomography (CT) for Trauma patients was also undertaken. There was confirmed funding for Trauma and Rehabilitation Co-ordinators and development of a job description. The Co-ordinators will also take on the role of key worker. An audit of attendance at Trauma Team Member training sessions was undertaken with a plan for enhanced awareness in the new year. It was agreed that the Consumables Resource Team in the Emergency Department will be trained to scribe for Trauma calls.
Medical and Surgical Clinical Outcome Review Programme	Key successes were identified in the Dysphagia in Parkinson's Disease (PD) gap analysis. This included members of the Multi-Disciplinary Team all	Some key concerns were noted and an action plan created to address these.	Key actions included: creating a dedicated specialist SLT post designated to PD patients;

	included in discussions of patients with PD who have swallowing difficulties; Every patient with PD who is seen by a Speech and Language Therapist (SLT) have their food, fluid, and medication route recommendations documented on their electronic discharge letter.		generating a bid for extra funding to employ inpatient PD Specialist Nurses; the design of a clinical pathway for the management of dysphagia in PD patients.

The reports of completed local clinical audits were reviewed by the provider in 2021/22. These are reported to through department's local governance teams and the Clinical Safety and Effectiveness Sub-Board. Some examples of actions undertaken following review are given below. 85% of clinical audits on the Trust Clinical Audit Plan were completed in 21/22. 8% remain in progress and 7% were abandoned.

Audit Name	Key Successes	Key concerns	Key actions
Audit of Changes in Practice in Palliative Care Due to Covid-19	The audit results demonstrated that the Quality of end-of-life care was equal to if not better than pre-pandemic even if the Specialist Palliative Care Team were not directly involved.	No key concerns identified	No key actions required
Audit Of Deliberate Self Harm	The audit evidence demonstrated that patients had regularly received the appropriate input and risk management interventions in relation to their presentation and level of risk. There was consistent evidence of the use of the Patient Safety Plan being fully completed for patients admitted to a Paediatric Ward. There was an increase in cases meeting the criteria in full.	A number of patients self-discharged before they had a risk management plan in place. There was limited evidence in the cases audited that the Patient Safety Plan was being utilised in adult areas.	Mental Health Clinical Nurse Specialists formulated an action plan to educate and encourage Medical Wards to contact the Mental Health Team for advice if patient wishes to self-discharge and to ensure patients on Medical Wards identified as being at risk of deliberate self- harm has a Patient Safety Plan Completed.

Audit of Adult Early Warning Score – Documentation of Observations and Response.	The audit results demonstrated a significant improvement in the recording and calculation of NEWS2 scores, corresponding with the introduction of the electronic observation recording platform.	No key concerns were identified.	The ongoing monitoring of compliance with standards for recording and responding to patient observations was integrated into the Tendable ward audit platform and care assurance process.
Audit of Compliance with Consent Policy	The audit demonstrated that consent forms were present in all case notes reviewed, with the following elements consistently completed; Procedure being undertaken, Risks of procedures, Signed and dated by health professional, and Patient signature for consent.	The key concern highlighted was the recurring theme of some elements not completed on the consent form	A system wide review of the Consent Policy, process and forms is in progress across the three Acute Trusts, which will address the concerns identified.
Audit Of Fluid Balance Charts	It was demonstrated that fluid charts are being updated.	Totalling of fluid balance at midnight was sometimes not completed	A quality improvement project in relation to fluid balance is being undertaken.
Audit of Changes in Practice in Neurology During Covid-19	There was no delay in providing lifesaving treatment and a good standard of care was given during the pandemic.	No key concerns identified	No key actions required
Audit of Biologics Outcome Monitoring	All patients had their management discussed. No patients in the sample had Covid-19 as a cause of death.	No key concerns identified	None key actions required
Audit of Escalation of the Deteriorating Patient	The Recognise and Respond Team were able to respond to referrals within 30 minutes in 89% of cases, and no discernible delays could be identified in	No key concerns were identified by the audit, however the method of capturing key performance data and metrics for the Recognise and	The key action identified was the continued rollout of the Alertive App into clinical practice, which will enhance the service provided by the RRT and

	the escalation to critical care in 70% of patients.	Respond Team (RRT) could be improved.	support prompt escalation and response to changes in patients' conditions.
Audit of Audiology Postal Repair Turnaround Times	The audit demonstrated that 99% (182/183) of repairs met the target turnaround time of 2 days, with 58% (107/183) being completed in the same day.	No key concerns identified	No key actions required
Audit of Achilles Tendon Rupture Management.	All patients with Achilles Tendon Injury were treated with functional bracing and were prescribed thromboprophylaxis, as per current clinical management pathway.	No key concerns identified	No key actions required
Audit Of Antenatal Steroids, Magnesium Sulphate - Compliance To National Health Service England (NHSE) Saving Babies' Lives Care Bundle Version 2 (SBLCBv2) And Clinical Negligence Scheme For Trusts (CNST) Element 5	There was 100% compliance with the use of magnesium sulphate for the past 3 months and 100% compliance of preterm babies with normathermia.	No key concerns identified	No key actions required
Audit Of Cardiotocography (CTG) In Women Presenting With Reduced Fetal Movements - Compliance To National Health Service England (NHSE) Saving Babies' Lives Care Bundle Version 2 (SBLCBv2) And Clinical Negligence Scheme For Trusts (CNST) Element 3 Recommendations	100% of patients had a computerised CTG and 97% were managed appropriately.	There were a few occasions when there was non-escalation.	The findings were circulated via the Fetal Surveillance Newsletter. They were added to the McLeod Maternity Assessment Unit (MMAU) key message board and added to the MMAU handover. Mandatory training will include actions for when criteria is not met.
Audit Surveillance Of Central Lines Infection	Audit results remained below the Matching	Paediatrics and the Critical Care	Results were disseminated with

Rate	Michigan benchmark of 1.4 per 1000 line days.	Complex were not included in this surveillance.	appropriate departments including Renal and Haematology and at the Hospital Infection Control Committee (HICC).
Audit Of Trust Commodes	The results demonstrated that 1401 Commodes were audited and there was 89% compliance between April 2021 and January 2022.	Occasionally an area has repeated fails.	If an area had repeated fails the Infection Prevention and Control (IPandC) Team worked with the staff in the area to encourage ownership of the importance of maintaining the cleanliness of commodes to prevent the spread of infection. The results were disseminated on the IPandC and Nursing Dashboards. There was communication of audit results and learning points to specific areas. Commode results were sent weekly to Divisional Leads and training provided where necessary.
Missed Dose Audit	The Critical Missed Medicines Audit Report was utilised to identify missed doses and allow further investigations. These were documented via Pharmacy Governance minutes.	No key concerns identified	No key actions required
Pharmacy National Benchmarking Audit	Results were above average for the percentage number of patients having medicines	No key concerns identified	No key actions required

	reconciliation within 24 hours. There was lower than average Pharmacy Staff turnover rate and an above mean level of the number of patients supported by Homecare.		
Controlled Drug Audit	The audit in January 22 demonstrated 100% compliance with ward area Controlled Drug Audits. There was a plan in place and improvements were seen in the completion of Theatres Controlled Drug Audits.	The trending and data review was not as robust as it could have been, due to limitations of the current system.	It was agreed to purchase an electronic controlled drug auditing tool to enhance data capture and trending abilities.
Audit of Obstetric Ultrasound Service Changes as a Result of COVID-19	Covid-19 did not affect the timings of patients having their anomaly scan within the recommended time frame.	No key concerns identified	No key actions required
Audit Of Mental Health Risk Screening	There was an established process in place in both the Adult and Paediatric Emergency Departments. The Paediatric Emergency Department compliance remained 90% or above (target 90%) since January 2020. Due to identified system issues, spot check audits commenced.	System issues within Symphony resulted in monthly compliance auditing being temporarily stopped.	An action plan was formulated to undertake a review of the Symphony issues with Information Technology Services to find a resolution.
Audit Of Paediatric Learning Disabilities Resources	The audit demonstrated success in many key areas. The results indicated that children and young people with learning disabilities received care that was well-adjusted to meet their individual needs and was responsive to	Use of rapid risk assessment resources was low (comparative to other data sets). This area saw an improvement over time, but still required targeted intervention.	An action plan was implemented to audit in line with the adult audit programme, which expanded clinical questions and breaks results down into emergency/elective

	recommendations. Good involvement of families was reported alongside good use of resources, suggesting an empowered clinical workforce. Results were sustained over time.		pathways. This enabled better targeted intervention.
Audit Of Paediatric Reasonable Adjustments And Use Of Autism Spectrum Condition Resources	This audit demonstrated that autistic patients were experiencing care at the Norfolk and Norwich University Hospital that was both aware of and responsive to their needs for reasonable adjustments. There was evidence to suggest that information about adjustments travelled well through the hospital environment with the patient, and there were no significant emergent points of failure in the existing systems. The audit demonstrated that autistic patients did not experience diagnostic overshadowing in most cases. It was evidenced that autistic patients were well-contextualised and considered holistically.	The main concern of note was the comparatively lower use of rapid risk assessment by clinical areas.	An action plan was implemented to move the Children and Young Person Autism Audit to align with the Adult Audit Programme, which has expanded clinical questions and breaks results down into emergency/elective pathways.
Audit Of Clinical Care of Autistic Patients	Compared to the Learning Disability specific audit, the results regarding recognition of communication and pain expression needs were higher in the elective autistic patient group. There was	The audit results demonstrated evidence of over reliance on carers to interpret the person's needs.	An action plan was formulated to implement a risk assessment tool that can be utilised in the Emergency Department and the Acute Medical Unit. Education provided to help Link

	evidence of excellent recognition of the need for carer support and in 100% of cases the support and adjustments required were identified and implemented for elective autistic patients. In emergency care, there was no evidence y diagnostic overshadowing, discrimination or inappropriate resuscitation decision making impacting patient care adversely.		Practitioners and key ward areas to engage with patients and include them in their care.
Audit Of Learning Disability Practice In The Emergency Department	No evidence of discrimination or overshadowing was demonstrated. This represented a key area in terms of patient safety and outcomes.	There was a decrease in the number of Learning Disability Risk Assessments being completed in September results when compared to the pilot in August	An action plan was formulated to improve: Emergency Department (ED) documentation of adjustments made; discharge measures for patients leaving from ED; completion of risk assessments. There was also a review of the questions being asked in the audit to ensure the nil evidence of diagnostic overshadowing / discrimination was accurate and well scrutinised.
Recommended Summary Plan For Emergency Care And Treatment Documentation Audit	The results demonstrated that 90% of Recommended Summary Plan For Emergency Care And Treatment (ReSPECT) forms were at the front of the healthcare records. 81% of patient's demographics	The key concerns identified that there was reduction in ReSPECT compliance compared with the previous two audit cycles.	As a result of the audit an action plan has been written which included: meeting with ReSPECT Leads on each ward to provide focused support of areas demonstrating poor

	and information about diagnosis were correctly recorded. For the period December 2021 to January 2022 Hethel ward were commended for their Consultant leadership in ensuring: 93% of ReSPECT forms had a Consultant counter signature; diagnostic information was present; and paperwork signed, dated and completed with General Medical Council (GMC) number with 100% correct demographic. Kilverstone ward were commended for ensuring 100% of ReSPECT forms were located at the front of notes which is essential in an emergency situation.		compliance; a ReSPECT Education Programme to support clinicians and Senior Nursing staff having ReSPECT conversations with patients.
Emergency Tracheostomy Safety Box Audit	The audit demonstrated that 100% of checklists were fully completed.	No key concerns identified	No key actions were required
Audit of Stress (Staff)	Dedicated Senior Health and Wellbeing Practitioner appointed to support the organisation in Health and Wellbeing programmes and strategy in relation to mental wellbeing.	Impact of COVID-19 on staff – burnout / Post Traumatic Stress Syndrome (PTSD). Insufficient rest / restore for staff before commencing backlog of cases. Demands of work required over next year due to elective recovery programme Constant change in last 2 years relating to COVID / impact of changes	Stress risk assessment to become embedded for all departments. Wellbeing considered when undertaking policy change. Wellbeing of staff considered when changing environments of work / developing new work programmes. Recognition to staff who have been working in difficult conditions for

		on staff Strains of relationships between staff when busy Impact of anxiety of staff when staffing levels at critical point (wintertime with impact of COVID isolation)	several months. Role modelling of behaviours from leadership of trust to 'ground floor' workers.
Audit of Duty of Candour	The Trust was able to demonstrate 100% compliance with Duty of Candour from April 2021 to July where performance dipped to 63.2%. Performance has been consistent at 100% from August 2021 to date.	None, the decrease in performance for July was investigated and correlated with operational pressures and decreased staffing levels throughout the organisation.	To continue support Divisions to maintain 100% compliance. To review performance on occasions that 100% is not achieved, to agree appropriate actions and to support staff to implement and complete action required to improve performance. To continue to report performance to Clinical Safety and Effectiveness Board.
Audit of Patient Experience in Audiology - Adult Rehabilitation	The audit demonstrated that where applicable, many patients responded either 'Strongly agree' or 'Agree' to the questions, indicating a high level of satisfaction with their adult rehabilitation appointment. A number of positive comments were made by patients.	The results found that the response rate was low (ranging from 0% for the Hear For Norfolk clinic patients, to 25% for the Norfolk and Norwich University Hospital (NNUH) patients).	As a result of the audit, an electronic version of the patient survey was designed to help encourage a higher response rate.
Audit of Patient Experience in Audiology - Vestibular Assessment, Paediatric Assessment, Bone	The audit demonstrated that where applicable, the vast majority of patients responded with either 'Strongly agree'	No key concerns identified	No key actions required

Conduction Hearing Systems (BCHS) Service, Hearing Therapy	or 'Agree' to the questions, indicating a high level of satisfaction with their Vestibular Assessment appointment. A number of positive comments were made by patients.		
Audit of Diabetes Eye Screening Service – Patient Experience	Patient satisfaction with the pre-appointment information and the overall clinic visit experience remained high, with 95% of patients responding positively. Consistently high rate of patient satisfaction in respect of interactions with the screening staff. 93% of patients felt safe from the risk of Covid-19 during their appointment.	No key concerns identified	No key actions required
Audit of the World Health Organisation (WHO) Surgical Safety Checklist Use in Endoscopy	100% compliance to WHO checklists for many months of the year	No concerns	No key actions required
Audit of Completion of LocSSIP (Local Safety Standards for Invasive Procedures) for Botox Injections	The results demonstrated that 100% of cases had a fully completed LocSSIP inside the notes.	No key concerns identified	No key actions required
Audit of the Documentation of the Bronchoscopy WHO Checklist	The results demonstrated that 100% of checklists were fully completed	No key concerns identified	No key actions required
Audit of Completion of LocSSIP (Local Safety Standards for Invasive Procedures) for Chest Drain	The results of the audit demonstrated that 100% of checklists were fully completed	No key concerns identified	No key actions required
Audit of the documentation of the Pleural WHO checklist	The results of the audit demonstrated that 100% of checklists were fully completed.	No key concerns identified	No key actions required
Audit of World Health Organisation (WHO)	The audit demonstrated a high level of	No key concerns identified.	

Triangulation Data	compliance with the triangulated data: electronic data achieved 100% compliance, documented data achieved 99.8% compliance and observational data achieved 100% compliance.		No key actions required
Audit of Completion of LocSSIP (Local Safety Standards for Invasive Procedures) for Central Venous Catheter (CVC) Placement - Critical Care Complex (CCC)	All elements that required 100% compliance were achieved.	No key concerns identified.	No key actions required
Audit of Completion of LocSSIP (Local Safety Standards for Invasive Procedures) Ear Nose Throat (ENT) Department	Of the 7 audited Ear Nose and Throat (ENT) Local Safety Standards for Invasive Procedures (LocSSIPs) a very high level of compliance, 99% (265/267) was demonstrated.	No key concerns identified.	Ongoing monitoring will be continued.
Audit of Completion of Local Safety Standards for Invasive Procedures (LocSSIP) for Urodynamics.	The audit demonstrated that compliance with the Local Safety Standards for Invasive Procedures (LocSSIP) documentation requirements was 100%.	No key concerns identified	No key actions required
Annual Re-audit Of Completion Of Local Safety Standards For Invasive Procedures (LocSSIP) For Fetal Blood Sampling / Ventouse / Forceps / Perineal Repair	100% compliance with completion of LocSSIP for all 4 interventions.	No key concerns identified	The aim is to move stickers online in the future once intrapartum care is transferred onto Maternity's electronic system E3
Audit of Interventional Radiology Unit (IRU) World Health Organisation (WHO) Checklist	100% compliant.	No key concerns identified	No key actions required
Audit of Peripherally Inserted Central Catheters by Vascular	The results of this audit demonstrated 100% compliance with the	No key concerns identified	No key actions required

Access Practitioners - Radiology Local Safety Standards for Invasive Procedures (LocSSIP)	completion of the Local Safety Standards for Invasive Procedures (LocSSIP).		
Audit of the Local Safety Standards for Invasive Procedures for Invasive Ear, Nose and Throat (ENT) Procedures - Removal and Replacement of Surgical Voice Prosthesis (SVR)	100% compliance was demonstrated for all standards.	No key concerns identified	No key actions required

Good News Story

Michelle Frost – Biomedical Scientist

From photographer to Specialist Biomedical Scientist, Michelle Frost talks about the Anti-Spiking Campaign she created, which has taken her all the way to the House of Commons.

Michelle is in the middle of writing a 3,000-word report to the Home Affairs Select Committee on the Anti-Spiking Campaign she and her team launched just before Christmas.

Michelle and the lab team have joined forces with the police, the SOS Wellbeing bus, selected clubs and bars, and more recently the University of East Anglia (UEA) to offer anti-spiking kits to anyone who thinks they (or a friend) have been spiked. They can ask at the bar or in UEA dorms for a kit to provide a urine sample, which is submitted to our lab for testing.

All samples are anonymous, and tested for substances connected with spiking, with results sent out via encrypted barcodes linked to the sample.

The aim of the Anti-Spiking Campaign is to raise awareness that it is a criminal offence to spike drinks or inject someone without their knowledge or consent, and to gather data on what substances are being used.

Early signs are encouraging as the data seems to be backing up the claim that the campaign here in Norfolk has seen a reduction in the number of spiking incidents, while nationally the trend is increasing.

Participation in research and development

The number of patients receiving relevant health services provided or sub-contracted by the Norfolk and Norwich University Hospitals NHS Foundation Trust in 2021/22 that were recruited during that period to participate in research approved by a research ethics committee was 5081.

Commissioning for Quality and Innovation (CQUIN)

The operation of CQUIN (both CCG and specialised) remained suspended for all providers until 31 March 2022. Providers did not need to implement CQUIN requirements, carry out CQUIN audits nor submit CQUIN performance data. For Trusts, an allowance for CQUIN has been built into nationally-set block payments.

Care Quality Commission (CQC) reviews

Norfolk and Norwich University Hospitals NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is unconditional.

The Care Quality Commission has not taken enforcement action against Norfolk & Norwich University Hospitals NHS Foundation Trust during 2021/22.

Norfolk and Norwich University Hospitals NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2021/22:

- **Unannounced focused inspection of Urgent and Emergency Care within the Emergency Department at the Norfolk and Norwich University Hospital.**

Table 1: CQC Ratings of Urgent & Emergency Care, reported July 2021

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent & Emergency Care	**Good**	**Good**	**Good**	**Requires Improvement**	**Good**	**Good**

There were improvements in the Safe and Well Led domains being rated as 'Good' with Responsive remaining at 'Requires Improvement'. The overall rating for Urgent & Emergency Care has also improved to 'Good'.

During 2021/22, the Norfolk and Norwich University Hospitals NHS Foundation Trust did not receive a Trust Well Led inspection by the Care Quality Commission, therefore, although the inspection of Urgent and Emergency Care services gave an overall rating of 'good' this has not affected the Trust's overall rating of 'Requires Improvement'.

Norfolk and Norwich University Hospitals NHS Foundation Trust intends to take the following action to address the conclusions or requirements reports by the CQC
A full quality improvement plan is in place to address these recommendations.

Table 2: CQC 'Must Do' and 'Should Do' Recommendations for Urgent and Emergency Care reported July 2021

Area	Level	Ref	Recommendation
CORE SERVICES			
Urgent and Emergency Care	**Must Do**	**MD1**	The trust must ensure they continue to do all that is reasonably practical to improve key national and trust performance targets such as the four-hour standard, triage within 15 minutes of patient's arrival, internal professional standards and time taken from decision to admit, ensuring risks to patients are effectively mitigated. (Regulation 12).
	Should Do	**SD1**	The trust should ensure that European Paediatric Life Support should be completed by appropriate staff by January 2022.
		SD2	The trust should ensure that staff complete checks on emergency medical equipment in line with trust policy.

The full CQC report can be viewed at: http://www.cqc.org.uk/provider/RM1

Norfolk and Norwich University Hospitals NHS Foundation Trust has made the following progress by 31st March 2022 in taking such action

Table 3: Progress on CQC 'Must Do' and 'Should Do' Recommendations for Urgent and Emergency Care reported July 2021

Area	Ref	Progress
Urgent and Emergency Care	**MD1**	The trust has evidence to demonstrate the standards are being monitored and there is awareness as to why the Trust isn't meeting agreed targets. Mitigations for the risks are in place, e.g., clinicians will go outside to run an admission unit in the car park if unable to offload ambulances. The Safer, Better, Faster (SBF) programme workstreams, monitor all aspects of this recommendation. There is a strong focus on targets. Triage assessment model – 74% of staff are now trained in triage which ensures peak times are covered. The trust has governance in place around harm to patients waiting in ED and this is raised and reviewed in the learning from deaths committee. SIG / RCAs are also completed if a patient comes to harm whilst waiting in ED. This recommendation is now business as usual.
	SD1	This recommendation has been merged into the surgical, emergency and critical care division wider recommendation on mandatory training. New rules / guidance around resuscitation training will allow staff to complete annual training online, with practical face to face training required bi-annually. ALS (Advanced Life Saving) training can be increased as the Rapid Response Team are able to deliver this, this mitigates any possible risk of online training. Other Trusts have moved to this model with no impact.
	SD2	Checks are completed on a daily basis – every 12 hours. On the 5th March 2022, Emergency Department audits reviewed showed compliance on checks being completed across all areas were between 98 – 100%. Once 7 data points is evidenced and available this will show improvements have been made and are business as usual.

Data Quality

The Norfolk and Norwich University Hospitals NHS Foundation Trust submitted records during 2021/22 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Table 4: Records of published data *(Data shown as at: December 2021)*

The % of records in the published data which included:	the patient's valid NHS number was:		the patient's valid General Medical Practice Code was:	
	NNUH	Nat Avg.	NNUH	Nat Avg.
Admitted patient care	99.9%	99.6 %	100%	99.7%
Outpatient care	100%	99.7%	100%	99.6%
Accident & emergency care	99.5%	98.9%	100%	99.5%

Information Governance Data Security & Protection Toolkit Attainment Levels

Norfolk and Norwich University Hospital Foundation Trust achieved the "Standards Met" assurance status against the requirement of the Data Security & Protection Toolkit for the 2020/21 reporting period.

Clinical Coding error rate

The Norfolk and Norwich University Hospitals NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2020/21 by the Audit Commission.

Improving Data Quality

The Norfolk and Norwich University Hospitals NHS Foundation Trust will be taking the following actions to improve data quality:

Complete Referral to Treatment (RTT) Audit Programme for 2021/22

Complete Audit Programme for Key Systems 2021/22

Data Quality (DQ) Team will forward reports to Information Asset Administrators (IAAs) to ensure systems not linked to PAS via an HL7 link are updated with key information i.e., Deceased Report, Change of NHS Number

DQ to request IAA,s have a Manual Reversion Policy in place to ensure continuity of service during a prolonged system outage

Monthly Data Quality Referral to Treatment Operational Meetings (RTTOMG) to discuss RTT performance by Specialty, discussing RTT issues / concerns, this is a forum to share best practice. Minutes are provided and can be used as a reference tool.

To provide RTT training and coaching to Operational Managers, Admin Managers and RTT Validators to support as part of their induction programme.

Produce a standardised Trust RTT Induction for employees who manage any part of the Referral to Treatment Pathway

Work with PAS Trainers to ensure training scripts are fit for purpose i.e. P/D Codes and changes to working practices due to the Covid 19 Pandemic

Produce a Waiting List Policy

Request IT to convert Waiting List Policy into eLearning

Implement a DQ metrics Dashboard to highlight performance issues at a glance

- Dashboard to be available on Power BI
- Escalation process on performance to RTTOMG and TAG

Monitor compliance via Audit results

Learning from Deaths

During the financial year 2021/22 2,397 of the Norfolk & Norwich University Hospital NHS Foundation Trust in-patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

515 in the first quarter, of which 3 were patients with Learning Difficulties, 4 had a Severe Mental Illness, 4 were Still Births and 5 were Neonatal Deaths.

566 in the second quarter, 5 were patients with Learning Difficulties, 4 had a Severe Mental Illness, 4 were Still Births and 6 were Neonatal Deaths.

668 in the third quarter, 4 were patients with Learning Difficulties, 11 had a Severe Mental Illness, 2 were Still Births and 8 were Neonatal Deaths.

648 in the fourth quarter, 3 were patients with Learning Difficulties, 7 had a Severe Mental Illness, 5 were Still Birth and 6 were Neonatal Deaths.

Table 5: Summary of In-Hospital deaths and deaths within 30 days of discharge for the financial year 2021/22

Financial Year 2021/2022	Total Discharges	Deaths within 30 days of Discharge	In-hospital deaths	Total Deaths	In-hospital Deaths with Learning Difficulties (1)	In-hospital Deaths with Severe Mental Illness (2)	In-hospital Still births (3)	In-hospital Neonatal Deaths (4)
Q1	21,444	286	515	800	3	4	4	5
Q2	18,447	282	566	848	5	4	4	6
Q3	17,846	280	668	948	4	11	2	8
Q4	17,415	234	648	882	3	7	5	6
Total	75,152	1082	2397	3478	15	26	15	25

Stillbirths delivered from 24 weeks notified to MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries in the UK)
Neonatal deaths from 22 weeks notified to MBRRACE-UK

Medical Examiner Reviews

Following the introduction of the Medical Examiner Service back in April 2019, our aim was to expand the Medical Examiner office throughout 2020/2021 to enable the scrutiny of all in-patient deaths, this has been achieved this year with the Medical Examiner Service being able to conduct a small number of additional reviews were requested. The Medical Examiner office is looking to expand their service to cover the scrutiny of community deaths.

Specialty Level Mortality Reviews

Specialty Level Mortality Reviews have still taken place during the ongoing pandemic which is reflected in the increased reviews over the course of the 2021/22 financial year. Of those, 27 deaths were escalated to the Structured Judgement Review process.

Table 6: Number of specialty level reviews completed and escalations to SJR

Financial Year 2021/22	Total Number of Specialty Level Mortality Review's Completed	Total Number of Deaths Escalated to SJR following Specialty Level Mortality Reviews
Q1	576	13
Q2	673	9
Q3	720	3
Q4	719	2
Total	2688	27

Child Death Overview Panel Reviews (CDOP)

By the end of quarter 4, 4 deaths were reviewed at the Child Death Overview Panel Review Group in relation to the 14 child deaths reported during 2021/2022. This includes 4 children who died elsewhere (2 children who were under paediatric follow up but died at home and 2 who were transferred to other hospitals for intensive care and died on PICU.) The delay in cases being discussed at CDOP is mainly due to awaiting conclusions of an inquest.

Case Record Reviews: Structured Judgement Review (SJR) Method

Following the implementation of the SJR process across the Trust in May 2019, trained SJR reviewers independently undertake case note reviews outside of their own specialty and make explicit judgements around the quality and safety relating to the patients last admission.

Criteria for SJR are aligned to those set out in the National Quality Board 2017 Learning from Deaths guidance and are as follows:

- Learning Disabilities
- Severe Mental Illness
- Homeless
- Significant concerns raised by family/carers about quality of care
- Significant concerns raised by staff about quality of care
- Death within 30 days of discharge (where concern is raised)
- All expected Child deaths
- Elective Procedures
- Alarm raised: audits, SHMI/HSMR/SMR alerts, concerns raised by CQC/ other external regulator
- Coroners Regulations 28
- Aligned to Trust QI priorities
- Additional random selection

Weekly SJR scrutiny panel are being conducted where SJRs flagging poor or very poor overall care are then reviewed with relevant expert input, allowing key learning and areas of focus for improvement work to be identified and the appropriate

governance response agreed. A monthly slot is reserved for all SJRs conducted (including those where overall care was judged adequate, good or excellent) in children and patients with complex care needs (LD, severe mental illness and homeless patients). This approach allows relevant specialist support teams e.g. LD liaison to input into the review and inform the governance response. It also enables sight of a proportion of all SJRs scoring overall care as adequate, good or excellent across the hospital. Advantages include the positive impact on culture of recognising notable practice and being able to thank teams as well as the targeting of Safety II approaches (i.e. learning from care that goes well not just care that does not as promoted in the National Patient Safety Strategy July 2019) to cohort of patients where care is often hardest to get right and where we are most likely to identify opportunities for learning and improvement which may ultimately help all patients.

Table 7: Case record reviews completed in relation to deaths which occurred during the 2021/2022 reporting period, including a breakdown by vulnerable group.

Financial Year 2021/22	Total Number of SJR's completed relating to in-patient deaths during the reporting period	Number of SJR's completed for patients with Learning Disabilities	Number of SJR's completed for patients with Severe Mental Illness	Number of SJR's completed for patients who were Homeless
Q1	50	7	12	0
Q2	34	5	6	0
Q3	48	1	5	1
Q4	53	9	13	1
Total	185	22	36	2

Table 8: Case Record Review - Perinatal Mortality Review Tool (PMRT)

Financial Year 2021/22	Total Number of PMRTs completed relating to Neonatal/Post Neonatal deaths during the reporting period	Total Number of PMRTs completed relating to still Births during the reporting period
Q1	4	3
Q2	7	4
Q3	1	1
Q4	0	0
Total	11	9

Investigations: Serious Incidents
Serious Incident deaths are investigated using Root Cause Analysis (RCA) methodology as required by the National Serious Incident Framework, rather than by Structured Judgement Review.

Table 9: Serious Incidents reported and investigations completed in relation to the deaths which occurred during the 2021/2022 reporting period:

Financial Year 2021/22	Total Number of Serious Incidents reported in relation to the deaths which occurred during the report period	Total Number of SI Investigations completed
Q1	6	6
Q2	2	2
Q3	5	2
Q4	6	1
Total	19	11

Total number of case record reviews and investigations in 2021/2022
By the end of Quarter 4, 39 case record reviews and 19 investigations have been carried out in relation to the 2,397 in-patient deaths reported during the 2021/2022 financial year, however, all in-patient deaths are scrutinised by the Medical Examiners Service.

In 4 cases a death was subject to both a case record review and investigation. These cases were escalated for a serious incident investigation following an SJR scrutiny panel.

The number of deaths in each quarter for which a case record review or investigation was carried out was: 24 in the first quarter; 19 in the second quarter; 9 in the third quarter; 6 in the fourth quarter.

Of the 58 deaths reviewed, 19 representing 0.8% of patient deaths during 2021/2022 (2,397) are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:
Quarter 1: 5 representing 1% of patient deaths during 2021/2022
Quarter 2: 4 representing 0.7% of patient deaths during 2021/2022
Quarter 3: 4 representing 0.6% of patient deaths during 2021/2022
Quarter 4: 6 representing 0.9% of patient deaths during 2021/2022

This number has been estimated using the following:

1. Case record reviews:

Table 10: SJR Case record reviews completed in relation to deaths which occurred during the 2021/2022 reporting period, where the death was judged to be more likely than not due to problems in care

Financial Year 2021/2022	Total Number of SJR's completed relating to deaths during the reporting period	Number of deaths judged at SJR to be more likely than not due to problems in care based on NCEPOD grading	% of Total Number
Q1	11	0	0%
Q2	6	2	33%
Q3	2	0	0%
Q4	0	0	-
Total	19	2	10.5%

These numbers have been estimated using the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) grading which it has been mapped to Royal College of Physicians (RCP) 'Avoidability' scores.

Table 11: PMRT Case record reviews completed in relation to Neonatal/Post Neonatal deaths which occurred during the 2021/2022 reporting period, where the death was judged to be more likely than not due to problems in care

Financial Year 2021/2022	Total Number of PMRT's completed relating to Neonatal/Post Neonatal deaths during the reporting period	Number of deaths judged to be more likely than not due to problems in care	% of Total Number
Q1	4	0	0
Q2	7	0	0
Q3	1	0	0
Q4	0	0	0
Total	12	0	0

Table 12: PMRT Case record reviews completed in relation to Still Births which occurred during the 2021/2022 reporting period, where the death was judged to be more likely than not due to problems in care

Financial Year 2021/2022	Total Number of PMRT's completed relating to Still Births during the reporting period	Number of deaths judged to be more likely than not due to problems in care	% of Total Number
Q1	3	0	0
Q2	4	0	0
Q3	1	0	0
Q4	0	0	0
Total	8	0	0

2. Serious Incident Investigations:

Table 13: Investigations completed in relation to patients who have died during the 2021/2022 reporting period where the death was judged to be more likely than not due to problems in care

Financial Year 2021/2022	Total Number of investigations completed	Number of deaths judged to be more likely than not due to problems in care following investigation	% of Total Number
Q1	6	5	83%
Q2	2	2	100%
Q3	5	4	80%
Q4	6	6	83%
Total	19	17	89%

Thematic analysis of the 13 deaths was conducted using the Human Factors Analysis and Classification System (HFACS). This is a coding framework adapted for the NHS Acute Care setting by Shale, S and Woodier, N, (2017) and enables contributory factors identified from investigations to be themed to highlight areas for improvement.

Learning from Case Record Reviews and Investigations
Below are areas where improvement work is required.

Methods and tools to share the learning include; Grand Rounds, SJR panel meetings, Local Mortality and Morbidity meetings, Governance Meetings and Trust wide OWLS (Organisation Wide Learning).

Table 14: Learning from Case Record Reviews – SJRs

	Themes identified through case record review	**Update/ Action**
1	**Sub-optimal communication with patients and families**	This was the overall top theme from all SJRs this year. SJRs highlighted suboptimal communication with patients and families as a top concern potentially reflecting the difficulties with communication during the Covid pandemic. The Trust has looked at a number of different ways of mitigating this issue through some limited and clear visiting made available where possible, establishing relatives liaison team provision when visiting very restricted, PALS 'Best wishes' service and virtual visiting through i-pads and Skype.
2	**Lack of timely recognition that a patient is approaching end of life**	This theme is linked with other themes emerging from the SJR process relating to timely diagnosis including a lack of a clear plan and oversight of complex patients and failures and delays in obtaining senior reviews. This issue will be highlighted through Learning from Deaths committee for discussion at M&M meetings. The potential to implement the Amber Care Pathway

		is being discussed with Palliative Care
3	**Non-compliance with the Mental Capacity Act**	This is a recurrent theme coming through the SJR process. The main sub-theme was no mental capacity undertaken. Other themes included best interest decision meetings not held and no evidence that best interest decision making included balancing of risks and benefits to the individual. An action plan is in place to address this issue which is a Trust wide concern
4	**Gaps in documentation**	The main theme was gaps in medical documentation. The Trust is still using paper case notes so there is a higher risk of misfiling and completeness and accuracy of record. Within the ICS Digital Health Strategy, there are plans to implement an electronic patient record and this together with the associated training, should help reduce the risk of gaps in documentation. There are also a number of initiatives taking place that will support more robust documentation including e-obs, Alertive and an EDL improvement workstream.
5	**Sub-optimal communication between teams**	There are a number of initiatives to improve communication between teams in the Trust including the roll out of Alertive and the full implementation of e-obs. These initiatives are mapping out key roles and responsibilities within specialties/departments and enabling the redesign and strengthening processes in support of improved communication.

Table 15: Learning from Case Record Reviews – PMRT

	Themes identified through investigations	Update/ Action
1	**Extreme Prematurity**	Extreme prematurity has been acknowledged as a continued theme throughout PMRT. The NNUH is a tertiary referral centre as we have a Level 3 NICU. This accounts for extreme prematurity being identified as a main or associated cause of death. Identifying women at risk of preterm birth and optimising their care is a key focus in recent Saving Babies Lives Care Bundle Version 2 report (2019). Maternity services have a specialist Consultant Obstetrician who runs a Preterm prevention clinic which includes offering cervical length measurements, cervical cerclage if needed and use of progesterone pessaries. In the last year in order to assist with identifying these women we have added a specific preterm

		birth risk assessment our booking appointment so this is also highlighted on the woman's electronic record. Other local hospitals are also aiming to implement care of these women in a specialist preterm prevention clinic. A recent change to ensure continued improvements and learning following preterm delivery is that every infant born between the gestation of 22 and 34 weeks gestation has an immediate case review. This to ensure appropriate care and perinatal optimisation has occurred.
2	**Impact of COVID and loss of access to GP surgeries to deliver antenatal and postnatal care.**	The COVID pandemic significantly impacted maternity services. This was due to changes in pathways of care, combined with a loss of community facilities to deliver antenatal and postnatal care. This theme has been noted throughout some PMRT reviews. The full antenatal schedule of care is provided to vulnerable women, women with complex physical and psychological medical conditions teenage parents and women with serious safeguarding concerns. Long term bases to deliver antenatal and postnatal care have been identified. The Trust is working with some GP surgeries to facilitate the return of midwives. This will ensure that all women receive the full schedule of antenatal and postnatal care.
3	**High maternity vacancy rate**	A high midwifery vacancy rate has been addressed by an ongoing and at pace recruitment drive. There is continued work to ensure the recruitment trajectory is completed with a focus on retention of our staff at the same time.
4	**Ensuring placentas are sent for full pathological examination**	A further theme noted within PMRT reviews was that not all placentas had been sent for examination. The royal College of Pathologists recommend that as a minimum, all placentas from babies requiring admission to a neonatal intensive care unit following severe fetal distress should be referred for full pathological examination including histology. The Trust guideline has been reviewed and amended in line with national guidance and then uploaded onto Trust docs. The changes have

		been disseminated to all staff via email, posters and at safety huddles. Further to this a placenta fridge has also been purchased.

The main themes identified through the Serious Incident investigations are listed below. This learning will be used to inform focused future quality improvement work to minimise recurrence.

Table 16: Learning from investigations

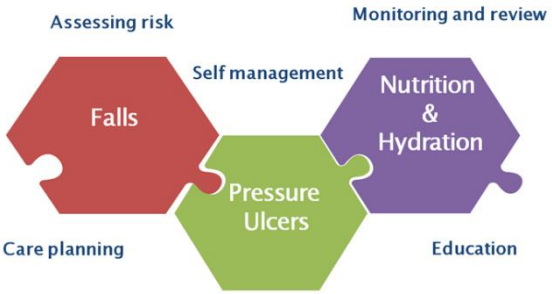
	Themes identified through investigations	Update/ Action
1	**Risks not identified**	Most frequent incidents which have been identified are falls with serious injury and Pressure Ulcers (cat 3 or above). We have introduced multifactorial falls assessment and 'Purpose T' skin integrity risk assessment, as part of a Quality Improvement Programme into Essential Care. Please refer to the below Essential Care Improvement Programme.
2	**Risks not acted upon**	We have introduced multifactorial falls assessment and 'Purpose T' skin integrity risk assessment. We have also commenced 'Tendable' audits, which are happening around falls and nutrition and hydration linked to Quality Improvement Programmes. Please refer to the below Essential Care Improvement Programme. We have implemented an electronic observation system (e-obs) to improve recognising and responding to deteriorating patients.
3	**Information transfer ineffective between teams**	We have launched a new system; 'Alertive'. The system is currently live and continues to be rolled out throughout the Trust. This is an integrated communication and workflow system, which supports critical altering, clinical messaging; both within and between teams, clinical teams, priorities and event monitoring.

Actions

Essential Care Improvement Programme –

The Essential Care Improvement Programme aims to reduce the number of reported incidents and drive demonstrable improvement in the prevention of patient harm. Although incidents may be sensitive to the number of available nursing staff, this programme requires a multidisciplinary approach.

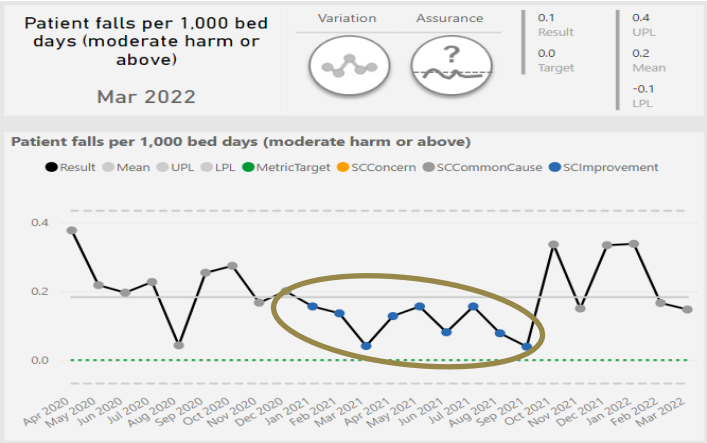
The programme is focused on commonly occurring themes across all three domains as shown -



Reducing Harm from Falls Quality Improvement Programme
The falls improvement programme is being rolled out across the Trust and will build on the initiatives from wave 1 with learning shared across the Trust.

The Tendable © audits are being used at ward level to identify areas for improvement. They started in March 2021 alongside the 1st wave QI programme, and the reduction in falls between January 2021 and September 2021 is evident on the falls data shown in chart below

Fig 1.0.



The Emergency Department will be testing a new change idea adopted from East Kent Hospital, this initiative reduced falls by 50%. The Yellow Falls Kit is a highly visual cue in order to raise awareness within the busy A&E departments of those patients at risk of falling.

Falls Policy
The new falls policy promotes compliance with NICE Clinical Guideline 161: 'Falls in older people: assessing risk and prevention' (2013), National Patient Safety Agency Rapid Response Report: 'Essential care after an inpatient fall' (2011) and NICE Clinical Guideline 176: 'Head injury: assessment and early management' (2014).

The multifactorial assessment tool identifies a patient's individual risk factors for falling in hospital :

- cognitive impairment
- continence problems
- falls history including fear of falling
- footwear
- pre existing health problems that may increase their risk of falling
- assessment of Osteoporosis risk
- medication both existing and new
- postural instability, balance and mobility problems
- visual impairment

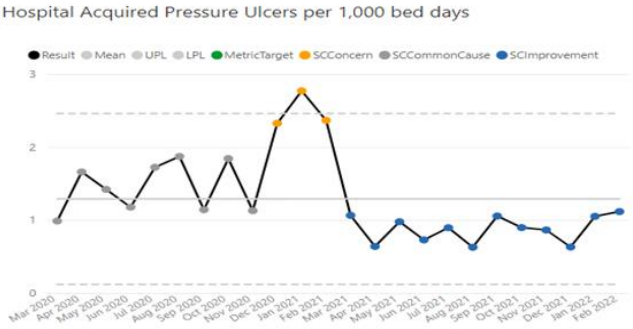
Individualised patient action plan as a result of multifactorial assessment –

- professional to give consideration to actions to take/implement.
- with the recognition of how these can change throughout the care journey

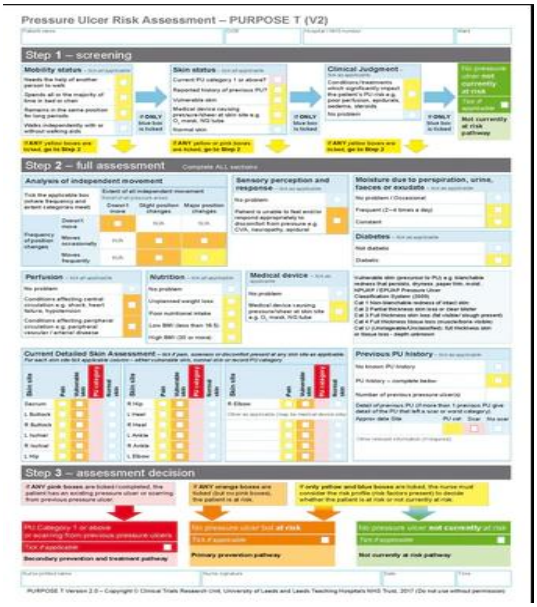
Falls Steering Group
This group will be responsible for monitoring and reviewing falls rates and trends, carrying out thematic reviews and advising on changes to practice in light of new and emerging evidence and best practice.

Pressure Ulcer Improvement Challenge

- Despite the ongoing covid admission rates, skin integrity risks from covid and additional admission pressures seen in the last 4 months, we have achieved an 18% reduction in reportable pressure ulcer incidents during admission 2021-22.



- Combinations of staff focus in key areas with QI projects and the support of a Full Tissue Viability Team have begun to see reductions across all areas.
- Early verification and correct categorisation have highlighted where additional educational support has been needed and identified a key project for 2022-23 focusing on clinical photography records.
- Refreshed and updated mandatory E-learning for all staff has been completed along with Tissue Viability input on new staff induction days
- Study days and adhoc teaching with use of the “pressure ulcer apples” are increasing staff knowledge and confidence with identification of early signs of damage, action and reporting.
- We have introduced a new up to date nationally approved Risk Assessment tool (Purpose T) to support more consistent risk assessment and identification of individualised patient care needs during their stay.
- Purpose T allows for RAG rating and the Trust have agreed our colour linked care plans to support individualised care for each patient with regards to their pressure area risks.



Nutrition and Hydration
The improvement focus has been on food charts, improving diet signage around meal choices and dietary needs of patients. Including finger food menu.

Areas for improvement identified in the Tendable© audits include dietitian review within 3 days of referral. Mouth care, MUST reassessment at 7 days and Care plans being evaluated daily

Nutrition Steering Group have oversight of QI projects and other improvement initiatives that are in progress.

QI projects will be reviewed, and further actions agreed at the next steering group in April

Update on Case Record Reviews and Investigations for 2020/2021
150 case record reviews and 2 investigations were completed after 1st April 2021 which related to in-patient deaths which took place before the start of the reporting period.

Of the 152 deaths reviewed, 24 representing 0.9% of in-patient deaths before the reporting period (2,694) are judged to be more likely than not to have been due to problems in the care provided to the patient.

This number has been estimated using the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) grading which has been mapped to Royal College of Physicians (RCP) 'Avoidability' scores (case record reviews), thematic analysis of the deaths investigations conducted using the Human Factors Analysis and Classification System (HFACS); a coding framework adapted for the NHS Acute Care setting by Shale, S and Woodier, N, (2017) and enables contributory factors identified from investigations to be themed to highlight areas for improvement, and Perinatal Mortality Review Tool.

48 representing 1.8% of the in-patient deaths (2,694) during 2020/2021 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Play Specialist Team

There is significant research on the importance of play for all children, and play is covered in national and international policy. A child's right to play is guaranteed in Article 31 of the United Nations Convention on the Rights of the Child, which also includes the right to appropriate facilities and non-discrimination in play provision (Davey and Lundy, 2011). In hospital and during treatment, play is recommended for the wellbeing of children by the Care Quality Commission (2014), the World Organisation for Early Childhood Education and the Department of Health (National Children's Bureau, 2005).

The play team at NNUH has always been an important part of service delivery but has never been afforded the opportunity to be reviewed and resourced as services have developed and evolved. However, this changed in late 2020 when we able to review our overall staffing establishment and increase the play team.

This has resulted in more than double the number of hospital play specialists and play assistants employed in the department, ensuring consistent cover across all areas, 7 days a week. This has in turn supported actions identified in the 2020 CQC Children and Young People's survey where we were an outlier for feedback relating to availability of play staff.

The team was fully recruited to in April 2021 and the last 12 months has seen really positive developments from a play perspective least of all feedback from the children and their families. Play is an important part of the holistic approach the Jenny Lind Children's Hospital takes with regards to the care they give to their patients.

Part 2.3 - Reporting against core indicators

Please note that the guidance 'Detailed requirements for quality reports 2020/21 published by NHS Improvement instructs that 'since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the trust by NHS Digital' (p17).

SHMI value and banding						
Indicator	NNUH Nov 20 – Oct 21 Published by NHS Digital	National Average	Best performer	Worst performer	NNUH 19/20	NNUH 18/19
SHMI value and banding	1.1860 Band 1	1.0001	0.7193	1.1860	1.1688 Band 2	1.1338 Band 2
Location: https://digital.nhs.uk/data-and-information/publications/statistical/shmi/2022-03/shmi-data > SHMI data at trust level **Latest version available** covers November 2020 – October 2021, published 10 March 2022. **The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons:** The Norfolk and Norwich University Hospitals NHS Foundation Trust has conducted a review of its high SHMI. The Trust has a higher palliative care case load than average, both regionally and nationally, and this is a major driver. A number of data quality issues have also been identified. A comprehensive SHMI action plan is in place which includes a SJR (structured judgement review) cohort review of a sample of deaths in the major SHMI outlying diagnosis groups						
% of patient deaths with palliative care						
Indicator	NNUH Nov 20 – Oct 21 Published by NHS Digital	National Average	Best performer – Lowest %	Worst performer – highest %	NNUH Nov 19 – Oct 20	NNUH Oct 18 – Sept 19
% of patient deaths with palliative care coded at either diagnosis or specialty level for the reporting period	54%	39%	39%	64%	52%	49%
Location: Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation, England, November 2020 - October 2021 - NHS Digital> interactive data visualisation > page 7 (contextual indicators: Palliative Care) **Latest version available** covers November 2020 – October 2021, published 10 March 2022.						

PROMS						
Indicator	2020/21				NNUH 19/20	NNUH 18/19
	NNUHFT	National Average	Best performer	Worst performer		
Patient reported outcome scores for groin hernia surgery	No data available	No data available	N/A	No data available	No data available	N/A
Patient reported outcome scores for varicose vein surgery	No data available	No data available	N/A	No data available	No data available	N/A
Patient reported outcome scores for hip replacement surgery	0.444 2020/21	0.465 2020/21	No data available	No data available	0.452 2019/20	0.457 2018/19
Patient reported outcome scores for knee replacement surgery	0.271 2020/21	0.315 2020/21	No data available	No data available	0.309 2019/20	0.319 2018/19

Location: https://digital.nhs.uk/data-and-information/publications/statistical/patient-reported-outcome-measures-proms/finalised-hip-and-knee-replacement-procedures-april-2020-to-march-2021

Patient Reported Outcome Measures (PROMs) in England: Hip & knee replacements
https://view.officeapps.live.com/op/view.aspx?src=https%3A%2F%2Ffiles.digital.nhs.uk%2F53%2F785BF7%2FScore%2520Comparison%2520Tool%2520Finalised%25202021.xlsx&wdOrigin=BROWSELINK

Current version uploaded: April 2020 – March 2021, Published 10 Feb 2022
Adjusted average health gain 'EQ-5D Index' scores

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that the outcome scores are as described for the following reasons: The number of patients eligible to participate in PROMs survey is monitored each month. Results are monitored and reviewed within the orthopaedic directorate prior to an action plan being agreed.

The Norfolk and Norwich University Hospitals NHS Foundation Trust intends to take the following actions to improve these outcome scores, and so the quality of its services: Our primary goal over the forthcoming months is to focus on improving the patient experience for patients that undergo primary knee replacement surgery and hip replacement surgery. A review of the process and action planning has taken place to ensure that quality improvements are made in line with patient feedback.

28 day readmission rates						
Indicator	2020/21 (NNUH reported based on the NHS Outcomes Framework Specification)				NNUH 19/20	NNUH 18/19
	NNUHFT (Apr 20 – Mar 21)	National Average	Best performer	Worst performer		
28 day readmission rates for patients aged 0-15	Average rate 10.9%	No data published	No data published	No data published	No data	12.74 April 18 – Jan 19
28 day readmission rates for patients aged 16 or over	Average rate 11.2%	No data published	No data published	No data published		
There is no data published since 2012/13. Data above has been based upon clinical coding within Norfolk & Norwich University Hospitals NHS Foundation Trust.						

Trust responsiveness						
Indicator	2021/22 NHS Digital				NNUH 19/20	NNUH 18/19
	NNUHFT	National Average	Best performer	Worst performer		
Trust's responsiveness to the personal needs of its patients during the reporting period.	72.9	74.5	85.4	67.3	67.1	68.1

Note: NHS OF publish this data on an ongoing annual basis, which began in August 2021, however, the August 2021 publication data did not include Trust Responsiveness, therefore, used the data used has been taken from the March 2022 publication.

