Trust Board (Public) - 7 June 2023

Wed 07 June 2023, 09:30 - 11:30

Norfolk and Norwich University Hospitals NHS Foundation Trust

A meeting of the Trust Board will take place at 9.30am on Wednesday 7 June 2023 in the Boardroom Norfolk & Norwich University Hospital

Papers for the meeting in public can be accessed via www.nnuh.nhs.uk

Agenda

Agenda

Tom Spink

00 TB Agenda Public 07.06.23.pdf (1 pages)

Clinical Visits 8.45am to 9.15am

All

1. Apologies, Declarations of Interest, Chairman's Introduction and Reflections on Clinical/Departmental Visits

Information/Discussion *Tom Spink*

2. Experience of Care – Equality, Diversity & Inclusion

Information *Nancy Fontaine*

Lee Brown, Rosie Bloomfield, Amrita Kulkarni and Sarah Higson attending

02 EDI Trust Board Update June 23.pdf (7 pages)

02(a) Ensuring Equality, Diversity and Inclusion are Embedded into Experience of Care Improvements.pdf (13 pages)

3. Minutes of the Board meeting held in public on 05.04.23

Approval *Tom Spink*

4. Matters arising and update on actions

Discussion *Tom Spink*

5. Chief Executive's Update - verbal

Discussion *Sam Higginson*

6. Freedom to Speak Up Update

Information *Fran Dawson - Lead FTSU Guardian*

06 FTSU June 2023.pdf (7 pages)

7. Reports for Information and Assurance:

Information, Assurance and Approval as specified

7.1. Quality and Safety Committee (30.05.23) - Committee Annual Report in Resource Centre

Pamela Chrispin

Information & Approval

07(a) Report on Quality & Safety Comm 30.05.23.pdf (3 pages)

7.1.1. Quality Account 2022/23 and Easy Read version - recommended for approval

Approval

07(a)(iii) Easy Read version - final draft.pdf (12 pages)
07(a)(ii) Quality Account 2022-2023 (final draft).pdf (121 pages)

7.1.2. Quality Priorities 2023/24 - recommended for approval

Approval

07(a)(iv) Quality Priorities 23.24 TB.pdf (16 pages)

7.2. IPR – Quality, Safety and Patient Experience data

Erika Denton and Nancy Fontaine

07(b) Quality Safety IPR report with added slides_7Beds in a Bay_FINAL.pdf (26 pages)

7.3. Finance, Investments and Performance Committee (31.05.23)

Tom Spink

Information

07(c) Report on Finance Investments & Performance Comm 31.05.23.pdf (2 pages)

7.4. IPR – Performance and Productivity data

Chris Cobb

Information

07(d)(i)a Report - Performance and Activity IPR.pdf (1 pages)
07(d)(i)b Performance and Activity IPR.pdf (33 pages)

7.4.1. Finance – Month 1 report

Roy Clarke

Information

07(d)(ii) Public Board Cover Sheet - M1 Finance Report.pdf (2 pages)
07(d)(ii) Trust Finance Report M01 - Public Board.pdf (6 pages)

7.5. People & Culture Committee (31.05.23)

Sandra Dinneen

7.6. IPR – Workforce data

Paul Jones

07(f) Workforce Trust IPR.pdf (12 pages)

7.7. Major Projects Assurance Committee (31.05.23) - Committee Annual Report in Resource Centre

Tom Spink

Information

07(g) Report on Major Projects Assurance Comm 31.05.23.pdf (1 pages)

8. Integrated Care Board Forward Plan

Discussion and Approval *Simon Hackwell*

08 NNUH TB June 23 ICB JFP.pdf (6 pages)

9. Questions from members of the public

Discussion *Tom Spink*

10. Any other business

Discussion *Tom Spink*

11. In its capacity as Corporate Trustee: Charitable Funds Committee (03.05.23)

Information *Joanna Hannam*

The next Board meeting in public will be at 9.30am on Wednesday 13 September 2023 in the Boardroom of the Norfolk and Norwich University Hospital

Our Vision
The best care for every patient

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

MEETING OF THE TRUST BOARD IN PUBLIC
WEDNESDAY 7 JUNE 2023

A meeting of the Trust Board will take place at 9.30am on Wednesday 7 June 2023 in the Boardroom Norfolk & Norwich University Hospital

Papers for the meeting in public can be accessed via www.nnuh.nhs.uk

AGENDA

	Item	Timing	Lead	Purpose
0	Clinical Visits	08.45-09.15		
1	- Apologies, Declarations of Interest - Chairman's Introduction - Reflections on Clinical/Departmental Visits	09.30-09.45	Chair	Information/ Discussion
2	Experience of Care – Equality, Diversity & Inclusion - Lee Brown, Rosie Bloomfield, Amrita Kulkarni and Sarah Higson attending	09.45-10.00	NF	Information
3	Minutes of the Board meeting held in public on 05.04.23	10.00-10.05	Chair	Approval
4	Matters arising and update on actions		Chair	Discussion
5	Chief Executive's Update	10.05-10.20	CEO	Discussion
6	Freedom to Speak Up Update Fran Dawson (Lead Freedom to Speak-Up Guardian) to attend	10.20-10.35	FD	Information
	Break	10.35-10.50		
7	**Reports for Information and Assurance:**			
	(a) Quality and Safety Committee (30.05.23)* i) Quality Account 2022/23 & ii) Easy Read version – for approval ii) Quality Priorities 2023/24 – for approval (b) IPR – Quality, Safety and Patient Experience data	10.50-11.05	PC ED/NF	Information, Assurance & Approval as specified
	(c) Finance, Investments and Performance Committee (31.05.23) (d) i) IPR – Performance and Productivity data ii) Finance – Month 1 report	11.05-11.20	TS CC RC	
	(e) People & Culture Committee (31.05.23) (f) IPR – Workforce data	11.20-11.35	SD PJ	
	(g) Major Projects Assurance Committee (31.05.23)*	11.35-11.45	TS	
8	Integrated Care Board Forward Plan*	11.45-11.55	SDH	Discussion & Approval
9	Questions from members of the public	11.55-12.05	Chair	Discussion
10	Any other business			
11	**In its capacity as Corporate Trustee:** Charitable Funds Committee (03.05.23)	12.05-12.15	JH	Information

*** Documents uploaded to Resource Centre**

Date and Time of next Board meeting in public

The next Board meeting in public will be at 9.30am on Wednesday 13 September 2023 in the Boardroom of the Norfolk and Norwich University Hospital

REPORT TO TRUST BOARD				
Date	**June 2023**			
Title	**Ensuring Equality, Diversity & Inclusion are embedded into Experiences of Care Improvements**			
Author & Exec Lead	**Lee Brown, Patient Experience Facilitator (Equality, Diversity and Inclusion) and Rosie Bloomfield, Patient Engagement and Experience Facilitator** **Professor Nancy Fontaine, Chief Nurse**			
Purpose	**For Information and Discussion**			
Relevant Strategic Commitment	**1. Together, we will develop services so that everyone has the best experience of care and treatment**			
Are there any quality, operational, workforce and financial implications of the decision requested by this report? If so explain where these are/will be addressed.	**Quality**	**Yes☐ No✓**		
	Operational	**Yes☐ No✓**		
	Workforce	**Yes☐ No✓**		
	Financial	**Yes☐ No✓**		
Identify which Committee/Board/Group has reviewed this document:	**Board/Committee:** **N/A**		**Outcome:**	

Background/Context

- The Patient Engagement and Experience Team was created in 2019. Since then it has grown with additional roles such as Patient Engagement and Experience Facilitator, and Patient Experience Facilitator (Equality, Diversity and Inclusion).

- The inclusion of these two roles demonstrates a deliberate and targeted focus on the experiences of patients who have traditionally been less well heard due to their protected characteristics and/or come from communities affected by deprivation or other social determinants of health. The nine protected characteristics defined in the Equality Act 2020 are:

- Age
- Sex
- Gender reassignment
- Being married or in a civil partnership
- Being pregnant or on maternity leave
- Disability
- Race including colour, nationality, ethnic or national origin

- Religion or belief
- Sexual orientation

The five social determinates of health are:

- Economic Stability
- Education Access and Quality
- Health Care Access and Quality
- Neighbourhood and Built Environment
- Social and Community Context

    - To better inform the Trust of the experiences of our patients the Patient Engagement and Experience team focussed on understanding NNUH patient demographics, and developing projects relating to and targeted at people who fall into the category of having one or multiple intersecting protected characteristics.

2 Key issues, risks and actions

2.1 The Patient Engagement and Experience team have been working on numerous work streams, outlined below.

2.2 **The Equality Delivery System (EDS) – to assess and understand our 'baseline' – what we do well, what we need to improve on.**

- The Equality Delivery System is an annual feedback and education framework mandated by NHS England. It has been designed to encourage NHS organisations to assess their services and discover and acknowledge where they are succeeding or faltering regarding equality, diversity and inclusion for both staff and patients.
- In 2022 evidence of patient based EDI was collected from LEDGes, Staff Networks and shared with the Patient Panel, before being analysed by the Patient Engagement and Experience team, with an overall NNUH self-graded rating of 'developing'. More information can be found here - Norfolk and Norwich University Hospitals NHS Foundation Trust » Equality Delivery System – EDS2 2022/23 (nnuh.nhs.uk)
- Developing means that the Trust has 'provided data and evidence to show relevant patients with higher risks due to a protected characteristic or at risk of health inequalities (50% of those using the service) have adequate access to the service', and that 'the organisation often consults with patients' regarding their needs. Key actions coming from the Trust's self assessment are:
- The need for a new suite of EDI training available to staff. This is one of the objectives within the Diversity, Inclusion and Belonging Strategy and early conversations with the Learning and Development team are already underway, with an objective to ensure 'when patients (service users) use the service, they are free from harm' (outcome 1C of EDS2022).
- Outcome 1D 'patients (service users) report positive experiences of the service' has led to consideration of the investigation and eventual creation of a reporting dashboard for bringing all feedback together including FFTs, PALS and Complaints, online feedback etc. This is one of our objectives within the Diversity, Inclusion and Belonging strategy, and exploration of what feedback we receive and the current gaps is being explored e.g. a question is to be added to online FFT to ask 'have you, or anyone in your immediate family, ever served in the British Armed Forces?' to further understand the experiences of patients who have served in the military. This phrasing was chosen by members of our Military Community Working Group, with an aim to add this to the physical FFT surveys.

2.3 **Diversity, Inclusion and Belonging Strategy – creating the framework to improve our 'hospital for all'**

- The Diversity, Inclusion and Belonging (DIB) Strategy ties directly to the objectives of the Caring with Pride Strategy and as previously noted, links to the EDS2022 self assessment.
- The strategy outlines staff and patient facing objectives for the next 1 to 5 years.
- Objectives have been set after consultation with various stakeholders, including different patient groups, Carers, organisational bodies and staff.
- The objectives outline how we as a Trust can provide excellent, equitable patient care based on what patients have told us, and what matters to them.
- As of June 2023 it has been decided that health inequalities objectives will be tied into the DIB Strategy to ensure equitable healthcare for seldom heard community groups are a key focus across the Trust
- The strategy is being finalised and anticipated publication in the coming months

2.4 **Health Inequalities improvement collaborative project – Maternity**

We have been lucky enough to gain funding from NHS England to involve service users in a health inequalities improvement collaborative project. We have focused our project on maternity due to our strong links with the Maternity Voices Partnership (MVP) and the brilliant work that was already happening regarding including service user reps in improvement work within the department.