Location: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/august-2020/domain-4-ensuring-that-people-have-a-positive-experience-of-care-nof/4-2-responsiveness-to-inpatients-personal-needs

Current version uploaded: March 22 // Next version due: March 23

The Norfolk and Norwich University Hospitals NHS Foundation Trust has taken the following actions to improve this data, and so the quality of its services: The NNUH performance showed an improvement compared to previous years, although below the national average for the period covered. The Trust has continued to implement its patient engagement and experience strategy and has focussed on reaching out via virtual means due to covid and engaging with the less well heard within our communities. It has also merged the complaints function into PALS over this period with a new team recruited and processes updated. The NNUH strategy contains experience of care as a key component with continued emphasis on equality, diversity and inclusion. The Patient Engagement & Experience Group (PEEG) continues to oversee divisional reporting against actions arising from all forms of feedback, including the Friends and Family Test (FFT), complaints and PALS and engagement with community groups including Healthwatch Norfolk.

% Staff employed who would recommend the trust						
Indicator	2021 NHS Staff Survey Results				NNUH 2019/20	NNUH 2018/19
	NNUHFT	National Average	Best performer	Worst performer		
Percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.	60%	66.9%	89.5%	43.6%	72.2%	62%

The percentage added for this year is taken from question 21d 'If a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation'

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this score is as described for the following reasons:

The 2021 results represent a difficult period where we're disappointed about our staff experiences of working at NNUH. Data from the 2021 staff survey has provided the Trust with strong evidence that there is significant work to be done to improve our staff experiences.

We are determined to make our hospitals a better place to work and are developing a three-year Improvement Plan to turn around our results. We will work together, both internally and with the wider healthcare system, to make transformational changes to the way in which we work, care for patients and each other.

% of patients assessed for Venous Thromboembolism (VTE)						
Indicator	2020/21 (Trust data)				NNUH 19/20	NNUH 18/19
	NNUHFT	National Average	Best performer	Worst performer		
Percentage of patients who were admitted to the hospital and who were risk assessed for VTE during the reporting period	No data available	No data available	No data available	No data available	99.27% Dec 2019 Q3= 99.13%	98.76% March 2019
VTE data collection has been paused for 2021/22 due to the Covid-19 pandemic. No official publication of data is available.						

C difficile						
Indicator	2020/2021 NHS Digital				NNUH 19/20	NNUH 18/19
	NNUHFT	National Average	Best performer	Worst performer		
Rate per 100,000 bed days of cases of C.difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period	14	15	0	81	8.6	9.8

Note: Data is always a year behind due to the publishing of data after the quality report deadline dates.

Latest data available for 2021/22

Location: https://www.gov.uk/government/statistics/clostridium-difficile-infection-annual-data#history (drop down selection of rate and hospital onset)

Current version uploaded: September 2021

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this rate is as described for the following reasons: The data have been sourced from the Health & Social Care Information Centre, compared to internal Trust data and data hosted by Public Health England.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services: Measures are in place to isolate and cohort-nurse patients with suspected and confirmed C.Diff, in order to contain the spread of infection, and our Infection Control team works in a targeted way to quickly contain any emergent outbreaks. Rapid response deep cleaning processes are in place to contain any suspected infections, and these are complemented by an established and effective programme of preventative deep cleaning, aimed at avoiding an outbreak entirely if at all possible.

Patient Safety Incidents						
Indicator	2020/21 NHS Digital				NNUH 19/20	NNUH 18/19
	NNUHFT	National Average (Rate)	Best performer (Rate)	Worst performer (Rate)		
Number and rate of patient safety incidents per 1,000 bed days	Rate 118.7 (n32,917)	63.7	15.2	235.8	Q1/2 Rate 49.7 (n8069) Q3/4 Rate 52.5 (n8585)	Q1/2 Rate 22.1 (n3541) Q3/4 Rate 46.1 (n7237)

Number and percentage of patient safety incidents per 1,000 bed days resulting in severe harm or death	Rate 0.25 (n69)	0.40	0	3.28	Q1/2 Rate 0.2 (n39) Q3/4 Rate 0.3 (n41)	Q1/2 Rate 0.13 (n21) Q3/4 Rate 0.24 (n37)

Note – NHS OF publish this data on an ongoing annual basis, which began in August 2021
Location: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-outcomes-framework/march-2022/domain-5---treating-and-caring-for-people-in-a-safe-environment-and-protecting-them-from-avoidable-harm-nof/5.6-patient-safety-incidents-reported-formerly-indicators-5a-5b-and-5.4

Current version uploaded: 17 March 2022
https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this number and rate are as described for the following reasons:
Through the improvements we have made to our incident reporting protocols, and our continuous focus on promoting psychological safety and just culture, staff feel safe recognising and reporting incidents. The increase in the rate and number of patient safety incidents for 2020 – 2021 includes the increased number of 52 week breaches that occurred during the COVID 19 Pandemic.

The Norfolk and Norwich University Hospitals NHS Foundation Trust is taking the following actions to improve the quality of incident reports and so the quality of its services by focusing on:

- building capacity and capability for incident investigations to identify systemic failings and ensure recommendations and actions are identified that address significant or emerging risks to patient safety.
- Continuing to promote a just culture and psychological safety so that staff feel able to speak up and report incidents without fear of blame

Review of Implementation of 7 Day Services

Providers of acute services are asked to include a statement regarding progress in implementing the priority clinical standards for seven-day hospital services. This progress should be assessed as guided by the Seven Day Hospital Services Board Assurance Framework published by NHS Improvement. Further information can be found at https://improvement.nhs.uk/resources/seven-day-services

In partnership with NHS England, NHS Improvement have introduced a new way of measuring seven day hospital services for all providers of acute services, replacing the previous survey with a self-assessed Board Assurance Framework.

Acute Service providers have not been required to submit a board assured self-assessment return or provide any monitoring reports to NHS England or NHS Improvement for 2021/22, against the 2017 Seven Day Services Clinical Standards.

The Norfolk and Norwich University Hospital (NNUH) has continued to internally monitor and report activity against each of the ten standards through appropriate operational groups within the organisation, to ensure that each of the standards are included in service design, delivery and improvement.

Following the release of Version 2 (8 Feb 2022) of the Seven Day Services Clinical Standards and Version 2 (8 Feb 2022) of the Board Assurance Framework for Seven Day Hospital Services, the NNUH will look to adopt the updated standards and reintroduce the BAF in order to provide reports to Trust Board.

Review of Speak Up Policy

The National Speak Up Policy has undergone a review by NHSi and will be available by 1st April 2022 according to an NGO update (National Guardian Office). We will review this and look to adopt with board approval, changes to support staff further in speaking up.

The Freedom to Speak Up: Raising Concerns (Whistleblowing) Policy (formally the Speak Up Policy) is for use by all staff and workers. It carefully explains; the steps, to raise and escalate a concern, how the concern will be addressed, how feedback will be given in line with best practice.

The Policy currently details the various concerns that should be raised - unsafe patient care, unsafe working conditions, inadequate induction or training for staff, lack of, or poor response to a reported patient safety incident, suspicions of fraud, or a bullying culture as examples– then outlines the process of reporting to a line manager or tutor, or, if unable to raise it with them, details of others who can be approached: Chief nurse, Medical Director, Chief Operating Officer, etc., and Freedom to Speak Up Guardians.

It identifies that if these escalation routes are not responsive staff can contact the Trust's Chief Executive or Chairman, and if necessary, outside bodies such as NHS England, Health Education England, NHS Counter Fraud Authority or the CQC.

The Policy outlines confidentiality and anonymous reporting of concerns and gives advice on support available for those raising concerns and explains how the Speak Up process works, including how staff will receive feedback and be thanked for raising their concerns. It reassures staff that detriment to speaking up is not acceptable and how this would be taken seriously and investigated by the organisation.

Freedom to Speak Up (FTSU) Guardian Service

The team;

- **Non Executive Director** – Sandra Dinneen
- **Executive Lead** – Paul Jones
- **Lead Freedom To Speak Up Guardian** – Frances Dawson

Rota Gaps

Health Education England (HEE) allocate junior doctors to our organisation, and as such we are working collaboratively with HEE to review and improve processes related to these rotations and the junior doctors experience whilst working here, so that they feel valued and part of our team. In addition the Trust recruits and appoints locally employed Doctors, Advanced Nurse Practitioners, and Physician Associates to support vacancies in training rotas.

NNUH has two Guardians of Safe Working Hours, who act as champions for safe working hours for Doctors and Dentists in training.

The Medical Director and Chief People Officer have a governance framework in place for reviewing, managing and escalating short or longer term gaps in rotas and provide reports to a number of groups and committees up to Trust board. Central records on rota gaps have not been held historically, this will change following the implementation of electronic rostering for medical and dental staff, phase one of the project is in progress beginning with the junior doctors.

A Medical & Dental Workforce Programme is currently under implementation which is intended to improve performance across a number of workstreams and subjects related to our medical and dental workforce, such as their rota's, gaps in their rotas, bank and agency use and paying promptly for additional hours worked. A number of the workstreams for this improvement programme include representatives from various grades of Doctors and Dentists in Training through to Consultant level.

Good News Story

Innovative programme helps train more doctors in robotic-assisted surgery

A new national training pilot (the first of its kind) has been devised by our Sir Thomas Browne Colorectal Unit and Intuitive, the pioneer of robotic-assisted surgery and makers of the da Vinci surgical systems. This has enabled surgical registrars, on the path to becoming consultants and who have had many years of surgical experience, to complete the training necessary in order to carry out bowel cancer operations on our two da Vinci systems.

In 2021 7 registrars participated and 5 of those completed the 1 tier fellowship on the da Vinci robot. This has enabled the registrars to apply for their fellowship without having to gain the basic training on the console, and in turn has expedited their future training by 3-6 months. In 2022 so far, a further 4 registrars have also completed their 1 tier fellowship.

This programme has been championed by Mr Irshad Shaikh, Consultant Colorectal and lead Robotic Surgeon here, and supported by Intuitive. Mr Shaikh, who teaches robotic surgery nationally and has helped the robotic colorectal programme in ten UK hospitals, said: "*I have consistently found that the registrar level trainees are left out in this programme and worked together with Intuitive to devise this training programme. I am very proud of the East of England deanery surgical registrars for successfully completing the first phase of robotic colorectal surgical training and delivering this first national pilot programme at NNUH*."

It is hoped that the programme will continue with the funding available from Intuitive Surgical. Mr Shaikh went on to say "We are grateful to the trust to provide the platform, intuitive surgical for the funding and trainees who committed to train occasionally over week ends as well. Now that we have acquired 'telepresence system', I can remotely train them on robotic case observation for them, whilst they are sitting in an area of conference hall or training laboratory or even any part of the Europe".

Eleanor Rudge, who took part in the pilot, said: "*There are plenty of hospitals within the UK that have access to robotic-assisted surgery, and yet surgical registrars at these hospitals often get very little actual robotic experience. However, we are lucky enough to have someone like Mr Shaikh, who has the vision, the know-how and the enthusiasm, which have all been key to allowing us access to this incredible opportunity. We have also had the support of the entire colorectal unit at NNUH – as a registrar group, we have worked in many hospitals in the region and it is very obvious to all of us that the support of this department is exceptional*."

Part 3 - Overview of the Quality of Care

Patient Safety

Restrictive interventions

Baseline: what increased the focus on restrictive interventions- CQC report- The need for robust evidence that the healthcare records for patients' subject to restraint are complete and in line with the trust's policy and procedure.

What you are measuring success on - Whilst it is the intention of the Organisation to capture and report all RI incidents, it is recognised that this may not be a SMART objective. Awareness of reporting requirement should be raised. Paradoxically, actions on the RI plan (and RRI work more widely) aim to both increase reporting and decrease the use of RI, which may mean it is difficult to track differentials and, therefore, improvement over time.

The journey so far this year (April 21 – March 22) including successes and challenges-

- Progress along agreed trajectory has been consistent and there are no concerns regarding ongoing progress at this time. The RRI leads recognise that as reporting and awareness continue to improve in the Trust, audit results may reflect this in some deviation from current progress.
- Reducing Restrictive Interventions Policy went to MHCC Board for approval
- A Standard Operating Procedure (SOP) for the use of Patient Safeguarding Mittens (Adult Patients) outside of Critical Care-has been approved at MHCC Board. This can be used by staff as a risk assessment and care planning.
- Patient Information Leaflet for Patient Safeguarding Mittens
- Continue with internal RCA processes via Reducing Restrictive intervention safety panel-(RRISP) each directorate has an allocated weekly slot to present 3-4 incidents for discussion.

- Continue to work with Governance teams to draw out themes from the RRISP panels, support with dissemination of learning and directorate leadership on scrutinising the performance and governance teams to feedback any highlighted care delivery issues for example- staffing issues, gaps in documentation, poor communication amongst teams and also notable practice for example- patient centred care, good communication, prompt access to support services through the governance meetings and shared learning channels.

What you are aiming to achieve over the next 12 months and beyond.

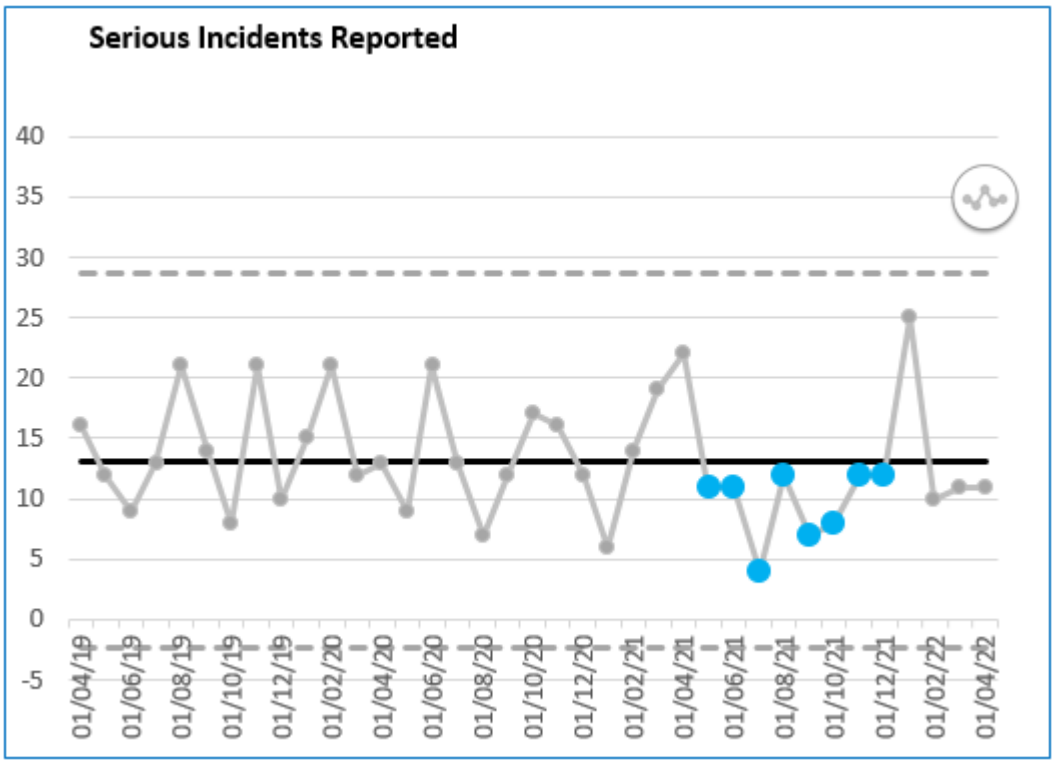
- Developing and holding drop in sessions for staff.
- ED Education clinic on Restrictive interventions.
- De-escalation training.

Serious Incidents (SIs)

All patient incidents, regardless of their severity, are recorded onto our local DATIX reporting system. This data is submitted quarterly to the National Reporting and Learning System (NRLS).

In the twelve months ending 31st March 2022, 205 Serious Incidents were externally reported to the national StEIS (Strategic Executive Information System).

Fig 1.0 Serious Incidents Reported April 2019 – March 2022



All incidents reported provide an opportunity for learning and continuous improvement in the quality and delivery of care to our patients. The Trust has continued to support a culture of no blame reporting through the daily Serious Incident Group and has improved the focus on support for staff involved in patient safety incidents.

There is a continued and increasing focus also on supporting patients and families through Serious Incidents investigation process to ensure that the patient voice is firmly at the centre of our investigations. This process is essential in the understanding of where care and service delivery problems have arisen. The Trust Family Liaison Officer (FLO) has at the time of this report, 45 Serious Incident cases where patients and families are undergoing varying levels of support according to individual needs and wishes.

Never events

'Never Events' are a sub-set of Serious Incidents and are defined as largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

In our hospitals there were two never events during the period covered by this Quality Account -

June 2021	Retained foreign object post procedure
Dec 2021	Wrong site surgery

EDMS Overview

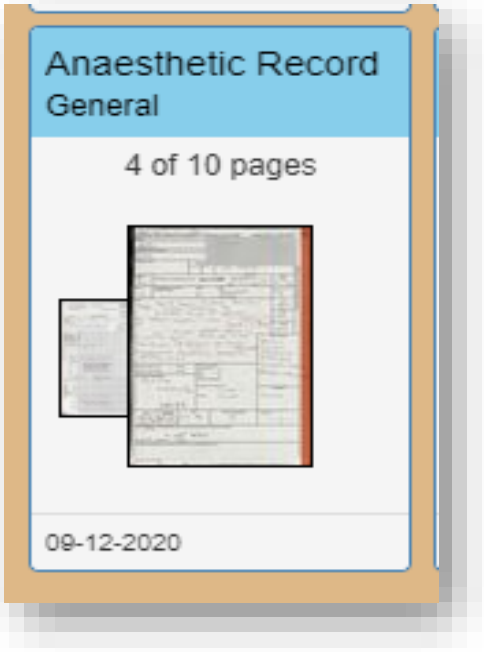
EDMS Project update
Following on from the last report in April 2021, the EDMS Project has progressed significantly and by the end of January 2022 137,303 case-notes had been successfully scanned into Medi-Viewer.

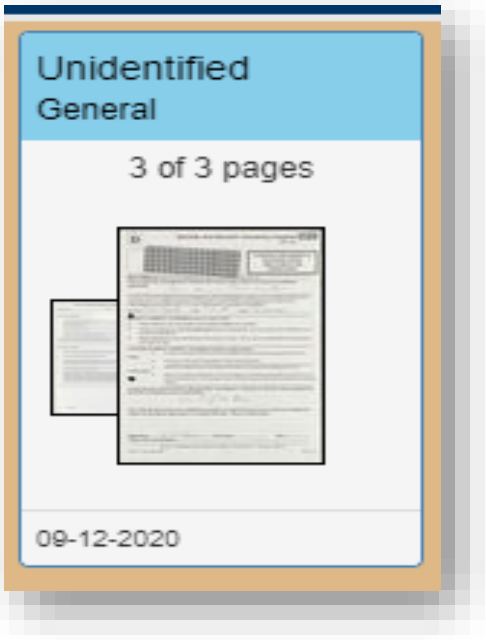
The Project is now in Phase 4 of the roll-out, with just 2 main areas to go-live; these are Ophthalmology and Paediatrics. It is hoped that the roll-out will be complete by the end of July 2022.

At the point when a Specialty is due to go-live, the Digital Health Transformation Team train both the Clinical staff and Admin Teams with the new processes. Following Go-live they are on hand to support staff.

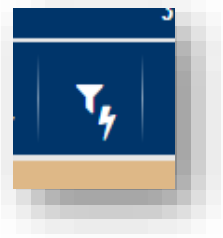
Medi-Viewer Taxonomy and 'B'Forms
In order to enable the user to navigate Medi-Viewer as easily as possible, Taxonomy and 'B' Forms are being created.

Taxonomy is the function within Medi-Viewer which identifies specific documents within the medical record. It will identify these documents in all digitised records across the Medi-Viewer system. An example might be Anaesthetic Reports.





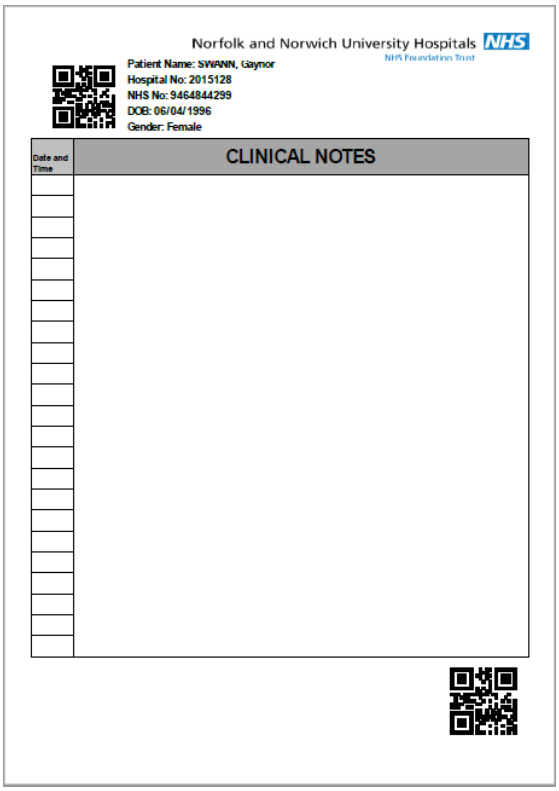
Previous examples show, the left hand document has been correctly identified by the taxonomy; note that the identity appears in the blue banner. By contrast, the right hand document has not been identified and is labelled appropriately.



Specific documents can be found in Medi-Viewer by using the Speed Filter function and ticking the relevant box/boxes in the list.

When a Specialty goes-live they are encouraged to identify several relevant documents which they use on a regular basis. The Health Records team will then set a series of rules which will enable Medi-Viewer to recognise the document in future. The Clinician will then be able to easily search for these documents.

In addition, Health Records will assist staff in an Outpatient setting by creating a **'B' Form** for a specific clinic. It contains a QR code which defines the document type when it is viewed in Medi-Viewer and automatically applies taxonomy rules so that it can be identified in thumbnail view. 'B' forms can be designed with clinic specific information such as body maps, speciality specific checklists, height/weight stamps etc. or any document specific to a clinic. When printing a B form as part of clinic prep, the patient identifier will automatically be populated in the document (please see example below):



3rd Party System ingestions

One of the ongoing workstreams is around establishing the 3rd Party System ingestions into Medi-Viewer.
It will benefit users greatly when in the near future the following systems will be ingested into Medi-Viewer. They include:

- EDT (clinic letters)
- WebICE
- ORSOS
- Bluespier

Additional workstreams/pathways

- Procurement is underway for a system called "iGrow", which is designed to replace the traditional Growth chart that is currently used in the Paediatric

department. This will assist the department enormously at the point when the case-notes are scanned.

- The Transformation Team are looking at the Research and Community pathways in relation to 3rd party access to Medi-Viewer.
- e-WinDIP which has been used by many clinical departments across the NNUH (including Health Records, Therapies, Eye Casualty), is being decommissioned and the data will be extracted and migrated into Medi-Viewer.

Conclusion

Clinicians will continue to experience a mixed economy of case-notes and digitised records. However, once the final Specialty goes live then no further physical case-notes will be created.

Once a set of case-notes has been digitised, all future documentation is scanned into Medi-Viewer as day-forward documentation. Day forward will continue until an Electronic Patient Record is implemented, at which point electronic forms will be generated.

Sarah Egleton
Head of Health Records
March 2022

Good News Story

Ketan Dhatariya

Consultant recognised as the world's top expert for diabetic ketoacidosis

One of our consultants has been recognised as the world's top expert for diabetic ketoacidosis – a condition which can prove fatal for people with either Type 1 or Type 2 diabetes.

Expertscape.com recognises Ketan Dhatariya, who works in our Elsie Bertram Diabetes Centre, as the leading expert in his field based on a number of factors including number of articles published in journals, as well as research and development.

"*This is wonderful. I am really honoured to be identified as world number one. It is a real feather in the cap of the department and the Trust as well*," said Ketan.

Ketan joined our hospital as a consultant in diabetes, endocrinology and general medicine in 2004, and became an Honorary Professor of Medicine at the UEA (University of East Anglia) in 2019.

He is a full time clinician with particular interest in inpatient diabetes – specifically regarding peri-operative diabetes care, the management of diabetes related emergencies, and the 'diabetic foot'.

He leads one of the largest foot clinics in the East of England. He also holds a number of national roles: he is the Chair of the Joint British Diabetes Societies Inpatient Care Group where he has led or co-authored the national guidelines on the management of various aspects of inpatient diabetes care including the guideline on diabetic ketoacidosis.

He is the Chair of the Examining Board for the UK Specialist Clinical Exam in Diabetes and Endocrinology; immediate past President of the Diabetes and Endocrine section of the Royal Society of Medicine, and an Associate Editor of Diabetic Medicine and BMJ Open Diabetes Research & Care.

Clinical Effectiveness

Mobile Cancer Unit

NNUH is the biggest cancer centre in the East of England and among the top four centres in England for numbers of treatments delivered. We provide services to patients from Norfolk and North Suffolk and further afield where we are the specialist centre. In 2018/19 there were 24,883 admissions to the Weybourne Day Unit (WDU), with an anticipate 10 – 15% increase year on year.

In 2019, anticipating the increase in demand for chemotherapy and the inability to expand our footprint we partnered with the cancer charity Hope for Tomorrow. The charity is dedicated to bringing cancer care closer to patients' homes via their Mobile Cancer Care Units (MCCUs). They have been working in partnership with the NHS since 2007 and have partnered with NHS Trusts all over the country to bring cancer care closer to patients' homes. The vison of the charity is to support patients who are going through cancer treatment by alleviating the stresses and strains of travelling for appointments, along with supporting NHS trusts in reducing hospital waiting times. This fits in well with the NNUH 5 Year Cancer Strategy and the Long-Term Plan to bring care closer to home and lead on innovative cancer services.

We undertook a postcode mapping exercise to identify four possible locations for the Mobile Cancer Care Unit; identified as being more than 20 minutes travel from the Norfolk and Norwich University Hospital. Following other Organisation's example we identified Supermarkets at Attleborough, Beccles, Dereham and Fakenham who all had large car parks, café, and toilet facilities, and were very keen to support their community.

In 2021, delayed slightly by Covid-19, we began our roll out of services site by site. Since February 2021 we have treated 89 patients with chemotherapy and are now at

all 4 sites each week. This is now an integral part of the NNUH chemotherapy service and offers staff the ability to rotate between venues.

One patient who is receiving treatment said:

> "The journey to the N&N is a round trip of fifty miles and I developed a phobia about the driving, parking and getting to my appointments. You can imagine my delight when I learned of the mobile unit! If I had been asked to imagine the best thing that could happen to help my treatments, I would not have been able to envision such a wonderful solution. Suddenly instead of my treatment being an ordeal it had become 'no big deal' at all. I felt like I was just popping down the road, as if I were just going to the shops."

From a clinical team perspective this is a fantastic achievement with huge enthusiasm from the nurses and clinicians. It enables the teams to work in a variety of settings, adapting skills and experience but most importantly meeting their patient needs and offering a first-class service.

Starting the service through Covid-19 gave us many challenges including restricting the number of chairs in use on the MCCU for social distancing, enhanced infection control procedures and maintaining staffing levels. The service has now been running for over one year with over 800 patients receiving treatment on the vehicle. This has provided local services to patients during a time of great anxiety and disruption, enabling them to continue their cancer treatment in a safe environment.

We are celebrating our belated first birthday at the Trust in May, showcasing the MCCU to patients, staff and public alongside local dignitaries and fundraisers. This is a fantastic opportunity to spread the good news and thank everyone for all their hard work.

Acute Services Integration

Norfolk and Waveney Acute Hospital Collaboration

Acute Provider Collaboration

The NNUH, the Queen Elizabeth Hospital in King's Lynn, and the James Paget University Hospital in Gorleston, make up the three acute Trusts in Norfolk and Waveney. Together we have a long history of working together, including the development of the Eastern Pathology Alliance, integrating our urology and ENT services and most recently the excellent partnership support to each other through the crisis and recovery phases of Covid-19.

Building on this history, together we are responding to the national requirement for greater collaboration within the NHS as outlined by NHS England and NHS Improvement. We are doing this by committing to increasing our levels of partnership working and collaboration through the creation of an Acute Provider Collaborative. This is an agreement to formally work in partnership, sharing knowledge and taking future decisions related to hospital services together. Each of the three hospital Trusts in Norfolk and Waveney will remain as individual organisations, each with their own identity and services that fit their geography and local population. By moving forward together, we believe that more patients will benefit from the knowledge, expertise, and innovation within each respective organisation.

Our Provider Collaborative is called the Norfolk and Waveney Hospitals Group (NWHG) and it comprises members from the Board of Directors from each of the three acute Trusts. This group meets regularly in a 'Committees in Common' forum to take joint decisions on the future strategy for our hospitals. There is a clear focus on the significant priorities that face our hospitals, including urgent and emergency care, elective recovery, finance and digital solutions. One of the things that we are doing together is developing an acute clinical strategy for our hospitals, which aims to deliver more sustainable and accessible services to meet the needs of people living in Norfolk and Waveney and further improve clinical outcomes

The Norfolk and Waveney Hospital Group Clinical Strategy

Building on the successes of our acute service integration work in ENT and Urology, the NWHG is committed to developing a joint clinical strategy in 2022/23. The aim of this is to ensure hospital services are sustainable, accessible and provide the best possible care for people living in Norfolk & Waveney. The starting point for this will be agreeing a framework which sets out the vision and aims for the strategy, defining our shared clinical aspirations and objectives. The framework will need to respond to the growth and changing health needs in our population over the next fifteen to twenty years, as well as core national, regional and local NHS requirements. The framework will set out the scope of the strategy for hospital services to come together and collaboratively work together to respond to. The project group is committed to engaging a wide number of people throughout the development of the strategy, in particular patients and patient groups.

Responding to Ockenden

The Norfolk and Norwich University Hospitals NHS Foundation Trust submitted compliance data against Ockenden Report (Part 1) requirements in June 2021 to NHS England and Improvement and feedback was issued in December 2021.

The feedback was RAG rated with four green compliant actions and four amber which require further evidence to demonstrate compliance. There were pieces of evidence submitted that were not acknowledged, and this was appealed.

Current outstanding actions:

Ockenden Report (Part 1)	
Actions outstanding	3 Actions IEA 3 & 7 • Multidisciplinary training 90% (Currently 89.2%) • CQC survey and action plan • Out of guidance SOP
Action Plan	• Implement new mandatory training non-compliance policy – across the 3 trusts • IT system cleanse of incorrect data to ensure accuracy • Nurse bank to add restrictions to bank contracts if PROMPT training not complete • CQC survey action plans underway • New birthing out of guidance policy in progress
Deadline	June 2022

Ockenden Report (Part 2) was released on 30th March 2022. The report detailed avoidable failings across the whole service with four pillars of recurrent themes:

Safe staffing levels	A well-trained workforce
Learning from incidents	Listening to families

As a whole, the Women's and Children's Division are reviewing the document, performing a rapid gap analysis and benching exercise to establish our position in relation to the report and compiling an action plan against the Immediate and Essential actions as required. This action plan will be available in April 2022, evidence will be reviewed at a Women's and Children's Evidence Group which will be reported into the Quality Programme Board.

Good News Stories

Early Pregnancy Assessment Unit (EPAU)

EPAU delivers care to women in the early stages of their pregnancy. Women are referred because they are experiencing complications in their early pregnancy (such as bleeding or pain) or have had problems with previous pregnancies. Most women who are referred require a scan and some attendances will result in women being told that their pregnancy is no longer viable or the pregnancy is considered very high risk.

The previous environment within which these women were cared for lacked privacy, space and was not located within easy reach of the rest of the department should an emergency arise.

Following a review of the footprint within the division the decision was taken to convert some of the siderooms on Cley ward to a new EPAU, facilitating an increased space for EPAU to ensure that patients (and their families) receive the personalised, sensitive and dignified care they require.

The new space has provided us with additional facilities to deliver some of the clinical treatments and care required by these women along with a quiet room, scanning room, large reception and nurses/ assessment room.

Appointing a Bereavement Nurse

Feedback from our patients experiencing pregnancy loss (<18 weeks pregnant) highlighted that there was a lack of support for women and their families following their loss. We have been very fortunate to work with one family who have set up the Chloe Blossom Foundation to support the implementation of a bereavement nurses specifically for this group of patients. Working with the family, the hospital charity team and the Gynae team we are just about to advertise the post.

"The Chloe Blossom Foundation has been created in memory of our little girl Chloe Blossom Matthews born 2nd May 2021. The foundation was formed to support other parents and families who sadly find themselves at such a heart breaking time in life. We look to support parents and families making memories they are able to treasure forever.
We hope by providing the financial funding for a Bereavement Nurse at The Norfolk and Norwich Hospital, this will help other families with their babies who have died through miscarriage, stillborn or termination."

The team have worked closely to ensure the post will deliver the care these families require and enhance the quality of the service we provide. The post will be supported by the Foundation for five years. In addition to the nurse post the Foundation will be working with the team to look at a bespoke bereavement space on Cley.

Patient Experience

During 2019 we recruited a brand new Patient Engagement & Experience Team, created a Patient Panel, co-created a strategy and brought volunteering under the patient experience umbrella.

We put in place some of the first foundations for achieving our co-designed ambitions and priorities.

In early 2020 we faced a global pandemic. This did not stop us – we forged a way through and found ways to push forward on the key priorities, keep momentum going to ensure the patient & carer voice at the NNUH was able to embed and grow louder whilst also developing innovative responses to keeping patients and families connected when visiting was halted.

The strategy was launched formally at the Trust AGM in early October 2020 and this review reflects on the progress to date to drive forward the voices of patients and families, especially those less well heard.

Our strategic aspiration for patient engagement and experience is:
NNUH is an outstanding organisation with exceptional patient and carer experience where people feel listened to, action is taken and we work in partnership with patients and carers, especially those who are seldom heard, to continually improve.

Our ambitions for patient engagement and experience:

- Working in partnership with patients is the norm – there is a strong Patient Voice including those who are seldom heard

- Services and pathways are co-designed with patients, staff and other stakeholders
- Feedback, whether complimentary or critical is proactively sought, coordinated, analysed & used to make improvements – 'you said, we did…together'
- All staff feel engaged, confident and empowered to proactively listen, respond and act - from the top and embedded throughout the organisation
- Volunteers support the patient experience to be outstanding through innovative roles and opportunities

To do this we need strong foundations:

- Build a team – staff, volunteers, patients, carers
- Build capacity – awareness raising, training, confidence, connections
- Build relationships – across the organisation, county and beyond

"As the Chair of the NNUH Patient Panel I like to feel that the panel members are there as representatives of the wider patient and carer family to ask those 'obvious' questions and challenge in a supportive and constructive way when necessary. Co-design is the way forward to achieve an NHS that is truly fit for purpose and can adapt and flex to suit the changing needs of its 'service users'"
Rosemary – Chair of Patient Panel

We identified 4 Key Priorities for 2019-2023; these are set out below, with progress to date in April 2021 – April 2022

We said we would…..	**We have……**
Strengthen partnership working with patients, volunteers and staff through: Strong patient voice via NNUH Patient Panel Patient Panel members embedded on range of committees, groups, etc. Patients and service users will be involved from the conception of any service change -all project initiation documents and processes must reflect this Provide support and training for staff to build capacity for co-design Provide resources to support capacity for co-design	Embedded a proactive, diverse and engaged Patient Panel + created a growing network of patient & carer led forums and groups – 'A network of voices, louder and stronger together'. The move to Teams and Zoom enabled this ongoing and development of new engagement opportunities. The Carers' Forum has strengthened during the year and contributed to improvements in policy and practice Norwich Maternity Voices Partnership (MVP) has worked closely with maternity dept on innovative engagement via Facebook and is integral to plans going forward Division for Clinical Support Services own

Volunteer roles will be innovative and developed to directly improve the care experience Partnerships with external partners and stakeholders will be developed to ensure consistency and to involve the seldom heard	Patient Forum has supported the involvement in a number of QI projects and the DAC build plan A Patient Panel member is now a key patient partner within Medicine Division Patient Panel members actively engaged with committees and groups – PEEG, HICC, Health & Safety, Quality Improvement, Transforming Outpatients, Nutritional Steering Group, Digital Transformation, Acute Integration consent Policy work stream, Complaints and PALS integration and transformation Developed Toolkits, training and support offer to support embedding patients and service users into any service redesign/improvement projects. New volunteering strategy rolled out focussing on innovative roles to support patients and families – at mealtimes, in discharge planning and settling in at home – supporting discharge to assess and 'safety netting' calls to ensure patients can remain safely at home. Key to this has been the driver scheme which ensure responsive and safe support to patients. The Butterfly volunteers supporting end of life patients were able to return and plans were developed for a bereavement hub. Partnerships and relationships developed with external partners to connect with those less well heard groups and ensure their voices are amplified supported the consultation and engagement for our corporate strategy with minority ethnic communities and carers groups, continue working closely with the Maternity Voices Partnership and the Women and Children's Division with plans to engage and work with children and young people better. Equality Delivery System (EDS) 2 action plans (divisional and Trust-wide) work carried out in relation to the patient focused outcomes was recognised as good practice regionally within the NHS East of England EDI network, nationally at the Heads of Patient Experience Network and at the annual Patient Experience for Improvement Conference (Mar 2022). A community survey was co- designed with staff networks and community contacts, the findings of the survey to influence future action plans

	and steer for EDS2 at the NNUH. Continued to work with Healthwatch Norfolk, virtually, especially in relation to the feedback via their website and greater involvement in eg PEEG and Accessible Information group. Strong partnership working strengthened with acute partners at JPUH and QEHKL as well as system partners NCH&C and the CCG. This enabled greater consistency around e.g. visiting arrangements and delivery of a pan Norfolk Carers Conference held via Zoom.
Create a culture where we really listen to patients and carers and take action, at all levels through: Provide and promote multiple ways for patients and carers to give feedback easily All staff will be supported, empowered to take action to rectify problems or concerns at the Point of Care (PoC) Increase the profile and availability of the PALS team Complaints policy and process will be reviewed and updated to ensure it is accessible, user-friendly and responsive	Engagement Team further developed a range of opportunities to connect and give feedback via virtual means – Care Opinion, Healthwatch website, Facebook, Twitter, Zoom meetings; QR codes and web links for surveys and latterly SMS survey requests. PALS continued to grow their support to families needing to connect to loved ones through 'letters to loved ones'and ensuring messages get through to patients on wards. Through the pandemic PALS supported the initial 'Relatives Liaison Team' and then the Family Liaison Service with keeping families and patients connected. They have developed Zoom opportunities for face to face meetings and calls and devised support for those wanting to make formal complaints. PALS piloted 'let's resolve it together' training to support staff to feel confident and empowered to rectify concerns on the spot. The pilot was completed with learning gathered and recommendations made a plan is in place for rolling out the training across the Trust. This will develop further to encompass formal complaints management PALS and Complaints merged into one front door service during the coming year ensuring the new Parliamentary and Health Service Ombudsman framework is enacted – the service is co-designed with colleagues and Patient Panel members. The new combined service and team has meant we have one front door to support people when they contact the Trust with different levels of complexities and concerns about their training. The team have been training and providing support to divisions to manage own responses and developing 'learning from' culture.

Build an infrastructure for reflection and learning from feedback through: Patient stories are utilised for learning at Board, other meetings, training, films etc. Make the data available and easily accessible for staff and others (e.g. Patient Panel) to use for learning and quality improvements Improve triangulation and analysis of patient feedback from all sources Processes will be developed to evidence that practice has changed following complaints and improvements have been sustained Publicise the feedback, actions and outcomes to encourage learning and inform staff and public of outcomes.	Patient stories are shasred and reviewed at Trust Board, Patient Engagement and Experience Governance Sub-Board (PEEG) and other key committees. Patient thanks are highlighted within daily communications within the Trust. IPR for some data – work in progress for IMI greater access + greater access to complaints + triangulation of positive and negative feedback to influence services. Better reporting and evidencing of changes via reporting to PEEG – divisional deep dives covering PALS/complaints/FFT and improvements – patient stories etc. New learning from strategy/process to go live. You Said We Did posters/ward boards embedded – and on website. Greater presence on website for Patient Experience and Engagement.
Develop a sustainable continuous Quality Improvement model that centres around the patient through: Implement the Quality & Safety Improvement Strategy and faculty Patients are involved as partners in QI projects from conception to implementation to evaluation Always Events are adopted as a patient centred QI methodology	Patient Panel members are involved in the ICS wide Quality Management Approach development. PP members are proactively approached by divisional colleagues to become involved in projects, provide feedback.

Good News Story

Emily Wells

Winner of Chief Nurse Information Officer of the Year

Emily Wells, Chief Nurse Information Officer (CNIO), has won the Digital NHS CNIO of the Year aware at the Digital Health Autumn Leadership Summit.

Emily has worked in the NHS since 2003 and specialised in Orthopaedics early on and quickly found her niche within surgery. Emily completed a Post Graduate Diploma at Masters level and became an Independent Nurse Prescriber. Whilst working as a Surgical Matron, Emily was asked to Lead on the implementation of Cerner at an integrated South London Trust. Emily has worked leading on digital projects for the past 10 years and became CNIO at the Norfolk and Norwich in 2020. Emily is also a Florence Nightingale Foundation Digital Leadership Scholar 2020.

Emily was nominated for the CNIO of the Year award by a member of the National Team (NHSX). It was confirmed that Emily won because of the following attributes:

Leadership – Successfully led and set up the NNUH technology enabled virtual ward during Covid-19, working with a wide range of stakeholders across numerous clinical specialties

Collaboration – Has generously shared learning with others across the country, presented on several national events that have been incredibly well received and enabled other areas to move forward at pace learning from the great work Emily has led on. HAs equally ensure NNUH have utilised learning from elsewhere to avoid duplication of effort.

Patient Focus – Has maintained a patient focus across all this work through ensuring a focus on patient satisfaction levels and patient benefits in bed days saved which enables other patients to utilise those physical beds

Staff focus – Has provided insights into the workforce opportunities that technology enabled care providers and highlights that this has been a truly multidisciplinary team success story.

Strategic Thinking – Has demonstrated thinking big i.e. opportunities beyond the current work e.g. opportunity of all specialties to engage with this model of care plus the possibility of a ‘digital’ hospital.

Emily said “*It was an absolute honour to have been awarded CNIO of the Year, I am passionate about digital and ensuring our nursing, midwifery and clinical professionals voices are heard. To have been nominated around the work and leadership of the Virtual Ward was particularly special because of the benefits the virtual ward brings to our patients*”

Staff Experience

NHS Staff Survey

The NHS Staff Survey 2021 launched at NNUH on 4th October 2021 and closed on 26th November 2021. The response rate for the Trust was 49% with 4,347 staff sharing their views, exceeding the 2020 48.1% response rate. The 2021 response rate was also above the national acute trust 46% average response rate (126 acute trusts).

2021 Staff Survey - benchmark results

In line with the commitment in the National People Plan the NHS Staff Survey has been redeveloped in line with the People Promise, which sets out what NHS staff can expect from their leaders and from each other. These set out, in the words of NHS people, the things that would most improve their working experiences – like health and wellbeing support, the opportunity to work flexibly, and to feel we all belong, whatever our background or our job. From 2021, the NHS Staff Survey will track progress towards the seven elements of the People Promise:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team

In addition to the 7 People Promise themes, there are two additional themes Staff Engagement and Morale.

National benchmarking Results – 126 acute trusts

NNUH score below the national acute trust average for All 7 themes of the People Promise and Staff Engagement and Morale themes.

There are no national or NNUH previous year comparisons for the People Promise theme scores due to changes in the 2021 survey. Previous years' results can however be compared by question level for 63 of the 99 questions (36 have changed/ new questions).

NNUH Staff Engagement and Morale scores have both declined compared to 2020 and this is also seen at national level with declines in the acute highest score and acute average scores, for both Staff Engagement and Morale.

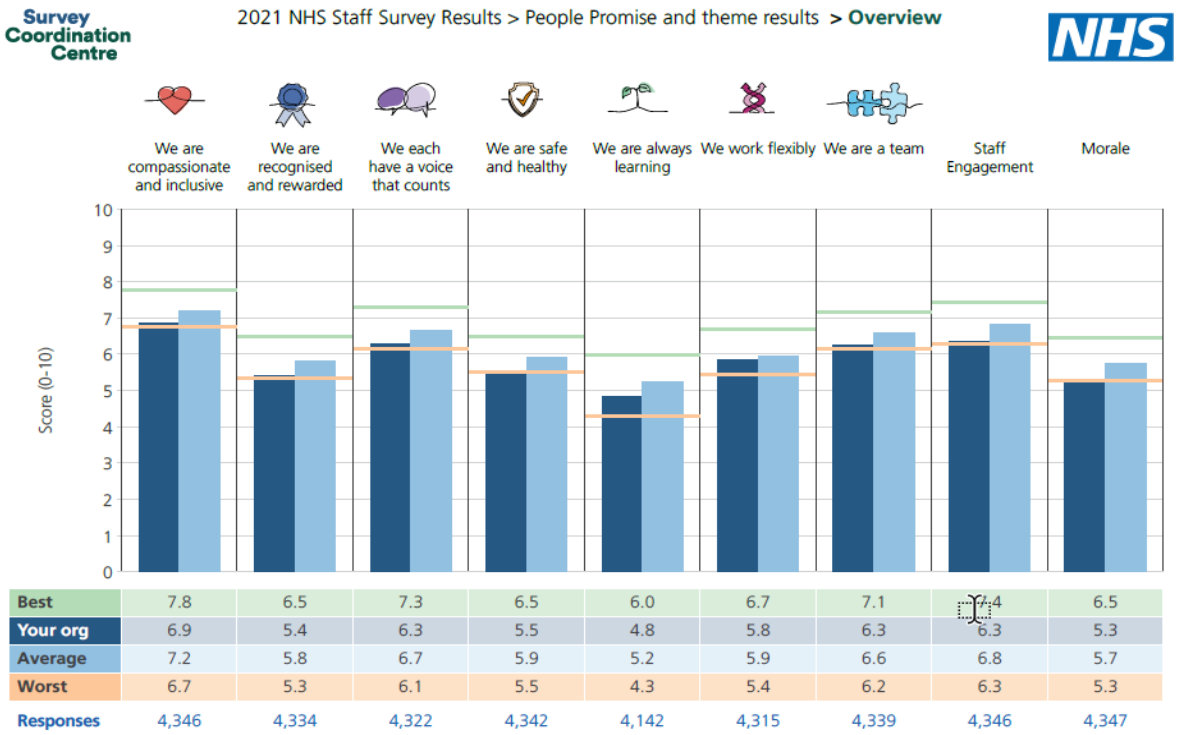
When comparing the NNUH 99 question scores from 2020 to 2021:

- 9 improved
- 5 stayed the same
- 49 worsened
- 36 have no comparison to 2021 year as they are different questions

The number of staff survey question results that are better/worse or equal to the national acute trust average 2021:

- 7 scored better than the national acute trust average
- 7 scored the same as the national acute trust average
- 85 scored worse than the national acute trust average

NNUH 2021 theme scores compared to the benchmark of 126 acute trusts



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	6.4	6.5
Your org	6.9	5.4	6.3	5.5	4.8	5.8	6.3	6.3	5.3
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	4,346	4,334	4,322	4,342	4,142	4,315	4,339	4,346	4,347

Next Steps

The 2021 results represent a difficult period where we're disappointed about our staff experiences of working at NNUH. Data from the 2021 staff survey has provided the Trust with strong evidence that there is significant work to be done to improve our staff experiences.

We acknowledge the suite of studies over recent years by academics and the Kings Fund, specific to health care settings which clearly evidence that Trusts with higher levels of staff engagement deliver services of higher quality and perform better financially, as rated by the Care Quality Commission. They have higher patient satisfaction scores and lower staff absenteeism. They have consistently lower patient mortality rates than other trusts. By improving our staff experience we should expect to also find improvements in the experiences and outcomes of our patients.

We are determined to make our hospitals a better place to work and are developing a three-year Improvement Plan to turn around our results. We will work together, both internally and with the wider healthcare system, to make transformational changes to the way in which we work, care for patients and each other.

We understand the huge pressures that our staff are under every day and, as we emerge from the height of the pandemic, we've a programme of work under way to reset the way we work and ensure that our staff receive the support they need. This includes a major investment in improved staff facilities which will make the most difference to our staff.

We want our staff to enjoy working at NNUH, to have fulfilling careers, and to remain with us. We have a significant health and wellbeing programme in place and will build on that to ensure our staff get help quickly when they need it.

Staffing levels are a significant issue, and we have several large-scale recruitment campaigns under way to help ensure we have the staff numbers we need. This includes the 96 international nurses who are due to join us by the end of May 2022. We are also working with other organisations across Norfolk and Waveney to recruit 800 healthcare assistants, with NNUH taking the largest cohort.

Other improvements are being taken forward in action plans produced by the divisions to address more specific issues.

A global first for NNUH using gel spacer for prostate cancer treatments

Prostate cancer specialists from the Radiotherapy Department at Norfolk and Norwich University Hospitals Foundation Trust have become the first in the world to use an innovative technique to help patients receiving treatment for prostate cancer.

Some patients receiving radiotherapy for prostate cancer will have their treatment split into two portions. The first stage of killing the cancerous cells uses a temporary radioactive implant, in a process known as high dose rate (HDR) brachytherapy. The second part is delivered as a powerful x-ray beam from outside the patient, in a process known as external beam radiotherapy, which is carried out over a number of appointments. During both stages, however, it is possible for healthy tissue to be damaged such as the large bowel which can become chronically inflamed.

By inserting a hyaluronic acid rectal spacer, it is possible to protect the neighbouring tissues from the potential damage caused by external beam radiotherapy. The rectal spacer insertion is usually carried out under local anaesthetic, one to two weeks prior to treatment.

The composition of other spacing devices has prevented their use during HDR brachytherapy treatment, as they limit the visibility of the ultrasound imaging, which is key for monitoring this type of brachytherapy treatment. The hyaluronic acid spacer does not interfere with the ultrasound signals which means the prostate gland and surrounding organs can be seen fully after the implant has been inserted. This allows the implant to be inserted during the HDR procedure without reducing image quality for the Clinical Oncologist placing the needle.

Since June last year, patients undergoing HDR brachytherapy have continued to receive a hyaluronic acid spacer during their procedure. For the initial 10 patients, we have collected data on the insertion and treatment delivered, showing the safe and beneficial use of a hyaluronic spacer. The data has been put forward in an abstract and accepted at ESTRO 2022 (European Society for Radiotherapy and Oncology) in Copenhagen this year. The team continue to collect and analyse the date, with an end goal of publishing a full write up including a larger cohort of patients'

There is currently a business case being established within the Medical Division to bring this technique into routine practice.

Statement from Healthwatch Norfolk

Healthwatch Norfolk Statement – NNUH Quality Account 2021/22

TO BE ADDED

Feedback from Governors

TO BE ADDED

Good News Story

Lorraine Snailum

Cardiology Housekeeper wins NHS Person of the Year Award

Congratulations to Lorraine Snailum, Cardiology Housekeeper, who has won the NHS Person of the Year award at the "Stars of Norfolk and Waveney" award ceremony organised by the Eastern Daily Press.

Lorraine has worked at the NNUH for 12 years and was nominated by her son's girlfriend. The judges said: "*Lorraine has worked tirelessly during the pandemic and deserves praise for her work. Her energy and support to colleagues is extraordinary*."

"*I was so proud to be nominated and really shocked when I was one of the finalists*" said Lorraine. "*I was invited to Norwich Cathedral for the ceremony and just couldn't believe that I won the award. I feel the award isn't just for me, it's for all of Cardiology as I work with some amazing people, and I am so proud of our department*."

Annex 2- Statement of Directors' responsibilities in respect of the Quality Account

The Directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendments Regulation 2011, 2012 and 2017 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of the annual Quality Accounts (which incorporate the above legal requirements).

In preparing the Quality Account, Directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered;
- The performance information reported in the Quality Account is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Account has been prepared in accordance with Department of Health guidance.

The Directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

Tom Spink
Interim Chairman

Date:

Sam Higginson
Chief Executive

Date:

Acute Medical Unit (AMU)	Rapid assessment and diagnosis unit for emergency patients
Bacteraemia	An infection resulting from presence of bacteria in the blood
BCIS	British Cardiovascular Intervention Society
Clinical Audit	The process of reviewing clinical processes to improve them
Clinical Governance	Processes that maintain and improve quality of patient care
Clostridium difficile, C difficile or C.diff	A bacterium that can cause infection
Coding or clinical coding	An internationally agreed system of analysing clinical notes and assigning clinical classification codes
CQC or Care Quality Commission	The independent regulator of all health and social care services in England.
CQUIN	Commissioning for Quality and Innovation. Schemes to deliver quality improvements which carry financial rewards in the NHS.
CT scan or Computed Tomography scanning	A technique which combines special x-ray equipment with computers to produce images of the inside of the body.
DAHNO	Data for Head and Neck Oncology, a database of information on head and neck cancer patients
Data Quality	The process of assessing how accurately the information and data we gather is held
Datix	A patient safety web-based incident reporting and risk management software for healthcare and social care organizations.
Decile	A statistical term, meaning one tenth of the whole.
Delayed Transfers of Care or DToCs	Term for patients who are medically fit to leave a hospital but are waiting for social care or primary care services to facilitate transfer
Dementia	The loss of cognitive ability (memory, language, problem-solving) in a previously unimpaired person, beyond that expected of normal aging
Dr Foster	A company that has developed a Hospital Standardised Mortality Rate and other data comparisons across the NHS
Drugs, Therapeutics and Medicines Management Committee (DTMM)	An internal committee that considers all drug related issues
Early Warning Score (EWS)	A clinical checklist process used to

	identify rapidly deteriorating patients
East of England Ambulance Service (EEAST)	The Ambulance Service which covers Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk.
Escherichia coli or E.coli	Part of the normal intestinal microflora in humans and warm-blooded animals. Some strains can cause disease in humans, ranging from mild to severe.
GPs	General Practitioners i.e. family doctors
Health Protection Agency (HPA)	An independent body that protects the health and well-being of the population.
HPV	Human papillomavirus – a DNA virus from the papillomavirus family that is capable of infecting humans.
Hospital Standardised Mortality Ratio (HSMR)	An indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than should be expected.
ICNARC CMP	Intensive Care National Audit and Research Centre Case Mix Programme
LoS	Length of stay
MDT	Multi-disciplinary Team, composed of doctors, nurses, therapists and other health professionals
MI or Myocardial Infarction	A heart attack, usually caused by a blood clot, which stops the blood flowing to a part of the heart muscle
MINAP	Myocardial Infarction Audit Project
MRSA	Methicillin Resistant Staphylococcus aureus, a strain of bacterium that is resistant to one type of antibiotic
MSSA	Methicillin-sensitive Staphylococcus aureus, a strain of bacteria that is sensitive to one type of antibiotic
NBOCAP	National Bowel Cancer Audit Programme
NCAA	National Cardiac Arrest Audit, the national, clinical audit for in-hospital cardiac arrest
NCE – National Confidential Enquiries	A system of national confidential audits which carry out research into patient care in order to identify ways of improving its quality.
Neonates	Medical term for babies born prematurely in the first 28 days of life
NHFD	National Hip Fracture Database
NICE	National Institute for Health and Clinical Excellence
NICU – Neonatal Intensive Care Unit	The unit in the hospital which cares for very sick or very premature babies

NIHR	National Institute for Health Research
NLCA	National Lung Cancer Audit
Norovirus	Sometimes known as the winter vomiting bug, the most common stomach bug in the UK, affecting people of all ages
NNAP	National Neonatal Audit Programme
NRLS	National Reporting and Learning System – A database of patient safety information
Palliative Care	Form of medical care that concentrates on reducing the severity of disease symptoms to prevent and relieve suffering
Paediatrics	The branch of medicine for the care of infants, children and young people up to the age of 16.
Perinatal	Defines the period occurring around the time of birth (five months before and one month after)
PHSO	Parliamentary and Health Service Ombudsman
PLACE – Patient Led Assessment of Clinical Environment	A national programme that replaced PEAT from April 2013.
PPCI – Primary Percutaneous Coronary Intervention	A treatment for heart attack patients which unblocks an artery by opening a small balloon, or stent, in the artery
Prescribing	The process of deciding which drugs a patient should receive and writing those instructions down on a patient's drug chart or prescription
Pressure Ulcer	Pressure ulcers are a type of injury that breaks down the skin and underlying tissue. They are caused when an area of skin is placed under pressure. They are also sometimes known as "bedsores" or "pressure sores".
PROM - Patient Reported Outcome Measures	A national programme whereby patients having particular operations fill in questionnaires before and after their treatment to report on the quality of care
Quartile	A statistical term, referring to one quarter of the whole
RCA or Root Cause Analysis	A method of problem solving that tries to identify the root causes of faults or problems
Screening	Assessing patients who are not showing symptoms of a particular disease or condition to see if they have that disease or condition

Sepsis	Sometimes called blood poisoning, sepsis is the systemic illness caused by microbial invasion of normally sterile parts of the body
Serco	The company that provides support services like catering, cleaning and engineering to the Norfolk and Norwich University Hospital
STEMI - ST segment elevation myocardial infarction	A heart attack which occurs when a coronary artery is blocked by a blood clot.
Stent	A small mesh tube used to treat narrow or weak arteries. Arteries are blood vessels that carry blood away from your heart to other parts of your body.
Streptococcus	A type of infection caused by a type of bacteria called streptococcal or 'strep' for short. Strep infections can vary in severity from mild throat infections to pneumonia, and most can be treated with antibiotics.
Stroke	The rapidly developing loss of brain function due to a blocked or burst blood vessel in the brain.
Surgical Site Infection (SSI)	Occurs when microorganisms enter the part of the body that has been operated on and multiply in the tissues.
TARN	Trauma Audit and Research Network
Thrombolysis or thrombolysed	The breakdown of blood clots through use of clot busting drugs
Thromboprophylaxis	Any measure taken to prevent coronary thrombosis
Thrombosis	The process of a clot forming in veins or arteries
Thrombus	A clot which forms in a vein or an artery
TIA or Transient Ischaemic Attack	This happens when blood flow to a part of the brain stops for a brief period of time. A person will have stroke-like symptoms for up to 24 hours, but in most cases for 1 – 2 hours. A TIA is felt to be a warning sign that a true stroke may happen in the future if something is not done to prevent it.
Tissue Viability (TV)	The medical specialism concerned with all aspects of skin and soft tissue wounds including acute surgical wounds, pressure ulcers and leg ulcers

Good News Story

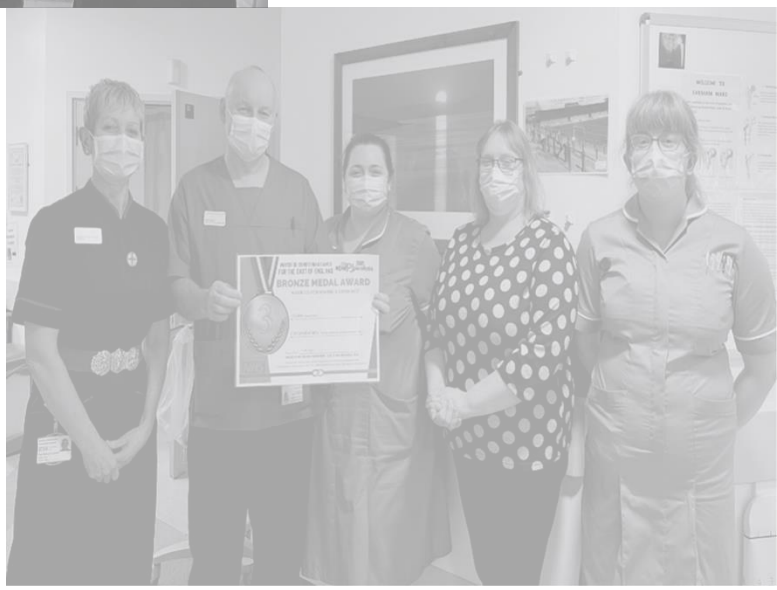
Deconditioning Games

As a Trust we've been invited to take part in the Deconditioning Games, an initiative launched by NHS England to help raise awareness of deconditioning and support innovation to prevent it.

Deconditioning is the loss of muscle and independence which can be caused by bedrest and decreased mobility, leading to an increased risk of falls.

The medals are awarded based on the results of the deconditioning initiatives. A bronze medal is awarded for testing something new in practice; a silver medal is awarded for being able to demonstrate that the initiative is making a difference; and a gold medal is awarded for being able to demonstrate an embedded initiative that's been shared with external and internal teams and policies, procedures and guidelines have been formally put in place as a result.

So far, we've been awarded a total of 12 medals – 5 bronze medals and 7 silver medals.



Just some examples of the initiatives we have received medals for are; Neurosciences feeding project, Earshams nutritional work and the discharge team introducing an educator role.

The Neuroscience feeding project was: to promote enhanced quality of care for patients with neurological conditions, such as Stroke, Multiple Sclerosis, brain tumours and Parkinson's Disease, and promote independence and neurological recovery during extra rehabilitation sessions focussed on eating and drinking.

Process: Six Physiotherapy Assistants were trained in Therapeutic feeding such as promoting use of the patient's weaker arm, use of modified cutlery to improve independence, strategies for visual impairment and coordination difficulties by Physiotherapists and Occupational Therapists. Speech and Language Therapists gave training on National standardised diet and drink modifications and basic swallow safety.

A&E	Accident and Emergency Department (See ED)
ACU	Acute Cardiac Unit
BPT	Best Practice Tariff
C.difficile (C.diff)	Clostridium difficile
CAM	Confusion Assessment Method
CAPE	Carer and Patient Experience Committee
CCC	Critical Care Complex
CDI	Clostridium difficile infection
CG NICE	Clinical Guideline from NICE
CHD	Congenital Heart Disease
CHKS	Caspe Healthcare Knowledge Systems
CLAW	Collaborative Learning Action Workshops
CMP	Case Mix Programme
CMT	Core Medical Trainee
CPR	Cardiopulmonary Resuscitation
CQC	Care Quality Commission
CQUIN	Commissioning for Quality Improvement and Innovation
CRM	Cardiac Rhythm Management
CT	Computerised Tomography
CYP	Children and Young Persons
DNACPR	Do not attempt Cardiopulmonary Resuscitation
DVT	Deep Vein Thrombosis
EADU	Emergency Admission and Discharge Unit
EAHSN	Eastern Academic Health Science Network
ECG	Electrocardiogram
ED	Emergency Department (See A&E)
EEAST	East of England Ambulance Service NHS Trust
ENT	Ear, nose and throat
EPLS	European Paediatric Advanced Life Support
EPMA	E-Prescribing and Medicines Administration
FFFAP	Falls and Fragility Fractures Audit Programme
FFT	Friends and Family Test
FTSU	Freedom to Speak Up
FY	Foundation Year
GCP	Good Clinical Practice
GIRFT	Getting it right first time
HALO	Hospital Ambulance Liaison Officer
HANA	Head and Neck Cancer Audit
HAT	Hospital Acquired Thrombosis
HES	Hospital Episode Statistics
HMCI	Her Majesty's Chief Inspector of Education, Children's Services and Skills
HSCIC	Health and Social Care Information Centre
HTA	Human Tissue Authority
IBD	Inflammatory Bowel Disease

IG	Information Governance
IGT	Information Governance Toolkit
IS	Information Services
IT	Information Technology
JAG	Joint Advisory Group
JPUH	James Paget University Hospitals NHS Foundation Trust
KF	Key Finding
KLOE	Key Lines of Enquiry
LMNS	Local Maternity and Neonatal System
MASH	Multi-Agency Safeguarding Hub
MINAP	Myocardial Ischaemia National Audit Project
MRI	Magnetic Resonance Imaging
MTPJ	Metatarsophalangeal Joint
N/A	Not applicable
NAD	National Audit of Dementia
NAOGC	National Oesophago-Gastric Cancer Audit
NBOCAP	National Bowel Cancer Audit
NCA	National Comparative Audit
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NDA	National Diabetes Audit
NDFA	National Diabetes Footcare Audit
NED	National Endoscopy Database
NELA	National Emergency Laparotomy Audit
NG	NICE Guidance
NHFD	National Hip Fracture Database
NHS	National Health Service
NHSLA	National Health Service Litigation Authority
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NJR	National Joint Registry
NLCA	National Lung Cancer Audit
NNAP	National Neonatal Audit Programme
NNUH	Norfolk and Norwich University Hospital NHS Foundation Trust
NOFERP	Neck of Femur Enhanced Recovery Programme
NPDA	National Paediatric Diabetes Audit
NPSA	National Patient Safety Agency
NRLS	National Reporting and Learning Service
PALS	Patient Advice and Liaison Service
PbR	Payment by Results
PCNL	Percutaneous nephrolithotomy
PE	Pulmonary Embolism
PICA	Net Paediatric Intensive Care Audit Network
PLACE	Patient-Led Assessments of the Care Environment
PODs	Patients' own drugs
PROMs	Patient Reported Outcome Measures

PSEC	Patient Safety and Effectiveness Committee
PSI	Patient Safety Incident
QI	Quality Improvement
QIR	Quality Incident Report
QS	NICE Quality Standard
RAG	Red/Amber/Green
RCA	Root Cause Analysis
ROP	Retinopathy of prematurity
SACT	Systemic Anti-Cancer Therapy
SAFER	Senior review, All patients, Flow, Early discharge, Review
SCEC	Surgery, Critical and Emergency Care
SEND	Special Educational Needs and Disability
SHMI	Summary hospital level mortality indicator
SHOT	Serious Hazards of Transfusion
SI	Serious Incident
SSNAP	Sentinel Stroke National Audit Programme
STP	Sustainability and Transformation Plan
StR	Specialty Registrar
T&O	Trauma and Orthopaedic
TACO	Transfusion Associated Circulatory Overload
TARN	Trauma Audit and Research Network
UKRETS	UK Registry of Endocrine and Thyroid Surgery
VC	Virtual Clinic
VTE	Venous Thromboembolism
WESB	Workforce and Education Sub-Board
WTE	Whole Time Equivalent

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Microsoft | Power BI

Quality & Safety

View in Power BI

Last data refresh:
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Downloaded at:
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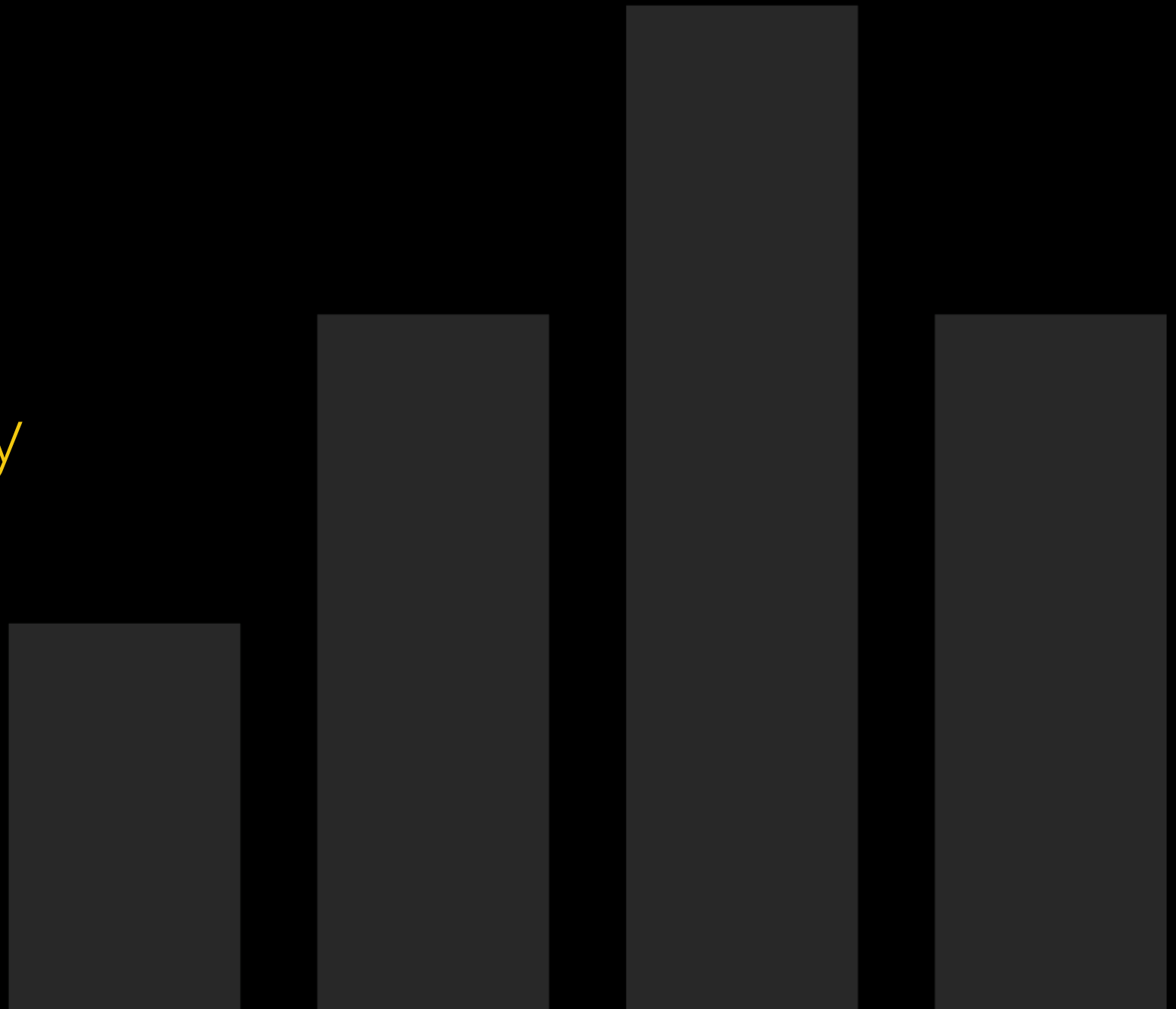

Quality Summary

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

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business intelligence

Topic	Metric Name	Date	Result	Variation	Assurance
Adult Safeguarding	Safeguarding Adults	Apr 2022	45	Improvement (Low)	No Target
Children & Midwifery Safeguarding	Safeguarding Midwifery	Apr 2022	2	Improvement (Low)	No Target
Complaints	Post-investigation enquiries	Apr 2022	2	Improvement (Low)	Capable
Patient Concerns	PALS % Closed within 48hours	Apr 2022	31.0%	Concern (Low)	No Target
Patient Falls	Patient falls per 1,000 bed days (moderate harm or above)	Apr 2022	0.3	Concern (High)	Unreliable
Patient Safety	Incidents	Apr 2022	1,928	Improvement (Low)	No Target
Pressure Ulcers	Hospital Acquired Pressure Ulcers per 1,000 bed days	Apr 2022	1.2	Improvement (Low)	No Target
Safer Staffing	Safe Staffing Care Hours Per Patient Per Day	Apr 2022	6.9	Concern (Low)	No Target
Safer Staffing	Safe Staffing Fill Rates	Apr 2022	78.50%	Concern (Low)	Not capable

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 2022

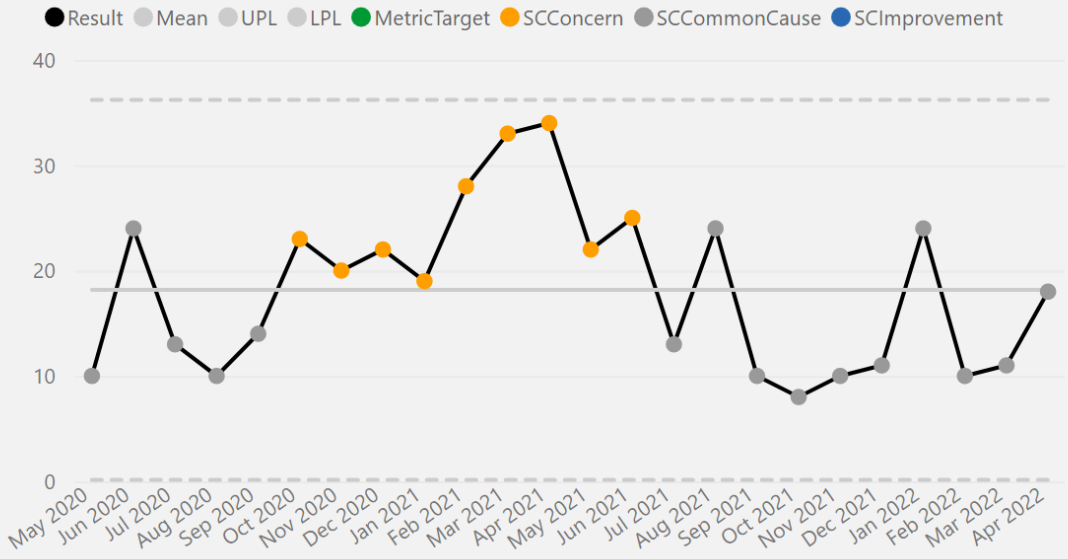
Variation	Assurance
	

18 Result
N/A Target
36 UPL
18 Mean
0 LPL

Analytical Commentary

Variation is Common Cause

Serious Incidents



Assurance Commentary

Following the increased focus of meeting Duty of Candour and confirmation of harm within 4 working days of the incident being reported, there has been a noteable improvement in timeliness of adverse events resulting in harm being discussed and reviewed.

20 patient safety incidents were reported onto STEIS in April 6 Patient falls
1 Delays (diagnostic or treatment)
2 Maternity/ Obstetric
4 Sub-optimal care
I Medication incident
1 Surgical Procedure Retained foreign object– Never Event

Improvement Actions

The daily incident group meeting continues to promote psychological safety and reinforces a just and learning culture where staff can report and discuss incidents in a supported environment.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Duty of Candour Compliance	Apr 2022	96%		Common Cause		Unreliable
Incidents	Apr 2022	1,928		Improvement (Low)		No Target

Pressure Ulcers

NNUH Digital Health
business intelligence

Hospital Acquired Pressure Ulcers per 1,000 bed days

Apr 2022

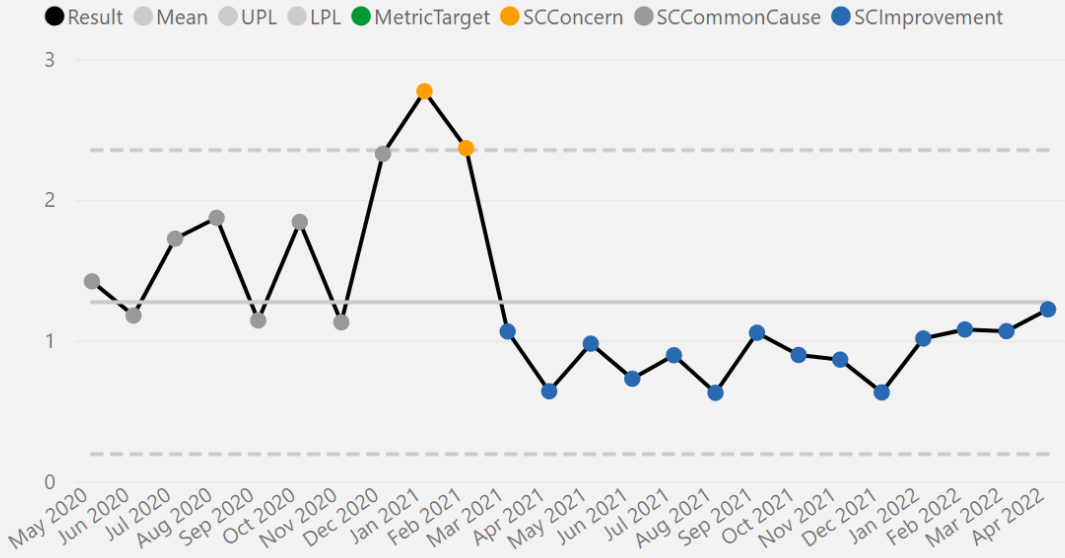
Variation | Assurance

1.2 Result	2.4 UPL
N/A Target	1.3 Mean
	0.2 LPL

Analytical Commentary

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

Hospital Acquired Pressure Ulcers per 1,000 bed days



Assurance Commentary

Pressure incidence remains relatively consistent over the last 3 months. April saw a slight rise in single patient with more than one area who were end of life and passed away within 48 hours.
April also had 6 device related incidence despite appropriate care but have all gone on to heal quickly.
Deep Tissue Injuries were high but only 1 broke down the others resolved and is a reflection of the acuity and on-going frailty of our inpatients currently.
Implementation of the new foam and dynamic mattresses has allowed for intensive education and focus on Purpose T and individual care needs in April and will remain a theme in May.

Improvement Actions

April saw the wards have feedback on their baseline use of Purpose T, Corresponding care plans and appropriate equipment use. Overall Purpose T use is good even in the areas still implementing it and accuracy is almost 100%. April saw some staff learning around availability of the new equipment when demand is high and reviews of clinical need of the patient for the most appropriate equipment to support mobilisation and rehabilitation with not just a single focus on pressure relief. This will remain a key focus in May as staff adjust and gain confidence in the new higher specification foams.

Patient Falls

NNUH Digital Health
business intelligence

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

Apr 2022

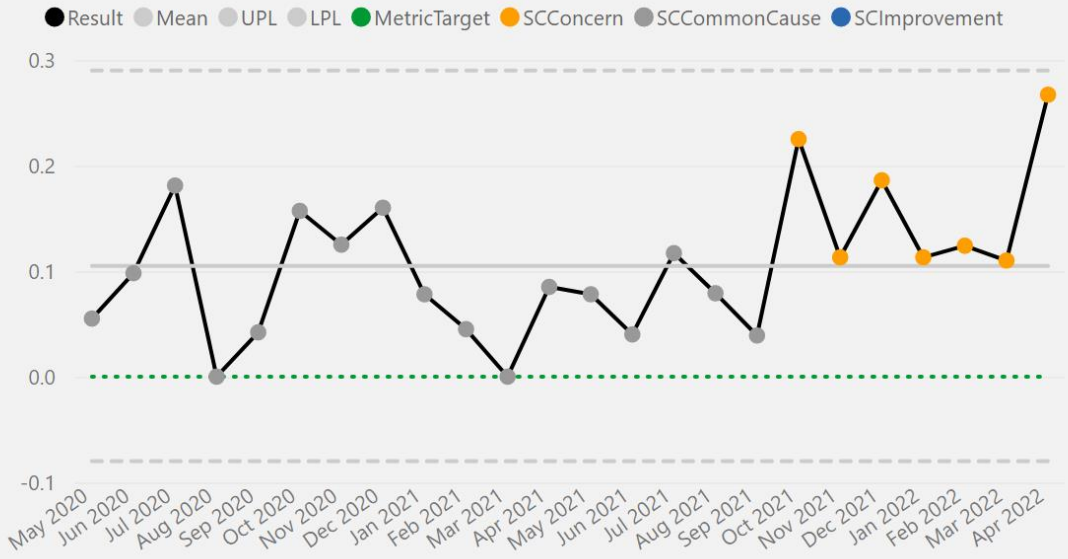
Variation	Assurance
H	?

0.3 Result
0.0 Target
0.3 UPL
0.1 Mean
-0.1 LPL

Analytical Commentary

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

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



Assurance Commentary

Number of falls 237 : 98% caused no or low harm
Number of falls that met SI criteria: 6

Improvement Actions

For the task and finish group to complete the Falls Policy.
A trial of the new Multi Factorial Assessment is being undertaken across two medical wards and one surgical. A review of this trial is due to take place w/c 16th May.
The Think Yellow project commences in the Emergency Dept w/c 16th May.
Teams are undertaking Enhanced Obs and Preventing Falls in Hospital training via ESR.

Patient Experience

NNUH Digital Health
business intelligence

Friends & Family Score

Apr 2022

Variation	Assurance
	

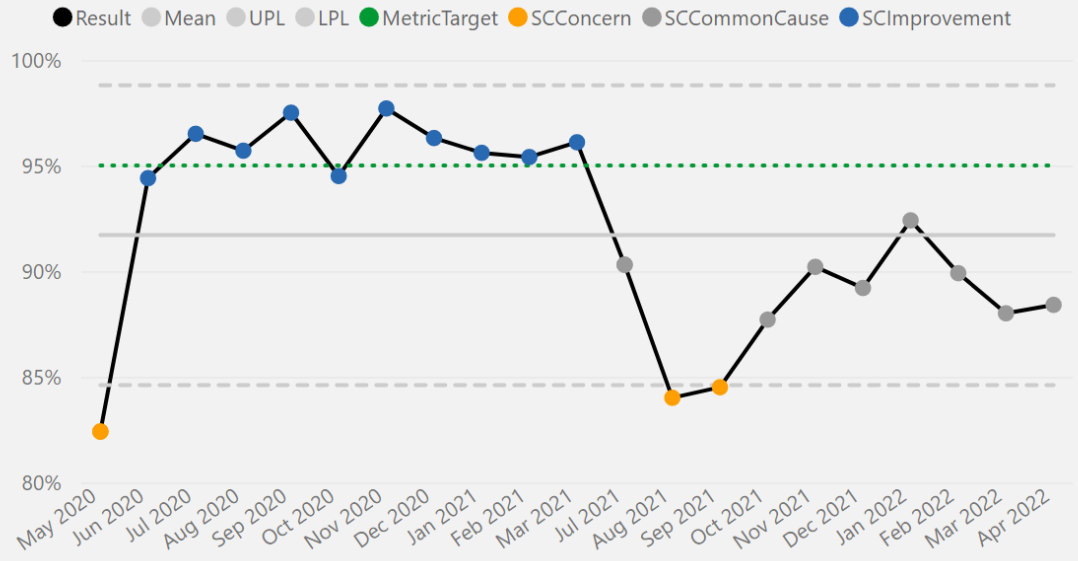
88.40% Result
95.00% Target

98.80% UPL
91.70% Mean
84.60% LPL

Analytical Commentary

Variation is Common Cause

Friends & Family Score



Assurance Commentary

A go live date has been agreed with Maternity services. Software provider confirms changes ready. Specialities who have not been able to readily access FFT information at source have been given access and support to improve their access to data. A process has been implemented with divisions to be informed of new depts/staff who need access to FFT data.

Improvement Actions

To continue to review the reduction of the FFT score in specific areas and to work with those teams to make improvements. To identify the next areas to bring forward FFT SMS roll out.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Compliments	Apr 2022	1,045		Common Cause		No Target

Patient Concerns

NNUH Digital Health
business intelligence

PALS % Closed within 48hours

Apr 2022

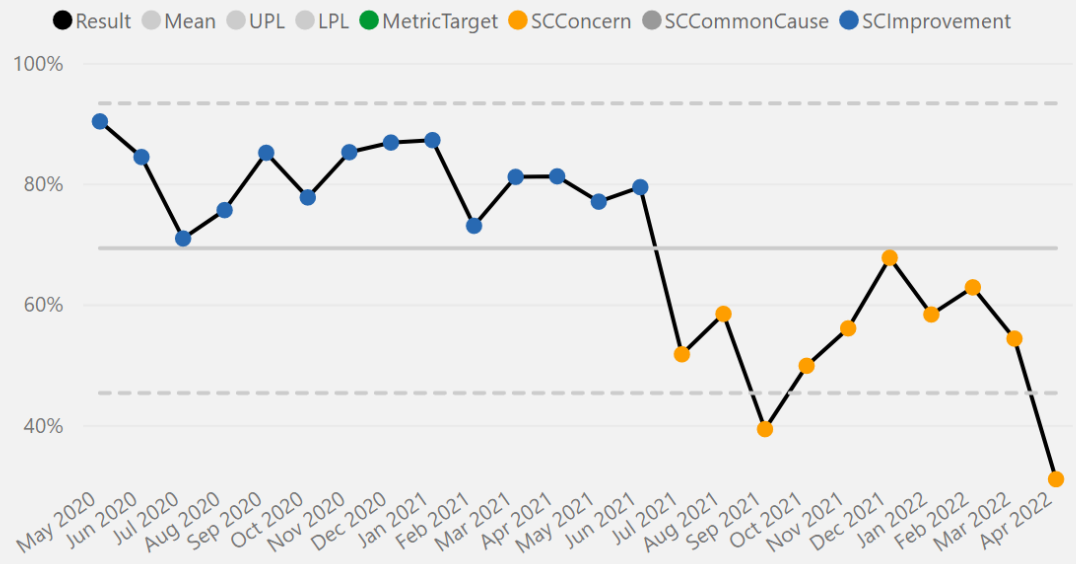
Variation	Assurance
	

31.0% Result	93.3% UPL
N/A Target	69.3% Mean
	45.3% LPL

Analytical Commentary

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

PALS % Closed within 48hours



Assurance Commentary

Total PALS matters received 487
Concerns = 291
Enquiries = 67
Signposting = 79
Best Wishes = 48
Suggestions = 01

Main Subjects (Top 3)
- Communications
- Appointment delays and cancellations
- Waiting times

The team is still awaiting the new member, due to start on the 30.05.22

Improvement Actions

For the team to continue embedding the new processes and the team are to review the drop in performance to identify if it is the process or increase in complexity of cases requiring greater timeframes.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
PALS Enquiries	Apr 2022	487		Common Cause		No Target

Complaints

NNUH Digital Health
business intelligence

Complaints - Trust

Apr 2022

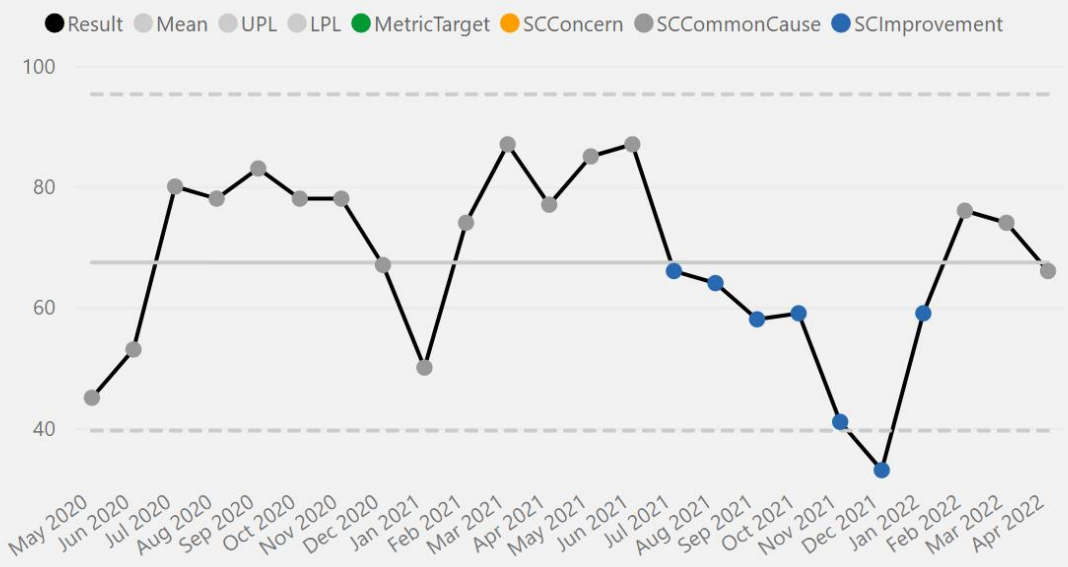
Variation | Assurance

66 Result
N/A Target
95 UPL
67 Mean
40 LPL

Analytical Commentary

Variation is Common Cause

Complaints - Trust



Assurance Commentary

Support for the divisions continues business as usual. The team are finalising definitions for outcomes of complaints in partnership with the patient panel.

Improvement Actions

The Divisional workshops are still planned to take place once resources with the team allow.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Complaints - Acknowledgement	Apr 2022	100%		Common Cause		Unreliable
Complaints - Response Times - Trust	Apr 2022	100%		Common Cause		Unreliable
Post-investigation enquiries	Apr 2022	2		Improvement (Low)		Capable

Palliative Care

NNUH Digital Health
business intelligence

Palliative Care Seen Within 48 Hours

Apr 2022

Variation | Assurance

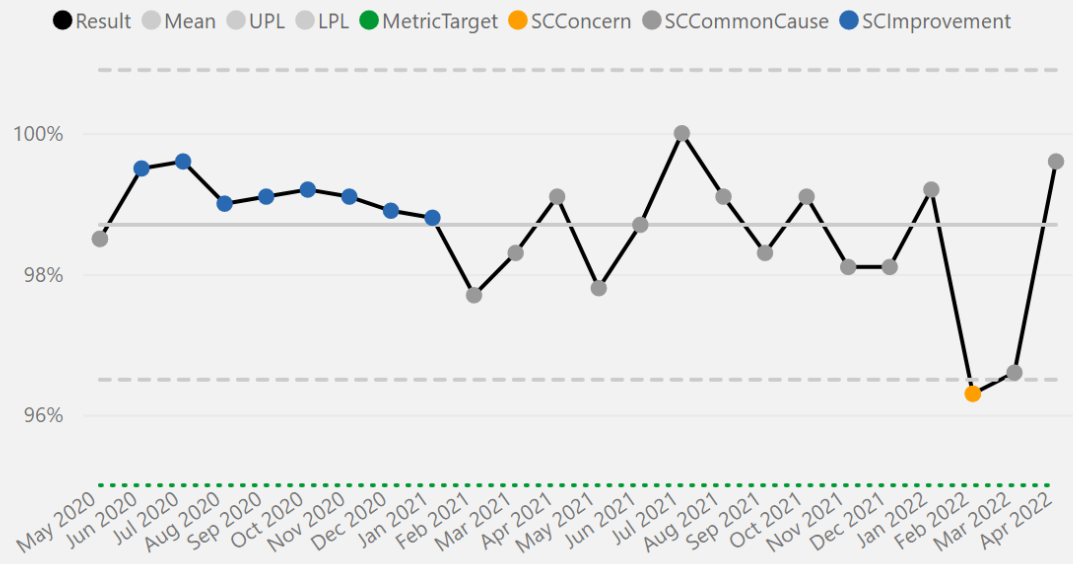
99.6% Result
95.0% Target

100.9% UPL
98.7% Mean
96.5% LPL

Analytical Commentary

Variation is Common Cause

Palliative Care Seen Within 48 Hours



Assurance Commentary

April 2022 shows that 100% of referrals to the Specialist Palliative Care team were seen within 48 hours. Originally this figure was below this (92%) ; we have worked with Information Services to address and correct this.
The service is a 7 day service and referrals are responded to 7 days a week.
The admin team for Specialist Palliative Care have worked incredibly hard to catch up with the back log of data inputting and our figures are now a more true reflection of the service. There will always be a slight delay in some data entry and some patients are still active to the team into the following month.

Improvement Actions

Moving forward the Nursing and Medical team continue to respond to the referrals received, ensuring the majority of referrals are seen within 24 hours due to the complexity/urgency of the referral.
The team plan to be even more responsive to end of life patients as not all end of life patients are referred to the team. This is a piece of work in progress.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Palliative Care Died in Trust and Seen by SPCT	Apr 2022	57.7%		Common Cause		No Target
Palliative Care IP Referrals Accepted	Apr 2022	223.0		Common Cause		No Target

Mortality Rate

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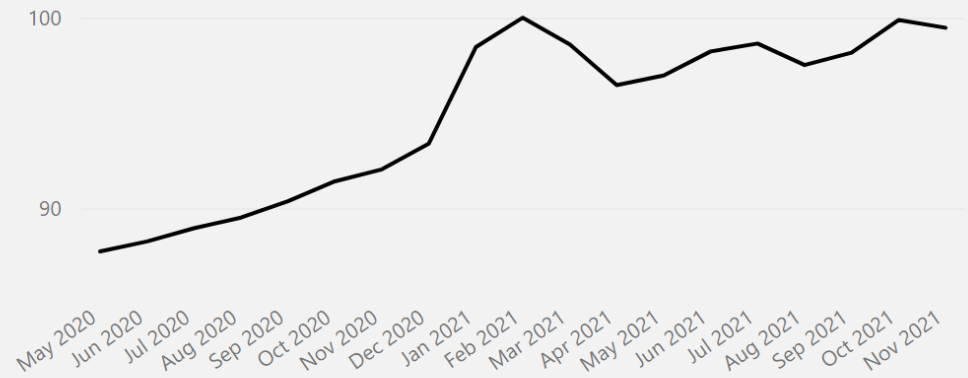
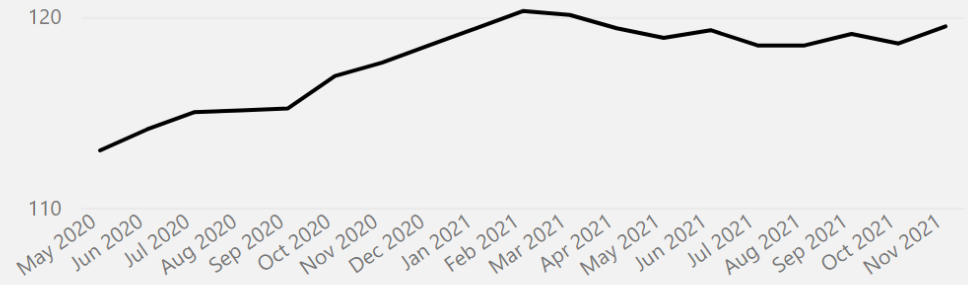
business intelligence

MetricName	Date	Result
HSMR	Nov 2021	99.46
SHMI	Nov 2021	120

HSMR



SHMI



Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Crude Mortality Rate	Mar 2022	5.30%		Common Cause		No Target

Assurance Commentary

Mortality data is scrutinised in detail at the Mortality Surveillance Group, and discussed at Learning from Deaths Committee where learning is shared and recommendations for Service Improvement are made by Multi-Disciplinary teams. Concerns are escalated to Clinical Effectiveness and Safety Sub-Board.

Improvement Actions

To continue with progress against the SHMI Action plan
For Divisions to continue to complete SJRs to reduce the backlog.
To continue the CUSUM alert (Coma, stupor and brain damage) review.

Safer Staffing

NNUH Digital Health
business intelligence

Safe Staffing Fill Rates

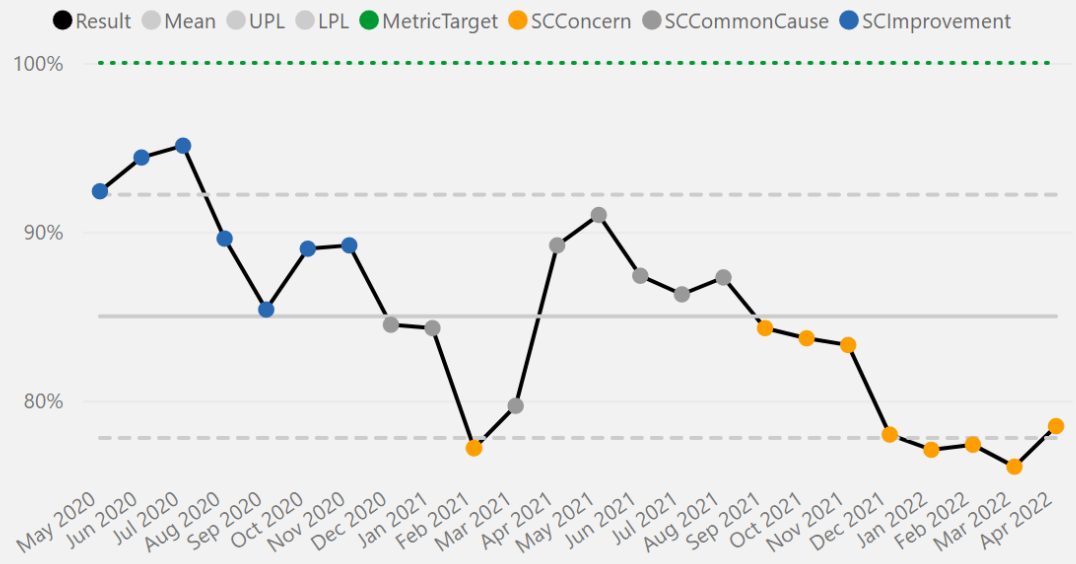
Apr 2022

Variation	Assurance		
L	F	78.50% Result	92.20% UPL
		100.00% Target	85.00% Mean
			77.80% LPL

Analytical Commentary

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

Safe Staffing Fill Rates



Assurance Commentary

In April, the RN/M vacancy rate was 12.9% (n=342.1 WTE) with a turnover rate of 1% (21.5 WTE) a decrease of 0.4% (10.8 WTE) from March. The Trust recruited 18.8 WTE RN/M new starters. HCA vacancies increased to 20.6% (n=281.8 WTE) in April with a Trust-wide turnover of 2.5% (24.2 WTE) in April, a 0.2% (1.5 WTE) increase from March. The Trust recruited 28.2 WTE HCA, a 10.72 increase from March. In April there were 16 areas with a RN vacancy rate above 20%, with 13 of these in Medicine. There are 16 areas across the divisions with HCA fill rates below 75% which can align to the HCA vacancies above 20% that were reported in 22 areas: 11 in Medicine, 6 in Surgery Critical and Emergency Care and 5 in Women's and Children. Trust-wide CHPPD increased in April to 6.9 from 6.6 in March. Red flags reduced by 198 in April to 1,803 with 70% remaining open. 528 were resolved and 46 raised in error. HCA Red flags report they are higher on a Friday were as RN shortfalls are higher on a Wednesday. Gateley remains to have the highest number of open red flags in April.