Throughout May and early June we have been jointly hosting listening events with the MVP across Norfolk with a focus on three main health inequalities:

- **Vulnerability**
  Chapelfield cohort has the largest cohort of vulnerable women and birthing people so one event will be held in the Forum, Norwich

- **Ethnicity**
  Breckland cohort has 29.4% ethnicity categorised as white other and 7.9% BAME so one event will be held in Watton and one in Dereham.

- **Rurality**
  North Norfolk with one event being held in Sheringham.

Service users have influenced the conversations so the themes that are coming out of the listening events are truly what matters to them.

The MVP will be working with us to summarise the themes coming through from the conversations and a small report/presentation will be put together. The MVP, the patient experience team and the Maternity team will then work together on looking at what we can learn from this and if there's any improvement projects that we can focus on as a result of what service users have told us.

2.5 **Accessibility Information Standards (AIS) Policy**

The Patient Engagement and Experience Team have published our Accessibility Information Standards (AIS) Policy (Trust Docs ID: 20348). This policy includes a supporting document listing reasonable adjustments available across the Trust to assist staff to meet the Standard. The policy was co-produced and reviewed

by key contacts who are covered by the Standard. The team are now working to support the implementation of the policy across the Trust with the focus on two pilot sites.

Current work includes:

- Staff awareness about the AIS Standards and the impact is has on their daily practices.
- Additional training packages – Communication Access Symbol training, promoting the AIS ESR training module and Trust communication trolleys.
- Pilot sites – audiology and ophthalmology.
- PAS alerts to support identifying patients with communication or information support needs.
- PAS alerts to identify Carers
- Additional contact field in PAS for Carers

2.6 **Carers**

The Patient Engagement and Experience team continue to consult and co-produce all elements of Carers work with Carers. This occurs through our bi-monthly Carers Forum, which is attended by Carers, staff, and Carers organisation representatives. The team also engage with Carers outside of the Trust by attending pre-existing channels such as the Young Carers Forum and twice-yearly Care for Carers dates at The Forum.
Recently the Trust was re-awarded its Carer Friendly Health Tick award by Caring Together – demonstrating the impact of the co-production work undertaken across NNUH

Current work includes:

- Working with Carers to re-evaluate the NNUH Carers Passport and what it includes. This comes in light of the Carers Voice & ICB launch of the Norfolk and Waveney Carers Identity Passport, and wanting to provide the best but least confusing provision for all Carers.
- Review of the Working in Partnership with Carers of Adult Inpatients guidance and Carers Partnership Agreement to ensure clarity of the presence of Carers on the wards and management of expectations of the duties they can/want to undertake while in the Trust.

2.7 **Veterans**

We have established a Military Community Working Group, which meets bi-monthly. Membership consists of veteran and ex-serving staff, patients, Carers and military organisation representatives. The membership influences the veteran and military workstream within the Trust, which includes:

- Submission of our Veteran Aware Re-accreditation, providing additional evidence of the services provided for veteran staff and patients and providing testimonials of experiences.
- Guiding and contributing to awareness throughout the Trust including the development of posters, arranging information stalls etc.

2.8 **Engagement with seldom heard communities**

- Throughout 2022 – present, the team have hosted and attended various engagement projects. This includes, but is not limited to young Carers, parents, LGBTQIA+ patients, Veterans and military personnel, and patients with neurodiversity.
- The purpose of all of this engagement is to listen to seldom heard communities about their experiences of our services. Any feedback which we receive is logged and shared with the relevant teams and staff to inform their service improvements.

- The Patient Engagement and Experience team can then offer support for teams and divisions to make the relevant changes needed in the instance of developmental feedback, or to spread the word of best practice when highlighting positive feedback e.g. the maternity team have reflected on FFT feedback from their service users and their partners and Carers. This has resulted in direct, positive changes such as food being provided for partners during their visits to the maternity department, and a change in visiting hours. This FFT feedback has been reinforced with the feedback from the health inequalities improvement collaborative project.

2.9 **Experience of care data – analysing the Friends and Family Test survey results by demographics**

- Data from January to March 2023 has shown that 9304 respondents provided Friends and Family Test demographic data. This is 6.86% of the patients who came through the Trust during the time period.
- 85.9% of these respondents consented to their data to be used (it is optional for patients to complete their demographic data when sharing their experience with us, so not all completed surveys included the patient's/Carer's demographics).
- Only 9.3% provided their age, 8.3% provided their disability status, 9.7% provided their ethnicity and 9.9% provided their gender.
- Our data is reflective of what we see in the Census data, however we need to consider that not every resident fills out the Census. Members of the public may have the same accessibility issues to the Census as they do with our FFT and this means we are still likely missing the demographics of several patients.

There is currently no conclusive evidence to state that patients with protected characteristics are having a worse experience with our services, however we do not have adequate data to prove either positive or negative due to the lack of demographics being reported. Reasons for this lack of reporting may be:

- FFT surveys are not being provided to patients and Carers.
- FFT surveys may not be accessible to patients and Carers e.g. language.
- Patients do not understand why they need to provide their demographics to us.
- Patients do not want to give demographics to us due to possible mistrust.
- Patients do not associate any positive or negative experiences with the intersections of their protected characteristics.
- FFT surveys are limited in what they can collect due to how someone may define themselves e.g. someone may not be non-binary but genderfluid.

- Actions are being taken to promote demographic questions being answered, such as the preparation a communications campaigns around "**Help us get to know our patients".** This will focus on why we ask the questions and the benefits of sharing it. Also working with volunteer co-ordinators to update volunteers on the benefits of asking the demographic questions, which will provide some confidence building for volunteers.

2.10 **Demographic Data on the Patient Administration System – PAS**

- Patient Administration System does not have all demographics available to record – sexual orientation and gender/transgender data collection are not available.
- Gender/Transgender – the Trust data quality team began reviewing the possibilities for PAS prior to COVID19 and were planning to establish a gender forum for these purposes. There is hope to reinstate this group to take the issue forward, and some work has already started regarding the identification of transgender patients.

- We are currently reviewing the gaps in identifying communication and language needs through the development of the Accessible Information Standards (AIS) Policy, the Interpreting and Translation Services Policy.
- This data does not include Carers and Veterans, though I will be looking to add those data sets if possible.

2.11 **Demographic Data from National Patient Surveys**

- There are a variety of national patient surveys available to us to help inform and benchmark our data. More information can be found here - Surveys - NHS Surveys
- There are limited number of patients who complete the national patient surveys, and the majority of respondents are White British.
- The lack of diversity within the respondents means that the results are difficult to analyse further due to the aforementioned low numbers.

- **Conclusions/Outcome/Next steps**

The Patient Engagement and Experience Team have embedded EDI as a core, golden thread of the NNUH approach to engagement and experience of care, and latterly linking Health Inequalities into the strategic approach.

Strong relationships across the Trust, externally and with specific groups have been established and provide strong foundations for further growth and the implementation of the Diversity Inclusion and Belonging strategy.

The collection, analysis and collation of evidence and available data for EDS and to inform the Diversity Inclusion and Belonging strategy has identified and underlined a core objective within the strategy for year one specifically to *'improve how we collate demographic data from our patients.'*

In order to achieve this objective we will need to:

- Ensure that patients and Carers understand why we are asking for their demographics – to improve our services and make sure that the Trust is providing equitable healthcare to all.
- Build strong and trusting relationships with our seldom-heard communities through attending their events, inviting them to co-produce projects with us, and listening to their opinions and implementing actions based on this. 'You Said, We Did' being highly visible to patients and Carers will enable them to feel more comfortable as they see that we take action.
- Ensure greater access to the FFT for patients and Carers through a range of ways to collect it - and are assisted where necessary e.g. literacy, language, visual impairments.
- As a Trust we will be working towards the Diversity, Inclusion and Belonging Strategy action to *'investigate a reporting dashboard for bringing all feedback together including FFTs, PALS and Complaints, online feedback etc.'* With a dashboard that connects all our data, including links to demographics in an easy to analyse way we will have the intelligence to be able to serve our patients and Carers' equity, diversity and inclusion needs. Digital Health/Business Intelligence support to develop this and data analytical support to interpret the data will be crucial to achieving this objective.
- Continuing work with the next cycle of EDS throughout the summer to ensure we are capturing the insight and experiences of our diverse demographic of patients and Carers. Improved demographic collection will enable us to demonstrate NNUH are providing equitable services for patients across every area of the Equality Act 2010 allowing NNUH to achieve the 'excelling' grade in the EDS.
- Continuing co-production and consultation with our Carers Forum.

- Continuing co-production and consultation with our Military Community Working Group.
- Working in collaboration with staff and communities to ensure the objectives of the Diversity, Inclusion and Belonging Strategy are met and are successful.

Future plans for engagement with seldom heard communities:

- Continuing to attend and host various engagement opportunities.
- Working with different stakeholders and local organisations to build trust with community groups before asking for their experiences. This will ensure that no person nor group of people feel like their experiences are being used to tick a box, nor that there is an opinion of the Trust that we are being tokenistic.
- Continue to approach patients and Carers with a 'What Matters to You?' approach in order to be fully informed by our service users and making no assumptions.

Recommendations:

The Board is recommended to:

- Receive this report for information and to note plans for further developments in equality, diversity and inclusion work across the Trust.
- Note the ongoing focus will include interactions and engagement with patients and Carers from seldom heard communities, using methodologies to receive feedback beyond the established feedback routes e.g. FFT. This will contribute to making the Trust as accessible as possible to ensure equitable healthcare for all.
- Note that the equality, diversity and inclusion work stream is vast, and support is needed across the Trust from all levels. The Trust's priority must be to understand and analyse the demographics of our patient population against their experiences and outcomes to increase our standards of care. The introduction of the Electronic Patient Record (EPR) is a tremendous opportunity to ensure we can do this simply and in a streamlined way across Norfolk and Waveney.

Ensuring Equality, Diversity and Inclusion are Embedded into Experience of Care Improvements

Report to Trust Board

June 2023

Lee Brown, Patient Experience Facilitator (EDI), he/him

Rosie Bloomfield, Patient Engagement and Experience Facilitator, she/her

Background/Context

The nine protected characteristics defined in the Equality Act 2010:

- Age
- Sex
- Gender reassignment
- Being married or in a civil partnership
- Being pregnant or on maternity leave
- Disability
- Race including colour, nationality, ethnic or national origin
- Religion or belief
- Sexual orientation

The five social determinates of health are:

- Economic Stability
- Education Access and Quality
- Health Care Access and Quality
- Neighbourhood and Built Environment
- Social and Community Context

The Equality Delivery System (EDS)

For Domain 1's submission we have scored each objective as follows:

	Outcome	Scoring Total
1A	Patients (service users) have required levels of access to the service	Developing / achieving
1B	Individual patients (service users) health needs are met	Developing / achieving
1C	When patients (service users) use the service, they are free from harm	Developing / achieving
1D	Patients (service users) report positive experiences of the service	Developing / achieving

Diversity, Inclusion and Belonging Strategy

The Diversity, Inclusion and Belonging (DIB) Strategy ties directly to the objectives of the Caring with Pride Strategy and as previously noted, links to the EDS2022 self assessment. Objectives have been set after consultation with various stakeholders, including different patient groups, Carers, organisational bodies and staff.

Our objectives include:

- Develop and introduce our Accessible Information Standards (AIS) Policy.
- Reach out, engage and develop partnerships with seldom heard community groups.

Health Inequalities Improvement Collaborative Project

Targeted engagement hearing the voices of maternity service users. Focused on the following health inequalities:

- **Vulnerability**
  Chapelfield cohort has the largest cohort of vulnerable women and birthing people so one event will be held in the Forum, Norwich

- **Ethnicity**
  Breckland cohort has 29.4% ethnicity categorised as white other and 7.9% BAME so one event will be held in Watton and one in Dereham.