Improvement Actions

The daily staffing meetings have been revised with a focus on open red flags this is reported trust wide 3 times a day. - The Nursing establishment acuity review planned for May. - The Safer Staffing policy has been circulated and will go back to NMCPB in June. 11 international nurses landed at the end of April with a further 12 expected in May. 7 of the April cohort are due to sit their OSCE in May with plans to be recruited in medicine and the other 4 into Surgery.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance

Infection Prevention & Control

NNUH Digital Health
business intelligence

MetricName	Date	Result	Target	Mean
C. difficile Cases Total	Apr 2022	10	N/A	7
CPE positive screens	Apr 2022	0	N/A	0
E. Coli trust apportioned	Apr 2022	4	119	4
HOHA C. difficile Cases	Apr 2022	1	57	2
Hospital Acquired MRSA bacteraemia	Apr 2022	0	0	0
Klebsiella trust apportioned	Apr 2022	0	25	2
MSSA HAI	Apr 2022	4	N/A	3
Pseudomonas trust apportioned	Apr 2022	1	24	1

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

Assurance Commentary

Following updated Infection prevention and control guidance for seasonal respiratory infections, a Covid-19: De-escalation plans & seasonal management document was agreed by Hospital Management Board.
- Stepped changes to support inpatient care returning to speciality settings and covid infections being managed similar to seasonal influenza.
- Local Covid states ceased
- Mask wearing continues
- 29.04.22 Day 6 asymptomatic screening ceased
- 11.05.22 Day 3 screening ceased
- Testing prior to discharge to care homes continues
- Inpatients that become symptomatic continue to be tested by PCR and isolated
- Plan to cease asymptomatic admission screening at midnight 15.05.22
- Patients with no clinical symptoms of Covid or immunosuppression can discontinue isolation following a negative LFT on day 6 and 7
- Exposed contacts do not require isolation unless on Mulbarton ward where there may be severely immunocompromised

Improvement Actions

Ongoing support & guidance for:
NICU - Supportive measures commenced 02.12.21 following an increase in Klebsiella ESBL within the unit. Closure of Period of Increased Incidence 25.03.22.
Kimberley Covid outbreak 1 declared 04.02. closed 08.03.
Dunston Covid outbreak 1 declared 08.02. closed 10.03.
Dunston Covid outbreak 2 declared 09.02. closed 09.03.
Dunston Covid outbreak 3 declared 18.02. closed 17.03.
Kimberley Covid outbreak 2 declared 21.02. closed 19.03.
Mattishall Covid outbreak 3 declared 22.02. closed 26.03.
Dunston Covid outbreak 4 declared 23.02. closed 22.03.
Kilverstone Covid outbreak 1 declared 23.02. closed 25.03.
Dunston Covid outbreak 5 declared 23.02. closed 10.04.
Gunthorpe Covid outbreak declared 23.02.22
Kilverstone Covid outbreak 2 declared 25.02. closed 19.04.
Kilverstone Covid outbreak 3 declared 17.03. closed 19.04.
16 Covid current outbreaks today.
Mattishall ward closed with noro virus 25.02. reopened 08.03

NNUH Staff COVID-19 Testing

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

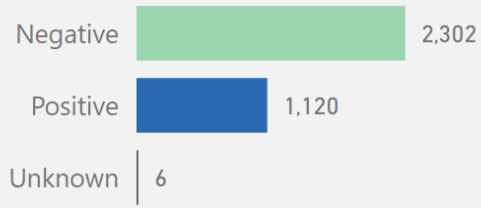
NNUH Digital Health
business intelligence

NNUH Staff Tested	Results Recieved	COVID-19 Confirmed	Median Hrs Test to Result
3,430	3,428	1,120	22.0

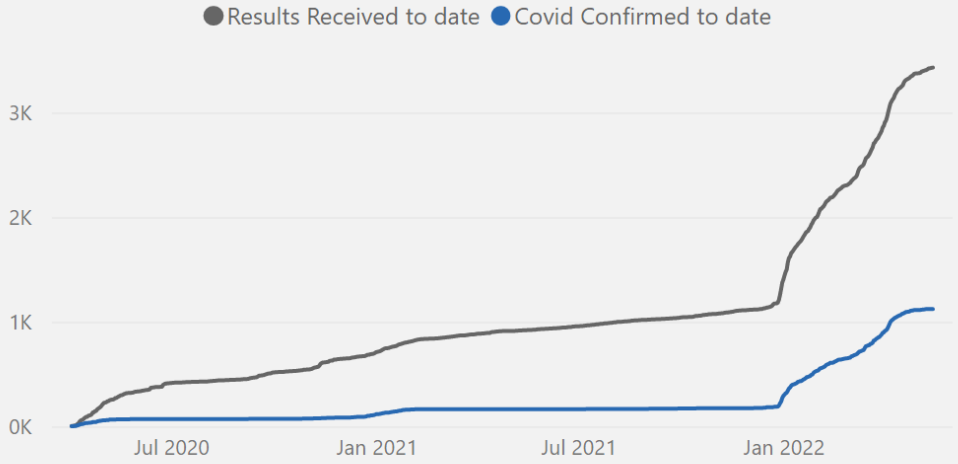
Unmapped Staff *

943

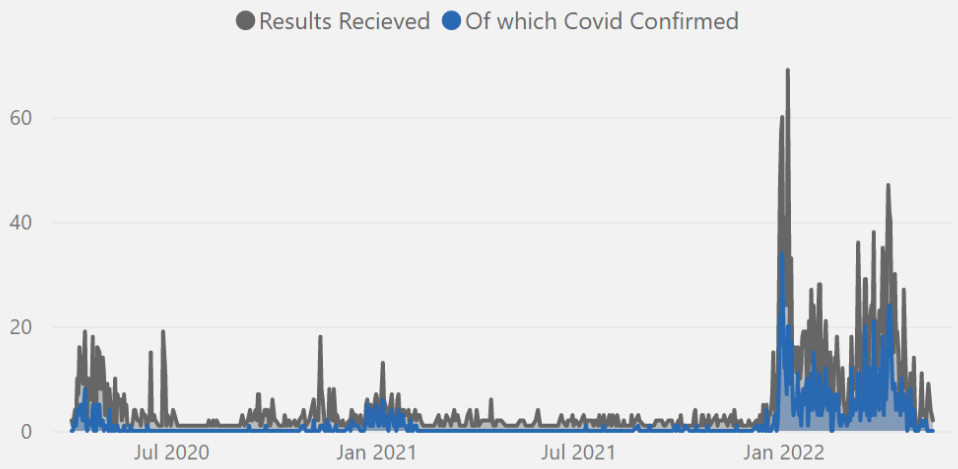
COVID-19 Status



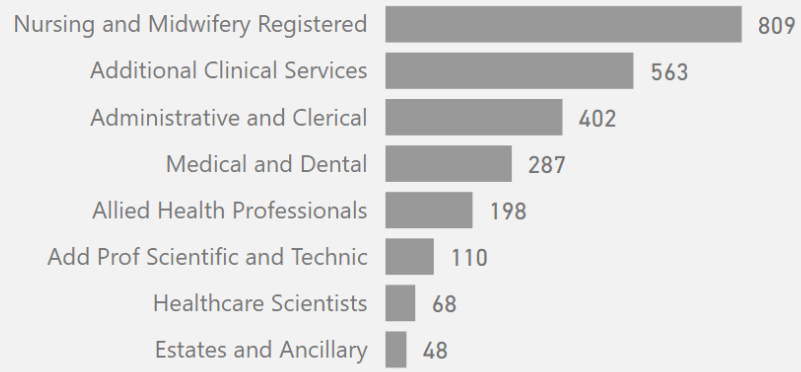
Cumulative NNUH Staff Testing to Date



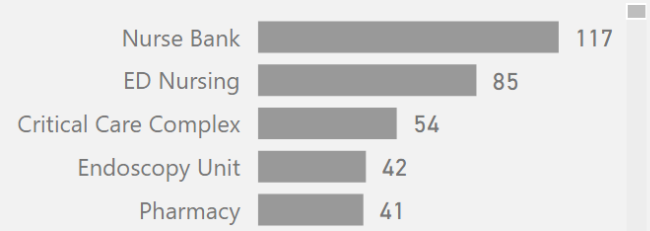
NNUH Staff Results by date of Result



Results Received by Staff Group



Results Received by Organisation (10+ results)



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

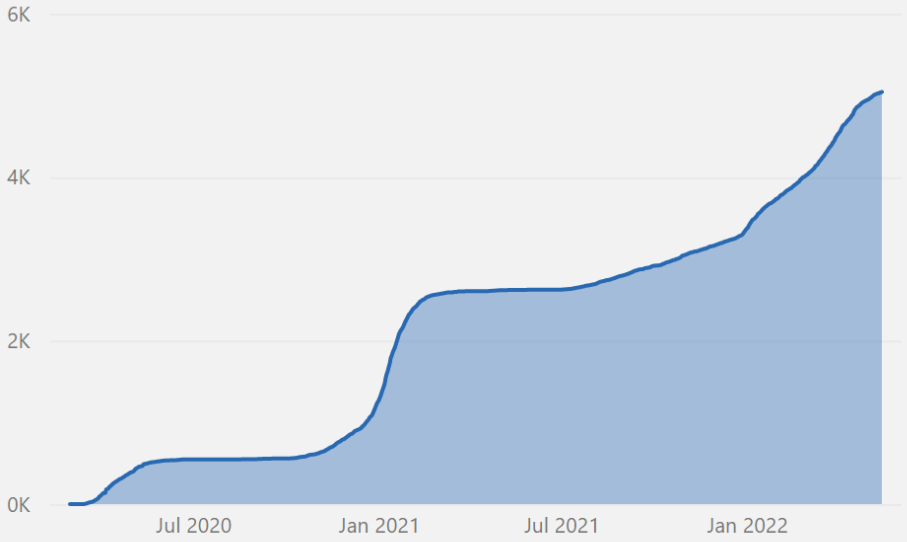
COVID-19 Report - Timeseries

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

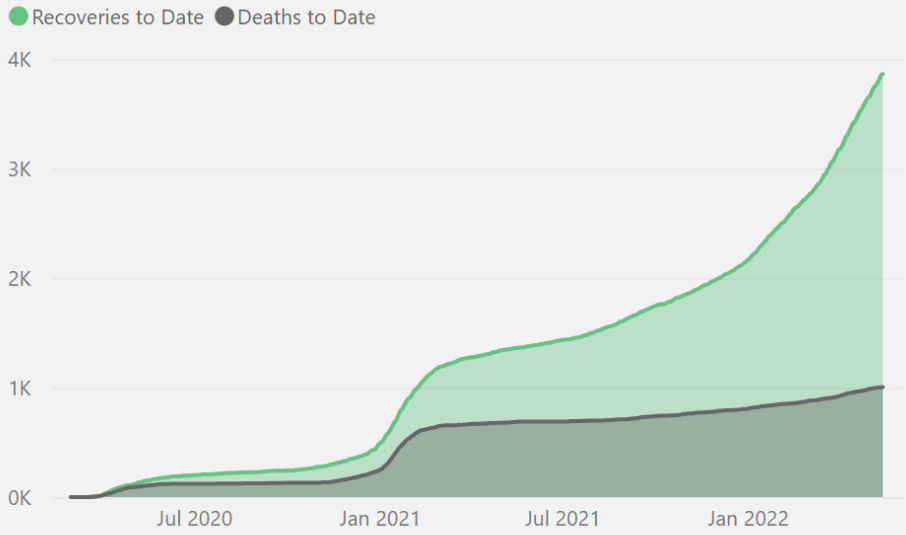
NNUH Digital Health
business intelligence

Cumulative	Total Swabs Taken	Patients Swabbed	Confirmed Cases	Recoveries	Deaths
01/03/20 - 15/05/22	223,999	71,616	5,041	3,862	1,004

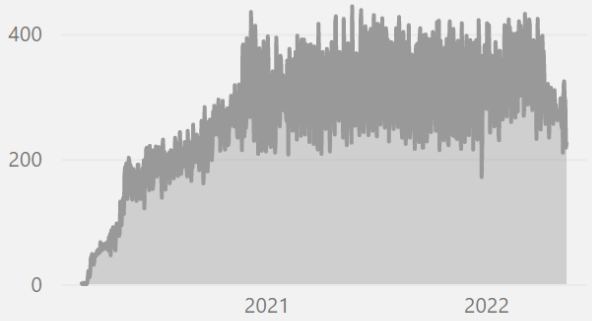
Cumulative Confirmed at NNUH



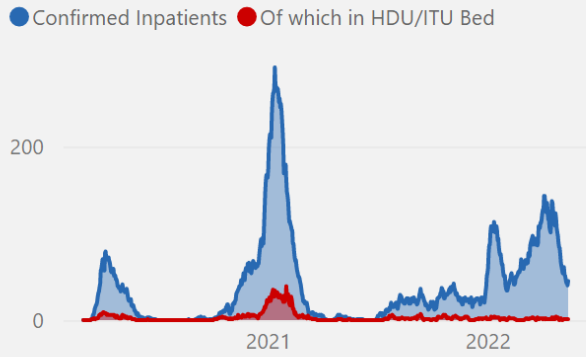
Cumulative Recoveries & Deaths



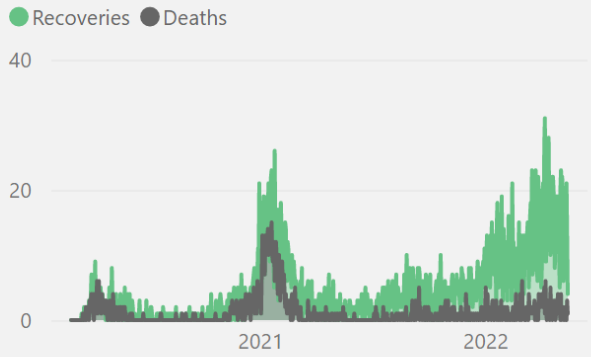
Patients Swabbed per day



Confirmed Inpatient per day (<=14 days)



Recoveries & Deaths per day



Maternity: Mothers

NNUH Digital Health
business intelligence

Mothers Delivered

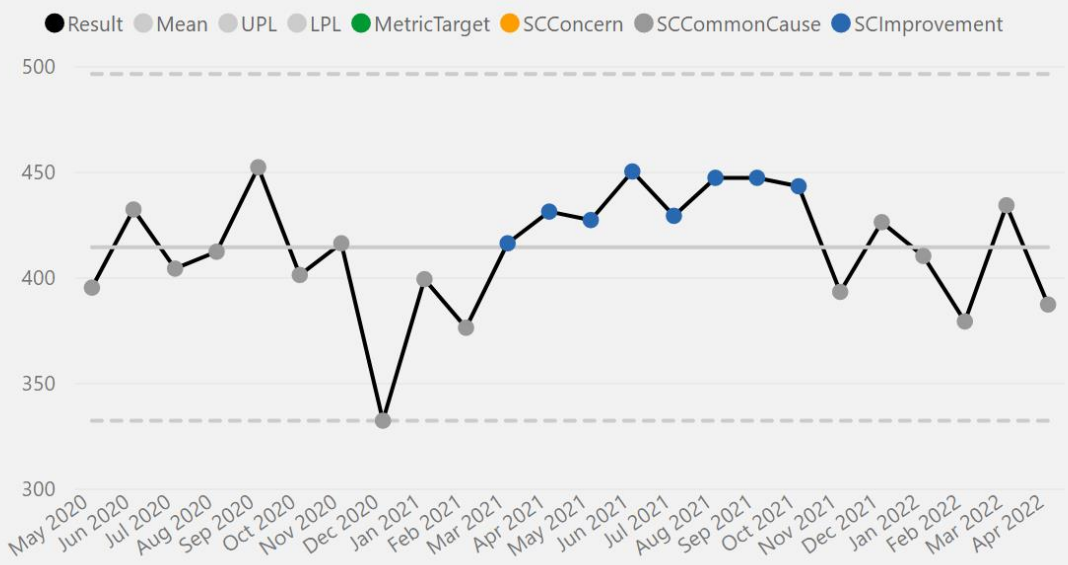
Apr 2022

Variation	Assurance
387 Result	496 UPL
N/A Target	414 Mean
	332 LPL

Analytical Commentary

Variation is Common Cause

Mothers Delivered



Assurance Commentary

We have reviewed our care in labour and we remain at 99.7%. We have seen a reduction in our 3rd/4th degree tears from 3.3% to 1.8% and a small reduction in our PPh rates from 4.6% to 3.9%. We had 4 BBA in April, all the cases have been reviewed and deemed unavoidable. We continue to submit and learn from our incident submissions.

Improvement Actions

Continue to share Learning with the teams.
Women to be reminded of the importance of making contact with their Midwife when in labour to avoid any potential BBA's.
We continue to monitor Caesarean clinical appropriateness via weekly CTG meetings chaired by the Intrapartum Lead Consultant and are awaiting outcome of a funding bid for a fetal monitoring lead clinician.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
1:1 Care in Labour	Apr 2022	99.7%		Common Cause		No Target
3rd & 4th Degree Tears	Apr 2022	1.8%		Common Cause		Unreliable
Births Before Arrival	Apr 2022	4		Common Cause		No Target
Post Partum Haemorrhage ≥1500mls	Apr 2022	3.9%		Common Cause		No Target

Mothers Delivered

387

Babies Delivered

398

Maternity: Babies

NNUH Digital Health
business intelligence

Unplanned NICU ≥37 week Admissions (E3)

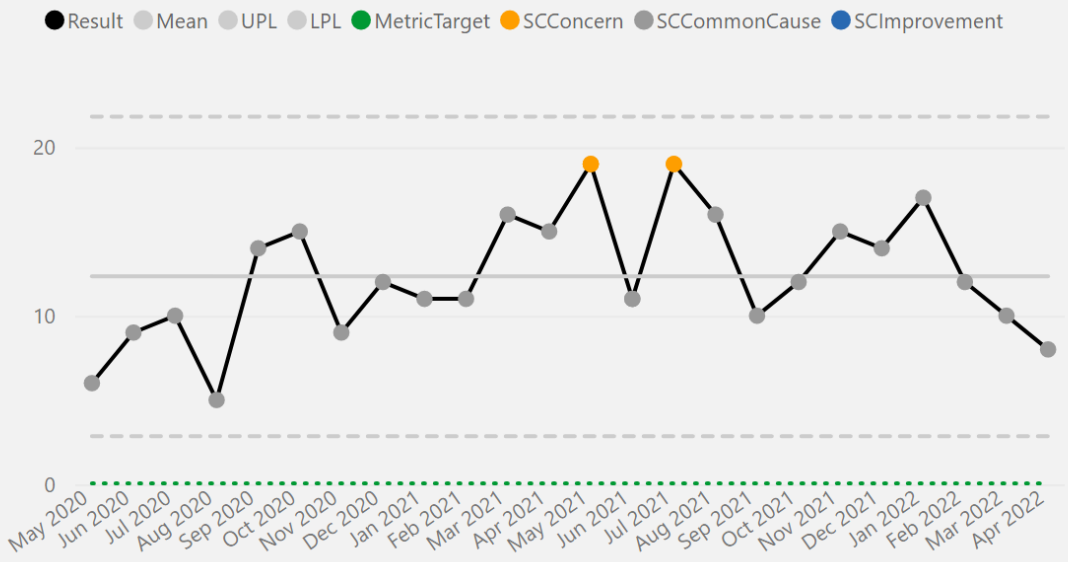
Apr 2022

Variation	Assurance		
	F	8 Result	22 UPL
		0 Target	12 Mean
			3 LPL

Analytical Commentary

Variation is Common Cause

Unplanned NICU ≥37 week Admissions (E3)



Assurance Commentary

We had 387 deliveries with 398 babies born in April. We have completed a cross divisional review of all babies delivered and transferred to NICU - preterm, that were either early or late neonatal deaths.

Improvement Actions

Cross divisional working group to evaluate preterm deliveries transfered to NICU.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Adjusted Still Births	Apr 2022	4		Not Applicable		No Target
Apgar score <7 @5, ≥37 weeks	Apr 2022	7		Common Cause		No Target
Early Neonatal Death	Apr 2022	0		Not Applicable		No Target
Mothers Transferred Out of Unit	Apr 2022	1		Common Cause		No Target

Saving Babies Lives

NNUH Digital Health
business intelligence

Topic	Metric Name	Date	Result		Variation		Assurance
Smoking Awareness	Smoking Status at Delivery	Apr 2022	10.1%		Common Cause		Unreliable
Fetal Growth Restriction	Less Than 3rd centile born > 37+6 weeks	Apr 2022	1%		Common Cause		Not capable
Fetal Growth Restriction	SGA detected Antenatally	Apr 2022	35%		Common Cause		No Target
Reducing Preterm Birth	Singleton Births Preterm	Apr 2022	6%		Common Cause		Unreliable
Reducing Preterm Birth	Singleton live births < 34 wks (AN corticosteroids within 7 days PN)	Apr 2022	33%		Common Cause		Unreliable
Effective Fetal Monitoring	CTG Training and Human factors situational awareness compliance	Apr 2022	88%		Common Cause		Unreliable

Assurance Commentary

The SBLCB action plan is to be put in progress and will be supported by the better Births midwife in the DDMD absence.

Improvement Actions

To increase compliance with carbon monoxide monitoring, we have created completed a set of actions:
1. Recruited inpatient and outpatient champions to work closely with the LMNS Public Health Midwife in driving up compliance at booking and 36 weeks.
2. Established regular meetings with champions, Public Health Midwife and DDMD.
3. Shared communications with all staff reminding them of the importance of CO monitoring compliance.
4. Training all MCA's in performing CO monitoring.

The maternity department are developing a training compliance policy for all statutory and mandatory training. There will be stricter rules around staff who DNA or are not up to date with training compliance.

New fetal monitoring lead midwife and PDM's have action plan to improve GAP training compliance.

Review data feed for <30week deliveries by Digital Maternity team, to confirm correct details are being pulled across.

Adult Safeguarding

NNUH Digital Health
business intelligence

Safeguarding Adults

Apr 2022

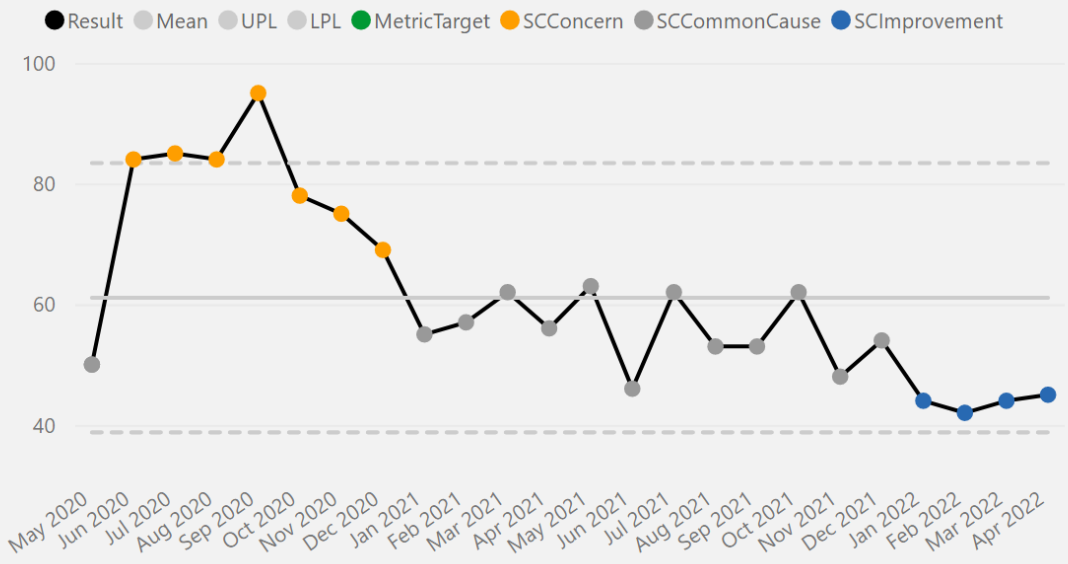
Variation	Assurance
L	

45 Result
N/A Target
83 UPL
61 Mean
39 LPL

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)

Safeguarding Adults



Assurance Commentary

NNUH continues to work alongside the other acutes, local authority and CCGs to streamline safeguarding processes. There has also been an increase in the number of domestic abuse cases being identified. Staff have been able to recognise and act promptly in responding to these concerns.

Improvement Actions

A task and finish group to review and align the safeguarding referral process across the system was convened on 29th April 2022 with partners from the Local Authority, CCGs and other acutes. The partners agreed to develop a Norfolk Threshold Guidance and a further meeting has been arranged for 17th June for partners to agree the guidance.

Children & Midwifery Safeguarding

NNUH Digital Health
business intelligence

Safeguarding Children and Midwife...

Apr 2022

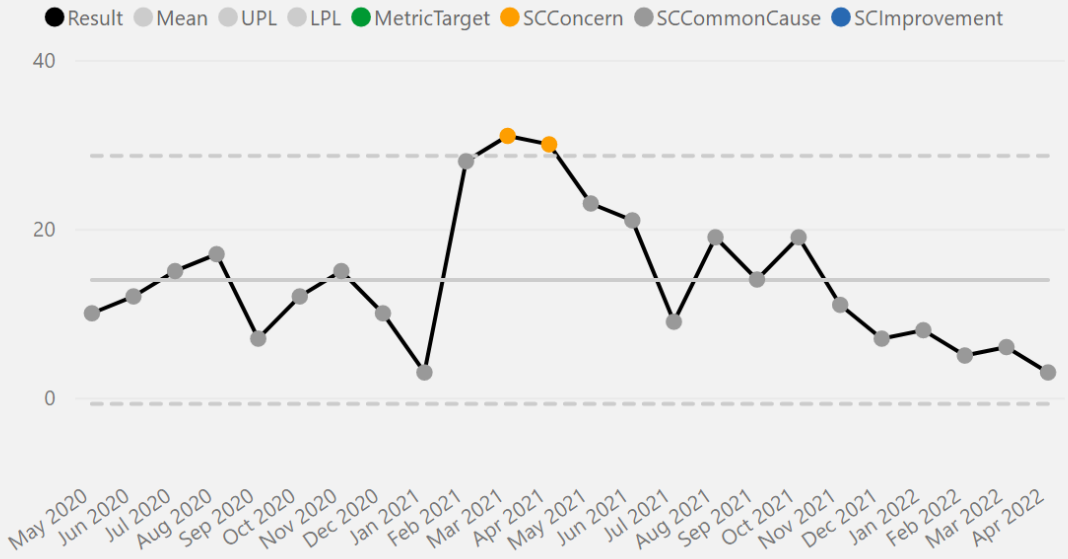
Variation	Assurance
	

3 Result	29 UPL
N/A Target	14 Mean
	-1 LPL

Analytical Commentary

Variation is Common Cause

Safeguarding Children and Midwifery



Assurance Commentary

There is work in development to introduce restorative supervision to support staff to continue to manage complex cases. Part of this work will be led by Professional Nurse Advocates alongside the Complex Health Hub.

Improvement Actions

There is ongoing collaboration within the Complex Health Hub to promote a trauma informed approach to working throughout the organisation.

Discussions are ongoing to develop the service specifications and pathways of care for Children's Mental Health.

Staff are being supported through supervision to manage complex cases.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Safeguarding Children	Apr 2022	1		Common Cause		No Target
Safeguarding Midwifery	Apr 2022	2		Improvement (Low)		No Target

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NHS Foundation Trust

REPORT TO TRUST BOARD

Date	**8 June 2022**
Title	**Chair's Key Actions from Finance, Investments and Performance Committee meeting on 25.05.22**
Author & Exec Lead	**Tom Spink – Interim Chairman (as Committee Chair)**
Purpose	**For Information**

1 Background/Context

The Finance, Investments and Performance Committee met on 25 May 2022. The meeting was quorate and was attended by Richard Smith (Staff Governor) as observer. Papers for the meetings were made available to Board members for information in the usual way via Admin Control.

The Committee considered the standard suite of information regarding operational and financial performance and actions to improve the Use of Resources position. The following issues were identified to highlight to the Board in public:

2 Key Issues

0	Clinical/Departmental visit	The meeting began with a departmental visit to the Mortuary, co-ordinated by Mr Lee Gibbs (Chief Anatomical Pathology Technician).
1	Performance & Productivity	The Committee has encouraged identification of a small number of key performance metrics, to reflect national priorities and challenges. The Committee commended the revision to the Performance IPR with the addition of its readily accessible summary to aid focus and monitoring: 1 – 104-Week Breaches – Better Than Trajectory 2 – 78-Week Breaches – Better Than Trajectory 3 – 62-Day Cancer – Off Track 4 – Ambulance Handovers – Improved 5 – 110% Activity – Off Track (Provisional Data) The Committee cross-referenced to the report on medical vacancies that had been received by the Quality & Safety Committee this month and whether that is having an impact on delivery in key areas such as the cancer and elective pathways. A report concerning medical recruitment will be prepared for the People & Culture Committee to review at its meeting in June.

2	(i) Financial Performance YTD (ii) CIP Plans and Progress	The Committee was updated on financial performance in the year to date, as detailed in the finance report. Associated risks relate particularly to 'claw back' provisions relating to clinical activity. The Committee has also requested a detailed report on Strategic Initiatives to enhance value for money and cost improvement in the Trust.
3	Business Case Approvals Process	The Committee reviewed and approved an updated Business Case Approvals Process, as previously agreed by the Management Board. The Committee discussed the balance between necessary controls to ensure good practice, whilst also facilitating people to put forward plans to develop services and make improvements. The Committee was advised that appropriate training will be provided to ensure that business cases are linked into our 5-year capital programme and to avoid unnecessary work. The Committee reviewed and approved a business case for continuation of our Virtual Ward for the period until the ICS Virtual Ward Plan is established. Our Virtual Ward was a crucial part of our response to the pandemic. It has capacity for up to 40 beds for patients who would otherwise require a hospital bed and it has been recognised nationally as both innovative and highly successful. The Committee also reviewed the Electronic Patient Record OBC in order to recommend this to the Board for approval.
4	Major Projects	There are a number of major capital projects underway or planned in the Trust and the Committee reviewed progress, notably including the: - Norfolk & Norwich Orthopaedic Centre (NANOC) – construction underway - Paediatric Theatres complex – construction underway - Diagnostic & Assessment Centre – Full Business Case nearing completion.
5	Committee Annual Report 2021/22	The Committee has undertaken its annual self-assessment and approved its Annual Report (as **attached**). The Report concludes that "*…. the Committee considers that it has achieved its Purpose during 2021/22 and that the Audit Committee and Board are entitled to take **assurance** from the work of the Finance, Investments & Performance Committee as part of the Trust's system of integrated governance*." There is ongoing discussion whether the remit of the Committee is too extensive to be covered within the time available and whether this may be addressed by creating a new forum with specific responsibility for capital investments, business cases and innovation/transformation. This could be either a new committee or a sub-committee of the FIPC. Once proposals on this are concluded, the Committee's Terms of Reference will be reviewed, together with associated reporting lines and Work Programme.

3 Conclusions/Outcome/Next steps

The next Committee meeting is scheduled for 29 June 2022, at which time it will consider performance in the Division of Surgery and Emergency Services and in Cromer.

Recommendations:

The Board is recommended to note the work of its Finance, Investments & Performance Committee and to receive its Annual Report 2021/22.

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FINANCE, INVESTMENTS AND PERFORMANCE COMMITTEE
ANNUAL REPORT 2021/22

1. Introduction

The Finance, Investments and Performance 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 March 2021. They are available to public and staff through the Trust intranet and website.

This Annual Report is generated 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 2022 the Audit Committee is accordingly scheduled to receive the Annual Reports of the Quality & Safety Committee, People & Culture Committee and Finance, Investments and Performance Committee, for information.

2. Committee Membership and Meetings

2.1 Membership

Membership of the Committee consists of three Non-Executive Directors, Chief Finance Officer, Chief Operating Officer, Chief Executive, Director of Strategy and Major Projects, Chief People Officer, Chief Information Officer and Clinical Executive (Medical Director or Chief Nurse).

2.2 Meetings

During 2021/22 eleven meetings of the Finance, Investments and Performance Committee were held. 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. Attendance was as set out in the table below. All meetings held in 2021/22 were quorate.

In addition to Committee members, meetings of the Committee have been routinely attended by Ms Jackie Hammond and Mr Richard Smith (Governor Observers). Other Directors and officers of the Trust have attended meetings as required. The work of the Committee is supported by the Board Secretary and his Assistant.

	28 April 2021	26 May 2021	30 June 2021	28 July 2021	6 September 2021	29 September 2021	27 October 2021	24 November 2021	26 January 2022	23 February 2022	30 March 2022
Mr Tom Spink (Chair of Committee & Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dr Pamela Chrispin (Non-Executive Director)	✓	✓	✓	**X**	✓	✓	✓	✓	✓	X	✓
Mr Roy Clarke (Chief Finance Officer)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr Chris Cobb (Chief Operating Officer)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mrs Sandra Dinneen (Non-Executive Director)	✓	✓	✓	✓	✓	✓	X	✓	✓	✓	✓
Prof Nancy Fontaine (Chief Nurse)	✓	✓	✓	**X**	✓	✓	✓	X	✓	✓	X
Mr Julian Foster (Non-Executive Director)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr Simon Hackwell (Director of Strategy)	**X**	✓	✓	**X**	✓	✓	✓	✓	✓	✓	✓
Mr Sam Higginson (Chief Executive)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Mr Paul Jones (Chief People Officer)	✓	✓	✓	**X**	✓	X	**X**	✓	✓	✓	X
Mr Anthony Lundrigan (Chief Information Officer)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

2.3 Reporting

In common with other Board committees, the papers for the Finance, Investments and Performance Committee are circulated to all Board members for information in advance of its meetings. In accordance with its Terms of Reference, a report from each Committee meeting has been made to the next meeting of the Board of Directors, as below:

FI&P Committee meeting	Corresponding Report to Board
28 April 2021	5 May 2021
26 May 2021	2 June 2021
30 June 2021	7 July 2021
28 July 2021	4 August 2021
6 September 2021	6 October 2021
29 September 2021	6 October 2021
27 October 2021	3 November 2021
24 November 2021	1 December 2021
26 January 2022	2 February 2022
23 February 2022	2 March 2022
30 March 2022	6 April 2022

3. Committee Work Programme and Annual Review

3.1 Annual Review of Committee Effectiveness

In March 2022, the Committee reviewed its performance and satisfaction of its Terms of Reference. This involved:

- questionnaire feedback from Committee members;
- feedback from Board members;
- evidence of performance against ToRs;
- consideration of reports received in the last year and draft Work Programme.

The Committee noted the feedback from the 2021/22 Annual Board Review Questionnaire – with 13/13 responses agreeing or strongly agreeing that the Committee effectively performs its role, as below (prior year in brackets for comparison):

	Finance, Investments & Performance Committee	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
26	Communication to the full Board on the activities of the Finance, Investments and Performance Committee is adequate and appropriate			(1)	9 (10)	4 (4)
27	The Finance, Investments and Performance Committee effectively performs its role.			(2)	7 (10)	6 (3)

The Committee discussed pressure on the Committee with respect to its Work Programme and oversight of the Capital Programme and operational performance. The Committee considered whether the remit of the Committee is too extensive to be covered within the time available and there are ongoing discussions as to whether this may be addressed by creating a new forum with specific responsibility for capital investments, business cases and innovation/transformation. This could be either a new committee or a sub-committee of the FIPC. The Committee's ToRs were last agreed by the Committee and approved by the Board in March 2021. Once proposals on proposed revision of oversight of capital developments are concluded the Committee will review its Terms of Reference accordingly.

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 advance notice to those who are responsible for producing reports of the timetable for them to do so. In March 2021 the Committee agreed its Work Programme. In March 2022 the Committee considered its draft Programme for 2022/23 and will review this again once proposals for the ongoing oversight of capital projects is agreed.

During 2021/22 the Committee has focused on issues across the range of its remit with particular focus on operational performance, actions in response to the Financial Governance Review, operational and financial planning and oversight of major estates projects, with reports including:

- Surgical Productivity (April & Sept 21)
- Elective Recovery Plan (May '21)
- PFI contract monitoring (May, June, Oct '21)

- Electronic Patient Record SOC (May ’21)
- Digital Strategy & projects (May, June ’21 & March ‘22)
- Emergency Care Improvement Plan (June & Nov ‘21)
- UoR Annual Assessment (June ’21)
- Elective Care Strategy & surgical capacity plans (July & Sept ’21)
- Green Plan (Sept ’21 & Jan ’22)
- Major Estates Projects – DAC, NANOC & Paediatric Theatres
- Operational & Financial planning 2022/23

4. Conclusion

The Terms of Reference for the Finance, Investments & Performance Committee specify that its **Purpose** is to:

“… provide scrutiny and challenge with regard to:

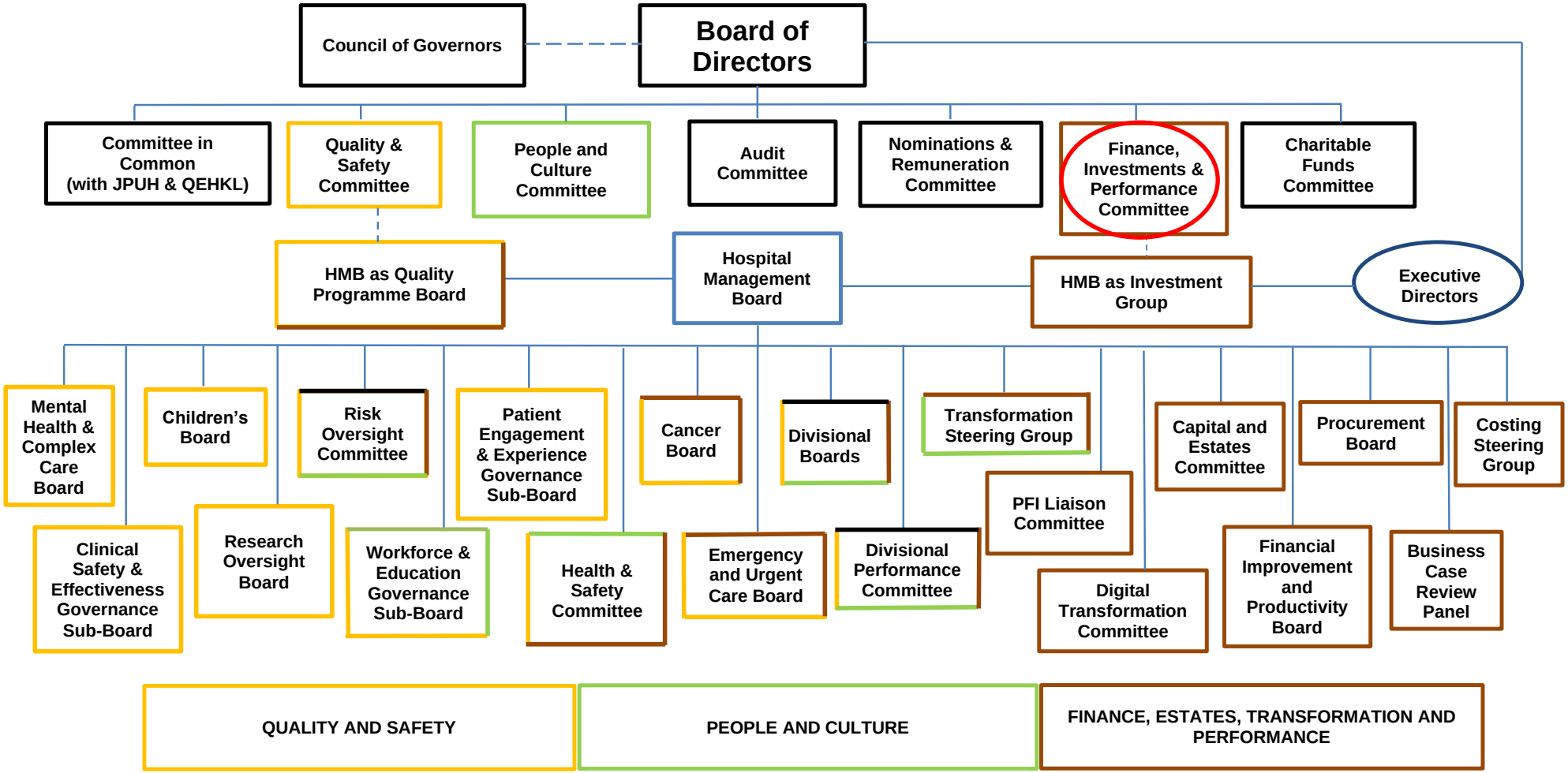
- *the Trust’s financial and operational planning and performance;*
- *its achievement of business and operational objectives;*
- *planning and delivery of capital investments and major projects;*
- *estates, facilities and digital strategy and implementation;*

in order to provide assurance and make appropriate reports or recommendations to the Board.”

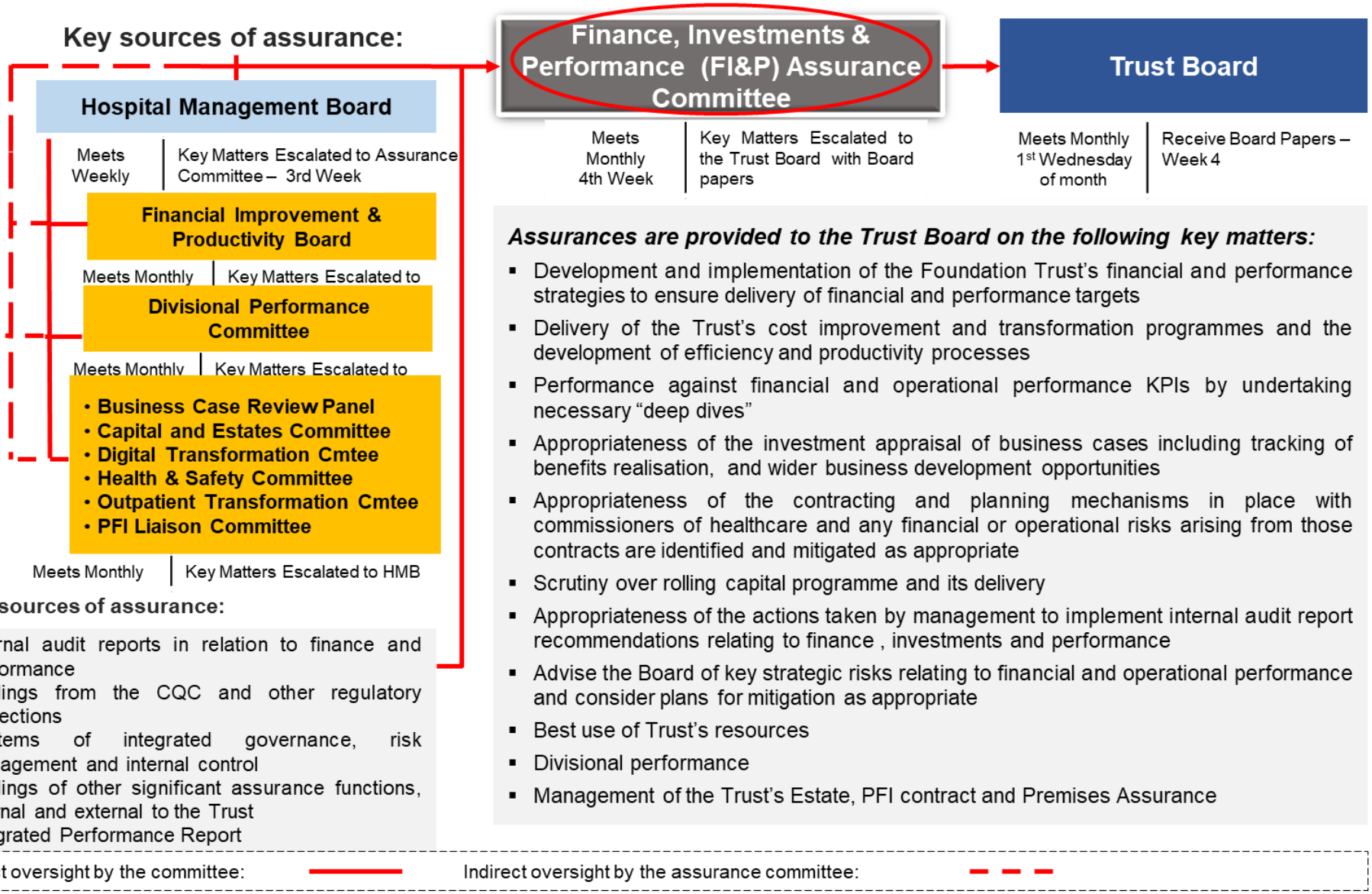
Reports from the Committee to the Board have highlighted the improved financial position and assurance with regard to operational and financial planning. The challenges relating to operational performance and major projects have also been noted and reported, together with the plans for additional focus and remedial action, in 2022/23. In the circumstances, the Committee considers that it has achieved its Purpose during 2021/22 and that the Audit Committee and Board are entitled to take assurance from the work of the Finance, Investments & Performance Committee as part of the Trust’s system of integrated governance.

Norfolk and Norwich University Hospitals NHS Foundation Trust

Board of Directors and Management Board Reporting and Accountability Structure



As at November 2021


Key sources of assurance:
Hospital Management Board
Meets Weekly
Key Matters Escalated to Assurance Committee – 3rd Week
Financial Improvement & Productivity Board
Meets Monthly
Key Matters Escalated to
Divisional Performance Committee
Meets Monthly
Key Matters Escalated to
• Business Case Review Panel
• Capital and Estates Committee
• Digital Transformation Cmtee
• Health & Safety Committee
• Outpatient Transformation Cmtee
• PFI Liaison Committee
Meets Monthly
Key Matters Escalated to HMB
Other sources of assurance:
Internal audit reports in relation to finance and performance
Findings from the CQC and other regulatory inspections
Systems of integrated governance, risk management and internal control
Findings of other significant assurance functions, internal and external to the Trust
Integrated Performance Report
Finance, Investments & Performance (FI&P) Assurance Committee
Meets Monthly 4th Week
Key Matters Escalated to the Trust Board with Board papers
Trust Board
Meets Monthly 1st Wednesday of month
Receive Board Papers – Week 4
Assurances are provided to the Trust Board on the following key matters:
Development and implementation of the Foundation Trust's financial and performance strategies to ensure delivery of financial and performance targets
Delivery of the Trust's cost improvement and transformation programmes and the development of efficiency and productivity processes
Performance against financial and operational performance KPIs by undertaking necessary "deep dives"
Appropriateness of the investment appraisal of business cases including tracking of benefits realisation, and wider business development opportunities
Appropriateness of the contracting and planning mechanisms in place with commissioners of healthcare and any financial or operational risks arising from those contracts are identified and mitigated as appropriate
Scrutiny over rolling capital programme and its delivery
Appropriateness of the actions taken by management to implement internal audit report recommendations relating to finance , investments and performance
Advise the Board of key strategic risks relating to financial and operational performance and consider plans for mitigation as appropriate
Best use of Trust's resources
Divisional performance
Management of the Trust's Estate, PFI contract and Premises Assurance
Key: Direct oversight by the committee:
Indirect oversight by the assurance committee:

Integrated Performance Report:

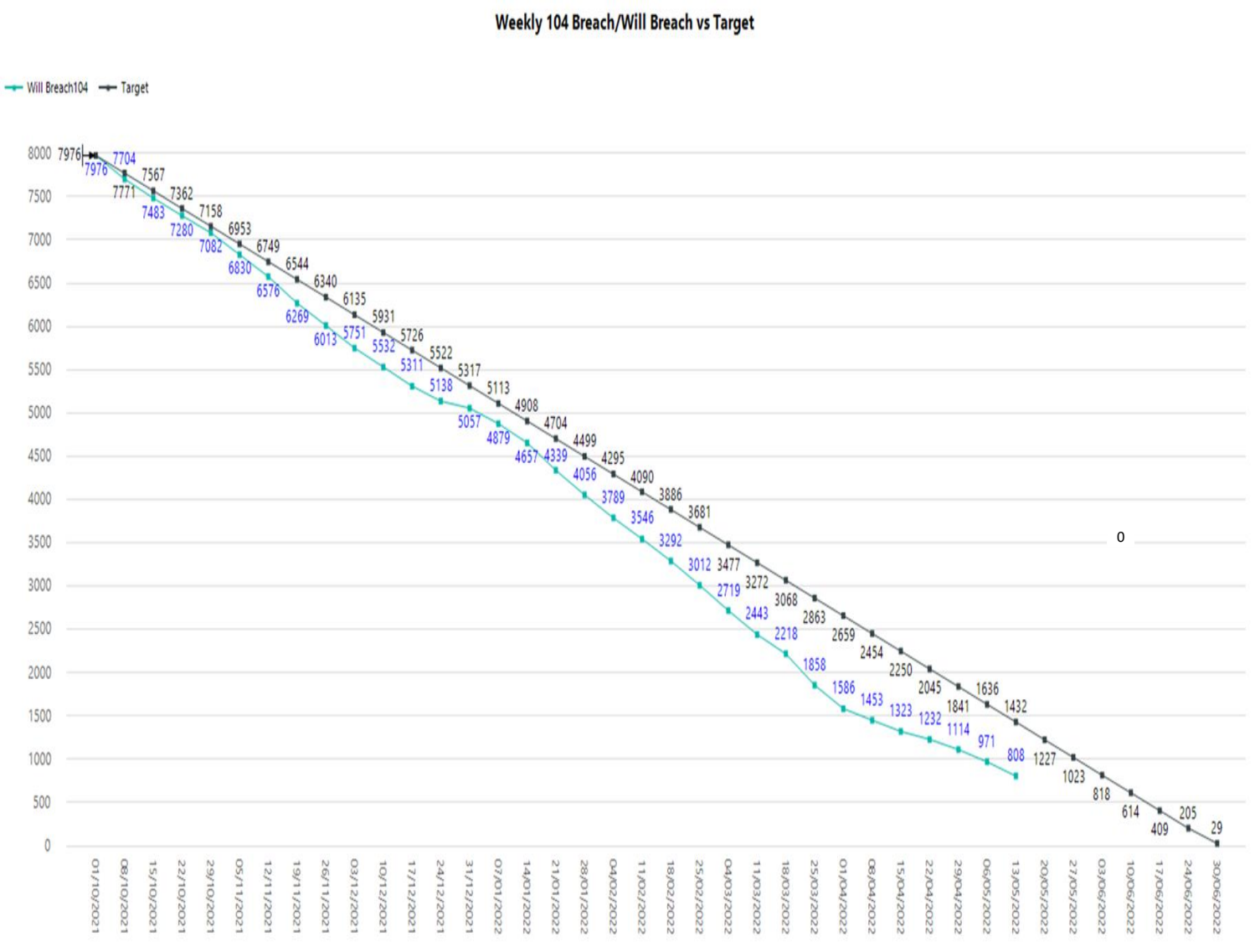
Performance & Activity Domains

April 2022

Key 2022-23 Operational Priorities

- 104-Week Breaches: Better Than Trajectory
- 78-Week Breaches: Better Than Trajectory
- 62-Day Cancer: Off Track
- Ambulance Handovers: Improved
- 110% Activity: Off Track (Provisional Data)

Performance – RTT 104 Week Breach Trajectory



Commentary

April 2022 Performance

In October 2021 the Trust had 7,882 patients forecasted to breach 104+ weeks before the end on June 2022. As of the 16th May this number has reduced to 764, of which 679 have either a TCI or PTCI in place.

The remaining 85 patients there are mainly in 2 specialities:

T&O - 33 patients. Grantham hospital has capacity and has offered mutual aid, which the teams are finalising.

ENT - 39 patients. Luton and Dunstable have agreed to undertake 17 cases. JPUH have capacity for 10 patients. Exploring the potential to send 5 patients to Stevenage. A QEH surgeon to start lists from Wednesday, 18th May with potential for weekend Medacs capacity.

The graph shown to the left displays the progress against the revised trajectory. The Trust is currently ahead of trajectory with an action plan supporting further interventions for specialities of concern.

Next Steps

1. All provisional TCIs to be actual TCIs by 27th May.

2. All patients to be sent out of county to be confirmed by 27th May.

3. Reporting to move to a daily view rather than a weekly view from May 23rd.

Risk To Delivery

GREEN

Performance – NNUH 104-Week Recovery Forecast (Specialty Level)

NNUH Digital Health
business intelligence

Previous weeks activity

Specialty		04/03/2022	11/03/2022	18/03/2022	25/03/2022	01/04/2022	08/04/2022	15/04/2022	22/04/2022	29/04/2022	06/05/2022	13/05/2022	18/05/2022	Weekly Target
120 - Ear Nose and Throat	Breaches	290	260	233	204	173	159	137	130	130	123	94	85	12
	Removals	35	30	27	29	31	14	22	7	3	7	29	9	
502 - Gynaecology	Breaches	411	386	360	330	312	294	267	250	233	214	178	152	20
	Removals	18	25	22	30	18	18	27	17	11	19	36	26	
110 - Trauma and Orthopaedic	Breaches	939	866	811	702	598	553	518	482	439	386	327	283	48
	Removals	82	73	55	109	104	45	35	36	31	53	59	44	
100 - General Surgery	Breaches	268	227	196	137	105	98	84	75	70	64	57	50	9
	Removals	50	41	31	59	32	7	14	9	2	6	7	7	
215 - Paediatric Ear Nose and Throat	Breaches	15	15	14	14	9	11	12	10	7	5	7	5	2
	Removals	1	0	1	0	5	-2	-1	2	0	2	-2	2	
140 - Oral Surgery	Breaches	120	113	105	92	82	78	70	63	58	41	35	28	9
	Removals	6	7	8	13	10	4	8	8	4	17	6	7	
840 - Audiology	Breaches	21	20	16	13	11	10	10	3	3	3	1	1	0
	Removals	18	1	4	3	2	1	0	7	0	0	2	0	
330 - Dermatology	Breaches	115	101	92	69	60	51	42	31	24	13	10	8	3
	Removals	5	14	9	23	9	9	9	0	4	11	3	2	
160 - Plastic Surgery	Breaches	90	79	66	55	50	43	45	39	39	33	30	27	5
	Removals	14	11	13	11	5	7	-2	6	0	6	3	3	
191 - Pain Management	Breaches	51	45	42	32	27	22	16	17	16	14	8	8	1
	Removals	1	6	3	10	5	5	6	-1	1	2	6	0	
108 - Spinal Surgery	Breaches	33	26	25	21	17	15	15	13	13	10	10	7	1
	Removals	7	7	1	4	4	2	0	2	0	3	0	3	
171 - Paediatric Surgery	Breaches	28	25	22	20	13	10	8	9	14	15	11	9	1
	Removals	5	3	3	2	7	3	2	-1	-5	-1	4	2	
214 - Paediatric Trauma and Orthopaedic	Breaches	33	30	27	21	13	12	11	11	11	7	6	5	1
	Removals	6	3	3	6	8	1	1	0	0	4	1	1	
101 - Urology	Breaches	128	105	76	48	37	35	33	27	19	16	10	8	2
	Removals	27	23	29	28	11	2	2	0	7	3	6	2	
143 - Orthodontic	Breaches	6	6	6	6	5	5	4	1	1	2	2	1	1
	Removals	4	0	0	0	1	0	1	3	0	-1	0	1	
107 - Vascular Surgery	Breaches	79	58	52	38	32	23	23	20	15	11	10	10	0
	Removals	7	21	6	14	6	9	0	3	4	4	1	0	
310 - Audio Vestibular Medicine	Breaches	13	13	11	11	4	4	4	4	2	1	1	1	0
	Removals	1	0	2	0	7	0	0	0	1	1	0	0	
219 - Paediatric Plastic Surgery	Breaches	8	8	7	7	5	5	5	5	2	2	2	1	1
	Removals	1	0	1	0	2	0	0	0	3	0	0	1	
130 - Ophthalmology	Breaches	45	35	34	23	16	13	12	8	9	9	6	5	3
	Removals	4	10	1	11	7	3	1	4	-1	0	3	1	
217 - Paediatric Oral and Maxillofacial Surgery	Breaches	12	12	11	7	7	4	4	4	4	2	2	1	1
	Removals	1	0	1	4	0	3	0	0	0	2	0	1	
173 - Thoracic Surgery	Breaches	1	1	0										0
	Removals	1	0	1										
	Weekly Removals	293	275	220	356	269	133	126	100	65	136	166	110	202

Patients with PTCI/TCI

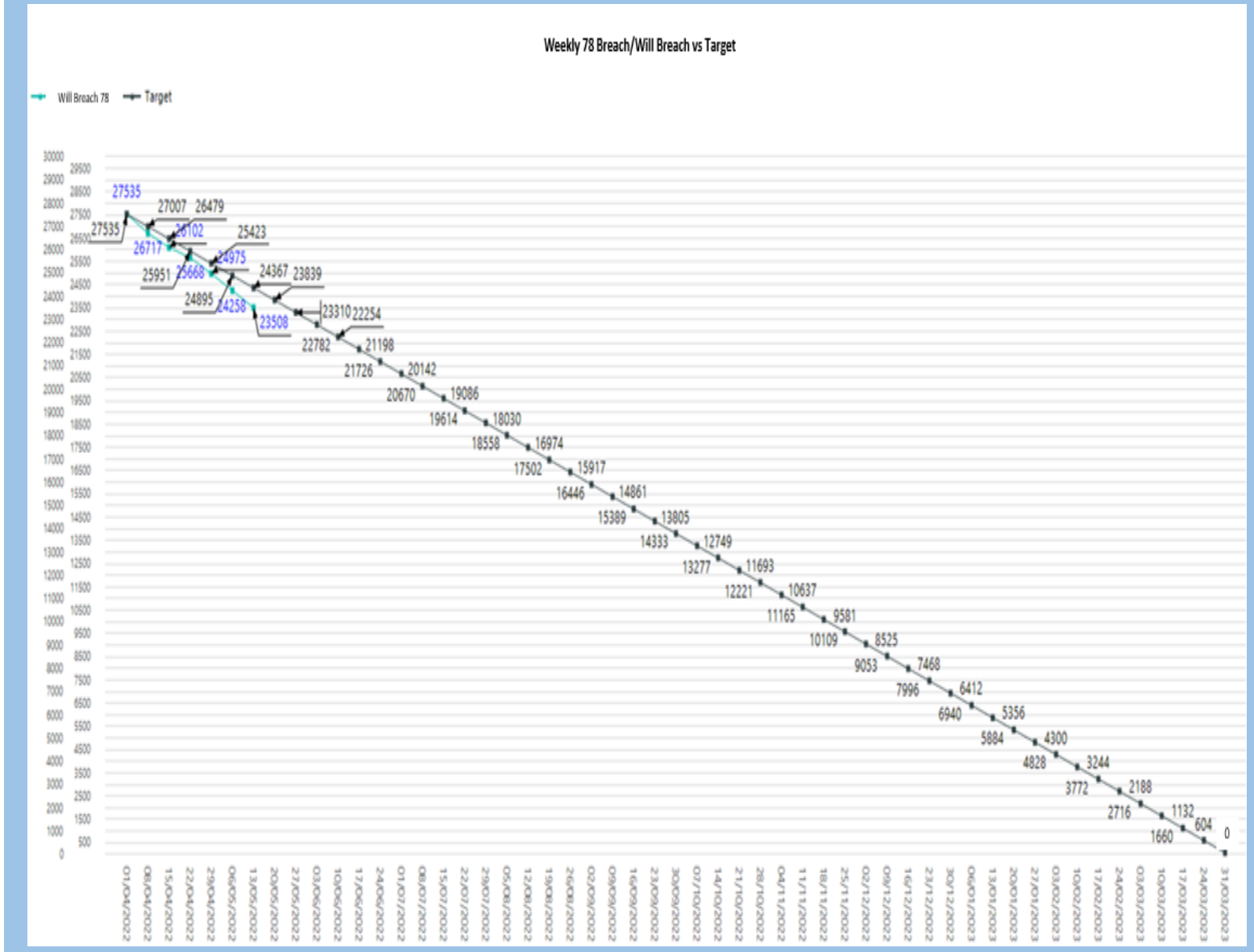
Specialty	Have TCI	Unbooked	20/05/2022	27/05/2022	03/06/2022	10/06/2022	17/06/2022	24/06/2022	01/07/2022	08/07/2022	15/07/2022	22/07/2022	29/07/2022	Patients Requiring a TCI
120 - Ear Nose and Throat	44	41	81	74	69	67	58	46	41	40	40	40	40	41
			4	7	5	2	9	12	5	1				
502 - Gynaecology	150	2	146	123	98	74	39	15	2	2	2	2	1	2
			6	23	25	24	35	24	13				1	
110 - Trauma and Orthopaedic	256	27	272	226	196	158	110	72	27	27	27	27	27	27
			11	46	30	38	48	38	45					
100 - General Surgery	47	3	49	35	31	28	24	14	3	3	3	3	3	3
			1	14	4	3	4	10	11					
215 - Paediatric Ear Nose and Throat	4	1	4	3	3	2	2	1	1	1	1	1	1	1
			1	1		1		1						
140 - Oral Surgery	27	1	26	15	9	4	3	1	1	1	1	1	1	1
			2	11	6	5	1	2						
840 - Audiology	0	1	1	1	1	1	1	1	1	0	0	0	0	1
										1				
330 - Dermatology	8	0	7	2	2	2	2	1	0	0	0	0	0	
			1	5				1	1					
160 - Plastic Surgery	27	0	26	18	15	12	11	5	0	0	0	0	0	
			1	8	3	3	1	6	5					
191 - Pain Management	8	0	7	4	3	2	2	2	0	0	0	0	0	
			1	3	1	1			2					
108 - Spinal Surgery	7	0	7	7	5	3	2	1	0	0	0	0	0	
					2	2	1	1	1					
171 - Paediatric Surgery	9	0	9	9	6	6	3	2	0	0	0	0	0	
					3		3	1	2					
214 - Paediatric Trauma and Orthopaedic	5	0	5	2	2	2	1	1	0	0	0	0	0	
				3			1		1					
101 - Urology	8	0	7	6	5	5	4	1	0	0	0	0	0	
			1	1	1		1	3	1					
143 - Orthodontic	1	0	1	1	1	1	1	0	0	0	0	0	0	
								1						
107 - Vascular Surgery	10	0	10	6	6	6	1	0	0	0	0	0	0	
				4			5	1						
310 - Audio Vestibular Medicine	1	0	1	1	1	0	0	0	0	0	0	0	0	
						1								
219 - Paediatric Plastic Surgery	1	0	1	1	1	0	0	0	0	0	0	0	0	
						1								
130 - Ophthalmology	5	0	3	2	1	0	0	0	0	0	0	0	0	
			2	1	1	1								
217 - Paediatric Oral and Maxillofacial Surgery	1	0	0	0	0	0	0	0	0	0	0	0	0	
173 - Thoracic Surgery	0	0	0	0	0	0	0	0	0	0	0	0	0	
			0	0	0	0	0	0	0	0	0	0	0	
Total Booked/Unbooked	619	76	30	126	81	81	109	100	87	2	0	0	1	
% Total Booked/Unbooked	89%	11%												

Patients Requiring a TCI on 1 July **76**

Further interventions

Specialty	Spire	QEHKL	L&D / Grantham	OPA/POA - for review of decision	P6	Patient no longer fit (3 codes to be added)	Awaiting Outcome	CT	Clock Stops Today	Booked for Injection / Pain	Review Letter	Echo Awaited	Covid	TCI Added today	Gynae Patients - treated but flagging under GS	Need TCI
120 - Ear Nose and Throat		5		3	5	1		2	4		6		1	6		8
502 - Gynaecology																
110 - Trauma and Orthopaedic	5			5	6	2			2	2	1	1	4	1		4
100 - General Surgery									1		1			1	2	1
215 - Paediatric Ear Nose and Throat				1												
140 - Oral Surgery					1											
840 - Audiology																
330 - Dermatology																
160 - Plastic Surgery																
191 - Pain Management																
108 - Spinal Surgery																
171 - Paediatric Surgery																
214 - Paediatric Trauma and Orthopaedic																
101 - Urology																
143 - Orthodontic																
107 - Vascular Surgery																
310 - Audio Vestibular Medicine																
219 - Paediatric Plastic Surgery																
130 - Ophthalmology																
217 - Paediatric Oral and Maxillofacial Surgery																
173 - Thoracic Surgery																

Performance – RTT 78 Week Breaches



Commentary

April 2022 Performance

The 2022-23 Operational Planning Guidance outlines the ambition to eliminate the 78-week breaches by the end of March 2023. The Trust continues to see a reduction in the over 78-week wait patients. With the continuing drive to eliminate the 104-week breaches and care plan validation, this is forecasted to continue to reduce. As of the 16th May the number of patients that need to be treated before the end of March 2023 has reduced from 27,535 to 23,317.

There is significant work required in the following areas to reduce the length of time waiting for first outpatients which are currently as follows:

T&O	Dermatology	Gynaecology	ENT	Ophthalmology
Upper limb **77-80 weeks**	See & Treat **64 weeks**	Menstrual disorders **66 weeks**	Adults **70 weeks**	Ocular thyroid and ocular plastics **66 weeks**
		General Gynaecology **68 weeks**	Kids **84 weeks**	Adrenal ocular plastics **72 weeks**

Improvement Actions

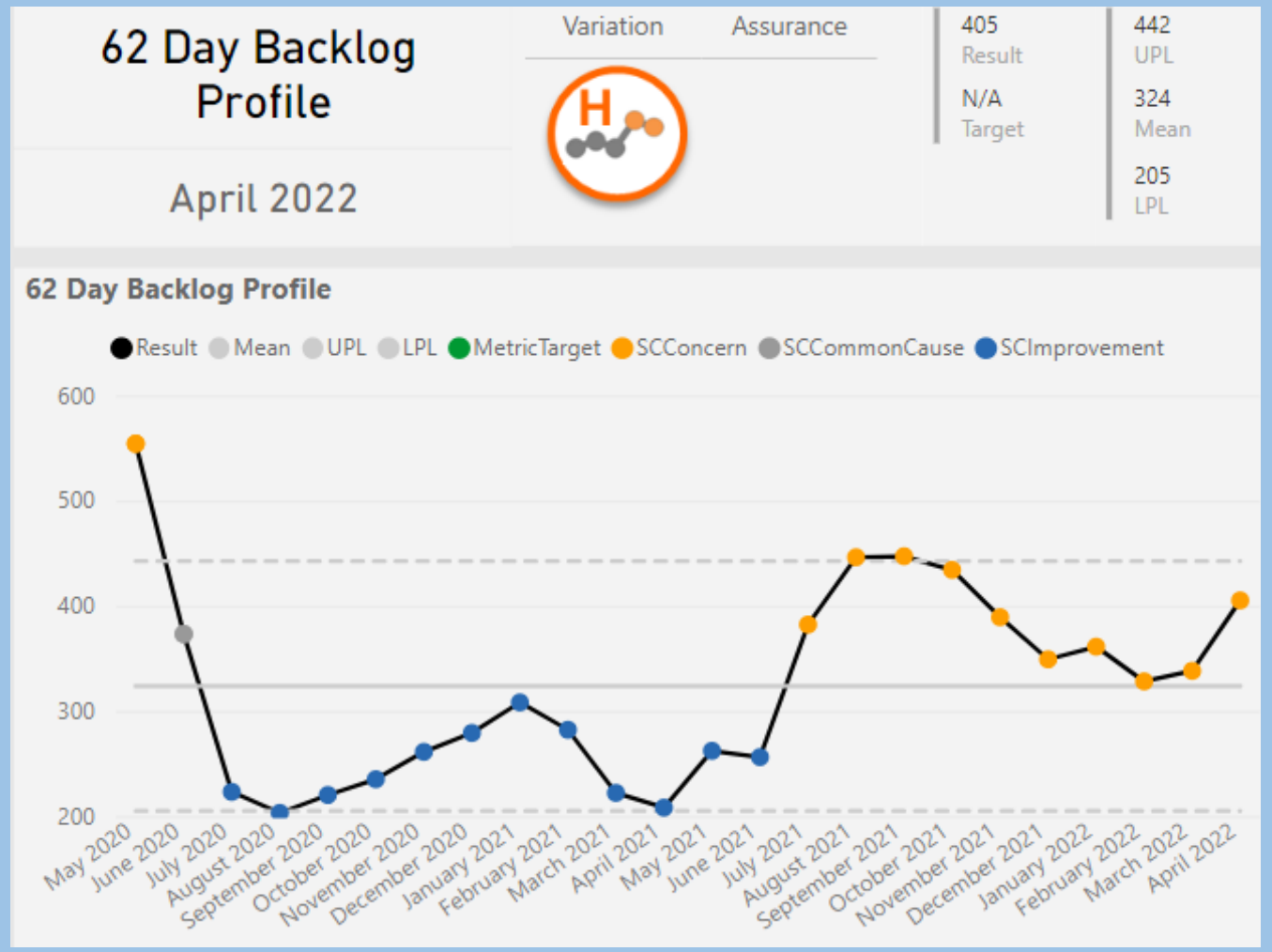
A set of 5 strategic capacity and sustainability interventions will help support and reduce the volumes of long waits, including:

1. Protection of ringfenced surgical beds.
2. Construction of NANOC.
3. Construction of Paediatric theatres.
4. Backfill of Paediatric theatres (main – conversion to adult) – business case required.
5. Participation in National POP pilot.

Risk To Delivery

GREEN

Performance – Cancer 62 Day Backlog Profile



Commentary

April 2022 Performance

Due to the continuation of increased 2WW demand and the concentration on delivering the Trust's 104-week position, there has been a continued increase in patients waiting over 62 days, with increases in Lower GI, Skin, Gynaecology and Urology. Urology theatre capacity has been transferred to the Gynae 104-week delivery; 18 theatre sessions in April.

Improvement Actions

1. Implementation of protected consultant administrative clinics to ensure patients on a cancer pathway have their diagnostic results processed as timely as possible. The new process commences 18/05/22.

2. Radiotherapy Insourcing has commenced to reduce the current delays to treatment across all body sites.

3. Additional weekend excision activity within Skin through May and June to tackle the increased number of patients referred onto the pathway.

4. Reinstated ''62 in 62'' performance monitoring, following the delivery of the 104-week requirement.

Risk To Delivery

RED

Performance – Surgical Cancer Recovery Plan

NNUH Digital Health business intelligence

Cancer Recovery Plan Tracker - Urology Cancer

RAG rating: Red – Not on Track | Amber – On Track | Green – Completed

	MILESTONE OR ACTIVITY DESCRIPTION	OWNER		START DATE		% OF TASKS COMPLETE
1	**Maintain 2ww Compliance and improve 1ww to 85%**		**Comments**		**RAG Status**	
1.1	Increase 1 stop clinics to 32 pnts per clinic which resumes 48 2ww slots per week	VW/SN	Ongoing discussions with Cons & GSOPD staff nurse	05/05/2022		
1.2	Extra OP capacity @ cromer	VW/OAK	Meeting arranged with Mr Al Kadhi & Cromer on 26/05	05/05/2022		
1.3	Change template for PSA results clinic	VW	Alter template to add new slots to assist with w/list	05/05/2022		
1.4	Review capacity and demand alongside job plans and outpatient productivity	VW/SN	Look at current capacity including theatres and capacity with weekend list reinstated	05/05/2022		
1.5	Adhoc 1 stop & PSA clinics to continue	SN	Accommodate where possible to help reduce the 2ww's	05/05/2022		
2	**Cancer Letter to be typed within 24hrs**		**Comments**			
2.1	1 stop clinics and CNS dictation already @ 24 hrs		N/A	05/05/2022		
3	**F/UP Results & Next Steps - Day 21**		**Comments**			
3.1	Increase establishment within CNS team to assist with F/UP & results reviews	IY/VW	Chasing ESR approved by CA til March 2023	05/05/2022		
3.2	MRI Results reviewed		Extra post from above to assist with this, skill mix of current establishment to fullfill this task rather than Consultant. Opportunity to reduce face to face apts and discharge sooner non cancer pathways	05/05/2022		
4	**Diagnosis/MDT - Day 28**		**Comments**			
4.1	Template BX lists @ Cromer to assist with backlog	VW/OAK	Meeting booked with Cromer end of May to discuss start date	05/05/2022		
4.2	Saturday GA cysto lists to assist with DM01 and potential diagnosis	IP	Adhoc lists requested	05/05/2022		
4.3	TURBT lists	IP	Loss of cancer lists at weekends & communal lists	05/05/2022		
4.4	Fusion bx on NPU	VW	PAS to be installed on bx equipment on NPU to enable us to book these on the LA lists	05/05/2022		
4.5	Loss of Friday LA laser list	IP/JE	Lack of theatre staff impact	05/05/2022		
5	**Decision to Treat - Day 28-37**		**Comments**			
5.1	Wait for 2nd MDT discussion following further tests	VW/SN	Possible delays in D-t-T	05/05/2022		
5.2	MDT OPA with consultant's waits	VW/SN	More capacity to be created to assist with this - templates? Consutant input needed (OAK)	05/05/2022		
5.3	Further tests - bone scans/PET scans/CT's	IY	Radiology capacity	05/05/2022		
5.4	Reporting of histology	IY/PH	Capacity & availability if all targets are met	05/05/2022		
6	**Refer out /TCI - Day 38**		**Comments**			
6.1	Request for Saturday robotic lists would assist booking large cancer surgery sooner	IP	Await outcome of MEDACS lists from June onwards	05/05/2022		
6.2	HIFU - referred to UCL	IY	Communication to be better once pt has been referred	05/05/2022		
7	**Backlog Reduction to Sustainable Level**		**Comments**			
7.1	Cromer activity will assist with sustaining w/lists	VW	Meeting in place	05/05/2022		
7.2	Adhoc clinics for new & follow ups	VW	Ongoing	05/05/2022		
7.3	Check cystoscopies for re-occurrence of bladder CA - biomarker trial	VW/OAK	Ongoing - a futher 300 cases to be trialled	05/05/2022		
7.4	Clinician aware of cancer targets and compliance			05/05/2022		
7.5	Capacity & demand modelling	VW	Start date TBC	05/05/2022		

Divisional Actions

	Action Description		Comments		Status/ RAG
1	Understand and map booking processes	IP	Division wide review of the different booking process across all Specialties	05/05/2022	
2	Liaise and invite to Surgical Cancer Recovery Meetings other services i.e. Imaging to understand bottlneck issues and actions to mitigate	IP	Division to invite other service representatives with direct impact on the various cancer pathways to attend cancer recovery meetings	05/05/2022	

Recovery Risks

Risk ID	Risk Description	Date Risk Identified	Risk Rating	Mitigating Action (Controls)	Action owner	Date due	RAG Rating
1	**Lower GI** - unable to find OPD clinic facilities	05/05/22	20	Scope NNUH OPD clinic room schedules with a view to better utilise and have visibility of OPD capacity to create clinic space to introduce 2ww one stop clinic	EA	30/06/22	
2	Skin /Plastics - Minor Ops capacity to deal with activity	05/05/22	20				
3	**All tumour sites** - Limited access to theatre capacity may impacting on activity	05/05/22	20		All	On-going	

Commentary

There are significant challenges and improvements necessary in cancer performance, full recovery plans and trajectories by Division have been requested. Action plans have been drawn up by the Surgical Division and their model has been shared with the wider Trust to replicate. Once action plans are created and agreed across the Trust, a robust formal recovery trajectory will be created to monitor delivery of plans.

Improvement Actions

1. Commencement of Cancer Recovery Meetings – held at specialty level.

2. Bi-weekly speciality level meetings to track delivery.

3. Divisional actions identified and being led by Deputy DOD.

4. Risks identified and support mitigations worked through as an MDT team.

5. Daily/Weekly reporting against the 62 in 62 process re-instated.

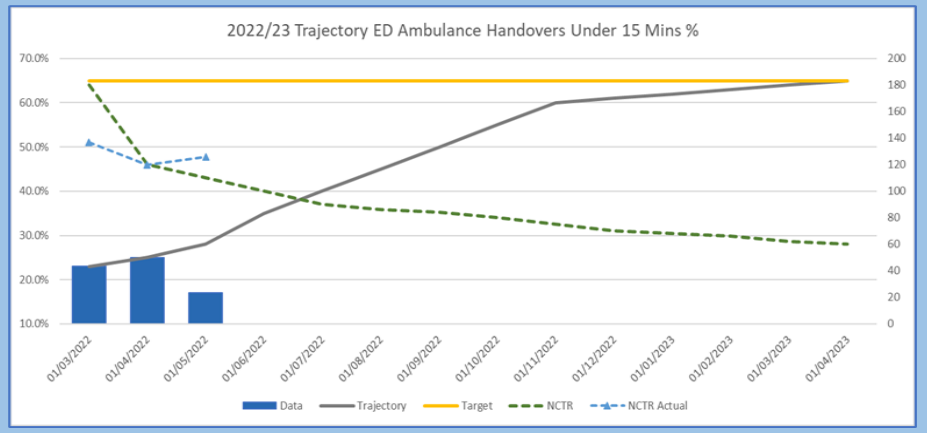
6. Long-term ambitions for a 7-day wait to initial appointment established.

Performance – Ambulance Performance < 15 Minutes

NNUH Digital Health
business intelligence

Hospital Name	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Total
Addenbrookes Hospital	42.13%	38.95%	31.43%	27.66%	29.52%	24.45%	25.13%	35.36%	34.48%	32.55%	31.87%	29.27%	25.57%	31.63%
Basildon & Thurrock Hospital	68.44%	66.29%	55.60%	54.18%	50.11%	44.82%	39.47%	35.69%	40.19%	45.17%	40.35%	26.01%	19.98%	46.93%
Bedford Hospital South Wing	57.65%	65.66%	60.42%	60.24%	53.22%	48.02%	47.45%	43.45%	43.26%	43.32%	42.32%	44.60%	38.31%	50.35%
Broomfield Hospital	44.24%	42.54%	66.86%	54.47%	47.73%	37.46%	29.57%	26.95%	30.39%	33.15%	22.51%	16.46%	19.85%	37.80%
Colchester General Hospital	33.22%	30.25%	30.88%	23.01%	14.77%	14.84%	15.13%	14.57%	16.46%	19.49%	16.94%	13.16%	11.53%	20.18%
Hinchingbrooke Hospital	23.37%	22.77%	21.05%	15.11%	13.27%	14.30%	12.56%	15.41%	12.23%	13.69%	16.04%	11.00%	11.67%	15.90%
Ipswich Hospital	39.89%	41.09%	35.26%	25.13%	27.23%	31.64%	31.20%	30.38%	27.00%	31.30%	30.32%	22.62%	21.95%	30.67%
James Paget Hospital	44.76%	36.36%	31.09%	31.93%	21.29%	24.28%	17.55%	20.92%	17.57%	22.75%	18.81%	17.34%	19.95%	26.34%
Lister Hospital	21.96%	19.20%	13.26%	14.75%	10.61%	6.90%	7.33%	7.96%	9.21%	8.32%	8.20%	5.44%	4.95%	11.28%
Luton And Dunstable Hospital	47.93%	47.89%	48.68%	46.28%	44.67%	44.18%	44.07%	38.85%	41.51%	39.37%	38.05%	36.51%	34.81%	42.84%
Norfolk & Norwich University Hospital	63.51%	57.12%	47.83%	43.56%	45.06%	34.32%	25.87%	27.1%	29.32%	26.28%	21.97%	19.51%	24.53%	38.92%
Peterborough City Hospital	18.93%	16.26%	9.83%	6.97%	4.86%	5.91%	7.45%	5.38%	5.27%	4.22%	4.55%	2.44%	4.01%	7.97%
Princess Alexandra Hospital	30.11%	25.43%	23.45%	21.50%	20.50%	19.01%	12.45%	12.78%	14.75%	17.29%	15.50%	11.99%	15.90%	18.98%
Queen Elizabeth Hospital	58.86%	52.50%	49.97%	46.31%	42%	37.76%	29.28%	32.39%	31.04%	41.41%	29.90%	20.49%	32.30%	39.86%
Southend University Hospital	21.04%	22.16%	21.53%	23.49%	19.15%	15.21%	13.93%	10.21%	13.20%	12.40%	9.79%	10.01%	13.66%	16.79%
Watford General Hospital	40.66%	34.81%	29.27%	25.90%	29.38%	28.06%	26.54%	25.17%	5.63%	6.69%	6.69%	6.70%	7.61%	24.73%
West Suffolk Hospital	52.47%	47.88%	46.01%	42.95%	41.25%	40.30%	38.41%	40.06%	36.41%	37.36%	41.34%	34.29%	36.39%	41.44%
Total	**42.88%**	**40.20%**	**37.44%**	**33.97%**	**31.35%**	**28.42%**	**25.58%**	**25.53%**	**25.27%**	**26.72%**	**24.45%**	**20.53%**	**20.95%**	**30.37%**
Rank	**2**	**3**	**6**	**6**	**4**	**7**	**9**	**8**	**8**	**9**	**10**	**9**	**6**	**7**

KPI	1. Ambulance Handover < 15 min		
Target	65%		
	Actual	Trajectory	Latest Update
Apr-22	25%	25.0%	
May-22		28.0%	
Jun-22		35.0%	Performance: Significantly improved performance from last month by 5% and on trajectory; best weekly performance in the region ranking joint 1st with Bedford
Jul-22		40.0%	
Aug-22		45.0%	
Sep-22		50.0%	Root Cause: This is directly due to the intense focus on ambulance performance, use of the trigger tool and following the reconfiguration of the ED footprint .
Oct-22		55.0%	
Nov-22		60.0%	
Dec-22		61.0%	Actions for the next period: focus on maintaining this level of improvement and reducing the variation out of hours – emphasis on early escalation and proactive management with the support of the HALO
Jan-23		62.0%	
Feb-23		63.0%	
Mar-23		65.0%	



Activity Planning – April 2022 - Forecast Against the Business Plan (Provisional)

NNUH Digital Health business intelligence

	Plan - Elective IP	Plan - Elective DC	Plan - Total	Actual Delivery - Elective IP	Actual Delivery - Elective DC	Actual Delivery - Total	% Acheivement of Plan Total	% Acheivement of Plan Elective IP	% Acheivement of Plan Elective DC
Total Elective Spells in Period	**1,149**	**8,007**	**9,157**	**911**	**7,297**	**8,207**	**89.6%**	**79.3%**	**91.1%**
Medicine	182	5,050	5,232	116	5,126	5,242	**100.2%**	**63.8%**	**101.5%**
Surgery	819	2,736	3,555	613	1,932	2,544	**71.6%**	**74.8%**	**70.6%**
W&C	148	219	368	181	232	413	**112.3%**	**122.1%**	**105.7%**
CSS	0	1	1	1	7	8	**765.6%**	**0.0%**	**669.9%**

Speciality	Plan - Elective IP	Plan - Elective DC	Plan - Total	Actual Delivery - Elective IP	Actual Delivery - Elective DC	Actual Delivery - Total	% Acheivement of Plan Total	% Acheivement of Plan Elective IP	% Acheivement of Plan Elective DC
General Surgery	111	154	264	82	126	208	**78.7%**	**74.3%**	**81.9%**
Urology	207	629	835	169	656	825	**98.8%**	**81.9%**	**104.4%**
Vascular Surgery	41	57	98	44	32	77	**77.9%**	**108.5%**	**56.2%**
Spinal Surgery	25	15	40	13	5	18	**45.5%**	**52.2%**	**34.2%**
Trauma and Orthopaedic	225	176	400	175	83	258	**64.5%**	**77.9%**	**47.3%**
Ear Nose and Throat	82	139	221	22	91	113	**51.3%**	**27.3%**	**65.3%**
Ophthalmology	3	525	528	2	202	204	**38.7%**	**63.8%**	**38.5%**
Oral Surgery	20	347	367	9	124	133	**36.4%**	**47.1%**	**35.7%**
Restorative Dentistry	0	1	1	0	0	0	**0.0%**	**0.0%**	**0.0%**
Maxillofacial Surgery	0	0	0	0	0	0	**0.0%**	**0.0%**	**0.0%**
Plastic Surgery	59	172	231	41	147	188	**81.2%**	**69.3%**	**85.3%**
Paediatric Surgery	27	32	60	14	34	48	**80.5%**	**51.3%**	**105.0%**
Thoracic Surgery	36	8	44	33	3	36	**81.9%**	**92.8%**	**35.9%**
Pain Management	0	161	161	0	115	115	**71.5%**	**0.0%**	**71.5%**
Intensive Care Medicine	0	0	0	1	0	1	**0.0%**	**0.0%**	**0.0%**
Paediatric Urology	0	0	0	0	0	0	**0.0%**	**0.0%**	**0.0%**
Paediatric Trauma and Orthopaedic	9	18	27	13	18	31	**114.0%**	**140.6%**	**99.9%**
Paediatric Ear Nose and Throat	0	8	8	2	15	17	**215.9%**	**0.0%**	**190.1%**
Paediatric Ophthalmology	0	0	0	0	5	5	**0.0%**	**0.0%**	**0.0%**
Paediatric Oral and Maxillofacial Surgery	0	0	0	0	7	7	**0.0%**	**0.0%**	**0.0%**
Paediatric Plastic Surgery	0	0	0	3	6	9	**0.0%**	**0.0%**	**0.0%**
Paediatric Gastroenterology	2	14	16	0	12	12	**76.6%**	**0.0%**	**88.3%**
Paediatric Endocrinology	1	9	10	1	18	19	**181.8%**	**95.7%**	**191.4%**
Paediatric Audio Vestibular Medicine	0	0	0	0	0	0	**0.0%**	**0.0%**	**0.0%**
Paediatric Respiratory Medicine	2	34	37	0	0	0	**0.0%**	**0.0%**	**0.0%**
Paediatric Medical Oncology	0	0	0	0	18	18	**0.0%**	**0.0%**	**0.0%**
Paediatric Rheumatology	0	7	7	0	19	19	**259.7%**	**0.0%**	**259.7%**
Paediatric Diabetes	0	0	0	0	0	0	**0.0%**	**0.0%**	**0.0%**
Paediatric Cystic Fibrosis	0	0	0	0	0	0	**0.0%**	**0.0%**	**0.0%**

Commentary

The focus on the delivery of the 104-week breaches impacted the volumes of activity through theatres due to complexity/case mix. The Surgical Division re-allocated theatre sessions to the W&C Division to allow Gynaecology to meet the 104-week requirement.

Activity Planning – April 2022 - Forecast Against the Business Plan (Provisional)

NNUH Digital Health
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							% Acheivement of Plan		
	Plan - Elective IP	Plan - Elective DC	Plan - Total	Actual Delivery - Elective IP	Actual Delivery - Elective DC	Actual Delivery - Total	Total	Elective IP	Elective DC
Speciality									
General Internal Medicine	0	0	0	0	0	0	0.0%	0.0%	0.0%
Gastroenterology	36	1,868	1,904	11	1,808	1,820	95.6%	31.8%	96.8%
Endocrinology	2	3	5	1	5	6	111.6%	39.9%	159.5%
Clinical Haematology	39	820	859	16	824	840	97.8%	41.7%	100.5%
Blood and Marrow Transplantation	1	17	18	0	0	0	0.0%	0.0%	0.0%
Palliative Medicine	0	1	1	0	0	0	0.0%	0.0%	0.0%
Cardiology	29	273	302	21	244	265	87.8%	71.9%	89.5%
Paediatric Cardiology	0	0	0	0	0	0	0.0%	0.0%	0.0%
Stroke Medicine	0	0	0	0	0	0	0.0%	0.0%	0.0%
Transient Ischaemic Attack	0	1	1	0	0	0	0.0%	0.0%	0.0%
Dermatology	3	327	330	2	297	299	90.5%	63.8%	90.8%
Congenital Heart Disease	0	0	0	0	0	0	0.0%	0.0%	0.0%
Respiratory Medicine	14	85	98	10	86	96	97.3%	70.6%	101.6%
Respiratory Physiology	2	0	2	0	0	0	0.0%	0.0%	0.0%
Adult Cystic Fibrosis	3	0	3	0	0	0	0.0%	0.0%	0.0%
Infectious Diseases	0	0	0	0	0	0	0.0%	0.0%	0.0%
Renal Medicine	26	28	54	26	51	77	141.5%	100.7%	179.2%
Neurology	3	54	57	0	125	125	217.5%	0.0%	230.0%
Clinical Neurophysiology	1	1	2	0	0	0	0.0%	0.0%	0.0%
Rheumatology	0	176	176	0	203	203	115.6%	0.0%	115.6%
Paediatrics	5	41	46	0	29	29	63.1%	0.0%	71.2%
Paediatric Neurology	0	0	0	0	1	1	0.0%	0.0%	0.0%
Neonatal Critical Care	0	0	0	0	0	0	0.0%	0.0%	0.0%
Well Baby	0	0	0	0	0	0	0.0%	0.0%	0.0%
Elderly Medicine	0	3	3	1	11	12	366.8%	0.0%	350.9%
Obstetrics	0	0	0	62	0	62	0.0%	0.0%	0.0%
Gynaecology	111	82	192	104	101	205	106.8%	94.1%	123.9%
Midwifery	0	0	0	0	0	0	0.0%	0.0%	0.0%
Clinical Oncology	26	1,720	1,746	30	1,769	1,799	103.0%	116.3%	102.8%
Interventional Radiology	0	1	1	1	7	8	765.6%	0.0%	669.9%

Activity Planning – April 2022 - Forecast Against the Business Plan (Provisional)

NNUH Digital Health
business intelligence

	Plan - First	First - Face to Face	First - Telephone	First - Video	% Achievement of Plan First
Total Outpatient Attendances	**21,991**	**14,179**	**2,656**	**427**	**78.5%**
Medicine	6,256	3,297	994	22	68.9%
Surgery	11,787	8,523	1,175	32	82.5%
W&C	2,583	1,864	172	214	87.1%
CSS	1,349	490	316	159	71.5%

	Plan - First	First - Face to Face	First - Telephone	First - Video	% Achievement of Plan First
General Surgery	1,129	1,137	271	0	124.8%
Urology	1,356	943	420	0	100.5%
Vascular Surgery	158	133	3	0	86.2%
Spinal Surgery	177	90	4	0	53.0%
Trauma and Orthopaedic	1,481	1,205	55	0	85.1%
Ear Nose and Throat	1,365	970	114	1	79.5%
Ophthalmology	1,832	1,235	5	7	68.1%
Oral Surgery	534	274	0	0	51.3%
Restorative Dentistry	5	5	0	0	95.7%
Orthodontic	40	49	0	0	123.4%
Maxillofacial Surgery	27	22	0	0	81.0%
Neurosurgical	0	0	0	0	0.0%
Plastic Surgery	315	278	3	0	89.2%
Paediatric Surgery	239	164	10	6	75.2%
Thoracic Surgery	26	17	0	0	65.1%
Emergency Medicine	15	5	0	0	34.2%
Anaesthetic	14	0	0	0	0.0%
Pain Management	140	69	91	0	114.3%
Intensive Care Medicine	0	0	0	0	0.0%
Paediatric Urology	20	14	6	0	100.0%
Paediatric Trauma and Orthopaedic	257	84	173	1	100.4%
Paediatric Ear Nose and Throat	209	107	19	0	60.1%
Paediatric Ophthalmology	181	136	0	2	76.3%
Paediatric Oral and Maxillofacial Surgery	0	0	0	0	0.0%
Paediatric Plastic Surgery	21	15	0	0	71.8%
Paediatric Intensive Care	0	0	0	0	0.0%
Paediatric Gastroenterology	47	34	0	0	72.3%
Paediatric Endocrinology	24	24	1	1	108.2%
Paediatric Clinical Haematology	4	2	1	0	71.8%
Paediatric Audio Vestibular Medicine	248	221	0	0	89.2%
Paediatric Dermatology	31	36	0	0	114.8%
Paediatric Respiratory Medicine	20	17	6	0	115.8%
Paediatric Medical Oncology	1	0	0	0	0.0%
Paediatric Rheumatology	29	9	0	0	30.8%
Paediatric Diabetes	3	1	0	0	31.9%
Paediatric Cystic Fibrosis	0	0	0	0	0.0%

Commentary

Most outpatient areas under-performed with only a handful of specialities delivering the 110% standard. The removal of the COVID-19 restrictions mid-month will help Divisions increase throughput in May 2022.

Activity Planning – April 2022 - Forecast Against the Business Plan (Provisional)

NNUH Digital Health
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	Plan - First	First - Face to Face	First - Telephone	First - Video	% Achievement of Plan First
General Internal Medicine	501	364	0	0	72.7%
Gastroenterology	653	87	192	0	42.7%
Endocrinology	185	101	1	0	55.1%
Clinical Haematology	459	461	19	8	106.4%
Clinical Physiology	188	107	0	0	56.9%
Hepatology	135	60	14	0	54.9%
Diabetes	302	124	111	13	82.1%
Blood and Marrow Transplantation	0	3	0	0	0.0%
Audio Vestibular Medicine	146	115	8	21	98.4%
Clinical Genetics	15	0	0	0	0.0%
Palliative Medicine	302	204	2	0	68.3%
Allergy	2	1	4	0	261.0%
Cardiology	704	407	107	1	73.1%
Paediatric Cardiology	0	28	1	0	0.0%
Stroke Medicine	0	0	0	0	0.0%
Transient Ischaemic Attack	100	86	18	0	103.6%
Dermatology	1,186	897	0	0	75.6%
Congenital Heart Disease	0	12	4	0	0.0%
Respiratory Medicine	216	186	37	0	103.1%
Respiratory Physiology	75	7	110	0	155.6%
Adult Cystic Fibrosis	1	0	0	0	0.0%
Infectious Diseases	0	0	140	0	0.0%
Renal Medicine	82	30	5	0	42.6%
Medical Oncology	0	0	0	0	0.0%
Neurology	505	306	32	0	66.9%
Clinical Neurophysiology	322	249	0	0	77.4%
Rheumatology	397	247	1	0	62.4%
Paediatrics	451	204	151	0	78.6%
Paediatric Neurology	36	57	0	0	160.4%
Neonatal Critical Care	0	0	0	0	0.0%
Well Baby	0	0	0	0	0.0%
Elderly Medicine	125	63	1	0	51.0%
Obstetrics	570	339	0	207	95.9%
Gynaecology	1,112	929	2	0	83.7%
Gynaecological Oncology	47	57	0	0	121.2%
Midwifery	0	0	0	0	0.0%

	Plan - First	First - Face to Face	First - Telephone	First - Video	% Achievement of Plan First
Physiotherapy	623	306	166	101	92.1%
Occupational Therapy	351	110	30	27	47.6%
Speech and Language Therapy	37	8	10	11	78.5%
Podiatry	117	78	0	0	66.6%
Dietetics	302	47	105	19	56.5%
Clinical Psychology	0	0	0	0	0.0%
Orthotics	205	53	0	0	25.9%
Child and Adolescent Psychiatry	19	5	1	1	37.2%
Medical Psychotherapy	0	0	0	0	0.0%
Clinical Oncology	1,075	223	200	0	39.3%
Interventional Radiology	3	13	3	0	510.4%
Diagnostic Imaging	0	0	1	0	0.0%
Chemical Pathology	0	0	0	0	0.0%
Audiology	496	310	0	0	62.5%

Supplementary Report

Non-Elective Care

Non-Elective Summary Overview

NNUH Digital Health
business intelligence

NNUH Non-Elective Recovery & Improvement Plan 2022/23 - Current Performance Position from BI Report dated 1/5/22

Core Clinical Review Standards

KPI	1. Ambulance Handover <15 min			2. Ambulance Handover <30 min			3. Ambulance Handover <60 min			4. Initial Assessment <15 mins			5. Admitted within 1 hour of clinically ready to proceed			6. Total Time in ED <12 hours			7. Average Time in ED (Non-Adm)			8. 4hr Standard		
Target	65% (N)			95% (N)			<5% (N)			100% (N)			100% (N)			>98% (N)			<220 min (N)			95% (N)* Being phased out		
	Actual	Trajectory	April	Actual	Trajectory	April	Actual	Trajectory	April	Actual	Trajectory	April	Actual	Trajectory	April	Actual	Trajectory	April	Actual	Trajectory	April	Actual	Trajectory	April
Apr-22	25.0%	25.0%		52.0%	50.0%		30%	32.0%		36.6%	31.7%		30.4%	19.2%		93.6%	88.4%		241	293		71.9%	63.90%	
May-22		28.0%			54.0%			28.0%			40.0%			24.0%			89.0%			290			64.00%	
Jun-22		35.0%			62.0%			25.0%			49.0%			30.0%			90.0%			286			66.00%	
Jul-22		40.0%	On trajectory due to ED space reconfiguration and reduction in pathway 1 - 3 delayed discharges		69.0%	On trajectory - focus on early intervention has supported improved position		20.0%	Follows same pattern as 15 and 30 min as on plan; trigger systems used along with cat 2 rapid release		62.0%	Better than trajectory with a clear focus on ensuring early review of patients to stream to other services. Safety Nurse will continue to prioritise this standard		38.0%	Significantly better than trajectory - whole hospital focus on pulling people out of the department with proactive escalation from ED		90.5%	Well above trajectory linked to the improvement in CRTP performance. ED Flow admin roles focus on unblocking delays		280	1 min off the 4hr standard and significant reduction of nearly an hour overall in 1 month; new ways of working and physical space supporting		68.00%	Achieved a figure over 70% for the first time since September 2020; new layout and less exit block supporting this
Aug-22		45.0%			75.0%			16.0%			68.0%			49.0%			91.0%			275			70.00%	
Sep-22		50.0%			80.0%			12.0%			76.0%			57.0%			92.0%			270			72.00%	
Oct-22		55.0%			84.0%			10.0%			80.0%			70.0%			94.0%			261			76.00%	
Nov-22		60.0%			88.0%			9.0%			86.0%			78.0%			95.0%			250			78.00%	
Dec-22		61.0%			91.0%			8.0%			89.0%			87.0%			96.0%			240			85.00%	
Jan-23		62.0%			92.0%			8.0%			95.0%			94.0%			97.0%			232			89.00%	
Feb-23		63.0%			93.0%			7.0%			98.0%			98.0%			97.5%			228			91.00%	
Mar-23		65.0%			95.0%			5.0%			100.0%			100.0%			98.0%			220			95.00%	

Non-elective Improvement Additional Internal KPIs

KPI	9. SDEC Activity as total of emergency presentations excl. ED			10. Average Time in ED (Adm)			11. Virtual Ward Activity			12. Average LOS			13. Pathway Zero NC2R			14. GP Streaming			15. D2A 1 - 3 Patients NC2R (now <6.5% of bed base, was 2.5%)			16. Discharges Before 12 Noon		
Target	30% (N) Local 60%			<220 min(N)			Avg. 60 Patients (L)			4.5 (L)			50 (L)			28% (L) - System KPI			60 (L) - System KPI			25% (N)		
	Actual	Trajectory	April	Actual	Trajectory	April	Actual	Trajectory	April	Actual	Trajectory	April	Actual	Trajectory	April	Actual	Trajectory	April	Actual	Trajectory	April	Actual	Trajectory	April
Apr-22	53.0%	53.10%		519	635		14	20		4.9	5.4		40	68		18.6%	15%		120	120		22%	14%	
May-22		53.00%	On trajectory but acuity has been high reflecting lower suitable patients; NHSEI site visit on 23 May to commence expansion plans		625	Reduced average wait time by 2hrs as a result of improved flow enabling ED to be more effective		25	Generally acuity has risen and it has proven challenging to find more patients ready to be transferred onto virtual ward. Team expanding criteria to front door and admission avoidance; being embedded in R2G reviews		5.4	Improvement mainly due to drive on more effective R2G and divisional focus on C2R and increasing pathway zero discharges		67	Fully achieved trajectory target reduction		16%	Changes to criteria and focus on increasing numbers seen has driven improvement of over 3%. ED to oversee service as BAU whilst UTC work is refined		110	A significant improvement has been seen as we had risen back up to December levels of 166 patients on the backlog. Whole system focus on recovery		15%	On track with trajectory - trigger system driving earlier discharges and new discharge suite area open
Jun-22		54.00%			620			30			5.3			66			17%			100			16%	
Jul-22		54.50%			613			32			5.2			65			18%			90			17%	
Aug-22		55.00%			599			35			5.1			64			19%			86			18%	
Sep-22		56.00%			580			41			5			63			20%			84			19%	
Oct-22		56.50%			542			46			4.9			62			22%			80			20%	
Nov-22		57.00%			500			49			4.8			61			24%			75			21%	
Dec-22		57.50%			402			54			4.8			60			25%			70			22%	
Jan-23		58.00%			300			56			4.7			58			26%			68			23%	
Feb-23		59.00%			240			58			4.6			55			27%			66			24%	
Mar-23		60.00%			220			60			4.5			50			28%			60			25%	

Non-Elective Recovery Plan Action Update

NNUH Digital Health
business intelligence

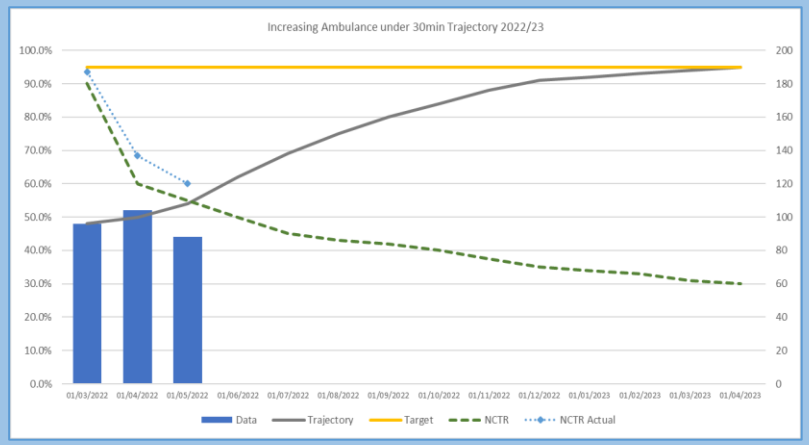
NNUH Non-Elective Core Activities 2022 - 23 (Recovery, Winter & Resilience Planning)								
	Action	Pathway	SRO	Deputy SRO	Delivery Lead	Due this period	Progress Update	RAG
1	PAU Medical Model - step 1: adopt new KPIs step 2: open	In	ED	CJ	DMu	No	Clinical reference group developing pathways - looking at how we incorporate frailty as well currently but good clinical engagement . Still work to do but currently on track for the step 1 target	G
2	Reinstate Discharge Suite Phase 1 then enhance phase 2	Out	CC	CP	TM	Yes - part 1 complete	New area opened April as planned also looking at solution for ED	G
3	ED Reconfiguration - Phase 1	In	ED	TL	LLF	Yes - part 1 complete	Went live for main changes on 14th April as planned; phase 2 not due until end of May and is on track as work is underway	G
4	UTC Developments	In	ED	LH & CK	LW	No	NHSEI Meeting held - awaiting new national guidance to be released so all other work on pause	A
5	SAFER Bundle - Launch and rollout CLD/EDDs/EDLs	Through	NF	RC	MC	No	Commenced peer reviews in Medicine and CLD digital development started	G
6	Centralised Bed Management - Go Live phase	Through	NF	RC	MC	No	Out to recruitment for B4 Bed Managers - operating model drafted	G
7	OT D2A Service - Commence	Out	CC	CP	KR	No	Recruitment underway for interim model - NHSEI facilitated workshop held and agreed model and approach	G
8	Discharge Hub Model - Launch electronic ToC & new roles	Out	CC	CP	CF	No	ToC due to go live in month, out to recruitment for more DISCOs	G
9	Surgical SDEC Expansion - Launch new pathways	In	ED	BB	LE	No	To be part of NHSEI supported plan - on site w/c 23rd May	A
10	Medical SDEC Redesign - New access pathways	In	ED	BB	EM	No	To be part of NHSEI supported plan - on site w/c 23rd May	A
11	HomeFirst Unit - ongoing model go live	Out	CC	CP	TF	No	Recruitment started - linked to bed modelling, PID in progress	A
12	Ambulance Cohort Service - 24/7 model	In	ED	TL	CH	No but complete	Dedicated cohort in ED in place with reservist model	G
13	Space and Bed base review	ALL	CC	CP	ALL	Yes - Started	Commenced - template with divisions for review; outputs to HMB in May	G
14	Review and incorporate NHSEI 'in' recommendations	ALL	CC	CP	CH	Yes - Started	Meeting with NHSEI scheduled work to amalgamate started	G
15	Virtual ward long term model	Out	CC	CP	SG	No	Ongoing action underway - looking at front door admission avoidance and medical models	G
16	Centralised NEPTS model	Out	CC	CP	CH	No	Meeting with CCG and ERS - test of change to commence next month	G
17	ChED, CAU & Paed SDEC	In	ED	CK	CT	Yes - Started	Linked to ED reconfiguration - joint meetings commenced	A
18	Roll out 7 day services standards	ALL	CC	CP	CH	Yes - Started	Need to incorporate into other workstreams - desktop review underway	A
19	Diagnostic Imaging IPS and recovery plan	Through	NF	RC	SM	Yes - Started	Initial minor works to increase capacity completed. Detailed plan being worked up with divisions	A

Performance – Ambulance Performance < 30 Minutes

NNUH Digital Health business intelligence

Hospital Name	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-2i	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Total
Addenbrookes Hospital	92.18%	89.21%	78.60%	70.58%	70.93%	68.39%	68.20%	81.17%	82.11%	77.44%	78.25%	70.00%	71.65%	77.15%
Basildon & Thurrock Hospital	97.35%	97.44%	93.46%	92.43%	87.39%	83.89%	83.33%	76.09%	82.67%	89.63%	80.36%	64.68%	60.36%	85.26%
Bedford Hospital South Wing	96.53%	98.07%	95.33%	93.55%	92.85%	88.70%	86.91%	80.14%	84.71%	83.54%	83.70%	87.48%	81.10%	88.99%
Broomfield Hospital	97.15%	97.79%	98.42%	90.02%	87.67%	75.22%	72.20%	65.59%	71.65%	72.52%	62.17%	49.42%	55.58%	78.35%
Colchester General Hospital	98.44%	98.29%	97.78%	89.50%	77.02%	82.29%	84.08%	79.11%	80.89%	88.00%	84.08%	74.02%	76.50%	86.11%
Hinchingbrooke Hospital	78.80%	76.56%	68.39%	58.54%	48.34%	51.75%	52.79%	55.30%	49.10%	56.88%	54.63%	42.14%	51.95%	58.13%
Ipswich Hospital	92.12%	92.03%	87.98%	80.40%	79.63%	80.99%	75.25%	77.71%	74.77%	72.01%	71.90%	67.17%	72.71%	79.34%
James Paget Hospital	91.73%	84.97%	80.15%	82.07%	68.89%	71.15%	57.13%	72.69%	65.83%	67.87%	55.03%	54.23%	57.76%	72.14%
Lister Hospital	82.58%	84.51%	70.23%	67.51%	60.68%	52.60%	45.81%	51.58%	55.14%	49.45%	50.75%	41.01%	31.25%	59.17%
Luton And Dunstable Hospital	88.36%	89.78%	91.38%	90.02%	86.62%	84.69%	85.09%	80.29%	81.42%	80.95%	78.10%	79.12%	78.61%	84.51%
Norfolk & Norwich University Hospit	93.03%	86.88%	81.62%	77.23%	80.10%	65.44%	57.90%	57.45%	60.03%	54.91%	46.49%	43.24%	51.25%	69.41%
Peterborough City Hospital	77.58%	65.26%	48.83%	41.77%	38.15%	41.16%	48.27%	38.10%	39.20%	36.91%	37.48%	28.28%	33.89%	45.80%
Princess Alexandra Hospital	70.96%	66.52%	61.97%	59.38%	59.62%	50.64%	41.76%	45.70%	47.16%	50.78%	44.81%	40.62%	50.69%	53.96%
Queen Elizabeth Hospital	87.72%	78.07%	79.95%	72.95%	70.72%	66.75%	56.37%	59.53%	59.28%	72.84%	61.41%	43.66%	62.47%	68.09%
Southend University Hospital	89.75%	87.87%	84.96%	85.76%	83.09%	70.71%	68.41%	57.38%	64.61%	56.70%	49.09%	40.76%	45.92%	71.60%
Watford General Hospital	85.40%	83.36%	76.66%	70.88%	72.03%	75.18%	72.30%	69.32%	57.35%	55.64%	50.89%	52.36%	54.01%	71.01%
West Suffolk Hospital	93.94%	93.24%	91.31%	89.30%	91.84%	89.28%	84.66%	87.54%	88.38%	88.57%	91.07%	85.17%	89.28%	89.61%

KPI	2. Ambulance Handover < 30 min		
Target	95%		
	Actual	Trajectory	Latest Update
Apr-22	52.%	50.0%	Performance: Improvement on the 45% reported last month and just ahead of trajectory despite a poor start to the week on the bank holiday, which has negatively impacted the regional ranking placing us 7th out of the 17 Trusts for that weekend but normally we do achieve over 50% and rank in the top 5 Root cause: same as the 15min standard but with enhanced early escalation to proactively release crews; challenges impacting performance has been EEAST staff to open cohort but reservists now in place Actions next period: maintain position and work to eliminate avoidable delivery as had a number of patients where we missed by minutes (earlier calling of crews if they cannot come straight in)
May-22		54.0%	
Jun-22		62.0%	
Jul-22		69.0%	
Aug-22		75.0%	
Sep-22		80.0%	
Oct-22		84.0%	
Nov-22		88.0%	
Dec-22		91.0%	
Jan-23		92.0%	
Feb-23		93.0%	
Mar-23		95.0%	