- **Rurality**
  North Norfolk with one event being held in Sheringham.

Accessibility Information Standards (AIS) Policy

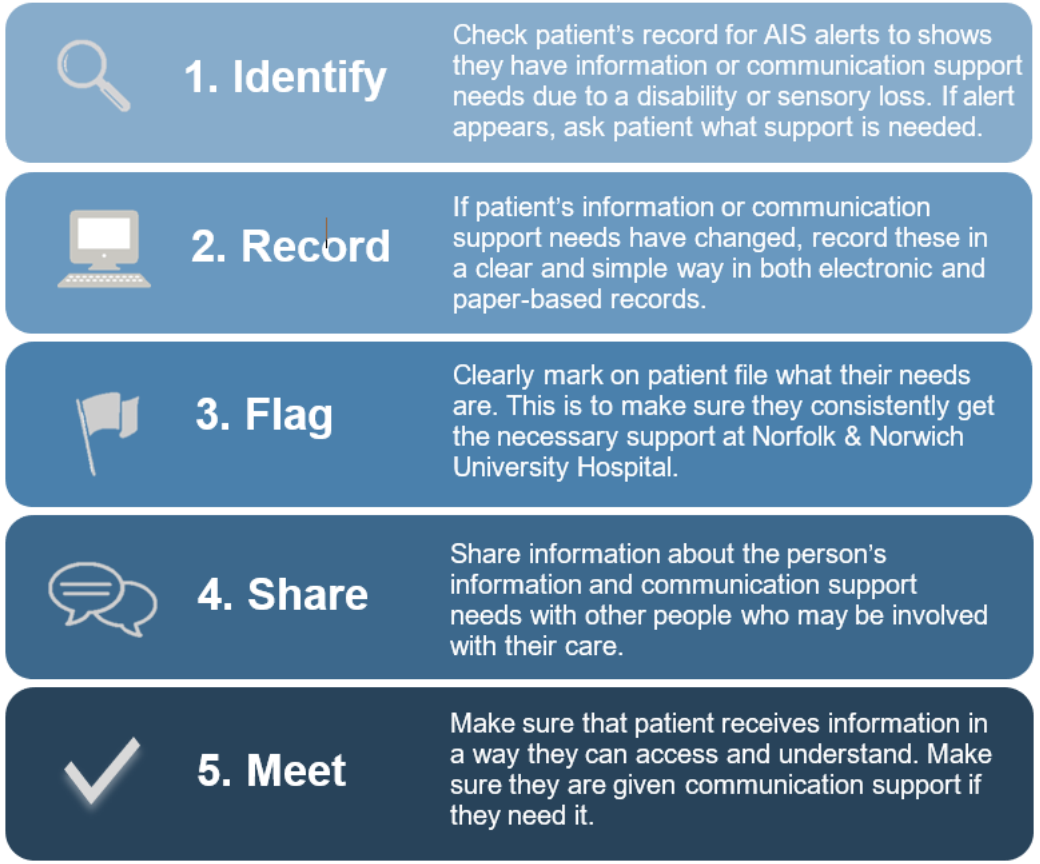
Published our Accessibility Information Standards (AIS) Policy.

Includes a supporting document listing reasonable adjustments available across the Trust to assist with meeting the Standard.

The policy was co-produced and reviewed by key contacts who are covered by the Standard.

The team are now working to support the implementation of the policy across the Trust with the focus on two pilot sites.

Accessibility Information Standards (AIS) Policy



Engagement with Seldom Heard Communities

NNUH Patient Engagement & Experienc... @PatientExp_N... · Apr 1
We're having a great morning at @NansaNorfolk's Neurodiversity Festival collecting feedback on our Diversity, Inclusion and Belonging Strategy 🗣️

1 3 282

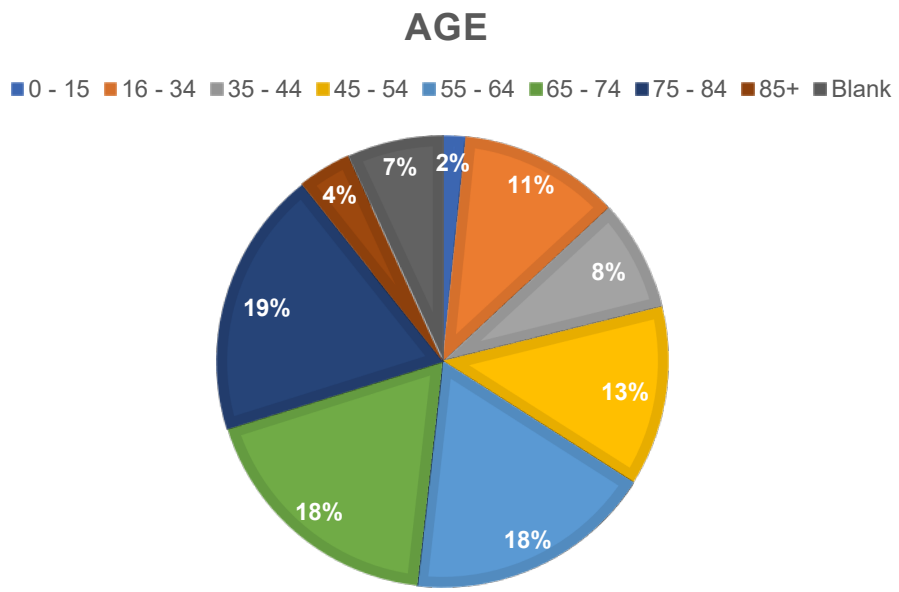
NNUH Patient Engagement & Experi... @PatientE... · Nov 29, 2022
The team have had the pleasure of working closely with @MvpNorwich to make sure we're hearing the voices of families in the Norwich area.

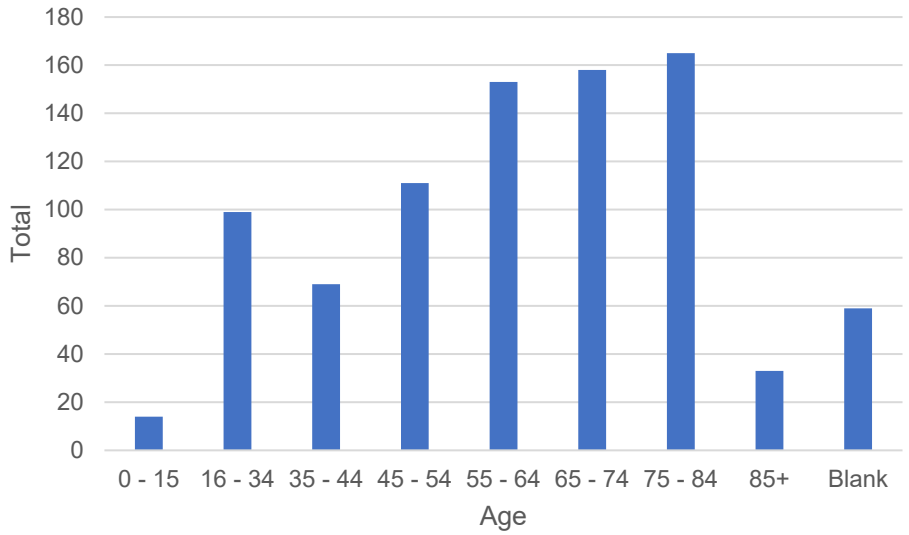
> **Norfolk & Norwich MVP** @MvpNorwich · Nov 29, 2022
> Out and about with @NNUH_Rosie again chatting to families at Mile across Phoenix Centre Tiny Tots 💜
>
> @NandW_LMNS @SJP12345 @PatientExp_NNUH

2 5

Experience of Care Data

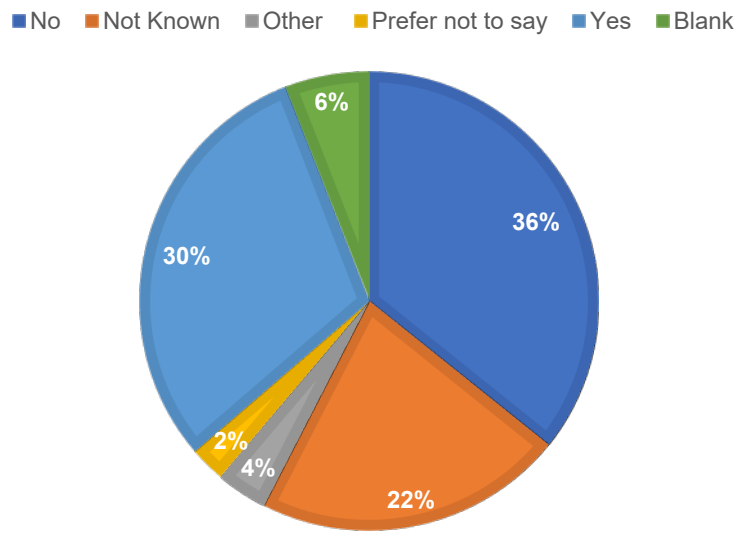
Breakdown of patient ages from FFT data Jan – March 2023

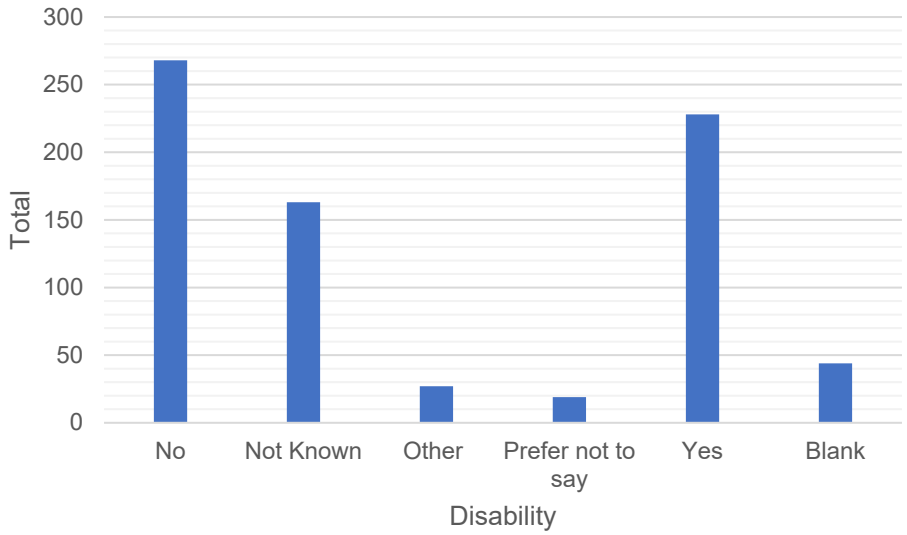




Experience of Care Data

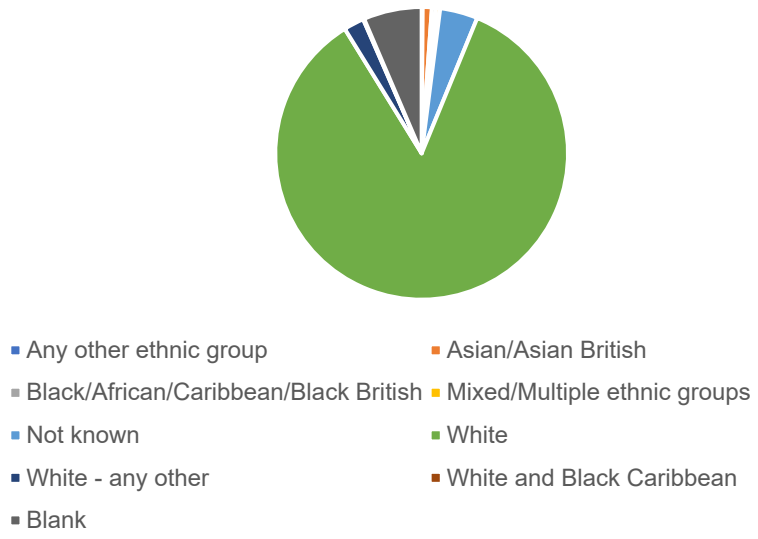
Breakdown of patient disability declaration from FFT data Jan – March 2023