Performance – Ambulance Performance > 60 Minutes

NNUH Digital Health business intelligence

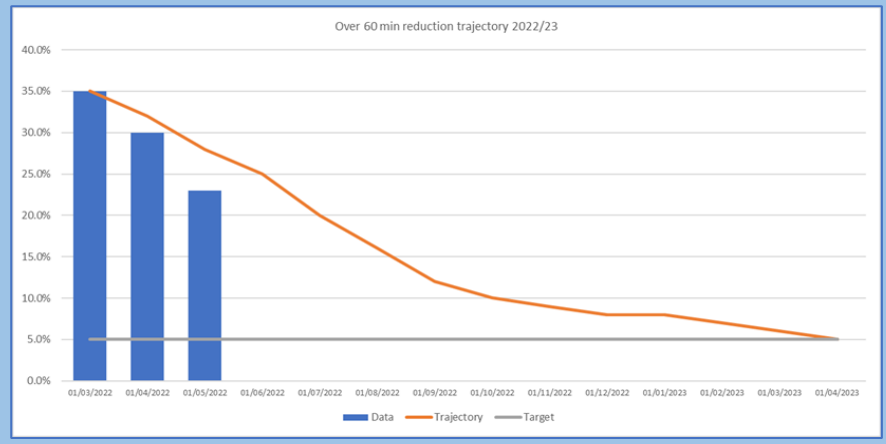
Hospital Name	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	Total
Addenbrookes Hospital	1.37%	1.72%	6.22%	13.31%	11.89%	13.99%	12.52%	6.19%	4.74%	7.66%	6.73%	13.06%	11.98%	8.38%
Basildon & Thurrock Hospital	0.32%	0.41%	0.78%	1.83%	4.33%	4.95%	4.51%	8.05%	5.47%	2.10%	6.77%	16.13%	18.68%	5.00%
Bedford Hospital South Wing	1.30%	0.34%	1.29%	1.96%	1.91%	5.17%	5.17%	9.03%	6.28%	7.38%	5.62%	4.38%	7.97%	4.29%
Broomfield Hospital	0.40%	0.04%	0.12%	3.70%	3.12%	10.68%	12.41%	15.42%	11.82%	13.79%	20.74%	27.16%	24.47%	10.07%
Colchester General Hospital	0.17%	0.33%	0.23%	2.46%	8.30%	7.52%	4.95%	6.09%	5.64%	2.26%	4.01%	8.60%	6.62%	4.17%
Hinchingbrooke Hospital	4.34%	5.51%	9.10%	16.48%	26.78%	18.45%	18.04%	18.97%	22.39%	15.75%	20.10%	30.65%	19.94%	16.84%
Ipswich Hospital	1.73%	1.51%	3.12%	4.65%	5.84%	7.26%	10.87%	9.15%	10.57%	14.49%	11.15%	14.91%	12.41%	7.96%
James Paget Hospital	2.11%	5.65%	7.46%	8.05%	17.63%	15.52%	25.99%	13.72%	17.78%	16.97%	27.88%	29.66%	23.97%	14.76%
Lister Hospital	5.36%	3.57%	9.97%	12.80%	16.17%	20.34%	25.64%	21.45%	17.96%	21.64%	17.65%	23.72%	36.20%	16.81%
Luton And Dunstable Hospital	1.59%	1.81%	1.19%	1.59%	2.59%	4.44%	3.76%	7.28%	6.49%	6.95%	8.38%	9.21%	8.50%	4.71%
Norfolk & Norwich University Hospital	0.83%	2.41%	5.16%	8.22%	7.67%	18.49%	23.18%	23.89%	22.29%	27.70%	36.78%	38.70%	31.59%	16.10%
Peterborough City Hospital	4.16%	13.04%	25.40%	29.64%	32.31%	27.46%	21.58%	32.66%	28.78%	31.54%	33.01%	38.57%	36.52%	26.15%
Princess Alexandra Hospital	8.93%	10.09%	17.88%	17.96%	15.25%	23.90%	30.33%	29.07%	26.88%	25.12%	31.26%	34.62%	20.87%	21.73%
Queen Elizabeth Hospital	4.52%	10.04%	9.04%	13.47%	17.02%	19.16%	26.85%	26.30%	27.87%	0.1396	21.74%	44.30%	25.14%	19.02%
Southend University Hospital	0.89%	2.07%	2.75%	3.10%	4.95%	8.72%	13.31%	17.18%	15.96%	23.74%	29.70%	35.01%	33.10%	12.17%
Watford General Hospital	3.84%	4.24%	7.20%	10.60%	11.07%	8.99%	10.68%	10.68%	11.97%	10.57%	12.85%	12.36%	11.07%	9.01%
West Suffolk Hospital	0.32%	0.69%	1.38%	2.72%	0.94%	3.19%	5.34%	4.33%	3.43%	3.12%	2.65%	4.98%	2.40%	2.66%

KPI	3. Ambulance Handover > 60 min		
Target	5%		
	Actual	Trajectory	Latest Update
Apr-22	30.2%	32.0%	
May-22		28.0%	
Jun-22		25.0%	
Jul-22		20.0%	
Aug-22		16.0%	
Sep-22		12.0%	
Oct-22		10.0%	
Nov-22		9.0%	
Dec-22		8.0%	
Jan-23		8.0%	
Feb-23		7.0%	
Mar-23		5.0%	

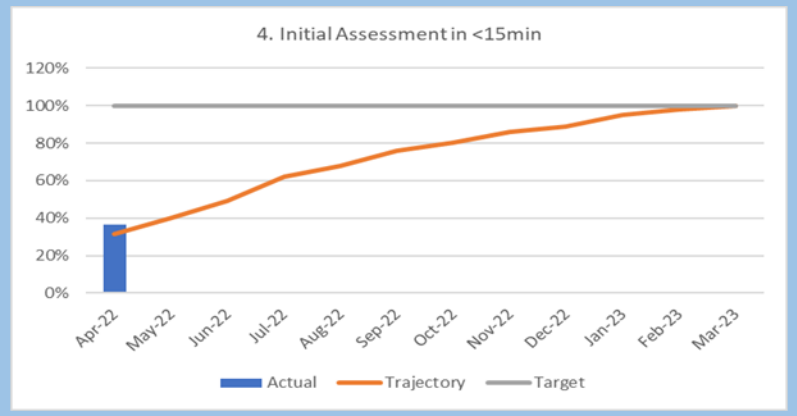
Performance: month on month and weekly improvement seen and also slightly ahead of trajectory; ranking 12th out of 17 compared to previous months when we were bottom

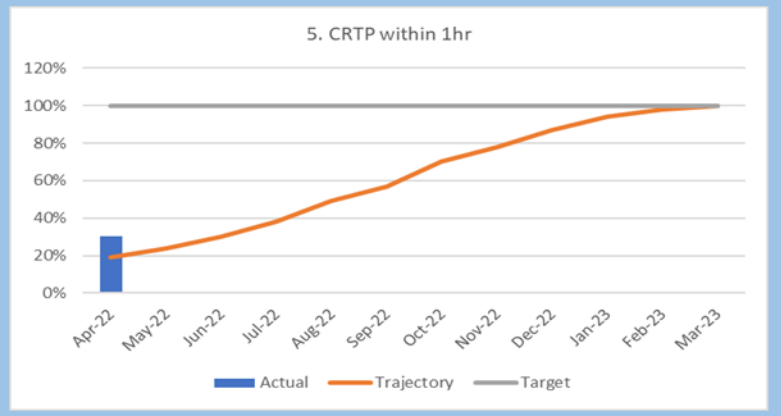
Root Cause: proactive escalation/interventional management and use of cohort areas alongside the <15 & 30 min actions

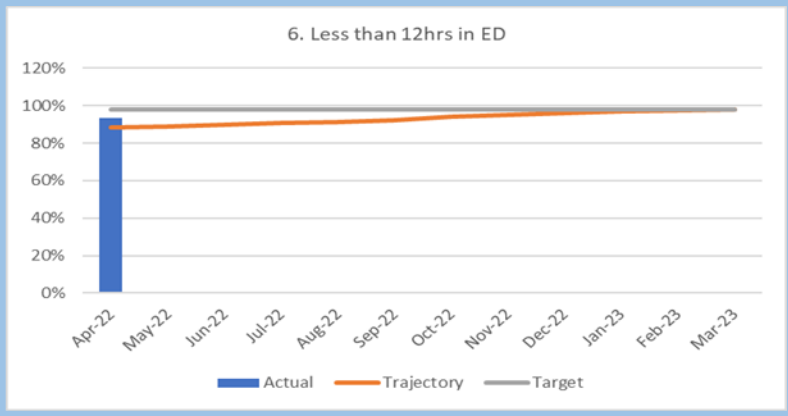
Actions for next week: smooth the peaks and further reduce the total volume of breaches plus a focus on reducing the length of time for patients that we have failed to receive as a quality priority

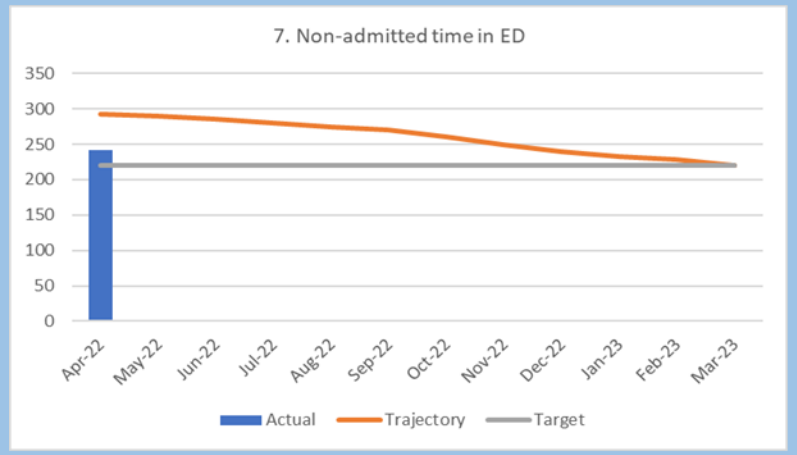


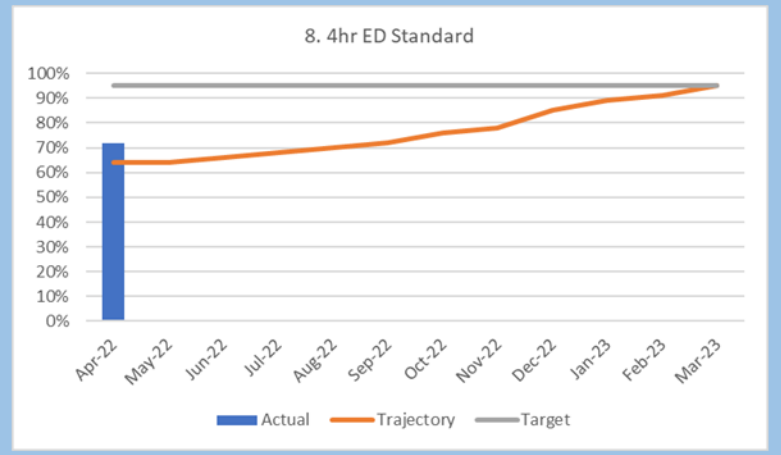
Performance – ED Performance

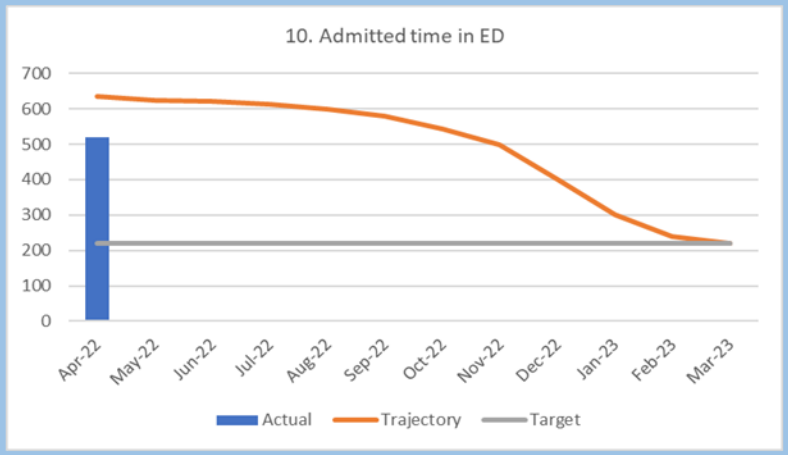










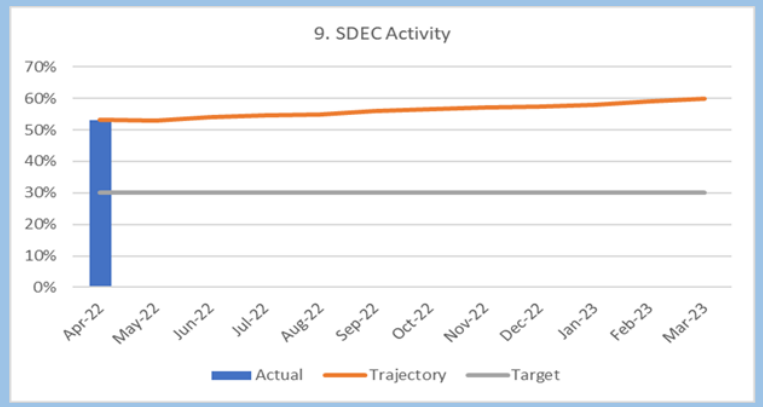


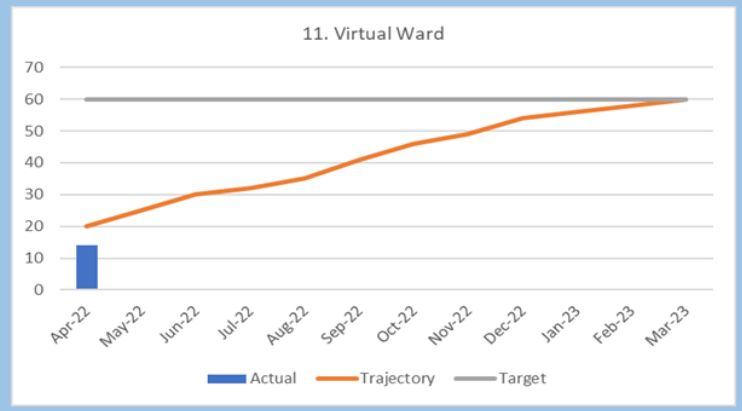
Performance: Ahead of trajectory for all of these standards with a significant reduction seen in the total average time for patient journeys in ED for admitted and non-admitted

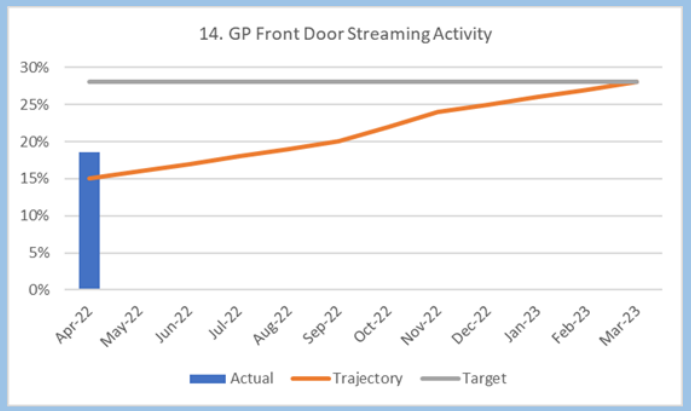
Root Cause: The use of the trigger tool to identify potential delays earlier and responsive action to decompress has assisted the improvements along with reconfiguring the ED

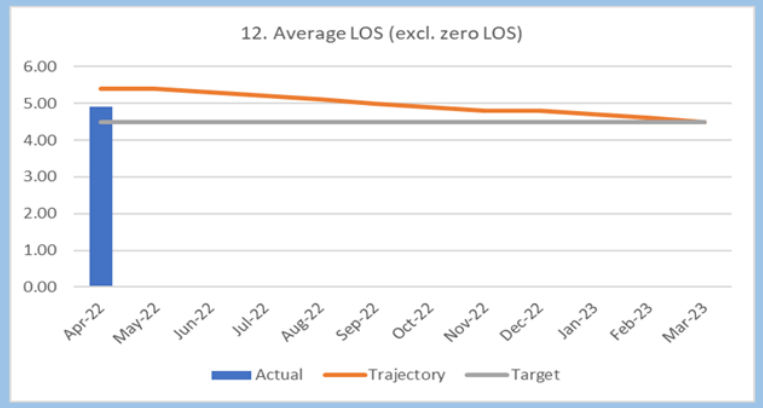
Actions for next period: Main focus is further reducing the total time in ED and working towards a zero tolerance approach to over 12hrs; this will drive improvements across all of the other standards. ED Flow Admin roles to be better utilised to track patients journeys and the NHSEI Improvement Team coming to work alongside the teams w/c 23rd May

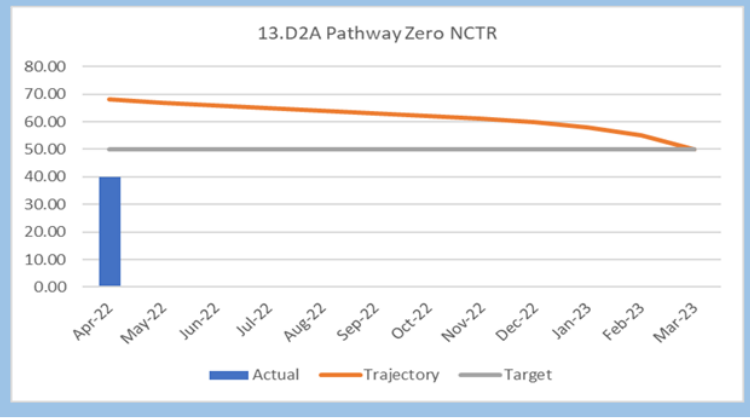
Performance – Through & Out: Alternative Pathways & Discharge

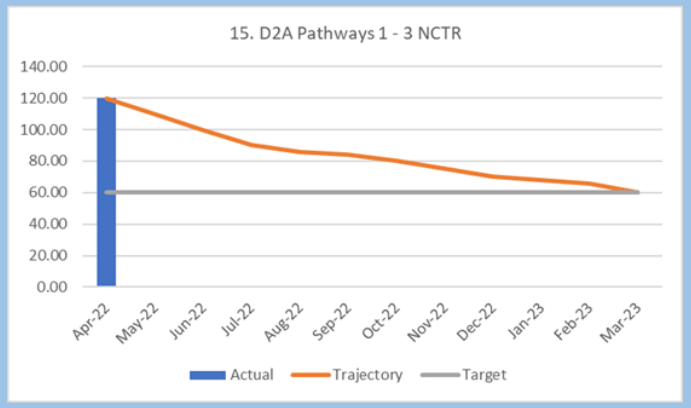










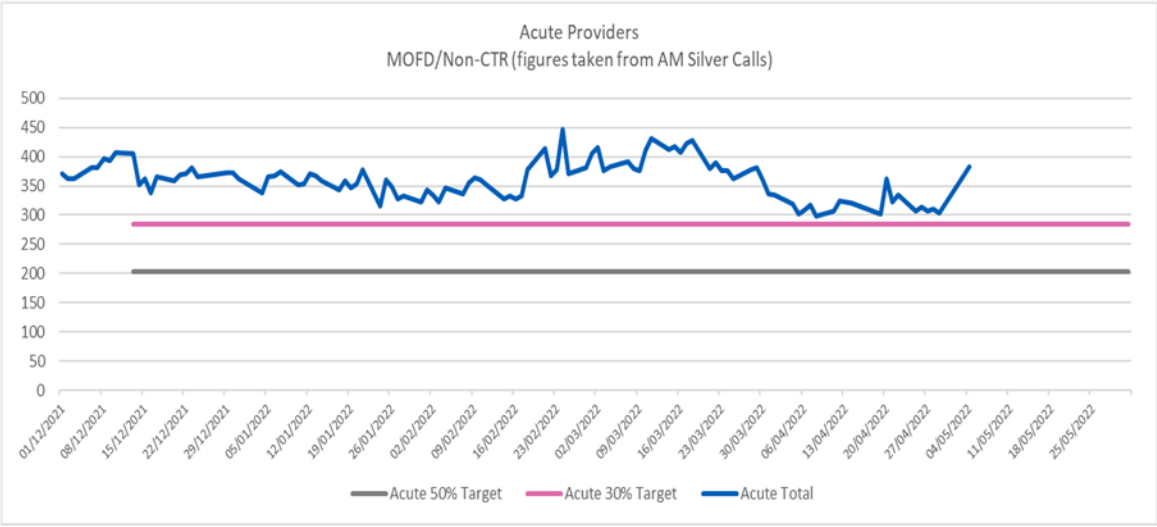


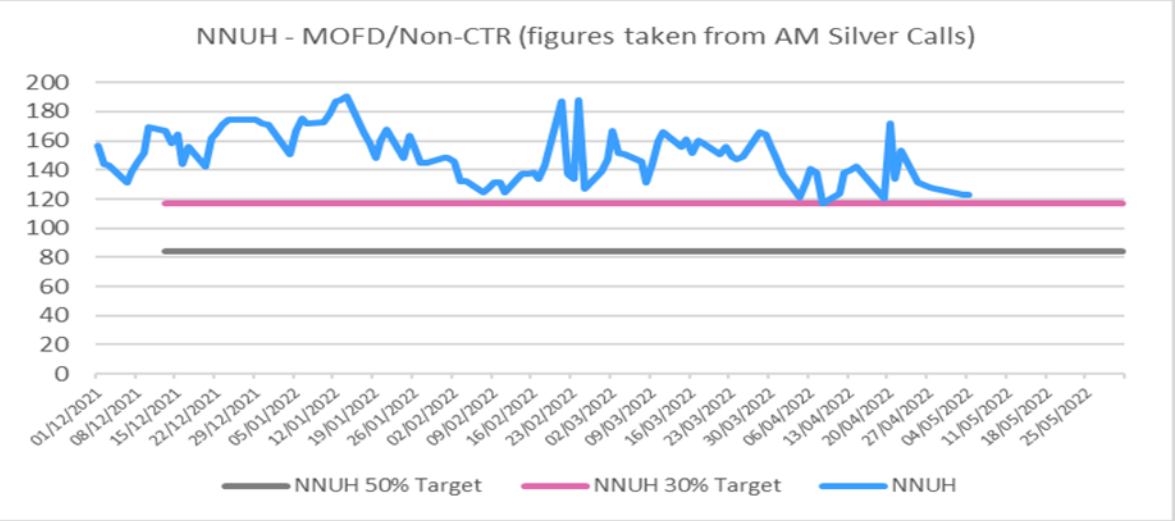
Performance: Ahead of trajectory for all areas except Virtual Ward, which is below where it should be; most significant improvement is reduction in pathway zero discharges

Root Cause: Acuity is high and covid activity reducing so fewer patients suitable for Virtual Ward with current criteria. Improvements are linked to push on discharge internally and externally

Actions for next period: Expand VW criteria to include front door. NHSEI on site in May to commence SDEC pathway improvements. Bed modelling to be completed for next month including LOS reduction plans

Performance – Criteria to Reside





D2A Pathway Counts: Patients with No Criteria to Reside

D2A Pathway	D2A Pathway Count	%
0	56	30%
1	34	19%
2	72	40%
3	7	3%
TBA	14	8%
TOTAL	**182**	**30/70 Split**

Commentary

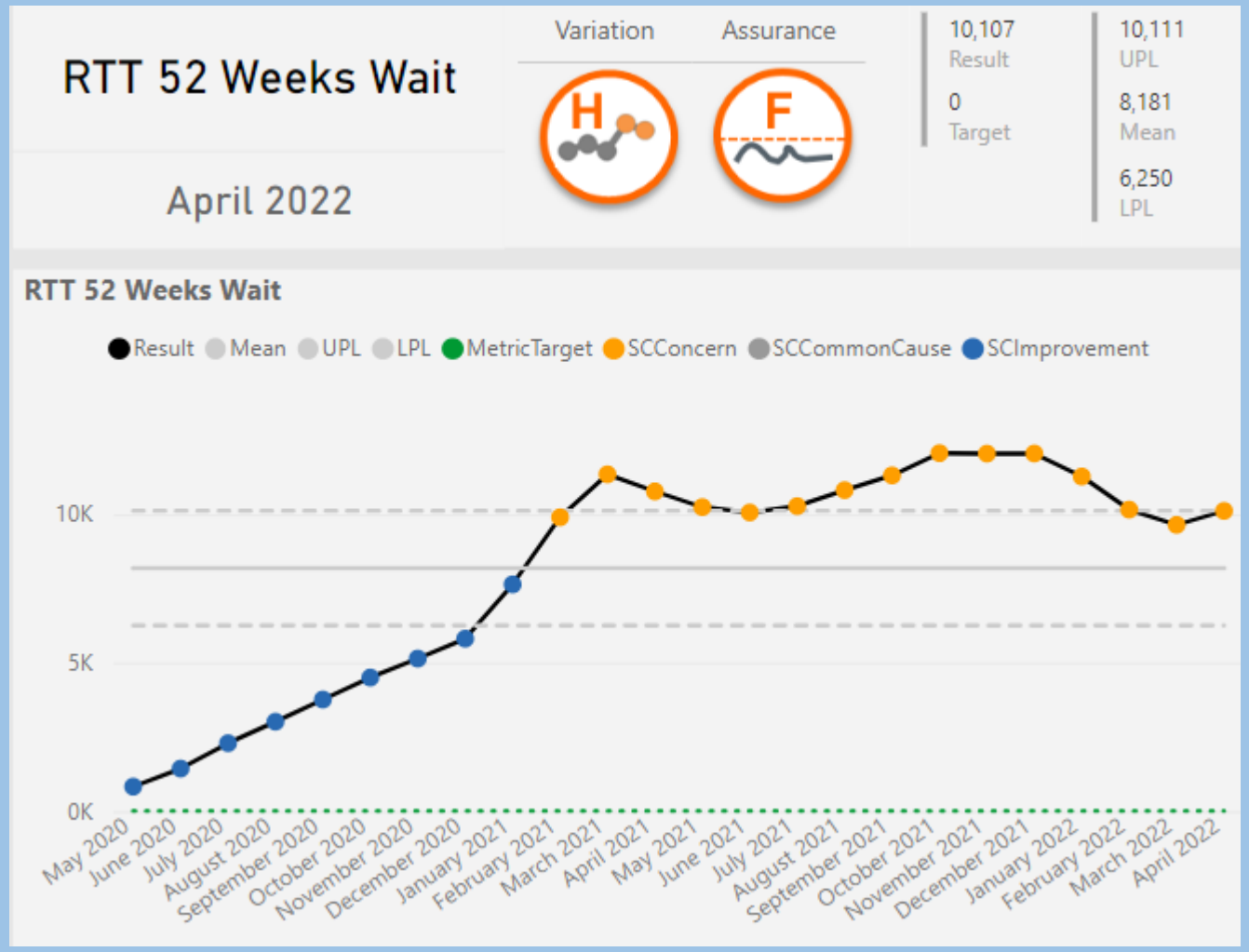
Performance: The top charts are taken from the ICS Gold Group Dashboard and show the overall number of patients without a criteria to reside as a system and for NNUH - we have seen a reduction in Central Norfolk, just meeting the initial 30% reduction. However, this fluctuates and is not yet a sustainable improvement, meaning that further work is required to deliver the May 2022 end of month target of 110. Positively, we have seen a significant improvement in pathways zero and 1 and the NNUH compliance with reporting CTR has sustained at the 80% target.

Root Cause: Internally, we have introduced Band 5 roles to support better quality Transfer of Care Forms and also introduced a number of better digital tracking processes to target more timely discharge. Externally, the Central Norfolk UEC Lead has been proactively supporting us to escalate and address specific pathway delays.

Actions for the Next Period: NNUH has signed up to be one of the ECIST sites for rolling out Criteria Led Discharge against their latest improvement model; workshop planned for late May 2022. The digital version of the ToC will go live and NHSE/I are facilitating a task and finish group between NNUH and NCHC specifically around the OT assessment model and demand modelling, so the CCG can commission the right level/type of onward capacity.

Elective Care

Performance – RTT 52 Week Breaches



Commentary

April 2022 Performance

There has been a slight increase in the number of 52 week+ breaches in April.

Current performance:

Surgical Division	8,209
W&C	1,714
Medical Division	112
CSS	12

Of the 10,047 patients, 7,271 are in 4 specialities. These are:

T&O	2,665
ENT	2,075
Obstetrics & Gynaecology	1,572
Dermatology	959

The Trust continues to receive assistance from Medacs through to the end of June for 6 specialities. Outsourcing to Spire will also continue with an agreement that they will perform 420 T&O procedures before the end of June.

Improvement Actions

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

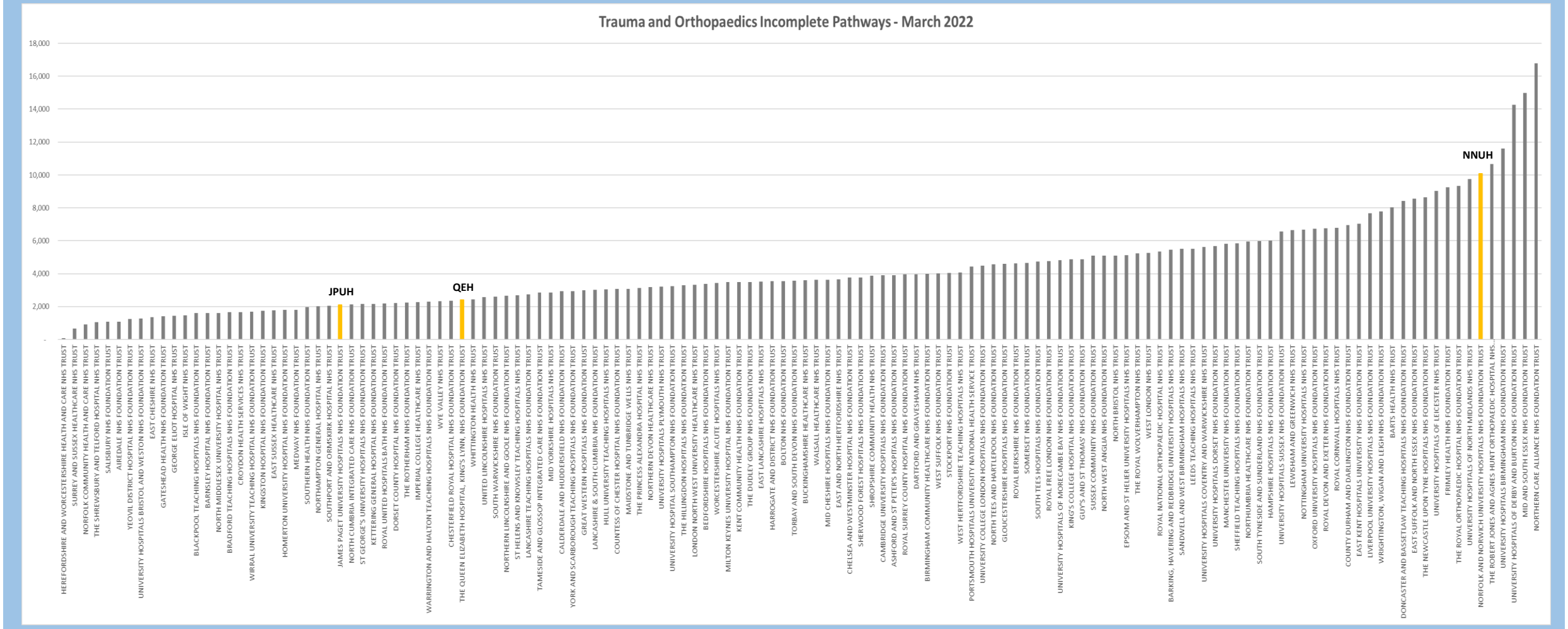
2. Insourcing and Independent Sector solutions are continuing.

3. Development of 5 interventions to increase theatre capacity is ongoing.

Risk To Delivery

GREEN

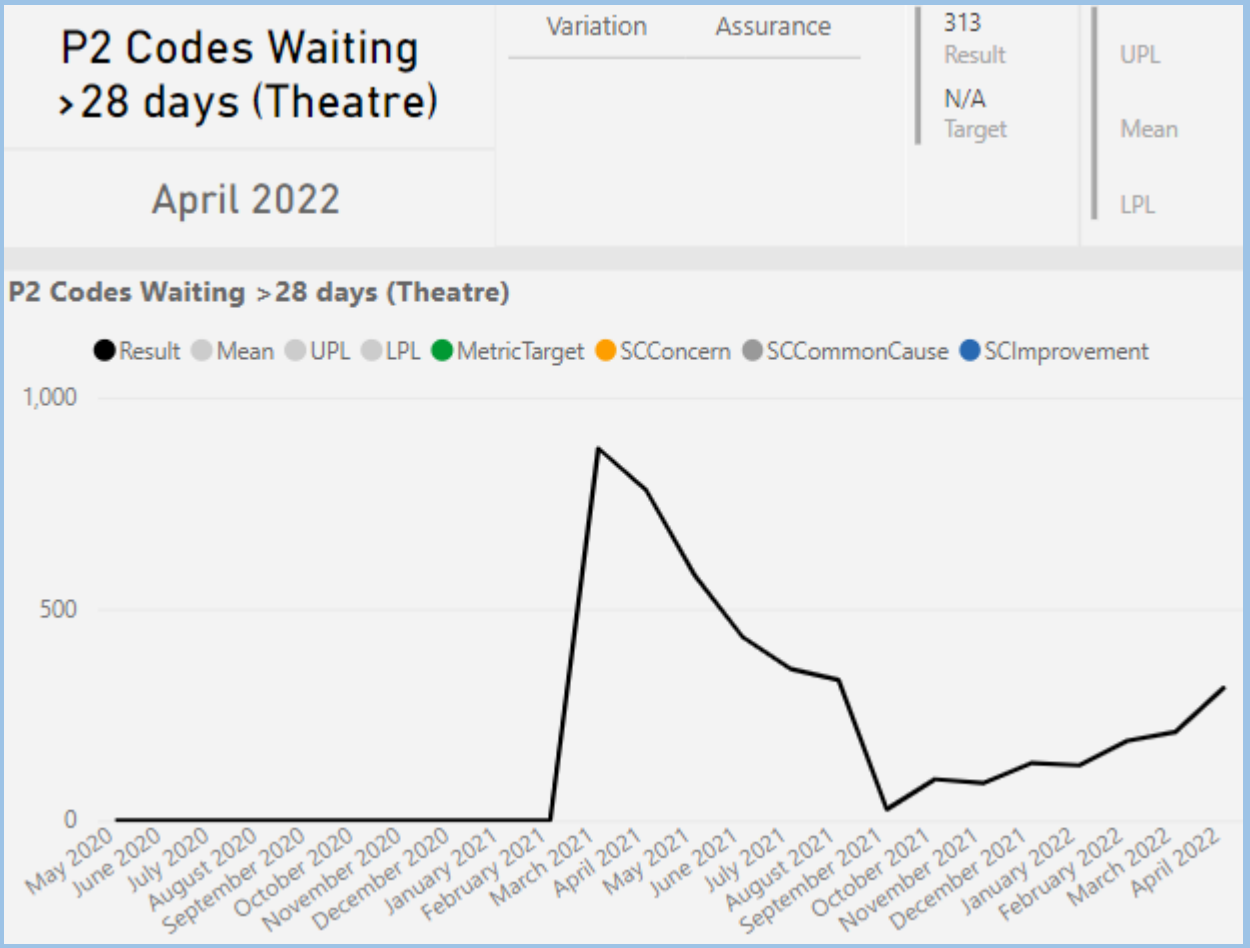
Performance – T&O Waiting List Benchmarking



Comments

NNUH had the 6th largest Orthopaedics Waiting List in England as of March 2022 with 10,072 patients.

Performance – P2 Patients Waiting > 28 Days for Theatre



Commentary

April 2022 Performance

The P2 position deteriorated in month with the number of patients waiting >28 days reaching 313. The level of bookings did increase in month with 51% of the backlog dated, however, the clearance of our longest waiting patients has continued to have an impact.

Continuing Improvement Actions

1. Continuation of booking controls to ensure only prioritised patients are booked.

2. Validation of patients to ensure P2 prioritisation is appropriate.

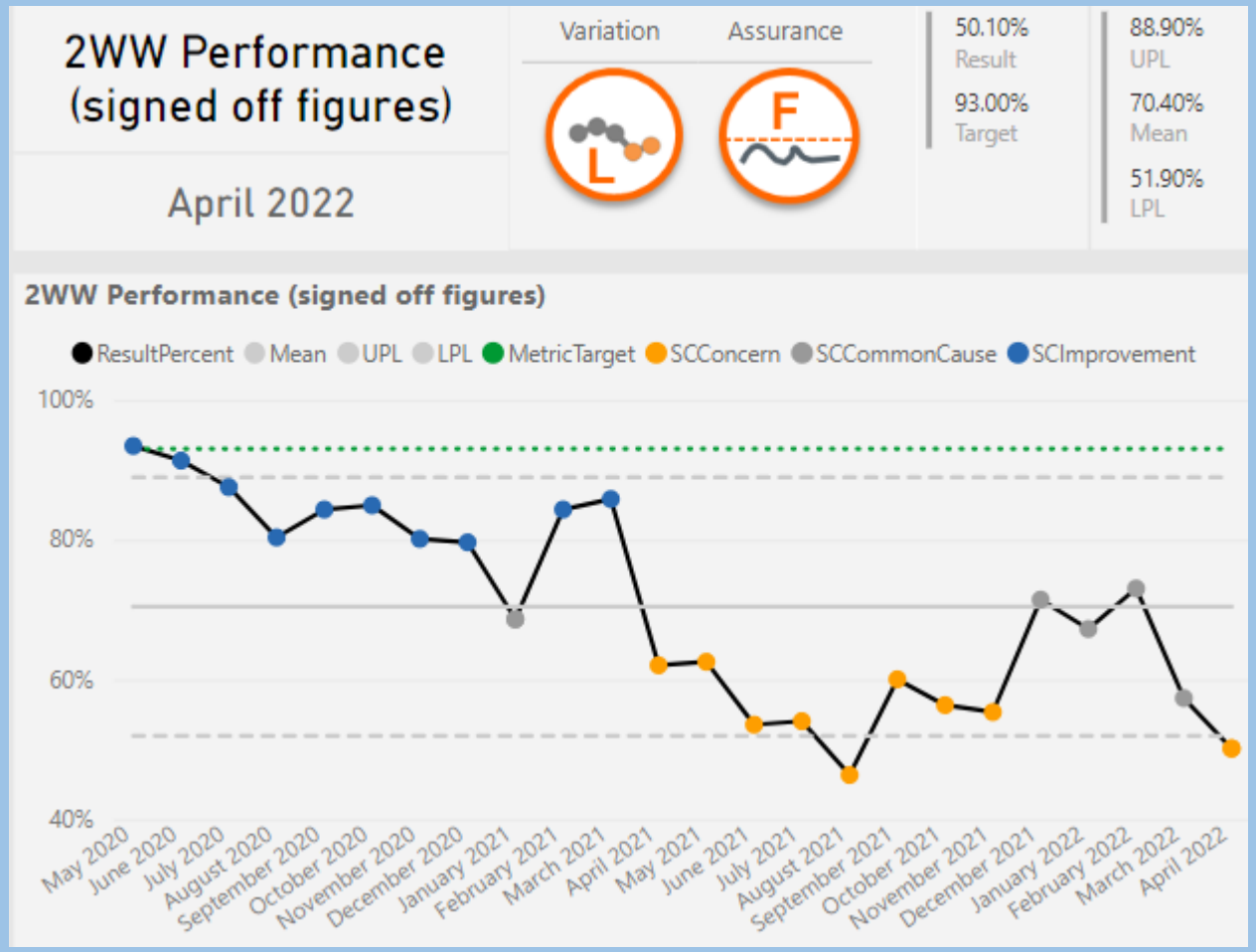
3. Ensure all P2 patients are POA'd.

4. Clinical review of remaining backlog being completed.

Risk To Delivery

RED

Performance – Cancer 2WW Performance



Commentary

April 2022 Performance (Provisional)

Reduction in performance due to sustained increases in referral numbers within Lower GI, Skin, Urology, Head and Neck and Upper GI.

Improvement Actions

1. Patients with a negative FIT test and no worrying symptoms are to be referred to a Primary Care Rapid Diagnosis service. The 3-month pilot commenced 10/05/22. Supporting a reduction in the Lower GI waiting list of circa. 30 patients a week.

2. Pilot of e-Derma Tele-Dermatology platform for 2WW patients to address capacity shortfall. The pilot start date TBC.

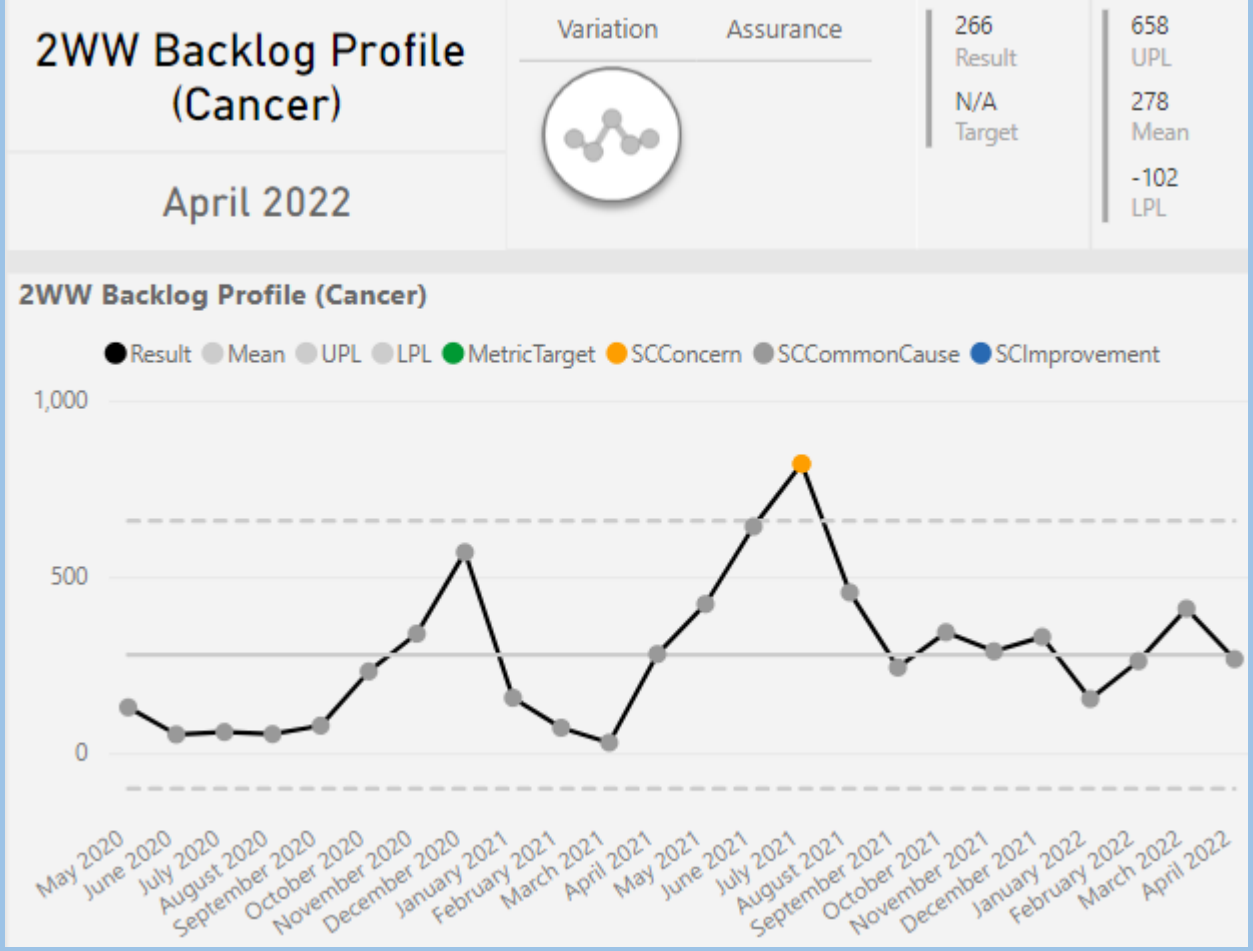
3. Review of all inappropriate referrals across all body sites to ensure training and support is given to our Primary Care colleagues.

4. Additional one-stop Urology clinics and increasing clinic capacity to pre-pandemic levels to address current over 14-day backlog.

Risk To Delivery

RED

Performance – Cancer 2WW Backlog



Commentary

April 2022 Performance

The 2WW backlog has started to reduce due to the interventions being implemented within the teams. This will result in poor performance against the operational standard in May and June whilst the backlog is cleared.

Improvement Actions

1. Patients with a negative FIT test and no worrying symptoms are to be referred to a Primary Care Rapid Diagnosis service. The 3-month pilot commenced 10/05/22. Supporting a reduction in the Lower GI waiting list of circa. 30 patients a week.

2. Pilot of e-Derma Tele-Dermatology platform for 2WW patients to address capacity shortfall. The pilot start date TBC.

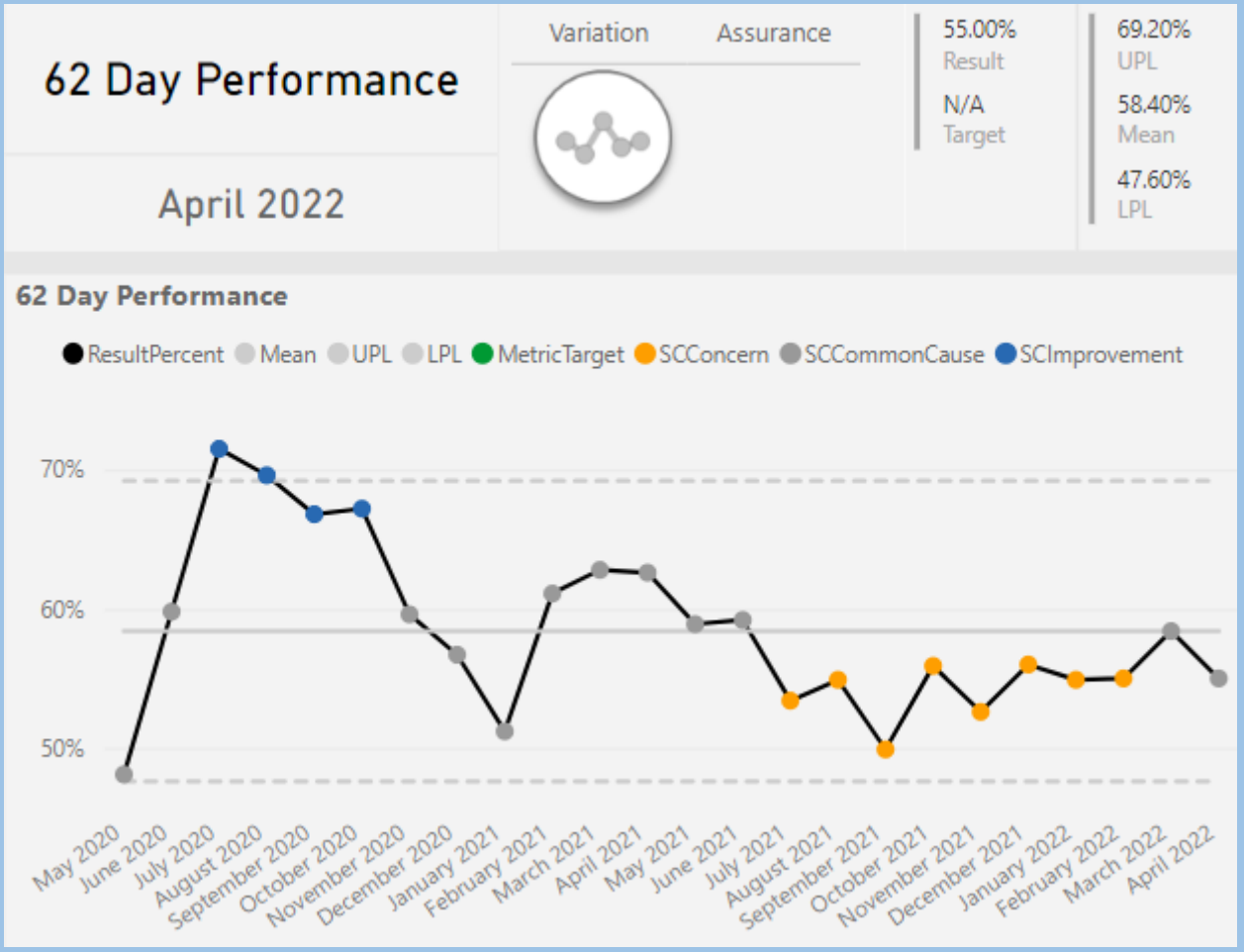
3. Review of all inappropriate referrals across all body sites to ensure training and support is given to our Primary Care colleagues.

4. Additional one-stop Urology clinics and increasing clinic capacity to pre-pandemic levels to address current over 14-day backlog.

Risk To Delivery

RED

Performance – Cancer 62 Day Performance



Commentary

April 2022 Performance (Provisional)

Due to the continuation of increased 2WW demand, and the concentration of tackling the Trust's 104-week position, there has been a slight increase in patients waiting over 62 days, with increases in Lower GI, Skin, Gynaecology and Urology. This has resulted in a continuation of poor performance.

Improvement Actions

1. Implementation of protected consultant administrative clinics to ensure patients on a cancer pathway have their diagnostic results processed as timely as possible. The new process commences 18/05/22.

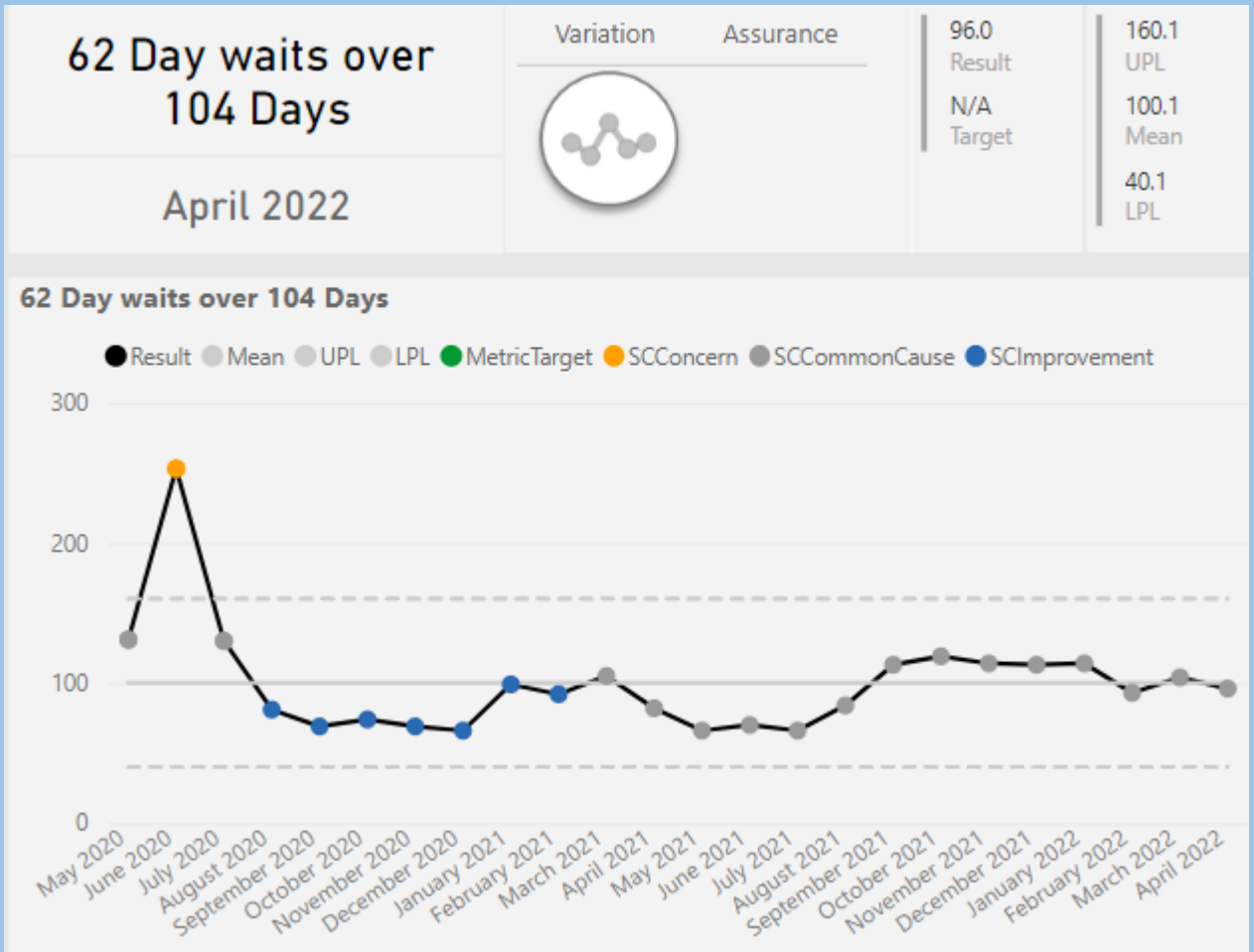
2. Radiotherapy Insourcing has commenced to reduce the current delays to treatment across all body sites.

3. Additional weekend excision activity within Skin through May and June to tackle the increased number of patients referred onto the pathway.

Risk To Delivery

RED

Performance – Cancer 62 Day Waits over 104 Days



Commentary

April 2022 Performance

The number of patients waiting over 104 days has reduced slightly in month, however, the large influx of 2WW patients and the focus on the reduction in the 104-week waiters has caused an increase in patients waiting over 62 days. There is a risk that this will transfer to an increase in the 104- day breaches in June.

Improvement Actions

1. Additional template biopsy capacity for Prostate patients at NNUH being created, regular Cromer sessions to go live once North Norfolk Macmillan Centre staffing case is confirmed.

2. Additional CTC sessions are planned in Q1 22/23 utilising Cancer Alliance funding.

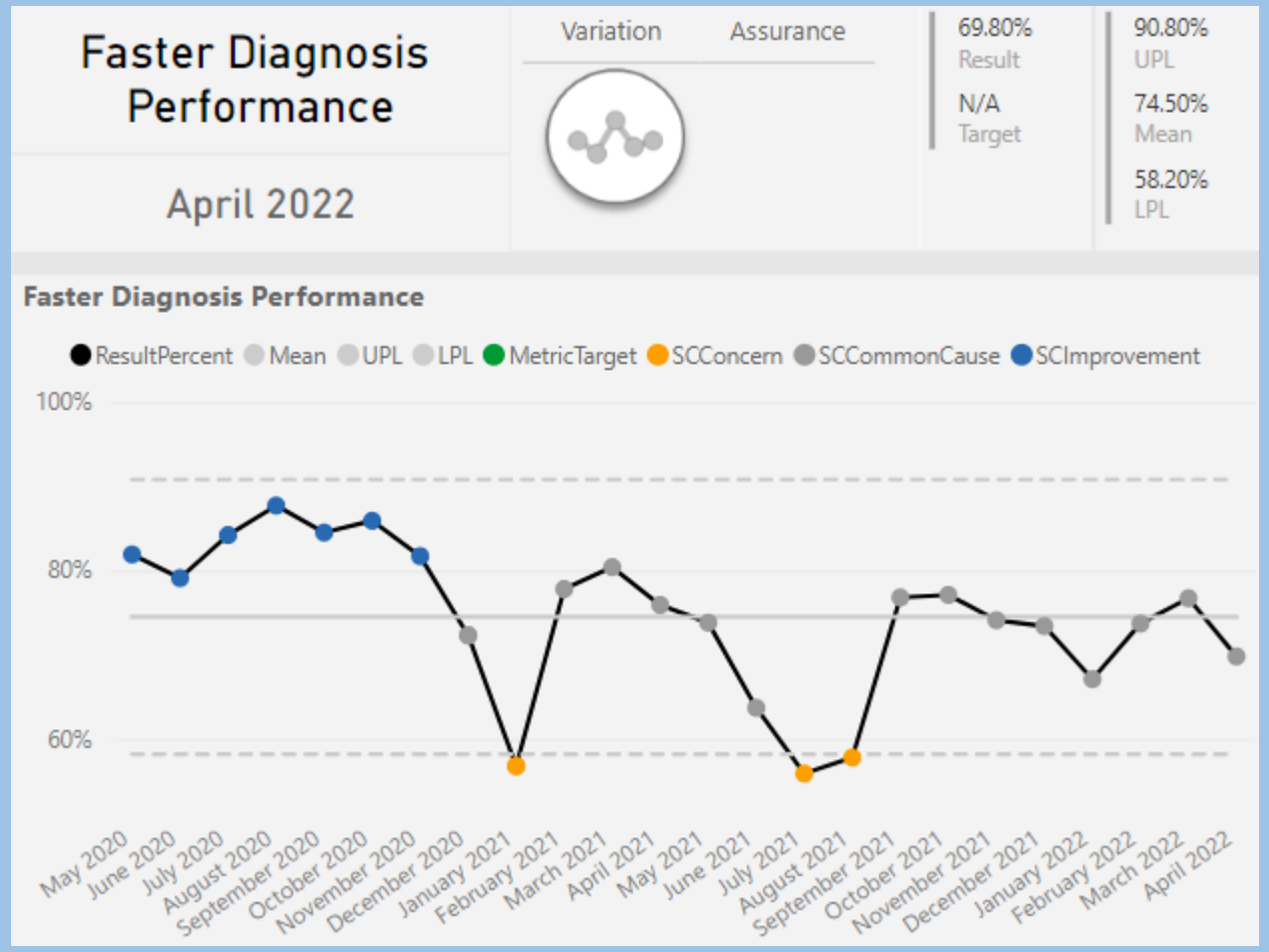
3. Surgical Division to continue to review Urology and Gynaecology theatre capacity to reduce delays to theatre.

4. Continued Outsourcing of Skin histopathology to reduce the overall wait for turnaround of diagnosis.

Risk To Delivery

RED

Performance – Faster Diagnosis Standard



Commentary

April 2022 Performance (provisional)

April's data is still not complete for Faster Diagnosis and is showing a reduced performance against our planned performance. We expect the performance at submission for April (02/06/22 deadline) to be close to or achieving the 75% standard.

Improvement Actions

Cancer Alliance funding agreed for a ''Float Patient Pathway Co-Ordinator'' resource to enable timely data entry for reporting accurate FDS performance, and to collect the key elements required for the best practice timed pathway CQUIN, currently awaiting ESR1 sign off to proceed with recruitment.

Risk To Delivery

AMBER

Performance – Waiting List Health Inequalities

Commentary

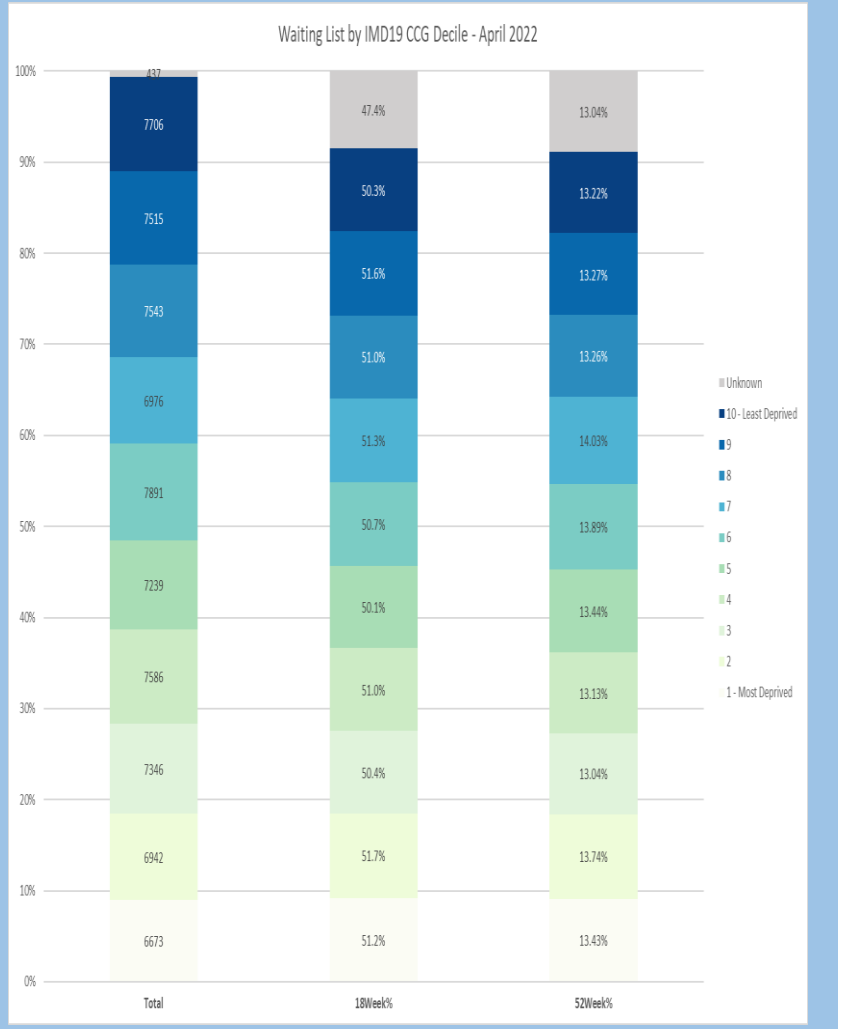
Trust Waiting List: Deprivation

As part of the monitoring of health inequalities, the Trusts waiting list is monitored for variation in demographics.

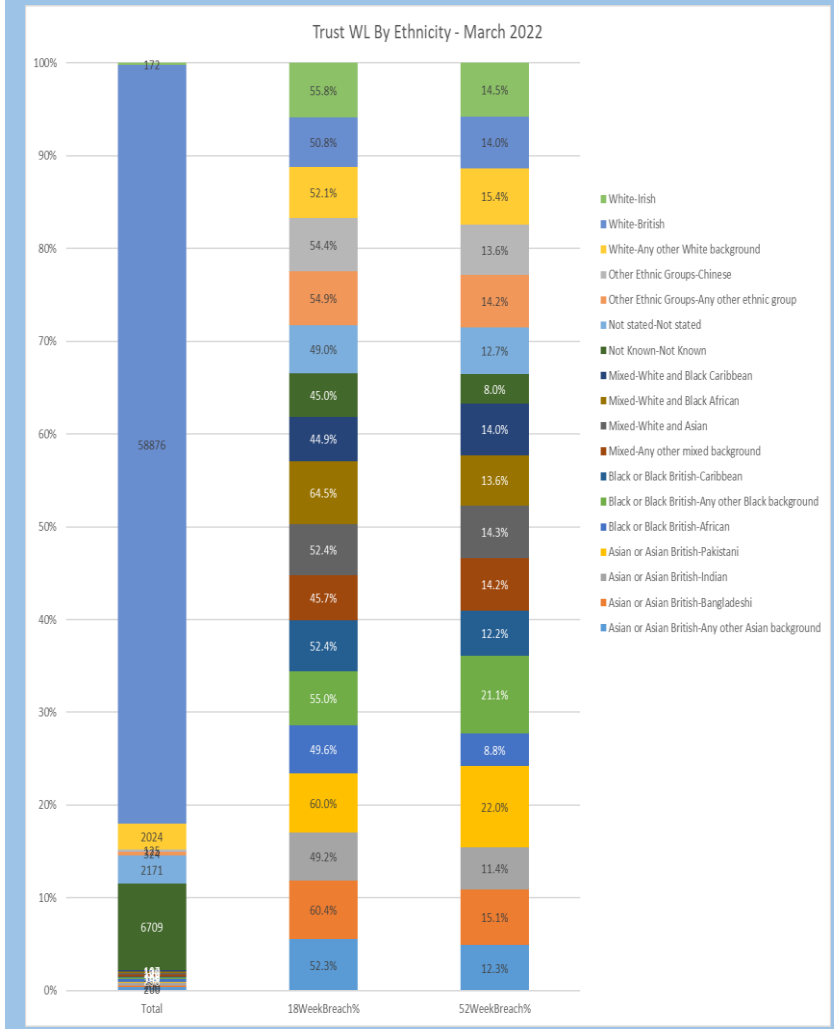
<u>The Index of Multiple Deprivation (IMD)</u>
The indices rank 32,844 small areas (neighbourhoods) across England. The indices comprise 39 indicators organised across 7 domains which are combined and weighted to calculate the overall Index of Multiple Deprivation. Outputs displayed in deciles (10 equal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

Broadly 50% of each indices group are waiting over 18 weeks and 13% of each group – over 52 weeks.

There was no significant variation or concern in April 2022.



Performance – Waiting List Health Inequalities



Commentary

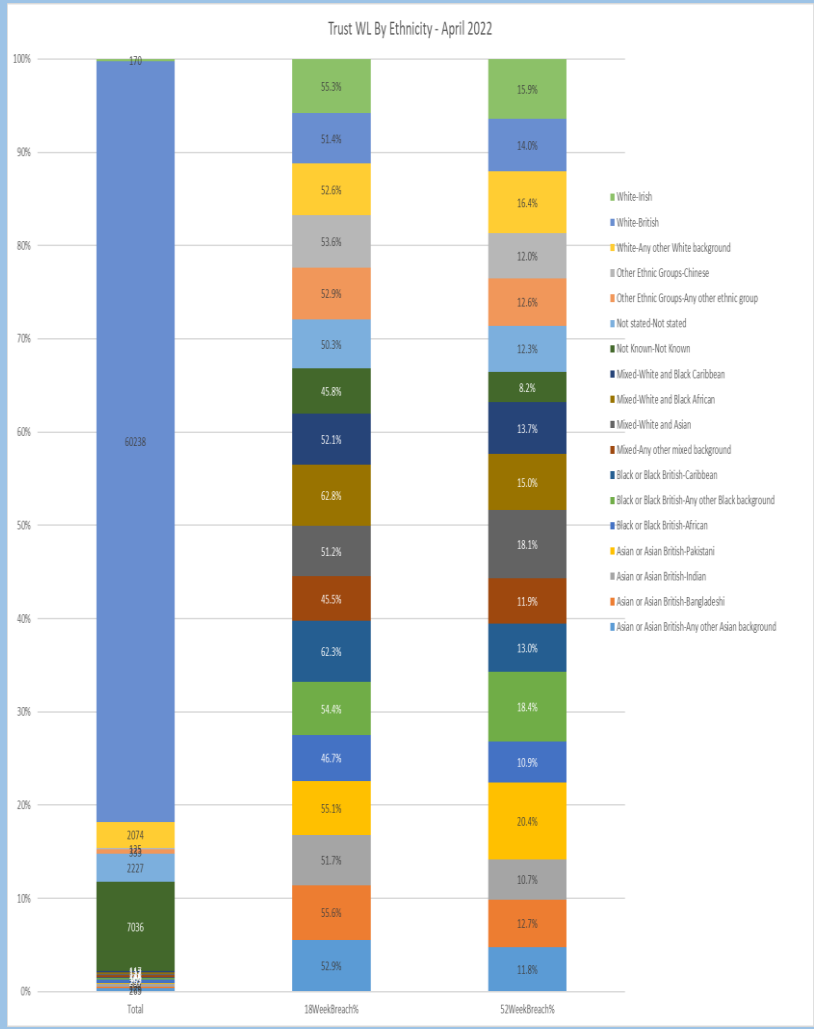
Trust Waiting List: Ethnicity

As part of the monitoring of health inequalities, the Trusts waiting list is monitored for variation in demographics.

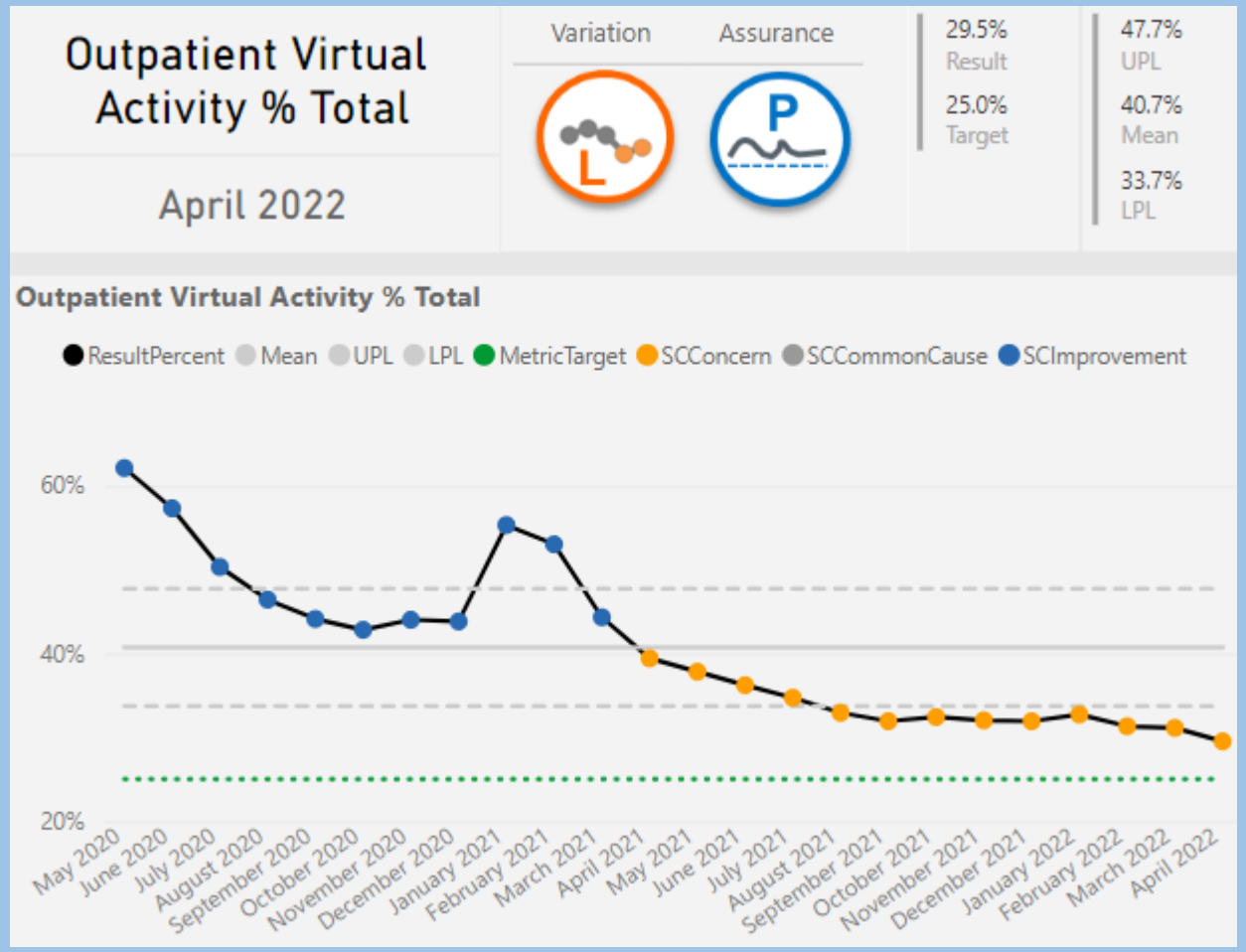
The waiting list is heavily weighted towards White – British (60,000 patients), with 30.000 patients waiting over 18 weeks and 8,000 patients waiting over 52 weeks.

Some smaller ethnic groups have moderate variances in % waiting over 18 or 52 weeks, but the volumes are small.

There was no significant variation or concern in April 2022.



Performance – Remote Outpatients



Commentary

April 2022 Performance

The Trust delivered 29.5% of its outpatient appointments remotely during April, which is a slight drop form 31% in March, however, we are still ahead of the 25% national target

The Trust remains in the upper decile nationally for numbers and % of outpatient appointments delivered virtually during February 2022. We also remain ahead of other Trusts locally.

Improvement Actions

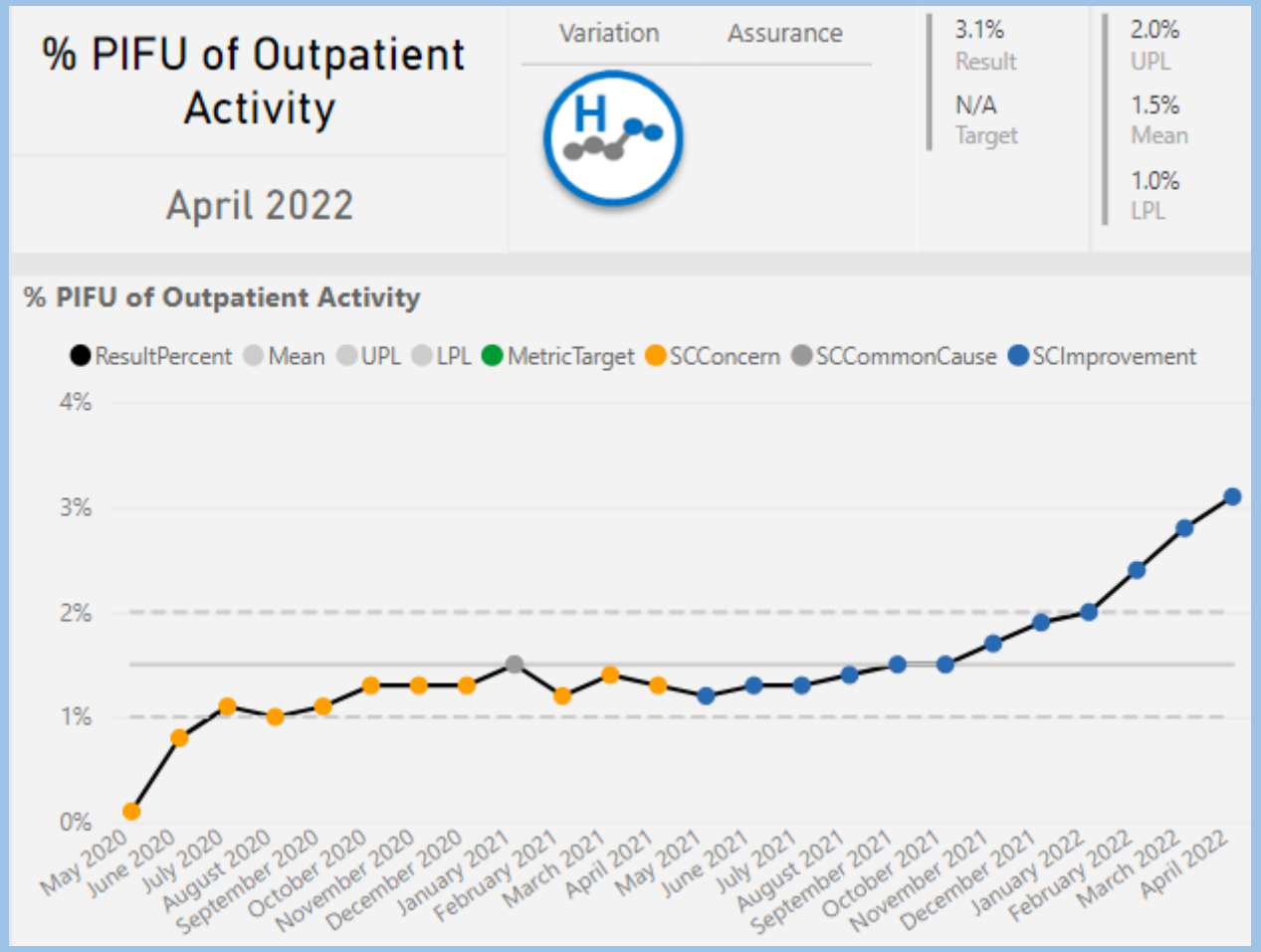
1. Virtual consultation (Attend Anywhere) is now available for HMP. This means virtual consultation will be available to a wider cohort of patients.

2. Attend Anywhere group calls are currently in the beta phase. A more advanced version with a wider range of functions will should become available early June. This will in turn lend itself to more clinics and increase virtual activity. First conversion from individual clinics to virtual group session has gone underway in Women's Health Physio.

Risk To Delivery

GREEN

Performance – Patient Initiated Follow Up (PIFU)



Commentary

April 2022 Performance

The Trust has delivered the national standard and PIFU activity continues to increase to 3.1%. With the commencement of POP, we will see a further rise in PIFU performance.

Improvement Actions

1. Currently set to go live with the DrDoctor platform from the 20th of May.

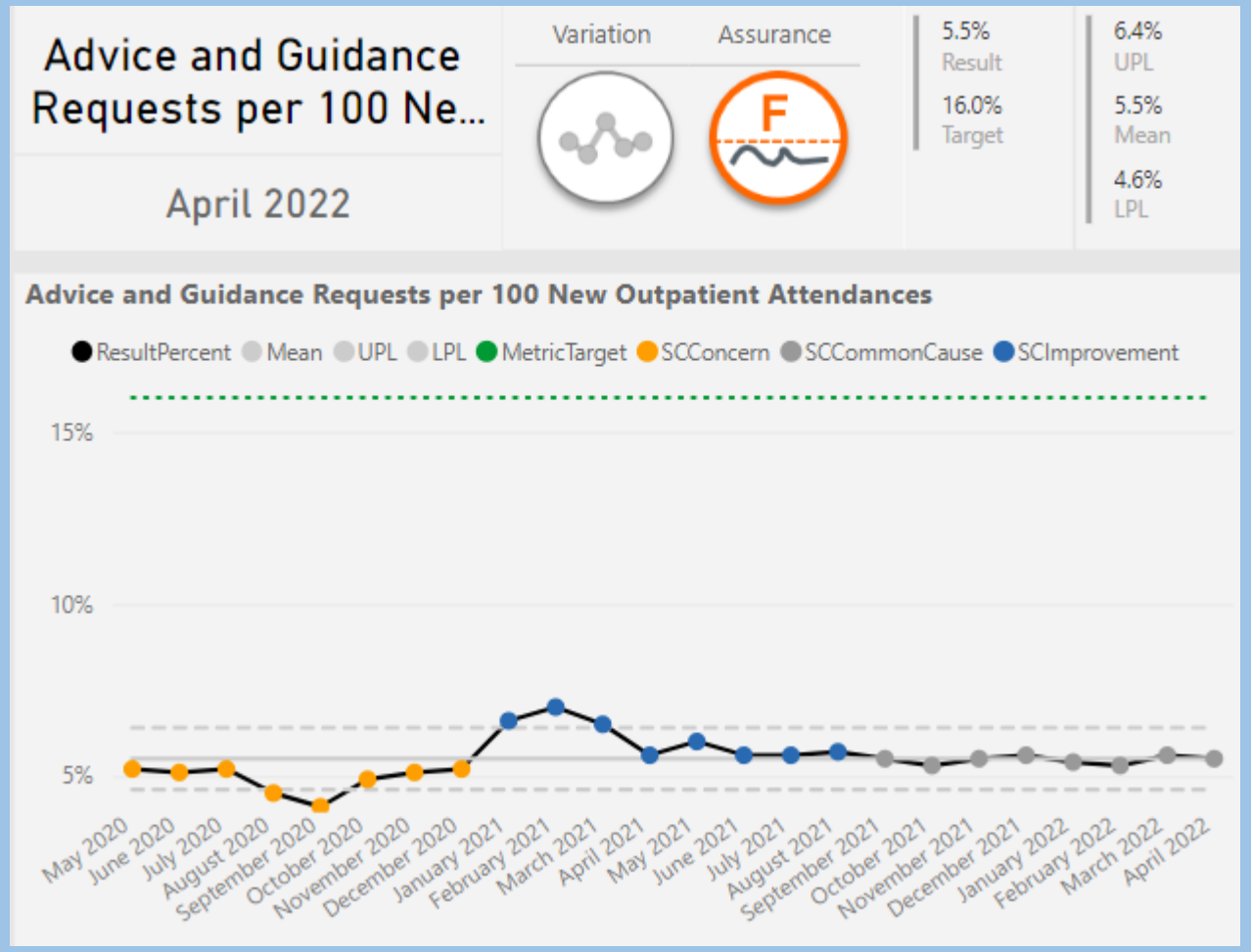
2. XPIFU is currently being rolled out across the specialities. The delivery team are engaging with clinicians to identify appropriate pathways for XPIFU. Those pathways are being designed. There are some patient pathways that may not be appropriate for standard PIFU, but may be appropriate for XPIFU. XPIFU, therefore, lends itself to a further cohort of patients per speciality.

3. The mentality change of "PIFU by Default" is being adopted for patients being seen in outpatient clinics. Daily reports are being produced to identify PIFU numbers with the ability to breakdown per clinician. Large adopters of PIFU are being mentioned in Comms to boost positivity around the programme.

Risk To Delivery

GREEN

Performance – Advice & Guidance



Commentary

April 2022 Performance

In relation to the newly introduced target of 12 A&G requests per 100 new outpatient appointments, we continue to sit below the target.

Improvement Actions

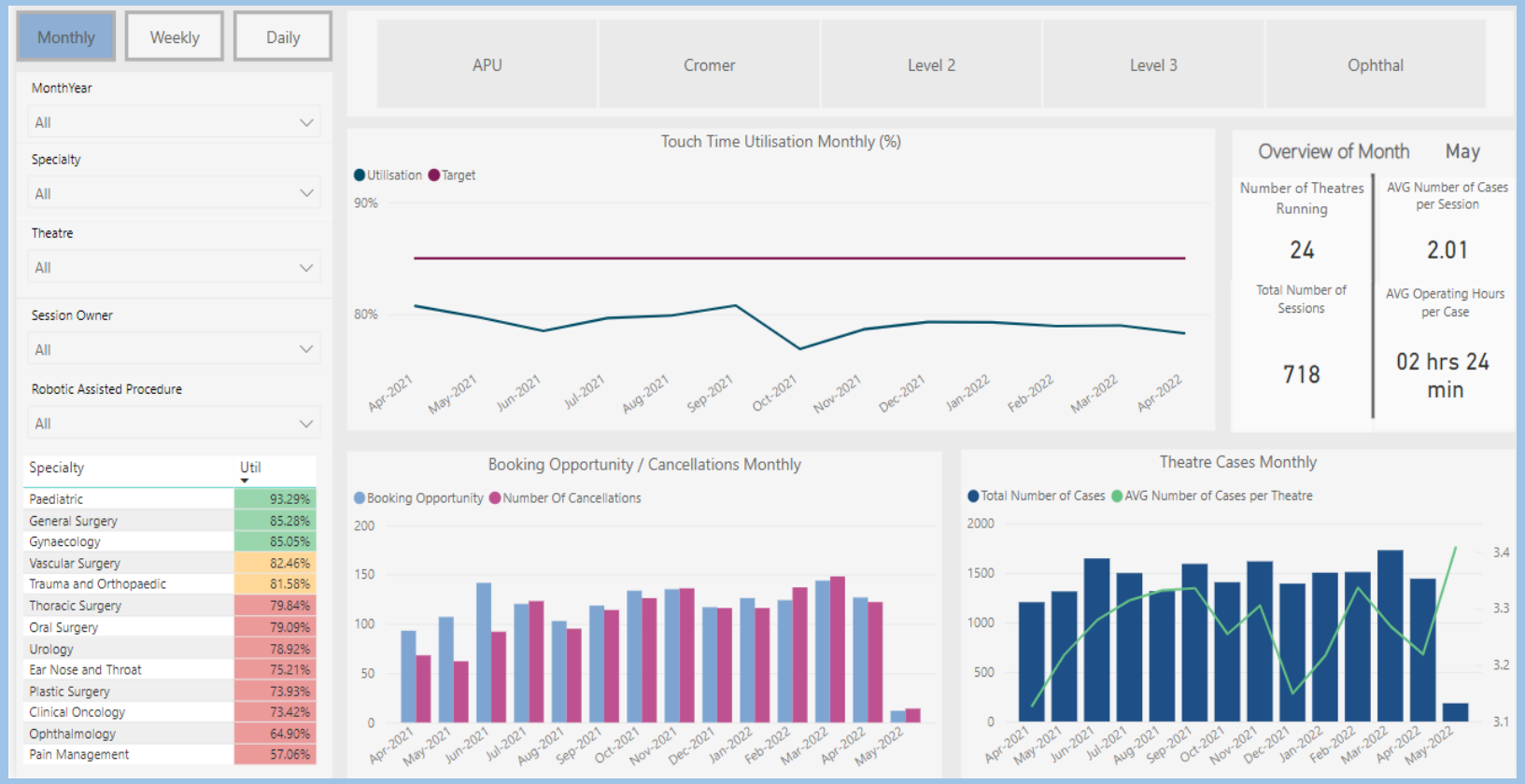
1. With focus being largely on POP, we have been advised by Head of Elective Access and Performance that BI do not currently have the capacity for this, so further work on the project will commence once BI have more capacity.

2. RITS request submitted to look into the possibility of A&G being provided as a triage option on the Outpatient Referral Console.

Risk To Delivery

RED

Performance – Theatre Dashboard: Utilisation



Specialty	Util
Paediatric	93.29%
General Surgery	85.28%
Gynaecology	85.05%
Vascular Surgery	82.46%
Trauma and Orthopaedic	81.58%
Thoracic Surgery	79.84%
Oral Surgery	79.09%
Urology	78.92%
Ear Nose and Throat	75.21%
Plastic Surgery	73.93%
Clinical Oncology	73.42%
Ophthalmology	64.90%
Pain Management	57.06%

Commentary

April 2022 Performance

The touch time delivery across all theatres maintained for a further month at 79.2%. In April, Level 3 theatres delivered 82%, with Level 2 down on prior month at 75%.

Inter case downtime continues to perform well with an average of 15 minutes.

Improvement Actions

1. Achieve/push for higher booking levels; work with the specialities with the worst performance to review booking challenges. Anticipated improvement in May.

2. Theatre data to be reviewed at the end of each session to ensure proactive closure of sessions reduced by last minute cancellations.

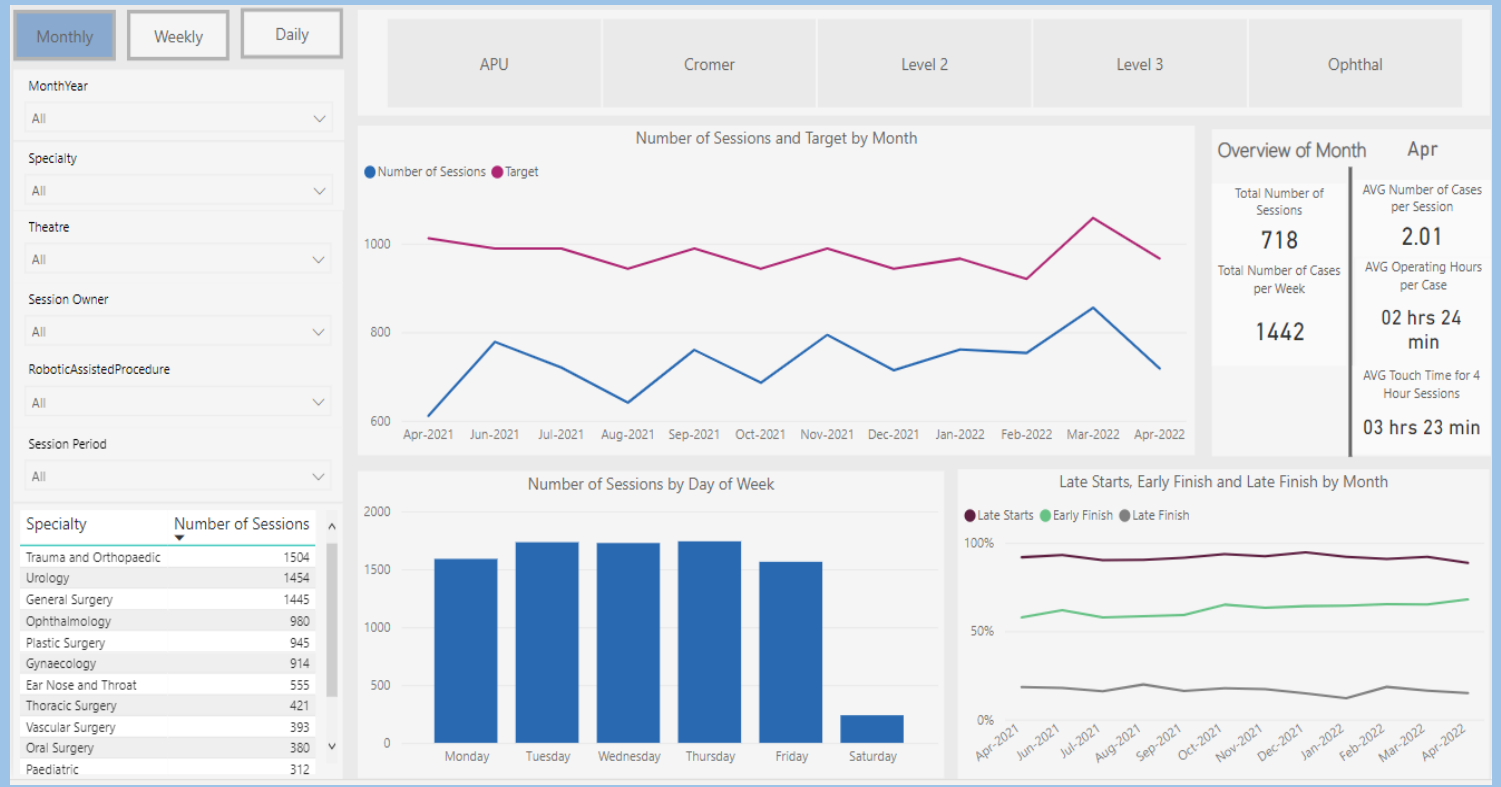
3. Specialties to ensure pool of patients ready for TCI are created to facilitate repatriation of sessions.

4. Weekly review meetings continue with focus on review of performance and prospective booking levels.

Risk To Delivery

AMBER

Performance – Theatre Dashboard: Sessions



Commentary

April 2022 Performance

Insourcing of additional theatre team during the week (via the Medacs agreement) supported delivery of 718 sessions through April.

Additional capacity continued across weekends via the Medacs Healthcare insourcing campaign, providing x 9 all day sessions per week.

Weekday provision throughout April was challenged through annual leave and COVID-19 sickness, but this is expected to upturn significantly in May 2022.

The level of on the day cancellations are the significant factor in early finishes, as the cancellations are too late to refill the theatre slots. The average early finish is in line with the peer and national medians.

Improvement Actions

1. Currently working with the NHSE/I to improve the start time.

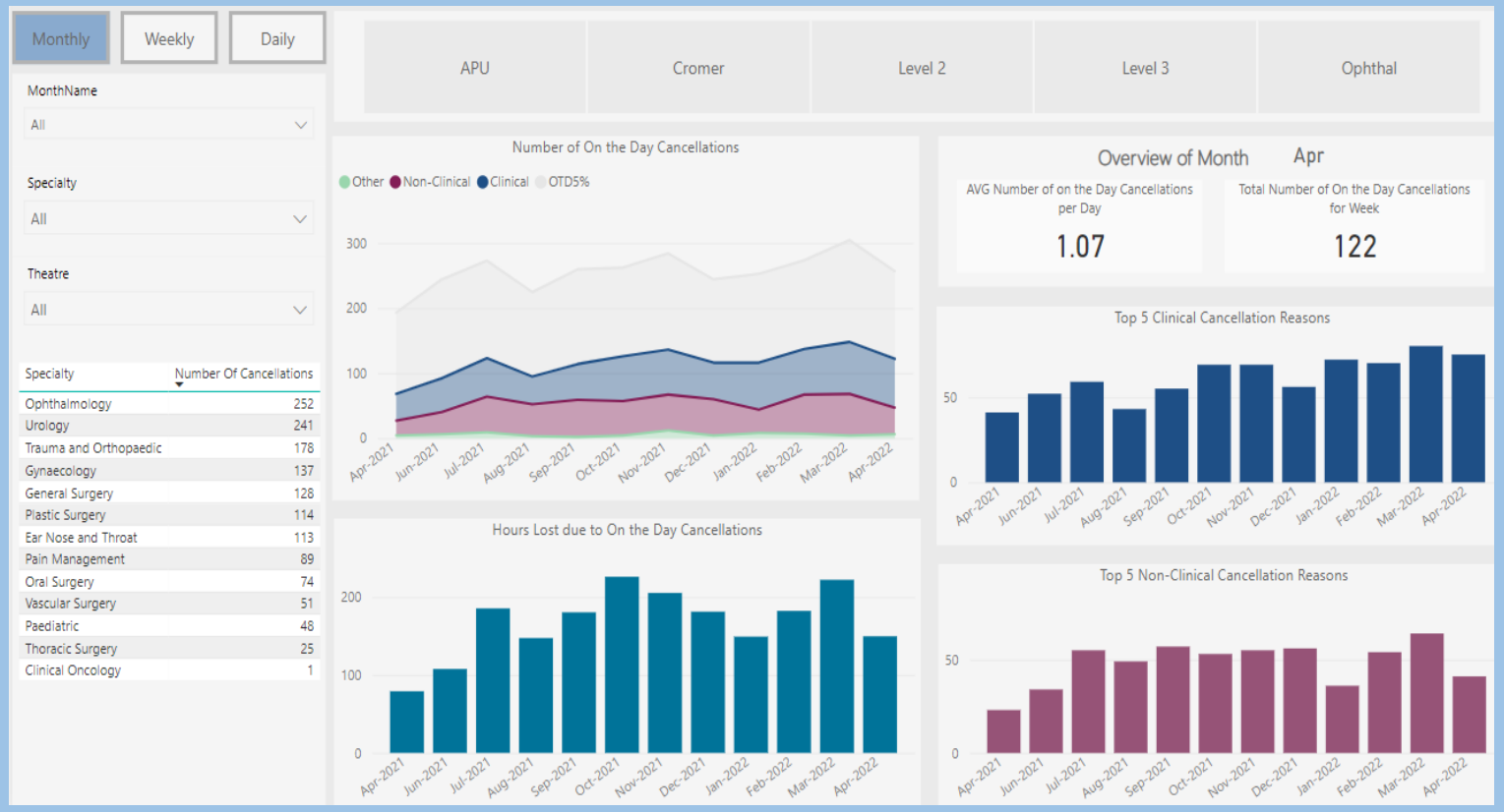
2. Continued application of the theatre 6-4-2 policy to reduce last minute cancellation of sessions through lack of cover.

3. Sessions continue to be prioritised for specialties with longest waits.

Risk To Delivery

RED

Performance – Theatre Dashboard: Cancellations



Specialty	Number Of Cancellations
Ophthalmology	252
Urology	241
Trauma and Orthopaedic	178
Gynaecology	137
General Surgery	128
Plastic Surgery	114
Ear Nose and Throat	113
Pain Management	89
Oral Surgery	74
Vascular Surgery	51
Paediatric	48
Thoracic Surgery	25
Clinical Oncology	1

Commentary

April 2022 Performance

The on the day cancellation rate reduced to 122 in month.

COVID-related reasons were the main reason for clinical cancellations.

Improvement Actions

1. Specialities to conduct RCA's for patients cancelled due to Op no longer being indicated to identify themes and inform action plan.

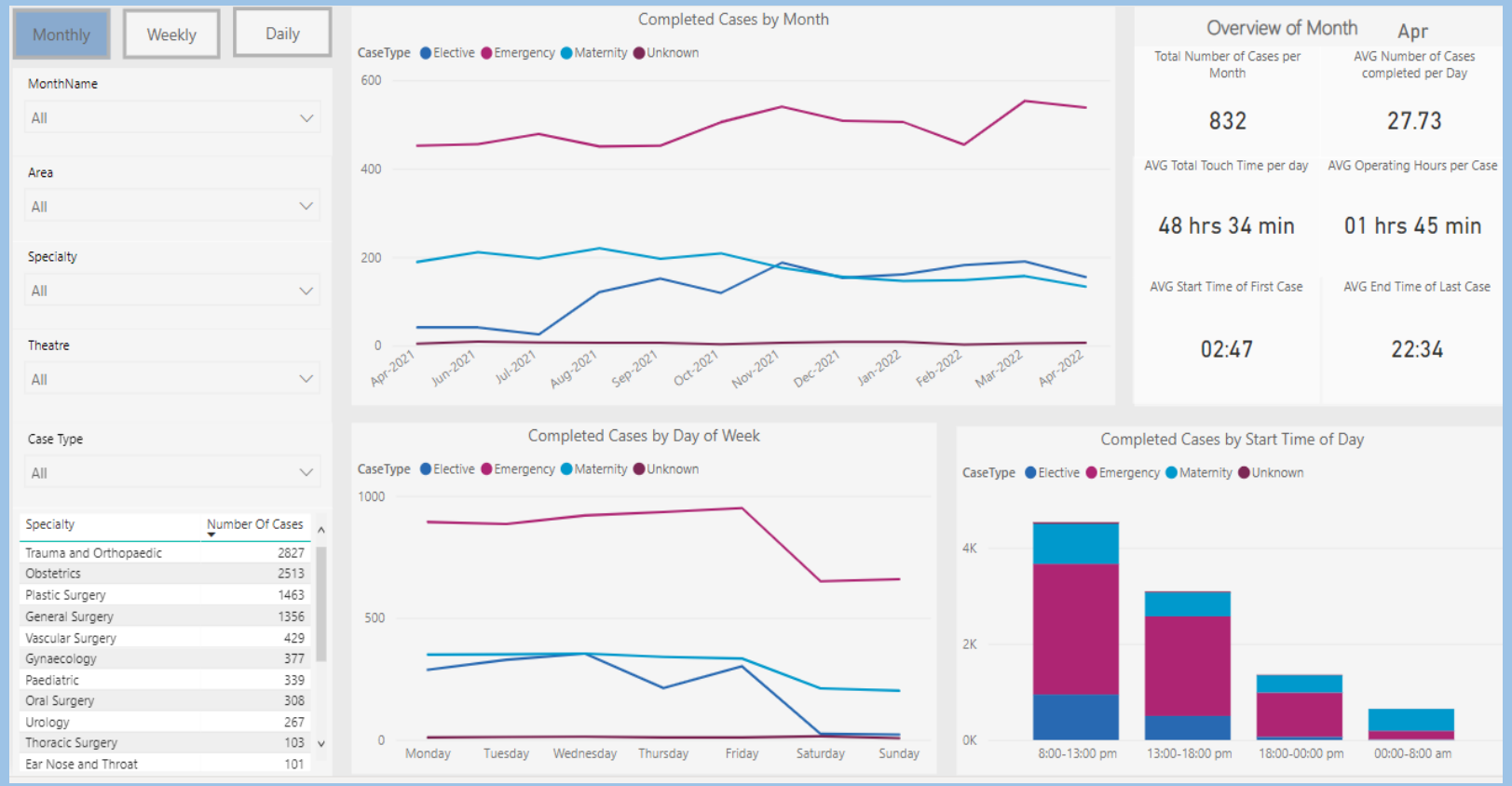
2. Patient testing adjustment now in place with a new SOP.

3. Review of administration support to facilitate pre-admission cancellation prevent role being reinstated.

Risk To Delivery

RED

Performance – Theatre Dashboard: Emergency Theatres



Commentary

April 2022 Performance

There was a significant increase in demand in April, with a total of 832 cases (696 in March) completed across all areas (including Obstetrics).

The demand for additional C-section capacity continues to place strain on staffing – business case to address shortfall to be presented to BCRP by Women and Children's in June 2022.

Improvement Actions

1. Reminder for specialties to attend the daily 08:15 meeting to facilitate flow through the NCEPOD theatres.

2. Trauma capacity returned to two theatres per day in response to demand.

Risk To Delivery

AMBER

REPORT TO THE TRUST BOARD

Date	**8 June 2022**			
Title	**Month 1 IPR - Finance**			
Author & Exec lead	**Roy Clarke (Chief Finance Officer)**			
Purpose	**For Information**			
Relevant Strategic Objective	**5. To deliver our financial plan and recovery programme, supporting the Trust's return to financial sustainability**			
Are there any quality, operational, workforce or financial implications of the decision requested by this report?	**Quality**	**Yes✓ No☐**	These are discussed throughout the document.	
	Operational	**Yes✓ No☐**		
	Workforce	**Yes✓ No☐**		
	Financial	**Yes✓ No☐**		

Context: This paper outlines the Trust's financial performance for April 2022 within the context of the current financial regime the NHS is operating under.

The Trust operational plan for FY22/23 is a deficit of £9.0m.

For the month of April 2022, the position on a control total basis is on plan. This is a breakeven position. The position includes a provision for income claw-back of £0.9m due to the Trust's activity performance falling below the required baseline offset reduced expenditure.

Activity: Month 1 activity forecast was significantly behind plan, with estimated activity at c.84% of elective plan. This suggests a maximum variable payment risk of c.£2.2m in month 1. However this needs to be offset by both the 'floor' (applied at System level), as well as the recognising the profiling for quarter 1. The resulting exposure for month 1 has been reduced to £0.9m and provided as such in the financial position. Surgery accounts for £1.6m of the estimated £2.2m maximum exposure, with key specialities being hit in both admitted and outpatient work. These include ophthalmology; oral surgery; T&O; ENT and dermatology. Of the value of reduced activity, £1.2m of this relates to New Outpatient, and Outpatient Procedure activity.

110% of 2019/20 Baseline: The Activity Metrics show the proportion of delivery against the 2022/23 plan, which is an activity baseline of 110% of 2019/20 delivery, which equates to 104% of weighted value in financial terms.

Forecast outturn is a £9.0m deficit, unchanged from the planned FY22/23 deficit of £9.0m. There is identified delivery risk to the £9.0m deficit plan of £39.6m which would result in a downside deficit of £48.6m. This is offset by mitigations totalling £39.6m resulting in the FOT £9.0m Deficit.

Cash: Cash held at 30 April 2022 is £89.9m. The closing balance is £10.7m above the FY22/23 submitted forecast as result of the continued delay to the capital programme and other working capital movements. Cash balances are forecast to reduce by c.£35.1m however remain positive in March 2023 thus no revenue support would be required.

Capital: For the month of April 2022, the Trust has underspent against plan by £4.5m. This significant underspend is caused by a number of schemes missing planned milestones. The current forecast outturn is to deliver £25.92m, which is £0.01m less than plan.

Norfolk and Norwich University Hospitals NHS Foundation Trust

Finance Report
April 2022

8 June 2022

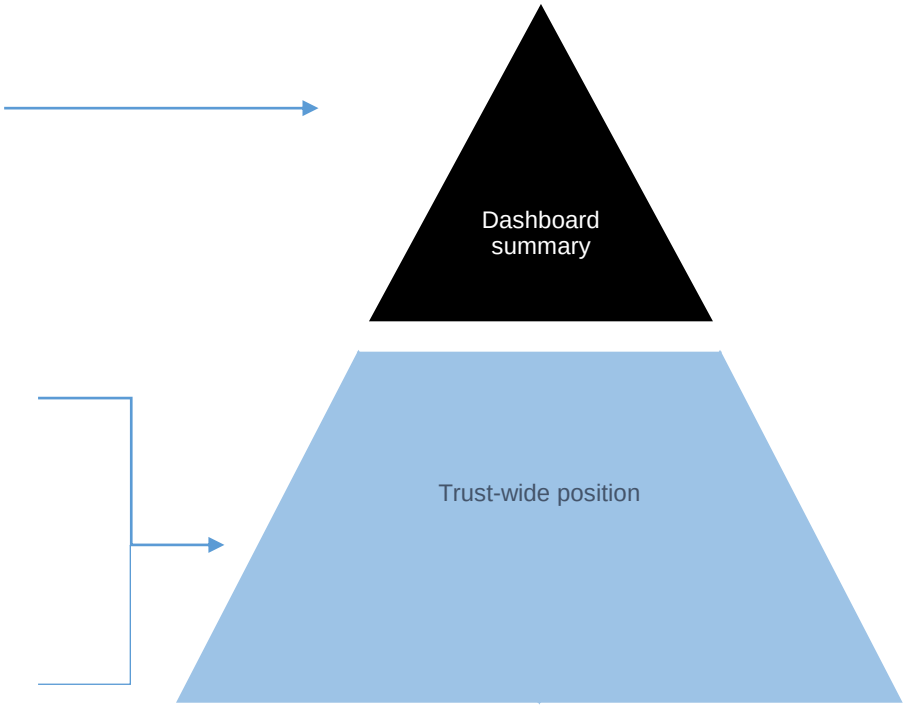
Roy Clarke, Chief Finance Officer

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.



1.1 Executive Dashboard

Norfolk and Norwich University Hospitals NHS Foundation Trust

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	In Month			YTD			
	Actual	Plan	Variance	Actual	Plan	Variance	RAG
SOCI	£m	£m	£m	£m	£m	£m	
Clinical Income	56.4	56.8	(0.4)	56.4	56.8	(0.4)	
Other Income	7.7	7.2	0.6	7.7	7.2	0.6	
TOTAL INCOME	**64.1**	**64.0**	**0.1**	**64.1**	**64.0**	**0.1**	
Pay	(38.1)	(38.1)	(0.0)	(38.1)	(38.1)	(0.0)	
Non Pay	(18.2)	(18.4)	0.2	(18.2)	(18.4)	0.2	
Drugs	(2.8)	(2.3)	(0.4)	(2.8)	(2.3)	(0.4)	
TOTAL EXPENDITURE	**(59.1)**	**(58.8)**	**(0.3)**	**(59.1)**	**(58.8)**	**(0.3)**	
Non Opex	(5.0)	(5.1)	0.1	(5.0)	(5.1)	0.1	
COVID (Out of System) Net Expenditure	0.0	0.0	0.0	(0.0)	(0.0)	(0.0)	
Reported Surplus / (Deficit)	0.0	0.0	(0.0)	0.0	0.0	(0.0)	
Other Financial Metrics	£m	£m	£m	£m	£m	£m	
Cash at Bank (before support funding)	89.9	79.2	10.7	89.9	79.2	10.7	
Capital Programme Expenditure	2.9	7.5	(4.5)	2.9	7.5	(4.5)	
CIP Delivery	0.8	1.4	(0.6)	0.8	1.4	(0.6)	
Activity Metrics*	%	%	%	%	%	%	
Day Case	91%		(9%)	91%		(9%)	
Elective Inpatient	75%		(25%)	75%		(25%)	
Outpatients - New & Procedures	83%		(17%)	83%		(17%)	
Outpatients - Follow Ups	100%		(0%)	100%		(0%)	
Value based Activity performance v baseline	84%		(16%)	84%		(16%)	

** Activity count as a % of 22/23 Planned Delivery*

Norfolk and Norwich University Hospitals NHS Foundation Trust

1.2 Executive Dashboard

Risk

A detailed refresh of the Financial Risk Register has been performed, resulting in 13 key strategic and operational risks for FY22/23.