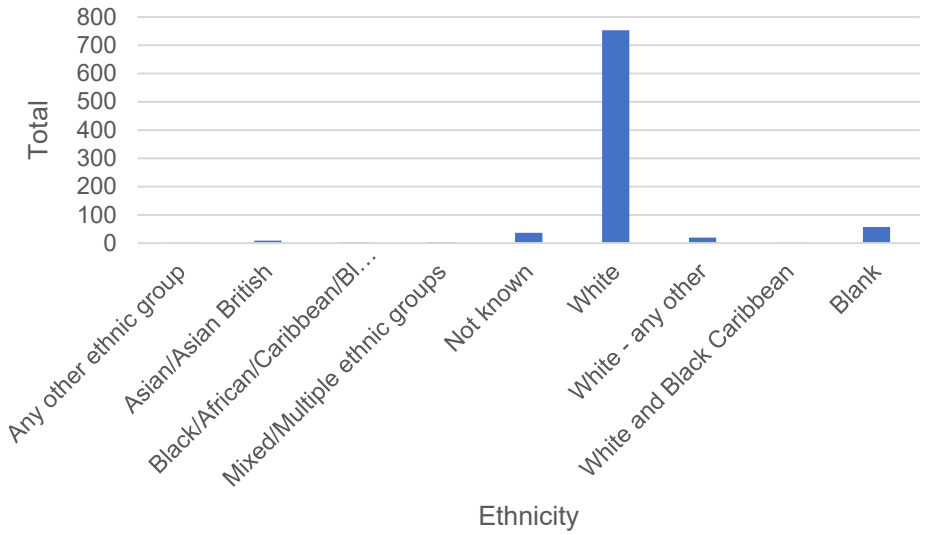




Experience of Care Data

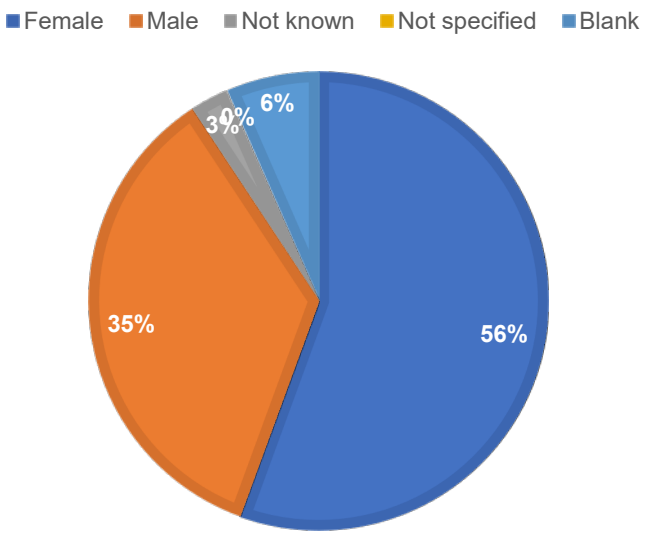
Breakdown of patient ethnicity from FFT data Jan – March 2023

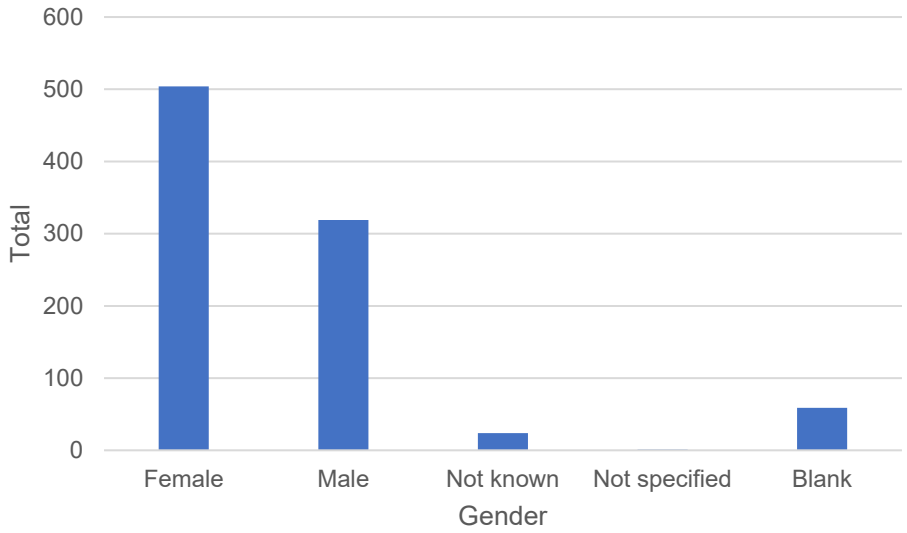




Experience of Care Data

Breakdown of patient gender from FFT data Jan – March 2023





Next steps

Equality Delivery System – engagement with seldom heard community groups and patients with protected characteristics throughout the months of summer ahead of the further collation and analysis of evidence in Autumn months.

Diversity Inclusion and Belonging Strategy – soft launch aim for July, with a launch event planned for September for prime engagement and awareness.

Accessible Information Standards - 6 month implementation plan from April - September covering internal communication and awareness, staff awareness and training, pilot sites and external communication.

Using patient engagement, demographics and social determinates of health to contextualise existing patient feedback – e.g. Health Inequalities Improvement Collaborative Project; complete 4 targeted engagement sessions before mid-June. Write up and agree improvements - MVP & Maternity led. Report back to NHS England on 13th July and report findings to clinical governance.

REPORT TO TRUST BOARD				
Date	**31/05/2023**			
Title	**Freedom To Speak Up (FTSU) Report**			
Author: **Exec Lead:**	**Frances Dawson (Lead Freedom To Speak Up Guardian)** **Paul Jones (Chief People Officer)**			
Purpose	**For Information and Discussion**			
Relevant Strategic Commitment	**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.** **4 Together, we will provide nationally recognised, clinically led services that are high quality, safe and based on evidence and research**			
Are there any quality, operational, workforce and financial implications of the decision requested by this report? **If so explain where these are/will be addressed.**		**Quality**	**Yes☐ No✓**	
		Operational	**Yes☐ No✓**	
		Workforce	**Yes☐ No✓**	
		Financial	**Yes☐ No✓**	
Identify which Committee/Board/Group has reviewed this document: N/A				**Outcome/decision/changes made: N/A**

1 Context

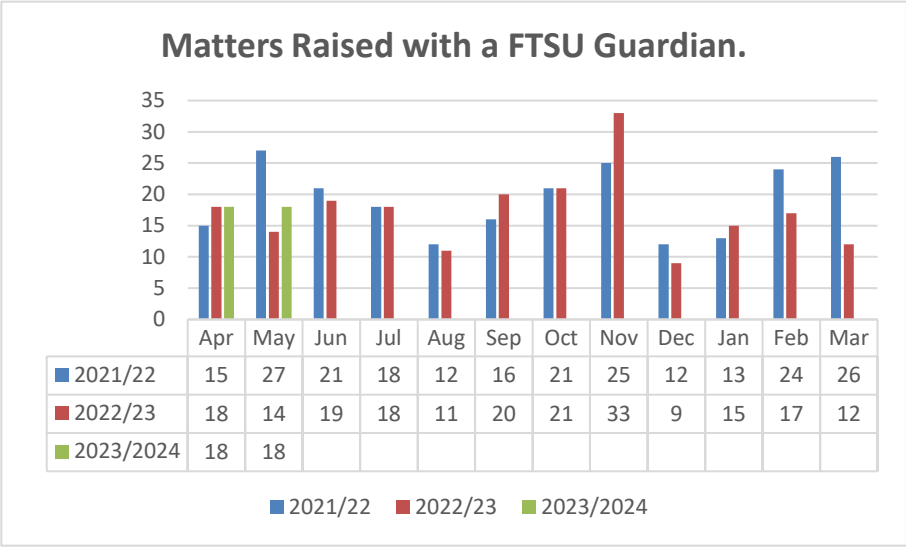
Speaking Up relates to anything that gets in the way of providing great care for patients or adversely impacts staff experience. It includes ideas for improvement and is the responsibility of all staff and workers within the NHS, to both speak up and support others when they do. The CQC reports there is a positive correlation between healthy speaking up cultures and CQC ratings within the NHS.

This report looks at speak up activity through the NNUH FTSU Guardian service. It considers main themes, learning from matters raised and considers actions to further embed and improve our practice and culture.

2 Activity

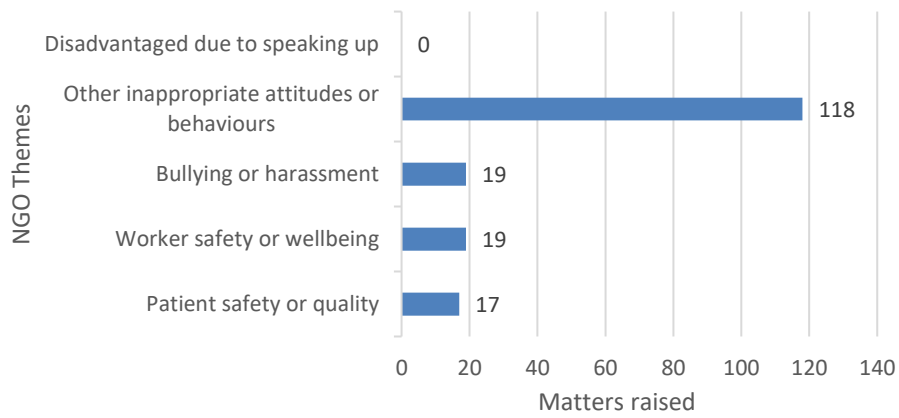
207 staff used the FTSU service in 2022. Forty-six additional conversations were started on the anonymous platform, compared to 230 and 35 respectively in 2021/22 (Fig 1). The anonymous platform includes Executive staff and FTSU Guardians.

Fig 1



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2021/22	15	27	21	18	12	16	21	25	12	13	24	26
2022/23	18	14	19	18	11	20	21	33	9	15	17	12
2023/2024	18	18										

Fig 2



3 Themes

Fig 2. Shows the NNUH key themes as reported to the NGO (National Guardians Office). This organisational data is published on the Model Health System dashboards (formerly Model Hospital). As with many other FTSU Guardian services across the NHS, the most common theme relates to staff relationships. Previously this category was not captured by the NGO. It was added at the request of the Guardian networks, to accurately reflect caseloads.

4 Learning

4.1 From themes - Most matters raised, relate to sensitive and often subjective experiences that can be difficult to share and therefore learn from. Other organisations have struggled with this and on discussion at regional meetings, no agreed pathway was identified amongst Guardians.

We have proposed a pathway to overcome this at the NNUH. This pathway has been presented to the People and Culture committee and NHSE, when they visited NNUH as one of the People Promise exemplar sites. We will engage with the JSCC, Diverse Staff Networks and the Staff Council, to gain commitment and seek feedback on the proposal. Following approval, we will work with the Communications Team to share this more widely in the organisation. Appendix I provides an overview of the proposal.