As part of FY22/23 annual planning 13 key strategic and operational risks with an initial score of ≥ 12, including three new risks that have been added to the risk register. 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.

There are nine risks rated as 'Extreme' on the risk register which have a potential risk assessed financial impact of £39.6m, of which £1.5m has crystalised in April due to Risk F, Income Deductions as a result of failure to deliver weighted elective activity in line with plan (£0.9m) and Risk B, Failure to deliver the efficiency requirement (0.6m).

Risk L, the risk inflation levels exceed those allowed for in the plan has increased from moderate to extreme in Apr due to the rising levels of inflation. The Trust needs to ensure inflationary pressures are monitored closely and mitigated where possible.

Income Deductions as a result of failure to deliver weighted elective activity in line with plan (Risk F) has a crystalised impact of £0.9m from April as a result of activity being c. 84% of the elective plan.

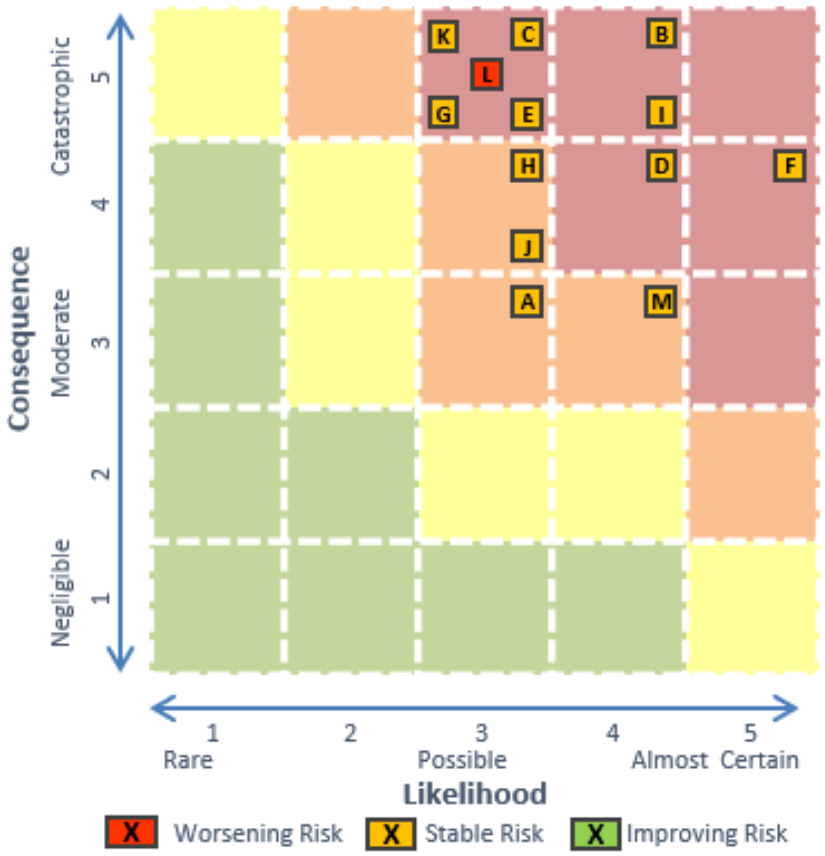
CIP Delivery for April was £0.8m, £0.6m adverse to the budgeted plan of £1.4m. This is comprised of a planning variance of £0.56m and a performance variance of £0.04m.

Gateway 2 approved CIP is currently £15.5m, £7.6m adverse to the Trust efficiency target of £23.1m. The risk adjusted forecast outturn CIP deliver for £14.6m based on the latest forecast financial performance of gateway 2 scheme, progress against milestone delivery and performance against quality and performance indicators. The remaining balance needs to be identified to support the Trust in the delivery of it's financial plan.

Management Actions:

- **Identify remaining CIP's to meet Trust's efficiency target**
- **Deliver on existing CQIA approved CIP including Month 1 shortfall**
- **Deliver Trust activity plan including Month 1 shortfall**

Risk Rating		Risks	Financial Impact FY22/23 £m	Risk Assessed Impact £m	YTD Crystallised Impact £m
Extreme	15+	B, C, D, E, F, G, I, K, L	76.4	39.6	1.5
High	9-14	A, H, J, M	6.0	0.0	0.0
Moderate	5-8	-	0.0	0.0	0.0
Low	1-4	-	0.0	0.0	0.0
Total			82.4	39.6	1.5
Risk mitigated through Non Recurrent YTD underspends & Release of Expenditure Reserves					(1.5)
Total			88.4	39.6	0.0



Norfolk and Norwich University Hospitals NHS Foundation Trust

2.1 Financial Performance – April 2022

For the month of April 2022, the position on a control total basis is on plan. This is a breakeven position. The position includes a provision for income claw-back of £0.9m due to the Trust's activity performance falling below the required baseline offset by reduced expenditure.

Income:
Income is reporting a favourable variance of £0.1m in April. This favourable variance is due to favourable variances in Devices income (£0.3m, R&D Income (£0.2m), Cancer Management (£0.2), Personalised Outpatient Programme (£0.1m), Digital Aspirant (£0.1m) and income relating to HR reservists and WPH&W contracts (£0.1m); all of which are offset by additional expenditure. The is offset by a provision for income claw back of £0.9m due to the Trust's activity performance falling below the required baseline.

Pay:
Pay for April is on plan. This is £0.3m of underspends across the operational divisions offset by £0.3m of income backed expenditure across HR & IT.

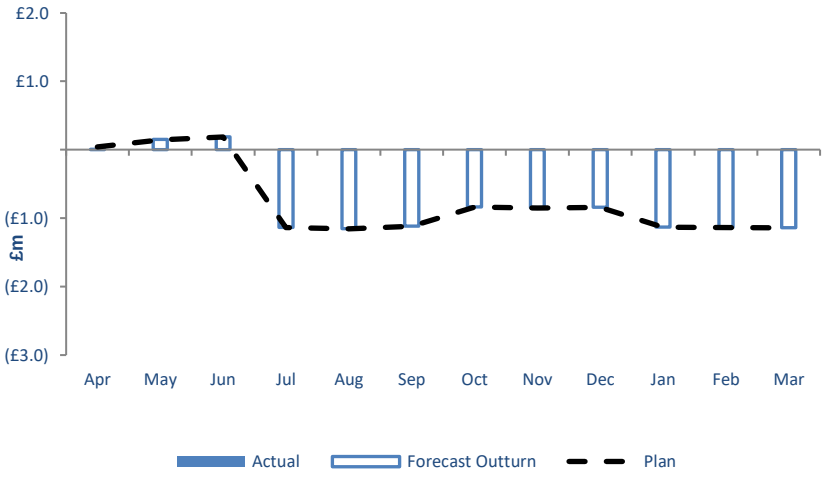
Net Drugs Cost:
There is a £0.4m adverse variance in April. This is due to an increase in non pass through drugs that are not recharged to commissioners based on usage. The increased expenditure is mainly within Rheumatology.

Non Pay:
There is a £0.2m favourable variance in April. This is made up of an underspend in Clinical Supplies of £0.6m as a result of the reduced activity levels offset by additional income expenditure across R&D and IT.

Non Operating Expenditure:
Non operating expenditure has a small £0.1m favourable to plan for April. This is as a result of reduced depreciation expenditure due to reduced delivery against the capital programme.

Out of System COVID 19 Expenditure:
The COVID-19 expenditure in month is £0.2m, with offsetting income of £0.2m and therefore an in month breakeven position. The main area of expenditure remains testing.

Monthly Reported Surplus/(Deficit)



Norfolk and Norwich University Hospitals NHS Foundation Trust

2.2 22/23 FOT

Forecast outturn is a £9.0m deficit, unchanged from the planned FY22/23 deficit of £9.0m. There is identified delivery risk to the £9.0m deficit plan of £39.6m which would result in a downside deficit of £48.6m. This is offset by mitigations totalling £39.6m resulting in the FOT £9.0m Deficit.

❶ **Risk:** Risk of income deduction for Trusts failure to deliver weighted activity in line with the plan. **Total Risk: £10.9m**
Mitigation: Full delivery of Activity Plan for remainder of the year would ensure the Trust receives only the £0.9m of deductions from April. **Total Mitigation: £10.0m.**
Net Risk £0.9m

❷ **Risk:** Risk of overspends due to failure to identify and deliver Trust's efficiency programme. **Total Risk: £9.3m**
Mitigation: Full identification and delivery of Efficiency Programme. **Total Mitigation: £9.3m**
Net Risk £0.0m

❸ **Risk:** Risk of overspends if inflation rates increase beyond levels allowed for within the plan. **Total Risk: £3.0m**
Mitigation: Inflation rates remain within levels allowed for within the plan. **Total Mitigation: £3.0m**
Net Risk £0.0m

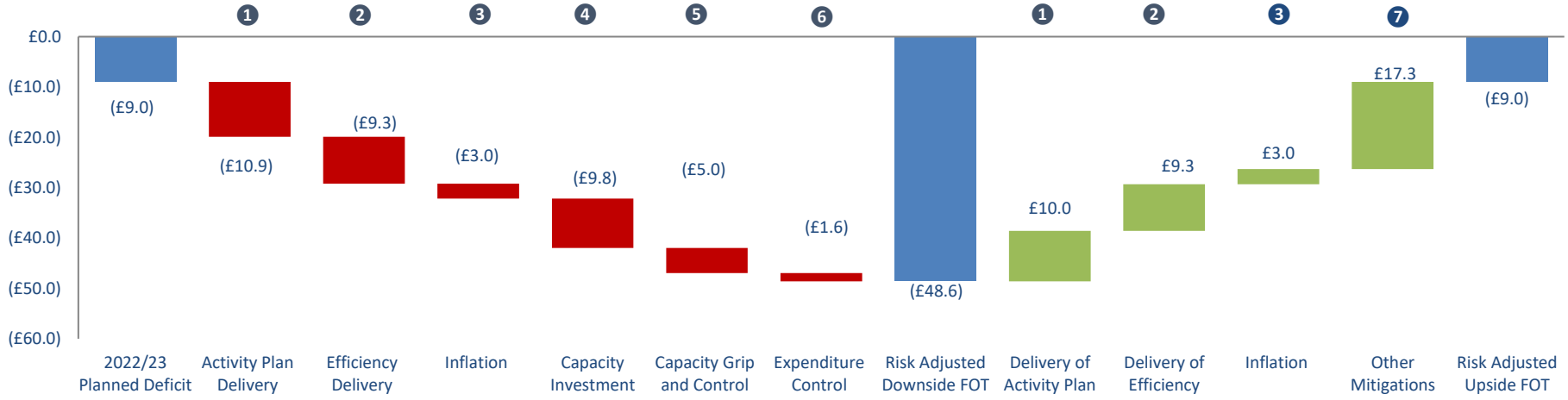
❹ **Risk:** Risk of requirement to add additional capacity at an additional cost. **Total Risk: £9.8m**

❺ **Risk:** Risk of the Trusts; capacity plan not reflecting available clinical space and workforce effective hours. **Total Risk: £5.0m**

❻ **Risk:** Risk of overspends due to failure to control in expenditure in line with plan. **Total Risk: £1.6m**

❼ **Other Mitigations:** Grip and control of expenditure plan including ensuring the use of the capacity available is optimised and other non recurrent underspends. **Total Mitigation: £17.3m**

This results in a risk adjusted upside forecast outturn of a £9.0m deficit, unchanged from the planned FY22/23 deficit of £9.0m



Microsoft | Power BI

Workforce

View in Power BI

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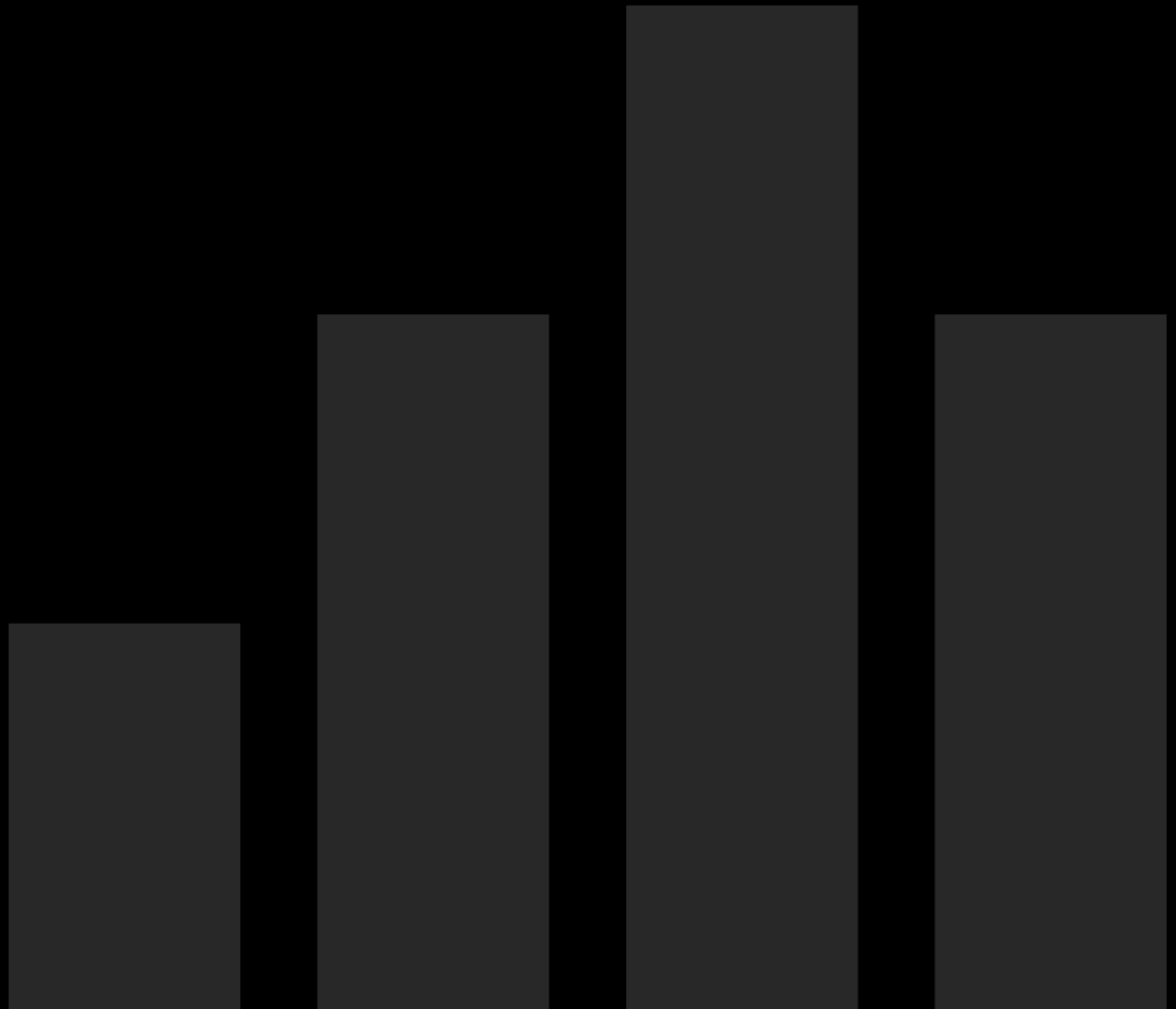


Workforce Summary

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
Non-Medical Appraisals	Non-Medical Appraisal	Apr 2022	82.5%	Improvement (High)	Not capable
Vacancies	Variance: Headcount (WTE)	Apr 2022	-1,057	Concern (Low)	Not capable
Sickness Absence	Monthly Sickness Absence %	Apr 2022	5.9%	Concern (High)	Unreliable

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 2022

Variation | Assurance

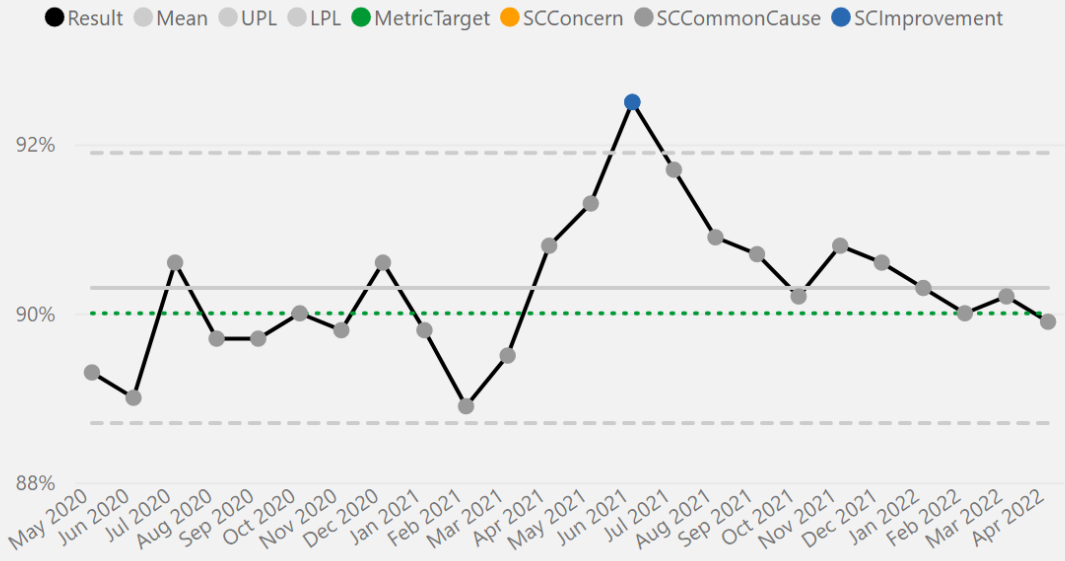
89.9% Result
90.0% Target

91.9% UPL
90.3% Mean
88.7% LPL

Analytical Commentary

Variation is Common Cause

Mandatory Training



Assurance Commentary

As at the end of April, the compliance rate was 89.9%. For Medical staff, the compliance rate for permanent staff was 89.4% - this figure reduces to 81.9% including the fixed term rotational junior doctors.

The latest data shows a slight drop in compliance which will have been impacted by leave and additional pressures created by the Easter break. It is expected for this to return above the 90% in the next reporting period. Divisions have been asked by Evidence Board to prepare trajectories to ensure staff are released to complete their mandatory training in a timely way.

The new Resuscitation eLearning is being finalised and is planned to launch next month, it is just awaiting a demonstration video to be added to the content before its final testing stages can be completed. This will move the current annual classroom requirement to bi-annual with an annual eLearning requirement.

Targeted emails will be sent to staff who have fallen below on their compliance.

Improvement Actions

April 2022 - Resuscitation eLearning is drafted

Non-Medical Appraisals

NNUH Digital Health
business intelligence

Non-Medical Appraisal

Apr 2022

Variation	Assurance
H	F

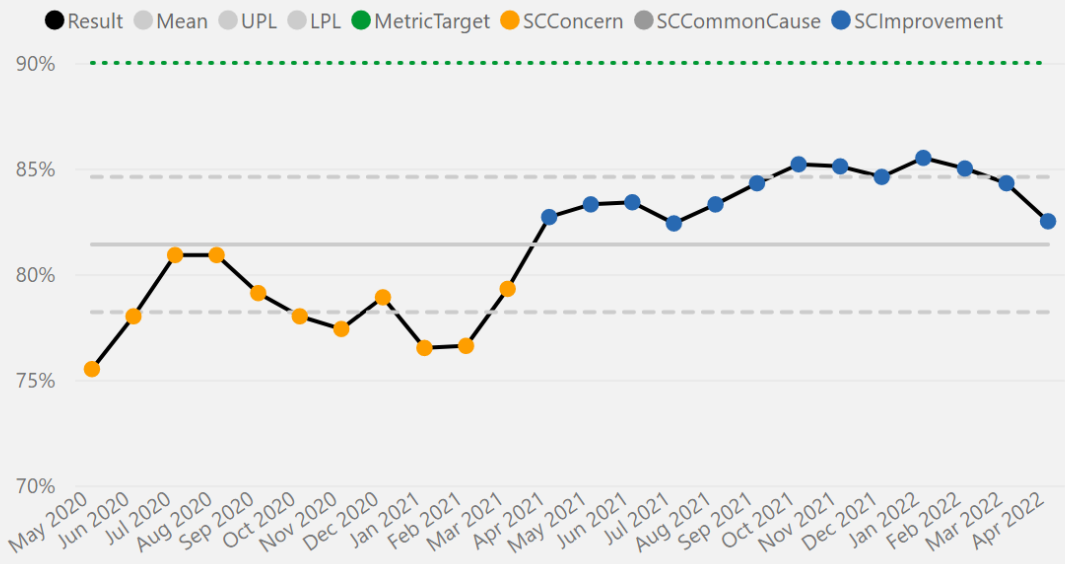
82.5% Result
90.0% Target

84.6% UPL
81.4% Mean
78.2% LPL

Analytical Commentary

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

Non-Medical Appraisal



Assurance Commentary

For the Use of Resources 3.1 recommendation, the Trust must achieve 80% compliance by August 2022, with the Trust internal target of 90%.

In the 12 months to April 2022, 82.5% of eligible staff (Non-Medical appraisals) had an appraisal. This is a decline in the position since March 2022.

To improve the appraisal experience for colleagues the process has been reviewed and a new improved process, known as Personal Development Review (PDR), has been introduced. This specifically aligns with our Corporate Strategy, Caring with PRIDE, enabling individual goals to be aligned to our vision and commitments. The PDR also includes a career conversation and a discussion regarding how their health and wellbeing can be supported.

Training sessions, guidance and a revised policy are available to support the cascade approach.

The transition from an rolling annual appraisal programme to a cascade approach which aims for PDRs to be completed between April and September will mean that compliance reduces for a short period. This is directly related to appraisals that have 'expired' but the member of staff is not yet due their PDR within the cascade approach.

Improvement Actions

April 2022 – The new Personal Development Review form alongside guidance and supporting documentation and training has been launched.

April 2022 – The new cascade approach has been launched.

Sickness Absence

NNUH Digital Health
business intelligence

Monthly Sickness Absence %

Apr 2022

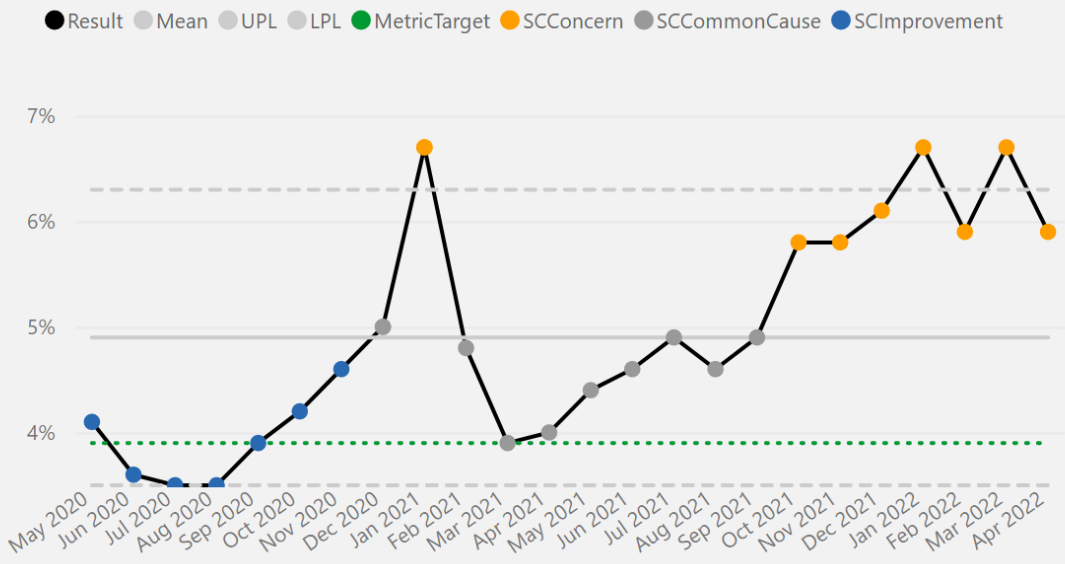
Variation	Assurance
H	?

5.9% Result	6.3% UPL
3.9% Target	4.9% Mean
	3.5% LPL

Analytical Commentary

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

Monthly Sickness Absence %



Assurance Commentary

The Operating Plan for 2020/21 has set a 12 month rolling average target of 3.9% for sickness. As at 30 April 2022, that rate is 5.5%. The monthly absence figure for April is 5.9%. This monthly absence is significantly higher than 3.9% in April 2021. This can be seen in the increase in short term absence and medium term absence.

All figures include Covid related sickness absence. Had Covid sickness been excluded the 12-month rolling average rate would be 4.4%, which could account for the increase in short and medium term absence.

The work related Occupational Health referrals continue to see concerns regarding the impact of covid having an impact of staff along with staffing levels / skill mix / resources for role. In last month 66% of work related stress cases seen by WHWB were from CSS division. This will be discussed at the Attendance Improvement Group to ascertain actions.

Two departmental areas have undergone a dedicated HWB survey in recent weeks. The evaluation of these have been shared with the leadership teams in order that future actions can be considered. Both areas scored extremely high in burnout metrics but the qualitative data from this piece of work provides intelligence on key areas to improve staff experience and wellbeing.

Improvement Actions

April 2022 – Introduction of the health & wellbeing passport

Staff Turnover

NNUH Digital Health
business intelligence

Monthly Turnover

Apr 2022

Variation | Assurance

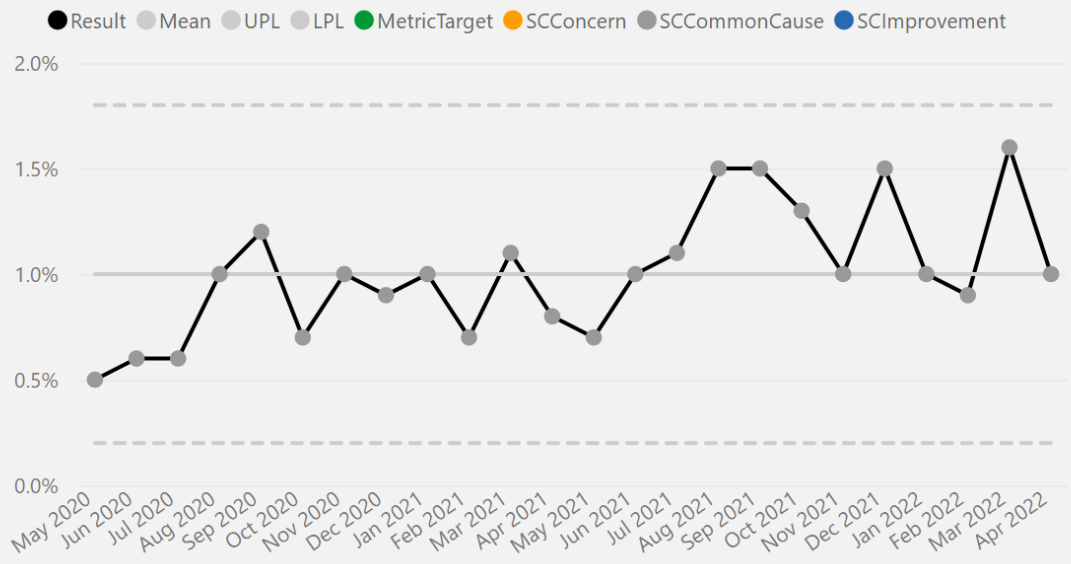
1.0% Result
N/A Target

1.8% UPL
1.0% Mean
0.2% LPL

Analytical Commentary

Variation is Common Cause

Monthly Turnover



Assurance Commentary

The monthly turnover rate for April 2022 is 1.0% which is a decrease from March (1.6%) and higher than April 2021 (0.8%). The 12-month average turnover rate is 14.2%, an increase of 0.2% from March 2022. By delivery of the actions outlined below, it is expected to see a decreased to 10%, overall, by the end of the financial year.

Each Task and Finish Group has met to establish the key actions for delivery over the next 6 months to a year that will make a positive impact on turnover at the Trust. For example, the Flexible Working Task and Finish Group have identified key deliverables such as understanding our data to enable divisional and organisational oversight of flexible working requests, eroster to become an enabler to enhance flexible working, EDI profiling, review of policy, inclusion of flexible working in our recruitment processes and so on.

The Task and Finish Groups will also confirm evidential criteria for the improvement action.
In support of employee retention and engagement activities, a People Promise manager has been recruited with a focus on improving employee experience, through developing a range of improvement initiatives. This is a 12-month fixed term post funded by NHSEI and will also work with colleagues in the wider system.

Improvement Actions

April 2022 – The task and finish groups for the 5 retention pillars have met to establish actions for each pillar.

Staff in Post

NNUH Digital Health
business intelligence

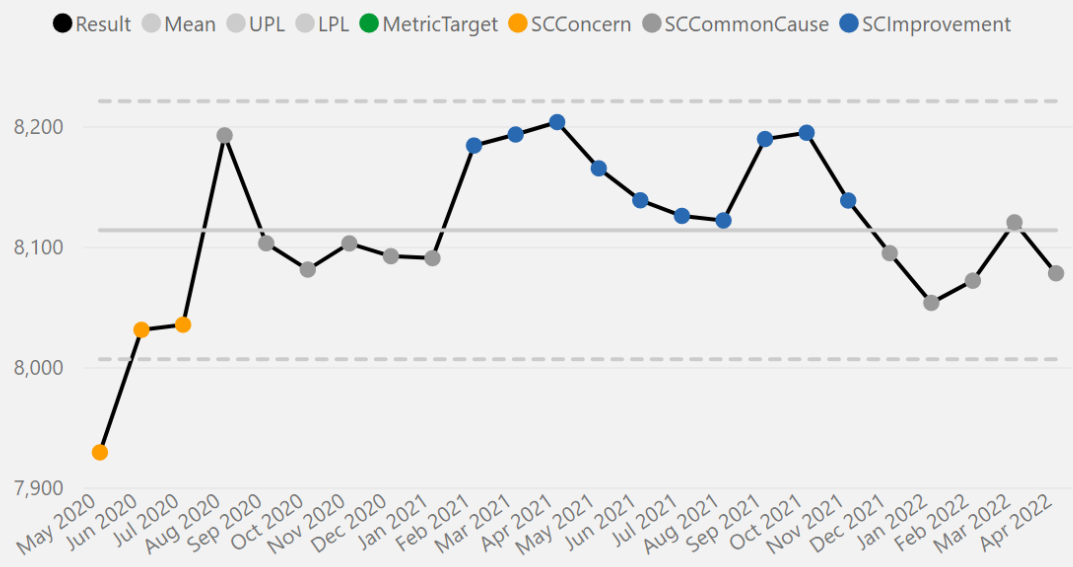
Actual Substantive Headcount (WTE)

Apr 2022

Variation | Assurance

8,078 Result
N/A Target
8,221 UPL
8,114 Mean
8,006 LPL

Actual Substantive Headcount (WTE)



Improvement Actions

April 2022 – International nurses have commenced at the Trust

Analytical Commentary

Variation is Common Cause

Assurance Commentary

Substantive staff in post is 8,078 for April 2022, a decrease from March 2022 (8,120). With the actions outlined below, it is expected to see an improved headcount by August 2022.

Along with the retention actions and staff engagement actions, crucial workforce roles have been identified, such as Nursing, ODP's and Healthcare Assistants and Medical Workforce. Recruitment trajectories for nursing across Medicine, Surgery, Midwifery and Paediatrics have been developed. Along with recruitment trajectories for healthcare assistants across Medicine and Surgery. These identify the trajectory of filling the vacancy gap to ensure robust plans are in place.

This focus on recruitment for these critical roles will lead to an increase in the headcount and assist the Trust to become less reliant on temporary workforce (bank and agency) to fill workforce gaps. The Temporary Staffing Team are also supporting Divisions in sourcing healthcare assistants to temporarily increase the staffing levels whilst recruitment is undertaken.

These actions are also supported by the first cohort of international nurses commencing at the Trust. An additional corporate induction programmes for Healthcare Assistants was delivered in April.

Vacancies

NNUH Digital Health
business intelligence

Variance: Headcount (WTE)

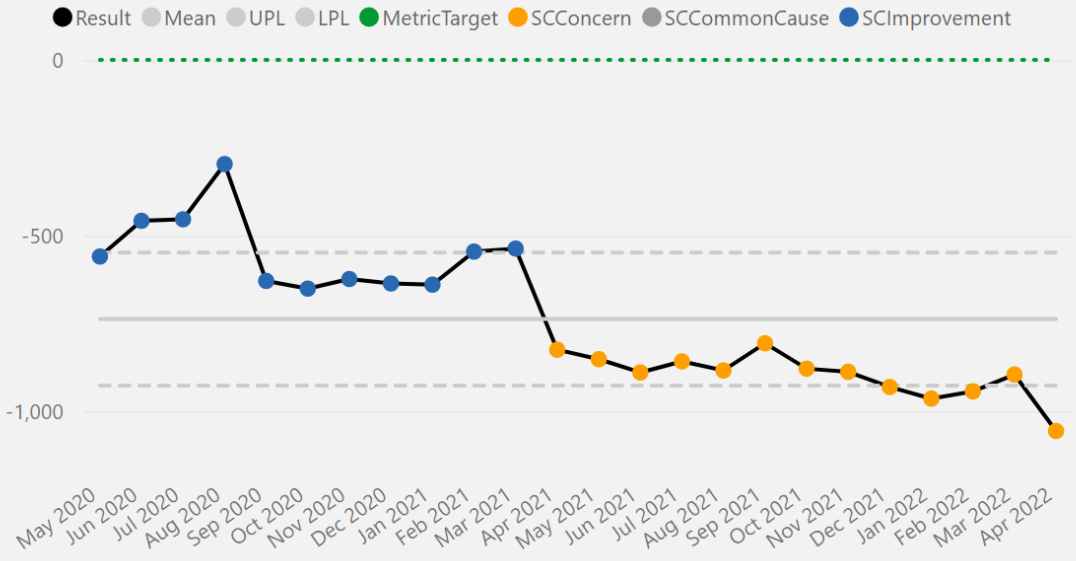
Apr 2022

Variation	Assurance
L	F

-1,057 Result
0 Target

-548 UPL
-738 Mean
-928 LPL

Variance: Headcount (WTE)



Improvement Actions

April 2022 – 90 newly qualified nurses are now recruited to commence between June and September

April 2022 – a total of 58 international nurses have joined the Trust.

Analytical Commentary

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

Assurance Commentary

The vacancy % for April is 11.6%; a 1.7% increase from March 2022 (9.9%) due to an increase in Budget of 118.6 WTE, combined with the 42.3 WTE decrease in staff in post.

With actions outlined below, it is expected to see an improved vacancy rate by August 2022.
58 international nurses have been recruited to the Trust with an additional 33 in our recruitment pipeline.

Following the introduction of career conversations, 90 third year students have now been offered a role at the Trust for a start dates ranging from June to September.
Healthcare assistant recruitment checks is now led by one Recruitment Officer to provide focused support.

This focus has streamlined the process, enabled provisional start dates to be agreed at the beginning of the recruitment check process and expediated provisional bookings made on the HCA training course, pending pre-hire checks. With support from our colleagues in Practice Development and Education, this revised process has enabled an additional training programme to be held in April, along with an additional 10 places per month during May, June, and July. This will enable an additional 45 Healthcare Assistants to join the Trust during this time.

Recruitment (Non-Medical)

NNUH Digital Health
business intelligence

Time to Hire - Total

Apr 2022

Variation	Assurance
	

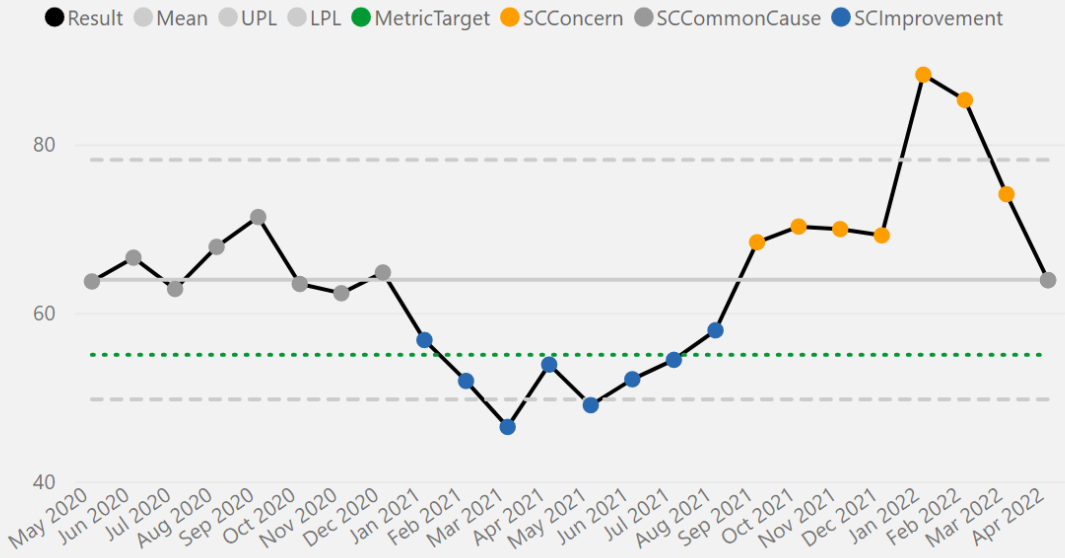
63.9 Result
55.0 Target

78.1 UPL
63.9 Mean
49.7 LPL

Analytical Commentary

Variation is Common Cause

Time to Hire - Total



Assurance Commentary

The implementation of continued recruitment improvements that have positively impacted on the Trust's time to hire are being embedded. Time to Hire for April 2022 is 63.9 days which is in line with the trajectory (to reduce to 55 by June 2022 – reportable July 2022) and has been on target since February 2022.

A significant improvement for April has seen the impact of two improvements on the time to check aspects of time to hire. This has been the introduction of the Internal Recruitment SOP and the conditional offer letter now being sent within 48 hours. The Internal Recruitment SOP has led to streamlining each element of the recruitment check process. This has significantly reduced the number of Pre-placement Health Questionnaires submitted to WHWB which reduced from 341 in March to 289 in April, as an example. The conditional offer letter is now sent, consistently, under 48 hours to the candidate and therefore improving the time to offer, instigating the recruitment checks more expediently and improving the candidate experience.

Improvement Actions

April 2022 – New internal recruitment SOP introduced to streamline recruitment checks

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Time to Hire - Time with Manager	Apr 2022	17.1		Common Cause		No Target

Job Planning

NNUH Digital Health
business intelligence

Job Plans Signed Off % (Within 12months)

Apr 2022

Variation | Assurance

F

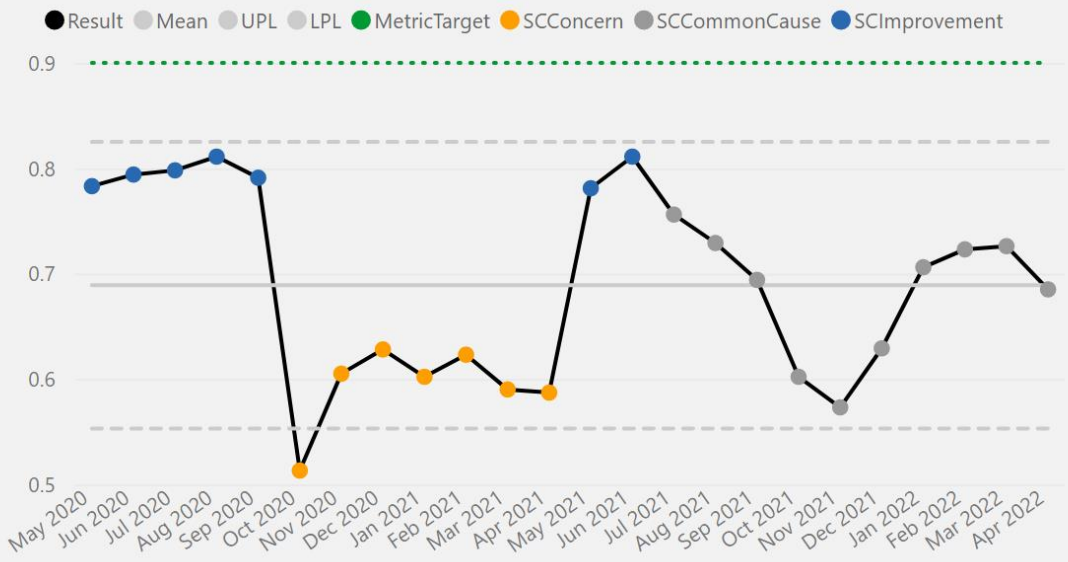
68.5% Result
90.0% Target

82.5% UPL
68.9% Mean
55.3% LPL

Analytical Commentary

Variation is Common Cause

Job Plans Signed Off % (Within 12months)



Assurance Commentary

April 2022 rate is 68.5% which is a decrease from March 2022 (72.6%).

The Job Planning Assurance Board meets monthly to review compliance and continues to look at ways to maximise the functionality within the eJob plan system and streamline processes for all users from the development to sign off stages for job plans.

A pilot commenced in April whereby job plans are automatically republished when they expire. This will streamline the processes for clinical staff, service directors and the eJob plan team. This pilot will be evaluated after 3 months.

Improvement Actions

May 2022 – Job plans will be automatically republished as they expire.

May 2022 – Roll over pilot commenced

REPORT TO THE TRUST BOARD

Date	Wednesday 8th June 2022		
Title	Staff Survey – Priority Improvement Actions		
Author & Exec lead	Sarah Pask, Head of OD & Learning and Julia Buck, People Promise Manager for Paul Jones, Chief People Officer		
Purpose	**For Approval**		
Relevant Strategic Objective	- Our NNUH Team: Together, we will support each other to be the best that we can be, to be valued and proud of our hospital for all.		
Are there any quality, operational, workforce or financial implications of the decision requested by this report? If so explain where these are/will be addressed.	**Quality**	**Yes✓ No☐**	**Increased staff engagement links to improved quality and performance**
	Operational	**Yes☐ No✓**	
	Workforce	**Yes✓ No☐**	**Staff engagement and morale**
	Financial	**Yes☐ No✓**	

1. Background/Context

1.1 The NHS Staff Survey results were published on the 30th March 2022. The feedback captured within our results has been reviewed and consulted with HMB, Diverse Staff Networks, JSCC, Staff Governors, Executive Team, Culture Change and Divisional Leadership Teams.

1.2 Feedback has also been triangulated from Freedom to Speak Up analysis, Leadership Survey, Narrative Feedback from the Staff Survey and the People Promise self-assessment.

1.3 A 3-year rolling improvement plan commenced in 2021, with listening events to gain a fuller understanding of the results. The overall themes identified in this year's survey are broadly similar, some issues will need to be addressed over multiple years to achieved desired changes. Cultural changes may take time for staff to feel and therefore report substantive improvements.

1.3 It is important to gain traction on the most important areas, these have been prioritised by our staff. These group into 6 priority areas for action and are captured on a 1-page improvement plan, with actions to address the concerns raised by colleagues. Key performance indicators have been added which will be reviewed with the individual workstream owners.

Staff Experience Implementation Plan – Priority Actions

NNUH Corporate and People and Culture Strategy: *Together, we will support each other to be the best that we can be, to be valued and proud of our hospital for all*

Staff concern identified	Action	Actions/Measures
1. Staff shortages Owner: Paul Jones	• Recruit to establishment • Reduce time-to-hire • Retention of existing staff • Reduce short term absence	• Reduce overall vacancy to 10%, with key clinical roles reduced to 5% by March 2023 • 55-day Time to Hire by end June 2022 • Turnover reduced to under 10% by end March 2023 • 20% reduction in staff activating absence triggers by end March 2023
2. Staff facilities Owner: Simon Hackwell	• Improvements in staff facilities • Staff engagement to understand what would make the most difference	• Priorities for improvement agreed, following consultation with staff (June 2022) • Delivery plan identifying timelines, communicated to staff (30 June 2022) • Revised parking offering and travel to work plan in place (December 2022)
3. Manager support and appreciation Owner: Chris Cobb	• Leadership visibility programme • New PDR approach launched • Promotion of 'Licence to Lead' to all line managers (Currently recorded as appraisers)	• Monthly Programme of senior management (Executives/HMB DMT) visits to service areas, (commence mid-June 2022) • Meaningful PDR discussion with line manager (increase in positive appraisal experience 2022 Staff Survey) • 500 x line managers to complete their 'Licence to Lead' programme with evaluated positive outcomes on staff experience by March 2023
4. Staff Wellbeing Owner: Nancy Fontaine	• Support for wellbeing at work – to help address "burnout" • Support to help with cost-of-living pressures • Action to minimise staff redeployments	• PDR Well-being conversation (90% by end Sept 2022) • Re-launch of Schwartz Rounds, PNAs & other support roles available to staff (end Sept 2022) • Programme of 'Rest & Restore days' (ongoing to March 2023) • Financial hardship support information available for staff (mid-June 2022) • 50% reduction in staff moves reported through E-Roster (October 2022)
5. Addressing poor behaviours Owner: Erika Denton	• Addressing poor behaviours from staff and managers • Addressing poor behaviours from service users	• Divisional actions agreed for areas with high incidence of bullying or feeling unable to speak up (end June 2022) • Revised 'Dignity at Work' policy launched with easier routes to raise concerns (Sept 2022) • New Leadership Standards – making clear expectations of all leaders (July 2022) • 'No excuse for abuse' campaign launched (June 2022) • Withdrawal of Treatment Protocol launched (July 2022)
6. Flexible working Owner: Paul Jones/ Wellbeing Guardian	• Improved access to flexible working for existing and new staff	• At least 25% of job adverts include option for flexible working (June 2022) • Divisional metrics in place, to monitor uptake of flexible working (Sept 2022) • Introduce divisional oversight for approval of flexible work requests, to ensure greater equity across the organisation (Sept 2022)

2. Key issues, risks, and actions

2.1 To ensure traction is gained on progressing the priority areas which are most important to staff, a number of enablers have been identified to support their successful delivery.

2.2 These key enablers:

- Every manager is required to share the staff survey results with their teams, where team responses are more than 11 x people. Together with their teams they will develop supportive local improvements which are within their own control.
- Each of the 6 x workstreams has an executive owner, to highlight their importance and ensure actions are progressed considering the needs of all staff groups
- Establish a Staff Council, with representation from each division and profession, to participate in improving staff experience and hold the organisation to account for making demonstrable progress
- Communication to staff to share the priority improvements and continue to provide a regular update on progress.
- In addition to the Staff Council, HMB will also receive a monthly highlight report. The existing Trust reporting template from the PMO has been adapted for this purpose

2.3 Staff Council

A Staff Council is identified as a key enabler. This will provide a forum enabling staff to engage and directly input into improvement actions and act as a Programme Board for the People Promise, working in concert to improve staff experience. It will also review progress on actions required to deliver the NNUH People and Culture Strategy.

The Council will have representatives from all staff groups, including our diverse staff networks and trade unions to adopt a partnership approach with divisional and managerial colleagues. Members of the Council will be expected to reach out to colleagues across their professional group to ensure a representative view. This will be communicated to colleagues detailing how they can express an interest in becoming a representative.

Research suggests that allowing staff to participate areas that are important to them, leads to a 50% reduced likelihood of staff burnout, which in itself forms one of our priority areas to support staff.

A draft terms of reference for the proposed Staff Council is currently being consulted on (Appendix A)

3. Conclusions/ Next steps

3.1 More staff than ever have shared their views on what is most important to them. This programme provides the visibility and clarity to support tangible improvements in staff experience. However, in addition to the proposed corporate workstreams it is also the responsibility of every leader to engage with their teams to improve the experience of people working within their span of control.

3.2 **Implementation Plan**

- The proposed Staff Council will be established following expressions of interest from staff
- The People Promise Manager will be following-up with each of the workstream owners, to formalise a workplan for each workstream, this will include clearly identified KPI's and milestones
- Each workstream lead will report to the Staff Council, and a monthly highlight report will also be discussed at HMB
- This will enable progress on each of the improvement actions to be tracked and provide assurance that outcomes are delivered
- The Staff Council will hold the organisation to account, regarding the delivery of the improvement actions

3.3 Overall governance will be reported via the Workforce and Education Sub-board (WESB) and the Trust's People & Culture Committee

Recommendation:

The Board is recommended to:

- Agree the Executive leads for each of the priority workstreams
- Endorse the principle that every leader will share their team results, and in conjunction with colleagues develop local improvements that will make a positive difference
- Support the communication of the improvement plan and provision of regular updates on progress
- Agree as a Trust Board a commitment to support improving staff experience as part of the above communication

Appendix A

NNUH Staff Council – Improving Staff Experience

Draft Terms of Reference

1. Introduction

We are committed to improving the day-to-day experience for staff at our hospital as part of our commitment to deliver on the goals of the NHS People Promise.

Evidence supports that a positive staff experience and staff engagement leads to improved patient outcomes and now, more than ever before, it's vital that we retain and value our staff.

The National NHS Staff Survey has highlighted a number of areas for improvement and this feedback has been triangulated from Freedom to Speak Up analysis, a Leadership Survey, Board Interviews, Narrative Feedback from the Staff Survey, and our self-assessment against the NHS People Promise commitments.

A set of priority actions for the next six months have been agreed, following consultation with staff which will provide initial focus for the Council.

It is recognised that some issues will need to be addressed over the longer term, with cultural changes taking time for staff to feel, and therefore report, a substantive difference.

2. Purpose

The purpose of the Staff Council is to provide a forum enabling colleagues to engage and directly input actions designed to improve staff experience. The Staff Council will act as a Programme Board to ensure delivery against the NHS People Promise and hold the organisation to account regarding this and the implementation of our People and Culture Strategy.

The Council will have representatives from all staff groups, including our diverse staff networks and trade unions to work in a partnership approach with divisional and managerial colleagues. Members of the Council will be expected to reach out to colleagues across their professional group to ensure a representative view.

The immediate priority actions aim see tangible progress against the areas that staff have told us matter most to them. The desired changes to culture will require ongoing review and adaption informed by quarterly pulse survey data, national staff survey outcomes, input from Council members and other feedback from colleagues.

To enable accountability and oversight, reports and information will be provided to the Staff Council from existing new and existing workstreams. Highlight reports will indicate progress against action plan milestones and key performance indicators (KPIs). Feedback will be sought from Staff Council members regarding the impact of these on staff experience.

The meetings will initially be chaired by Chief People Officer/Director of Workforce, but it is anticipated that over time the council will nominate its own chair.

3. Membership

Membership will include a cross representation of all staff groups:

- Chief People Officer or Director of Workforce
- Head of OD and Learning
- People Promise Manager
- Communications Lead
- Executive workstream owners or their nominated deputy
- Staff representatives from each workforce group in the Trust
- A nominated senior manager from each division
- Trade union representative
- Representatives from each of our Diverse Staff Networks

4. Support Arrangements

Secretariate support in the form of minutes and sharing of agenda and papers will be provided by a member of the workforce team.

The People Promise Manager will also provide support, ensuring reports and information is available to the Council. Progress on work will also be shared through regular communication updates to staff.

5. Meetings

Meetings will be monthly, via Teams to maximise accessibility across staff groups, with meetings scheduled for up to two hours.

The Chief People Officer will be the executive sponsor for the programme of work.

6. Duties

The key duties of the group are to:

- Provide a forum that enables staff to engage and contribute to progressing improvements to staff experience, particularly in respect of priority actions
- Hold the organisation to account as a Programme Board for delivering against the People Promise actions and regarding implementation of our People and Culture strategy
- Ensure proposed actions consider the needs of all staff groups
- Identify key enablers required to successfully implement actions or potential barriers to success
- Review highlight reports provided by each workstream, seek any clarification required to assess progress and escalate any items of concern
- Make suggestions regarding longer term priorities that may improve overall staff experience and actions required to deliver the People and Culture Strategy
- Ensure effective communication regarding the work of the group and how staff may contact members to discuss ideas for improvements

7. Reporting and Monitoring of Progress

Overall governance will be reported via the Workforce and Education Sub-board (WESB) and the Trust's People & Culture Committee. Monthly status updates on the agreed priority workstreams, will be reported monthly through Hospital Management Board (HMB).

The Staff Council has no delegated powers other than those specified in these Terms of Reference, but can escalate issues to the Workforce and Education Sub-board and subsequently to HMB