4.2 From staff experience – We have much to learn from each case and matters which are raised, particularly where there are recurrent themes which emerge. We aim to have visible data and KPI's to establish how effective speaking up is for staff and where possible share case studies of how this has constructively resolved concerns. Reporting quarterly on this will enable us to see how many cases remain open and will enable us to consistently follow an escalation route.

- Acknowledgement of matter raised – 2 working days
- Closure of matter raised – 28 days from meeting with a Guardian

- Exception reporting outliers (>28 days) to share with Executive lead for FTSU and relevant divisional triumvirate.

4.3 From Feedback of staff using the service - We have included another question for service users to comment on. "*If you had not used the FTSU service, what would you have done?"* Recent feedback has been included below but it is too early to propose themes. We suspect that wellbeing and speaking up are linked in many matters. The answers to this question will help us explore the true impact for staff and the organisation.

I would have found another job
I would not have approached my situation the same, and possibly would have had a negative outcome.

4.4 Protected characteristics – This will routinely be included in our reporting from April 2023 onwards and help us identify what more we can do to reach staff who may not be using the service.

5 Conclusions

The 2022 NNUH staff survey highlighted significant gaps, where staff do not have faith that speaking up will make a difference. Our data demonstrates that most issues relate to relationships, and this is in keeping with the national picture.

We have successfully helped in many matters and can replicate this approach as it is line with NNUH Communicating with Pride practice, however an absence of a functional learning pathway has limited the sharing of knowledge, staff stories and best practice. Learning form national case reviews is also an important aspect of our learning ambition to share through Hospital Management Board and other fora. We are expected to use the published NGO case reviews to further improve our practice as a Trust. The pathway needs to support the delivery of this.

Recommendations: The Board is recommended to consider the proposed learning pathway, provide any feedback and agree how best to support its adoption.

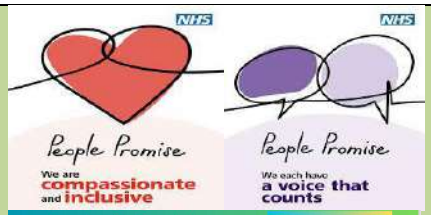
Appendix 1

Comparison of a matter raised using existing mechanisms, versus the *people promise (PP)* approach.

The table below demonstrates the pathway of a speak up matter, looking at how it is reported, what actions are involved, key identifiable themes, the potential population for learning and who the information can safely be shared with.

Bullying has been used as a typical example. Staff understand bullying is not an acceptable behaviour either to tolerate or to take part in, yet it remains a sensitive and complicated issue to speak openly about. It is likely to evoke negative emotions and for many this creates more barriers and reinforces negative perceptions. Stories cannot be easily shared even if someone has had a positive outcome, i.e., they no longer feel bullied as it will inevitably involve another member of staff and matters are rarely straightforward.

Matter raised in FTSU service	FTSU Reporting	Actions	Key themes	Potential Learning population	Shared with
Matter raised Bullying – member of staff feeling bullied by a team member.	Reported – Bullying matter logged for NNUH and national reporting. Division – may become aware of a bullying matter but nothing else as it would identify individual staff and no consent to share given. Not appropriate to share further due to sensitivity.	Staff and managers supported to address.	Bullying Detriment	Local – (4 people).	No pathway – no further sharing other than anecdotal No staff story.
Matter raised Bullying – member of staff feeling	Reported – bullying matter logged for	Staff and managers supported to address.	Multiple themes – supportive and positive messaging.	Trust wide.	HRBP's - Divisions.

bullied by a team member	NNUH and national reporting. HRBP's – people promise themes fedback to divisons monthly with FTSU KPI's and exception report. Consent - not given however able to safely share key messaging through one or more people promise themes – see *shared with.* Reporting to Board - improved narrative.	Themes translated into people promise messaging.	  Newsletter = People Promise (PP) FTSU noticeboard. Posters/emailed/archive and catalogue – are themes developing and changing? Have the same matters been raised? If so, this can trigger further targeted action. Newsletter signposts to relevant tools/OD/contacts/training/policies.		FTSU network - Newsletter across teams and departments. Positive messaging for managers to display. Staff networks, council, staff side. The Beat pages Organisational development/training. HR ops and PP exemplar work. Comms team. Divisons – staff survey traingualtion possible, targetted relevant themes (power BI) re: people promise pillars. Staff stories become possible, reinforcing speaking up is safe and can make a difference. Staff will see their lessons being shared trust wide.

- Adopting the PP themes, as opposed to the NGO themes, the FTSU service is asked to report on, enables positive and relevant messaging to occur that has fewer boundaries, even if sensitive at origin.
- A “noticeboard” of FTSU matters will enable any recurring themes to be identified and will not be solely reliant on the FTSU service to detect these. This is likely to improve the potential learning for the organisation and staff.
- Messaging can be targeted and proactive. Staff survey results are presented in alignment to these themes which gives us improved opportunity to influence, even in the absence of staff speaking up in an area.
- Messaging can be actioned in improved real time.
- Learning from the national case reviews can be shared using this same approach.

Freedom To Speak Up

Sharing Key Lessons Learnt From Matters Raised by Staff;

Help teams keep up to date, and share this with your colleagues.

1st edition 2023

Working flexibly can be productive. It requires two way trust and accountability. If you're worried it will not work, you could consider a trial. Agree how to measure whether it's successful for **both** parties. You may need to consider compromise on all sides, explore new ways of working and avoid a blanket approach, as staff feel some areas have done this.
Help us reach our full potential as a flexible employer to retain and attract staff.

Imagine feeling bullied. It's a scary, isolating place to be.
It can reduce us to shadows of our true selves.
It's debilitating.

However, if it were a medical disorder we would say, much of it is preventable and recovery **is** 100% possible.

Keep things simple and consider;

1) Be accountable for the impact your behaviour has on others. Be honest with yourself, are you easy to work with or have you become more difficult over time? Ask for help and support if this is you. Very few people intentionally bully. Most have fallen into bullying behaviours that when repeated over time can be viewed as bullying. We can help you in complete confidence if you want to change and get back to your old self.

2) If you're a manager, how confident are you that you know how to address bullying if someone in your team comes to you for help? You do need to appear confident, we know that moment really matters to the person speaking up. You might not really feel it, but don't worry HR can help you and the Speak Up Service can also offer guidance on how to avoid detriment and what best practice looks like. You are not on your own. We have learnt a great deal over the years and can help.

3) If you feel bullied, contact your line manager now. It's not OK to keep feeling this way. We can help and you can help yourself too. Time for positive change is now.
ftsug@nnuh.nhs.uk
01603 286891

(Draft Newsletter/Notice)

REPORT TO TRUST BOARD

Date	**7 June 2023**
Title	**Chair's key Issues report from Quality and Safety Committee Meeting on 30.05.23**
Lead	**Dr Pam Chrispin – Non-Executive Director (Committee Chair)**
Purpose	**For information and approval**

The Quality and Safety Committee met on 30 May 2023. 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 on this occasion, there were no governor observers.

In addition to consideration of the usual suite of information and reports concerning quality and safety in the Trust, the Committee received a series of reports in accordance with its Work Programme and relating to the Trust's annual priorities – in particular, improving ambulance handovers, delivering planned care targets and continuing our quality improvement journey. The following matters were identified to highlight to the Board:

1	Clinical Visit - Heydon and Ingham Wards with a focus on the stroke pathway	The meeting began with a very educational visit relevant to the remit of the Committee and the anticipated development of a stroke thrombectomy service. Key issues were identified as being: - exit block – with very lengthy delays in onward transfer of patients following acute stroke care to services in the community - deficiencies in soft FM and minor works support - the excellent facilities provided by the 'new' ward block (Ingham Ward) - the repeated use of beds in the Hyper Acute Stroke Unit (HASU) beyond agreed levels – such that patients admitted with stroke cannot be admitted to the HASU Committee members were advised that the Sentinel Stroke National Audit Programme (SSNAP) dashboard is readily available and visible within the clinical team, but it is not so visible to the Committee or Board. In order to give performance in the stroke pathway the profile that it deserves, the Committee requested that the SSNAP dashboard be added to the monthly Integrated Performance Report (IPR)
2	Quality Account 2022/23	The Committee reviewed the draft Quality Account 2022/23 which is **attached** and is recommended to the Board for approval
3	N&W ICS Quality Strategy	The Committee considered the Norfolk & Waveney ICS Quality Strategy (2022 – 2025). It was agreed that the ICS should be asked to identify the specific quality priorities for this year, so that we can seek to inform this and seek alignment with Trust policies.

4	Quality Priorities 2023/24	The Committee reviewed the proposed Quality Priorities for 2023/24, which are Included in the Quality Account. The Quality Priorities are **attached** and these are recommended to the Board for approval.
5	Maternity Update	The Committee received the latest update report from the Maternity team. There have been no serious incidents reported in the last month. With new starters due to join the team it will be at almost full establishment which is very positive. The draft Maternity Strategy is due for review by the Committee in July.
6	Incidents, Complaints, Compliments and National Audit	The Committee reviewed reported incidents, including review of two serious incident investigations. The Committee had a lengthy discussion about the management of formal complaints. The Committee was advised that a significant backlog of cases has developed. Action to address this position should be monitored by the Patients Experience and Engagement Group and the Committee will be kept updated on progress. The Complaint numbers will also be added to the Divisional Performance & Accountability Framework (PAF) to enhance visibility.
7	Safer Staffing (nursing)	The Committee received it's the latest regular report regarding staffing, in the context of quality & safety and noted an increasingly positive position, with significant improvements in Maternity, Surgery and new starters. Ongoing scrutiny on this aspect of the Trust is also revealing areas in which data held in ESR and finance systems do not reconcile (for example Cancer Alliance funded posts and Hoveton Ward) and rectifying this will enable greater certainty over the actual vacancy rate.
8	Committee Annual Report 2022/23	The Committee discussed its Annual Report, reflecting on the reports received during 2022/23. The Committee's Annual Report has been uploaded to the Resource Centre for information. The Committee's conclusions are inevitably influenced by the fact that the Trust has continuously been in a position of Severe of Extreme Operational position throughout 2022/23, with huge numbers of patients awaiting discharge into the community, and the ongoing need to accommodate additional patients in wards and corridors. Given the recognized association between heightened operational pressures and poorer clinical outcomes the Committee considers that the Audit Committee and Board are entitled to take **partial assurance** from the work of the Quality and Safety Committee as part of the Trust's system of integrated governance.
9	Corporate Risk Register	The Committee reviewed the CRR relevant to the remit of the Committee together with the 'Top-5' most Significant Risks, namely: i) Severe & Extreme Operational Pressure and delayed discharges necessitating use of additional escalation beds ii) Prolonged waiting times for elective and planned care iii) Availability and affordability of sufficient, appropriately qualified staff iv) Relative digital immaturity, cyber vulnerability and absence of robust modern digital infrastructure (EPR & PAS) v) Potential deficit in staff satisfaction, health & well-being, motivation, engagement & resilience with a 6th concerning ambulance handovers: vi) Acute pressure in our Emergency Department and lack of operational resilience in the Emergency Care Pathway The Committee raised the challenge as to whether the CRR will be improved by implementing the the Quality Priorities and Trust Annual Plan.

Conclusions/Outcome/Next steps: The next Committee meeting is scheduled for 27 June 2023 and will consider:

- Complex Care Pathways & Heart failure pathway review

- Patient Engagement & Experience Strategy progress
- Digital Health - e-obs update - care of the Deteriorating Patient and response to the Early Warning Score
- Clinical Quality Impact Assessment (CQIA) inc risk appetite for transformation

Recommendations: The Board is recommended to:

- **note** the work of its Quality & Safety Committee,
- **approve** the Quality Account and Quality Priorities, and
- **receive** the Committee's Annual Report 2022/23.

Norfolk and Norwich University Hospitals
NHS Foundation Trust

NNUH Easy Read Quality Account 2022-2023

Words you may not have heard before

In this document, you may see words that you have not seen or heard before. These words will be in a different colour and look like '**this**'. When you see them, you can come back to this page to see what they mean.

Word	Meaning
On page 4 you will see	
NNUH	Norfolk and Norwich University Hospitals NHS Foundation Trust
Quality	This means that something is safe and good
On page 5 you will see	
Chairman	This is someone who makes sure the people in charge of the hospital are doing their jobs well.
Clinical Professionals	A Clinical Professional is someone who looks after you at the hospital. They are different to a Doctor, Junior Doctor, Dentist, Nurse, Midwife or someone who works in Administration
On page 6 you will see	
Surgeon	A Surgeon is a Doctor who cuts into a poorly person's body to help make them better

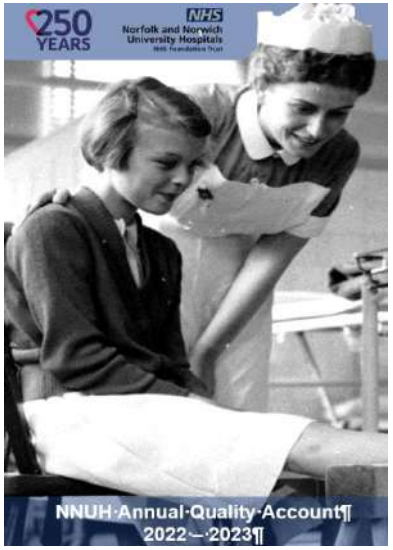
Words you may not have heard before

On page 7 you will see	
Emergency Department – you will also find this on page 9	This is the part of the hospital where poorly people who need to be seen straight away go
Delivery Suite	This is where Doctors and Midwives look after mum and baby
Midwifery Led Birthing Unit	This is where Midwives look after mum and baby
On page 8 you will see	
NCIR	Norfolk Centre for Interventional Radiology
Council	The Council are people who look after where we live
On page 10 you will see	
Virtual Ward	The Virtual Ward means patients can stay at home with their families and be cared for by hospital staff on their computer
Volunteers	Volunteers are people who help us by working at the hospital without getting paid

This is the Norfolk and Norwich University Hospitals NHS Foundation Trust. It has a very long name so we often say '**NNUH**' instead.

The NNUH find out why people are poorly and look after them.

This is Cromer District Hospital. They treat poorly patients during the day.



What is a **Quality** Account?

This is our Quality Account. We write this report every year.

The report is about what we did last year to make sure we care for patients in a safe way.

It is also about what we want to do this year to get better.

Introduction

My name is Sam Higginson and I am in charge of the hospital.

My name is Tom Spink and I am the Chairman.

My name is Nancy Fontaine and I am the Chief Nurse. I look after the Nurses, Midwives and other Clinical Professionals in the hospital.

My name is Erika Denton and I am the Medical Director. I look after the Doctors in the hospital.

Celebrating 250 years of our Hospital

In 2022 our hospital had lots of events as the NNUH became 250 years old

Our first poorly person was looked after on 11th July 1772. The hospital did not let people sleepover in the hospital until 7th November 1772.

This man was asked to look at other hospitals in 1758 to see how our hospital should look. He was called Benjamin Gooch and was a Surgeon. He was born in 1708 and died in 1776.

William Fellows met with other people to get money to build the hospital. He was born in 1706 and died in 1775.

This is what our hospital looked like in 1772. There were only 20 beds for poorly people to stay in. There were lots of rules for poorly people wanting to sleepover and they had to help with the washing.

What happened at our Hospitals in 2022 – 2023 year?

There were 139,041 Emergency Department visits at the NNUH and Cromer Hospitals.

The most poorly people were seen in the Emergency Departments in May 2022.

There were 4,975 babies born:

80 of them were twins 

184 were born at home

4,207 were born in the Delivery Suite

561 were born in the Midwifery Led Birthing Unit

The hospital has 1,424 beds which is a lot of beds!

We gave Ukraine some of our hospital beds because of the scary fight where they live. We wanted poorly people in Ukraine to have a bed to get better in.

The NCIR were given a very good award because of how much they care for their poorly people.

hear HelpEducateAwarenessRespond #NoToDomesticAbuse

Our hospital has worked with the local Council to care for our staff who may not be safe outside of work.

What we did well

In the past year 137 Nurses have come from all over the world to work at our hospital, with more Nurses coming soon!

The team who supports these Nurses has been given an award because of the amazing care they give them.

The Emergency Department are helping to stop unwell people from falling when they are being looked after there.

To do this they are using yellow blankets and yellow socks which help to stop people from slipping.

A new place for staff and poorly people to eat has opened at our Cromer Hospital.

Part 3 – What we hope to make better during 2023/2024

Care for more poorly patients through the Virtual Ward.

Continue to work together to make our maternity services safe and better for our pregnant women and babies.

Continue working with and getting more volunteers.

What we hope to make better during 2023/2024

To make staff happier when they come to work, the hospital will be getting more staff. The hospital will be making the areas where staff can rest and eat their lunch better.

People who have learning disabilities and are poorly in hospital are more likely to come back.

Sometimes we can do things to make this better.

The learning disabilities team are working on improving this.

Sadly sometimes things go wrong in the hospital. The hospital tries to learn from these mistakes.

There are now questions that can be asked to help with this, and there are some staff who are able to do this. The NNUH would like to train more staff to help with this.

Contact us if you would like this Quality Account in;

- Big Letters
- Braille
- Another Language

Our contact email address is: q-s.team@nnuh.nhs.uk

Our address is:

Norfolk and Norwich University Hospitals NHS Foundation Trust

Colney Lane

Norwich

NR4 7UY

If you are worried about your care or your families care, you can speak to our Patient Advice Liaison Service and Complaints Team. They would also like to hear what you were happy about. Their details are:

Phone Number: 01603 289036

Email: palsandcomplaints@nnuh.nhs.uk

250 YEARS

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

NNUH Annual Quality Account 2022 – 2023

Quality Account 2022/23 – 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 2022/2023 and identifies improvement opportunities the Trust will focus on.

This report also identifies and explains the Trust's quality priorities for 2023/2024.

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.**

Photo below: NNUH exterior in 1952

Celebrating 250 years of our wonderful Hospital….

We're celebrating our 250th anniversary in 2022. We saw our first outpatients on 11 July 1772 and first inpatients on 7 November 1772.

With the Foundation Stone laid in 1771, we became the 17th voluntary hospital founded in England with the original ideas proposed by the Bishop of Norwich. At the time Thomas Hayter asked local surgeon, Benjamin Gooch, to study the design and administration of London hospitals in 1758, to inform design of a hospital in Norwich. Mr Gooch later became a consulting surgeon at the hospital, although he never operated there.

Photo: Benjamin Gooch (1708 – 1776)

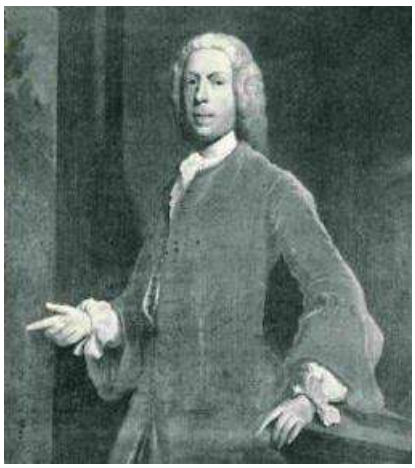


Photo: William Fellows (1706 – 1775)

After a pause, after the Bishop Hayter was transferred to London, the plans were later taken forward by William Fellowes who set up an open meeting at the Guildhall in Norwich in 1770 to discuss the hospital project where a committee was established, and subscription fund set up.

Our hospital was established in 1772 at a cost of £13,323, with a medical staff and matron, plus 20 beds ordered. In 2001, our hospital was rebuilt and opened at Colney Lane for a cost of £229m and now has over 1200 beds and 10,000 staff, treating over one million patients every year. We became a teaching hospital, in partnership with the University of East Anglia, after moving to the new site along with an increased focus on research as part of the Norwich Research Park.

Hospital Rules from 1782:

- No admission for anyone dying
- No admission for anyone suffering from anything infectious
- No admission for anyone suffering from anything incurable
- No admission for anyone heavily pregnant
- No admission for anyone with epilepsy
- No admission for anyone with venereal disease
- No surgeon, physician, treasurer or auditor will be paid
- No swearing
- No playing cards or dice
- Patients must help with the laundry if well enough
- Nurses must behave with tenderness to patients and respect patients

Photo (right): Old Hospital in 1772

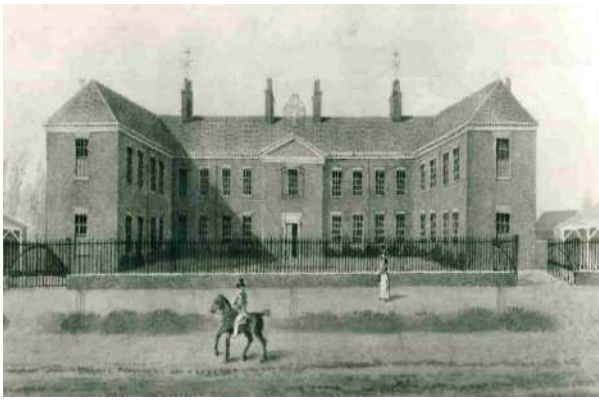


Photo (left): Outpatients casualty department at old hospital

A very warm welcome to the Norfolk and Norwich University Hospitals NHS Foundation Trust's Quality Account for 2022/23. 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.

There is no denying that this year has been an arduous time for the NHS and wider heath and care systems; our staff and volunteers have worked extremely hard in very pressured environments right across our organisation. I and the whole Trust Board want to recognise the constant and tremendous efforts everyone has gone to in order to provide a safe and responsive service to our patients especially during the various industrial action days we have encountered this year. You truly deserve our thanks.

As a Trust we acknowledge that that our level of quality of care, patient and staff experience has been impacted this year, despite the tremendous hard work of our staff. Throughout 2022/23 we have seen significant numbers of patients – between 150-280 on any day – with No Criteria to Reside and unable to leave hospital in a timely way due to lack of capacity in community and social care settings. This has meant the Trust taking unprecedented action in adding a 7th patient in a 6 bedded bay in some wards. We need access to more capacity in the community that will benefit patients and help us to reduce the use of escalation beds on our site and we are working very hard to address this issue with our partners.

In addition to the high numbers of No Criteria to Reside patients and use of escalation beds, there have been operational pressures for the Trust. From last April, we have treated 27,000 patients who had been waiting 78 weeks and we came remarkably close to clearing the backlog with just 169 patients remaining. Periods of industrial action late in the year made it difficult to re-book everyone by the end of March. The last few months have been particularly testing for our booking teams who deserve special recognition for their efforts in cancelling and re-booking so many patients as we manage our way through the disruption.

This difficult time is also reflected in our NHS staff survey results demonstrating how hard it is to work across our services. The results have seen us fall back both in comparison with last year's responses and against our 124 peer acute trusts, unfortunately putting us at the bottom of the NHS league table. As a Trust, I want to say sorry that we have not done as much as we said we would or to deliver the pace of improvements that you previously asked us for, as part of our People's Promise improvement plan we developed last year.

Together with the entire Trust Board, I am focused on delivering the commitments we made in our People Promise to ensure that NNUH is somewhere we all enjoy working and can thrive, safe in the knowledge that we're supported to deliver the best care for every patient. I recognise that we need to accelerate the delivery of these commitments and we need to do more this coming year which include addressing the main concerns the survey has highlighted. As part of that, we have identified a significant investment of £750,000 for staff facilities and further investment in large scale recruitment, particularly for overseas nurses as well as closer working with the wider integrated care system around discharges to reduce the number of patients with no criteria to reside.

There has been a couple of changes in our Trust Board this year with the appointment of Dr Ujjal Sarkar, a lead GP partner at one of the largest GP partnerships in the country, as Non-Executive Director in October. Also, the appointment of the Trust's Chair in March to Tom Spink, who has been the Interim Chair since May 2022.

We have opened our doors to Crackit Productions who will be filming in our Emergency Department for ITV's Emergency Nurses: A&E Stories until early June. The series will shadow colleagues who have given their consent to be included as they work their shifts across urgent and emergency care services at the hospital. Date for the showing of the series has not been released yet but I for one will be adding it to my watch list.

In November, the Care Quality Commission (CQC) carried out an unannounced inspection of Medical Care (including older people's care) where they visited five medical wards and spoke to colleagues in other areas around the hospital. The report reflects how impressed CQC inspectors were with the care and compassion of our teams. I'm particularly pleased that a culture of openness and honesty was seen throughout all levels of the organisation. It also highlights and echoes the challenges we have faced for many months with extremely high demand and the impact that has had on morale and retention. As I have previously mentioned we are working with our teams and system colleagues to reduce the operational pressures we face on a daily basis, and we are determined to improve.

In last year's Quality Account I mentioned that we were looking at and starting to join projects and services with the other two acute NHS Trusts in Norfolk & Waveney (James Paget University Hospital NHS Foundation Trust and The Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust); this year we have agreed to call ourselves the "Norfolk and Waveney Acute Hospitals Collaborative" enabling us to reach our ambitions for patient care through a shared vision and objectives whilst remaining separate organisations. As the collaborative develops, there will be more opportunities to support each other operationally, making our services more resilient across the three Trusts.

NHS
Norfolk and Waveney
Acute Hospital Collaborative

There are many projects which have already started such as the development of a joint Acute Clinical Strategy which is looking at the needs of patients and design services around them. The aim is to reduce long waits through collaborative working, improve health by acting early and tackling health inequalities. Three Diagnostic Assessment Centres (DACs) are planned, one at each hospital, to improve access to diagnostics and reduce waiting times for treatment, especially for a cancer diagnosis.

The biggest joint project for the Norfolk and Waveney Acute Hospitals Collaborative is the implementation of an Electronic Patient Record (EPR), which will transform our services in the longer term. At its most basic, the EPR will store and retrieve clinical information, everyone who works with patients will use it. We hope the EPR will make paper a thing of the past, improving efficiency and experience for patients and colleagues as well as providing more information for primary care professionals, universally saving time. At present we have had the outline business case approved and are in the procurement the stage, we hope to have a supplier identified by the autumn. It is a very exciting step towards a digital future for all three acute Trusts.

better joined-up care

Of course, there are many other NHS services in the wider Integrated Care System we are working with, and we are looking to accelerate our system working over this coming year and beyond. We are working closely with Norfolk Community Health and Care Trust around discharges impacting on operational services and the Priscilla Bacon Hospice Charity who are building a new facility next door to our main hospital on Colney Lane, supporting palliative care services for our patients.

Over the year there has been many initiatives launched in the Trust, such as the Personalised Outpatient Programme with the roll-out of patient initiated follow up (PIFU) appointments across specialities and "Red2Green" to help us improve our patient flow, increase the number of discharges happening earlier in the day and help reduce length of stay metrics. Whilst some initiatives are driven by NHS England a number come directly from our dedicated and compassionate staff. One such initiative is Lily Suite in ED; this suite offers families of patients who have died or who are in their last moments a dignified experience and help them spend time with their loved ones in a calm environment. I want to extend my thanks to Charlotte Grunbaum, Resus Lead, and Chris Chadwick, ED Consultant who came up with and implemented this suite which is gaining positive feedback from families.

Maternity services have continued to be in the spotlight with the release of the final Ockenden report at the very end of March 2022 and Kirkup Report into East Kent released in October 2022. Our Maternity team have been working hard on reviewing the areas identified in these reports, identifying where we have evidence meeting the requirements and actions for where there are gaps. A recent East of England peer review of our Maternity Service was positive as well as giving us some areas for thought. This peer review has helped in preparation for the CQC to inspect us as part of their schedule of unannounced maternity inspections across England.

Again, this year, 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.

More praise for our Maternity Services has come in the form of Hayley Summerfield, Co-ordinating Professional Midwifery Advocate and Birth Reflection Service Lead, and Rachel Appleton, Fetal Medicine Midwife, receiving the NHS England Chief Midwifery Officer (CMidO) Award, developed to reward the "significant and outstanding" contribution made by nurses and midwives and their exceptional contribution to nursing and midwifery practice.

Not only have individuals won a CMidO Award but the Norfolk and Waveney Local Maternity and Neonatal system (LMNS) Practice Development team (Phillipa Noble of NNUH, Mollie Haskey of JPUH and Catherine Weatherill of QEHKL), have won the Team of the Year. The three trusts collaborate and help to implement transformational projects in maternity from NHS England. The LMNS Practice Development team has been described as working cohesively with passion and enthusiasm, supporting new and innovative ways. An excellent example of collaborative working across the Trusts and wider system.

The NHS England Chief Nursing Officer (CNO) also has an award which Anita Martins, Cromer Hospital Matron, has received. Anita has worked in Cromer since 1995 and has been a Matron for the past 13 years. Just one example of Anita's outstanding contribution is that she was instrumental in getting the project off the ground for the new cancer unit which has now opened at Cromer Hospital. She worked with the Friends of Cromer Hospital to fundraise in her own time, outside of work. Congratulations Anita and thank you for dedication.

The Recognise and Respond Team (RRT) has won The Deteriorating Patients and Rapid Response Initiative of the Year award at the Health Service Journal (HSJ) Patient Safety Awards 2022. The award was for their expanded and enhanced Critical Care Outreach service which moved from 12 hours a day to a 24/7service last year. The RRT works across inpatient wards responding to acutely deteriorating patients, attending resuscitation calls in the hospital as well as delivering education, training and quality improvement projects. Congratulations on this well-deserved win. This is a real testament to the brilliant work that they have been doing over the last couple of years.

Looking forward to the year ahead there are some building works which are due to be completed, one is the paediatrics theatres, which will assist with meeting elective targets, we hope to see this completed in the summer. Another is the Norfolk and Norwich Orthopaedic Centre (NaNOC) which will be a stand-alone, Covid-secure, elective surgical facility containing, two new laminar flow theatres and a 21-bedded ward. Our hospitals Charity has pledged £2 million to this development – the largest donation in its history – and has already raised half that sum. It has set up a justgiving page for donations: https://www.justgiving.com/campaign/NANOC.

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

Introducing our newly appointed Chairman

Tom Spink

Tom Spink was appointed as Chair in March 2023 after taking up the Interim Chair role in May 2022. He has been a Non-Executive Director since June 2020.

Tom said: “I also want to add my enormous thanks to all members of staff and volunteers who have worked so tirelessly over the last 12 months, during an incredibly difficult period. Their efforts and dedication in support of patient care has been tremendous with dramatic improvements in elective waiting lists, improved cancer waits and one of the best 4 hr performances of any Trust in the country. The national award won by the NNUH Virtual Ward was a great accolade which was richly deserved. It was also hugely pleasing to see our maternity service achieve such positive results in the recent National Maternity Survey. These, and many other achievements, have been delivered despite the pressures of the aftermath of Covid and of course, the effects of industrial action which impacted patients and staff alike.

It has also been pleasing to see increased collaboration across the Norfolk and Waveney System involving the Queen Elizabeth, James Paget, NCH&C, UEA and many others on a variety of initiatives. This will be an increasingly important aspect of our work in the future and so I look forward to much greater collaboration across the system on projects including of course, the Electronic Patient Record, which will be of huge strategic importance to all the acute hospitals.

There have been many successes within the Trust during the year but in my view, the greatest disappointment has been the results of the Staff Survey. It is clear we have much to do and the board are determined to address the issues that have meant staff do not feel engaged and valued. From the analysis of the results, it is clear we have two priorities; reduction in vacancies and removal of 7 patients in a 6 bed bay. Plans are in place to address the vacancy issue. Addressing the 7 in 6 will be even more challenging as we know much of the solution involves other parts of the system including social and community care. However, the board are committed to doing all we can as quickly as possible, as we know, delivery of high quality patient care needs the right complement of engaged staff.

Once again, thank you all and I look forward to even greater success in the coming year.”

Tom Spink
Chairman

1.1 Million people live in Norfolk and Waveney

1,424 Hospital Beds

There were 139,041 Emergency Department Attendances at the NNUH and Cromer Hospitals

May 2022 saw the most patients across the Emergency Departments that year

Across the sites, we had 93,000 hours of voluntary support

4,975 births

Of which 80 were twins

184 were born at home

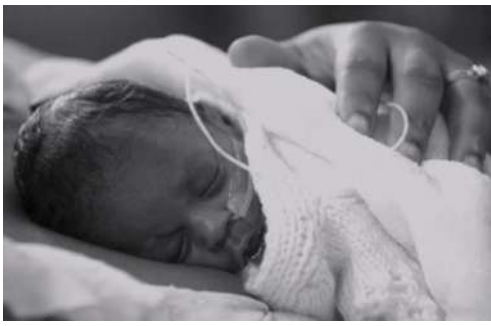
4,207 born in the Delivery Suite

561 born in MLBU

Spotlight on our Neonatal Intensive Care Unit (NICU)

Our NICU has been awarded a prestigious Gold Baby Charter Accreditation

The baby charity Bliss (Baby Life Support Systems) announced that our NICU has successfully completed its accreditation and shown that we have sufficient processes and facilities in place to deliver high-quality family-centred care.



What is Bliss?

Bliss exists to give every baby born premature or sick in the UK the best chance of survival and quality of life. They champion their right to receive the best care by supporting families, campaigning for change and supporting professionals, and enabling life-changing research.

Bliss Charter Accreditation

The Bliss Baby Charter is a growing programme, with over 175 neonatal units participating in the Charter, and has become a nationally recognised tool referenced in the NHS England Neonatal Critical Care Review, Neonatal Critical Care Transformation Review, the BAPM Quality Indicators and the RCPCH QI resource map, as well as being endorsed by the Scottish Government and included in the All Wales Neonatal Standards.

The Bliss Baby Charter is now the UK standard for developing, measuring and improving family-centred care, and achieving Bliss Baby Charter accreditation is an esteemed marker of quality.

Bliss Assessment within the NNUH NICU

The assessment was carried out on 3 August 2022 by Bliss Baby Charter Programme Lead Holly Sullivan and Volunteer Assessors Lynne Wainwright and Jonny Pearson.

The assessment team said: *"The culture of the Norfolk and Norwich University Hospital neonatal unit is clearly family-centred, with a team culture that prioritises families and their involvement in their baby's care. Parents on the unit spoke of an amazing, compassionate and dedicated team, and how the support of the staff enabled parents to build their confidence. The unit psychologist offers extensive support for families and does so in a variety of ways while trying to remove any barriers to families accessing his support. Additionally, there is a great collaboration between the outreach team and the family support team, which assists with a smooth transition from unit to home. Resources and displays used around the unit enable families to access information and support in a way that is suitable for them. There is also a range of accommodations both on and off the unit enabling families to stay as close as possible to their babies."*

Kate McColl, Family Care Sister and Baby Charter Lead at the unit, said: *"Being awarded our Gold Baby Charter Award means so much to myself and the entire team. It brings to the forefront all the amazing work the NICU team does to ensure the baby and family are at the centre of all we do. "Family-centred care is embedded within our unit through the tireless work from all staff members - from our housekeepers, allied health professionals, through to our nurses and doctors – every single person has taken a role in our Baby Charter journey. It has taken us four years to get to our Gold Award due to the Covid-19 pandemic. Ensuring family-centred care during our assessment period was a challenge but due to the passion and commitment, our team has for the best outcomes for our families we were able to achieve our award. We look forward to continuing our accredited journey."*

Part 2 – Priorities for improvement and Board Assurance Statements

Spotlight on the Norfolk Centre for Interventional Radiology (NCIR)

NCIR achieves 'Exemplar Status'

The NCIR has been recognised by the British Society of Interventional Radiology (BSIR) for their commitment to the development of high-quality services.

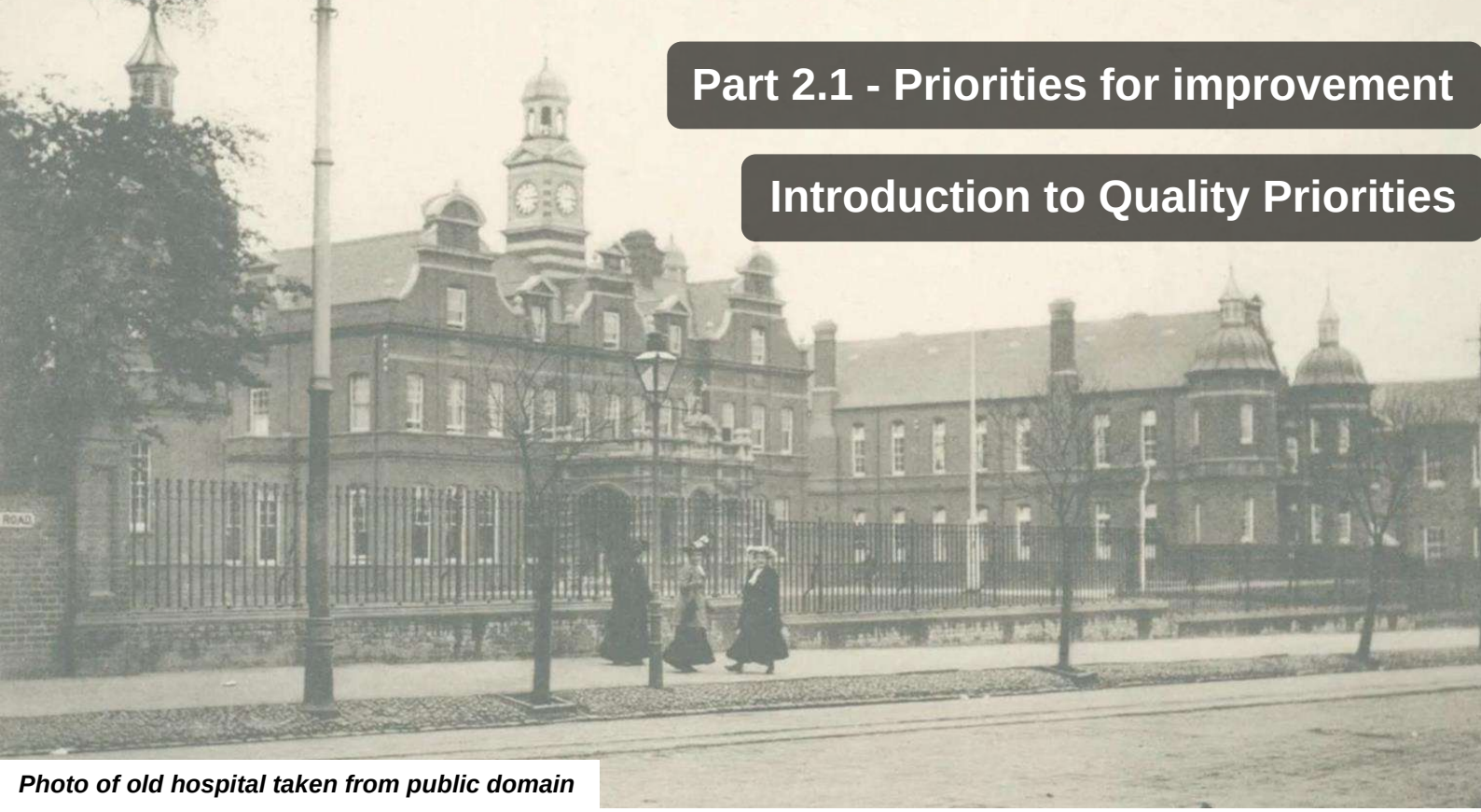
The BSIR has awarded 'exemplar status' to the department because of the commitment they have shown towards patients care.

The multidisciplinary team, which consists of; IR consultants, nurses, operating department practitioners, paramedics, radiographers and support workers, have patient care and experience at the centre of their practice.

The team have developed new key roles, such as an audit practitioner to support the key commitments of exemplar sites such as the Vascular Registry and their commitment to meeting the Vascular Commissioning for Quality and Innovation.

The team are dedicated to learning and improving patient care and get regular positive patient feedback. The development of key projects continues in the NCIR, with them being involved in the development of an accredited IR Practitioner course and planning for service delivery of Mechanical Stroke Thrombectomy.

Mark Lewis, Consultant Radiologist said: *"This is great news and I'd like to thank all colleagues for their efforts. The 'exemplar status' represents the highest achievement for an interventional radiology department in this country, and it shows we offer an up to date, high quality, safe and committed service to our patients."*



Part 2.1 - Priorities for improvement

Introduction to Quality Priorities

Photo of old hospital taken from public domain

The 10 Quality Priorities for 2023/2024 contained in this account, were proposed by Hospital Management Board (HMB), 6 are existing priorities from 2022/2023 that have been refreshed, and there are 4 new priorities (*):

Patient Safety

- Embed our patient safety culture through the implementation of the Patient Safety Incident Response Framework (PSIRF) and the application of system-based approaches to learning *
- Safe Personalised Care for service users of Maternity and Neonatal services
- Elective Recovery: Reduce outpatient waiting list backlog

Clinical Effectiveness

- Elective Recovery: Improving Surgical pathways and outcomes *
- Non-Elective pathways fractured neck of femur (#NOF) *
- Improving Non-elective Pathways and Patient Flow

Patient Experience:

- Shared Decision Making and Personalised Care
- Improving equity of access to services
- Improving equitable experience of services *

Staff Experience

- Improve Staff Experience

The Quality Priorities set are aligned to our strategic commitments, and associated threats to support continuous improvement and to reduce some of our highest risks. In addition to linking our quality priorities with our strategy commitment, business assurance framework, risk register and corporate risk register, we have also linked

them to the Norfolk and Waveney Integrated Care System (ICS) quality priorities recently published in their Quality Strategy. They have identified four priorities:

1. Well-Led through a culture of compassionate leadership
2. Focussed on improving care quality and outcomes
3. Using insights around health inequalities and population health to achieve fair outcomes
4. Ensuring services are safe and sustainable for now and for future generations

The Board of Directors chose to refresh the quality priorities for 2022/2023 to align to the new Trust Strategy 'Caring with PRIDE' 2022-2026 published in April 2022. 11 new priorities were introduced; 8 were set to be met over 2 or 3 years with 3 to be completed in a year. The progress of these priorities is contained within our 'Quality Priorities Update' (pages 25 – 37).

The following 2022/2023 Quality Priorities will be absorbed as 'business as usual' in 2023/2024:

- Improve surveillance of patients who have delayed surgical treatment - (Harm review process)
- COPD pathway improvements
- Safe record keeping and results management
- Orthopaedic pathways
- Home First Model

New Quality Priorities for 2023/2024

Patient Safety

QP1 – New priority - Embed our patient safety culture through the implementation of the Patient Safety Incident Response Framework (PSIRF) and the application of system-based approaches to learning	
Rationale	The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. This is replacing the current Serious Incident Framework. • NHS Patient Safety Strategy • Strategic commitment 1, 2, and 4 • Risk Register: 2211 and 567 • Norfolk & Waveney Integrated Care System (ICS) – Quality Priority 2 & 4
How we will do this	• Write and publish a Patient Safety Incident Response Plan (PSRIP) • Revise governance structures to support PSIRF • Ensure sufficient resource is in place to manage PSIRF and meet national requirements via business case • Train staff in new learning response methods e.g. After Action Review • Write new Incident Management and Investigation Policy • Update the Learning from Deaths Policy to include the link with PSIRF • Ensure processes within Datix (incident reporting system) are revised to support PSIRF • Communicate PSIRF to staff and patients including carers and families • Go live with PSIRF in September 2023 in line with other ICS providers • Revise regular reports to Board Sub-Committees to reflect PSIRF requirements • Remove inappropriate related performance measures from all dashboards / performance frameworks
Improvement Measures	QP1a By November 2023, 100% of Serious Incident Investigations (RCA) completed to conclusion.

	QP1b Revised Governance processes signed off and in place by September 2023 QP1c Increased use of Learning Response Tools (After Action Review (AAR) and Patient Safety Incident Investigations (PSIIs). QP1d Number of staff trained in conducting Learning Responses, • 5% staff trained in AAR: Governance teams trained in multidisciplinary team (MDT) Thematic Review QP1e 90% of staff have completed level 1 (essentials of patient safety), 85% of staff completed level 2 (access to practice) of the patient safety syllabus. QP1f Required resource is obtained and essential posts recruited to meet requirements QP1g PSII meet national standards for investigation QP1h The patient safety incident response policy is published on the website.
Executive Lead and Delivery Leads	Chief Nurse Associate Director of Quality & Safety (Patient Safety Specialist)

QP2 - Safe Personalised Care for service users of Maternity and Neonatal services	
Rationale	Central to Better Births is the principle that maternity care should be personalised and safe. Care should be centred on the woman, her baby and her family; based around her needs and decisions, where there has been genuine choice informed by unbiased information. This is essential to ensuring that women receive the best care possible The concerns raised in the recent Ockenden and Kirkup reports have highlighted the importance of positive, learning cultures underpinned by relational leadership. Creating the conditions for a positive safety culture in teams across the NHS is crucial to ensure that women and families using NHS services receive high quality care and better outcomes. • Strategic commitment 1. • Norfolk & Waveney Integrated Care System – Quality Priority 2, 3 & 4
How we will do this	• Co-production and implementation of Personalised Care Support Plans (PCSP) • Participation in the Perinatal Culture and Leadership Programme • Deliver SCORE culture survey as a means to understand current culture within teams and identify key themes that can be used to enhance team working.
Improvement measures	QP2a: Progress tracked against the delivery plan for PCSP QP2b: By March 2024 each person has a sharable PCSP which records what matters to them, their outcomes and how they will be achieved QP2c: Achieve SCORE Survey response rates between 40% and 60% QP2d: Improvement plans are agreed, tailored to survey results and feedback.
Executive Lead and Delivery Leads	Chief Nurse Director of Midwifery Service Director Obstetrics

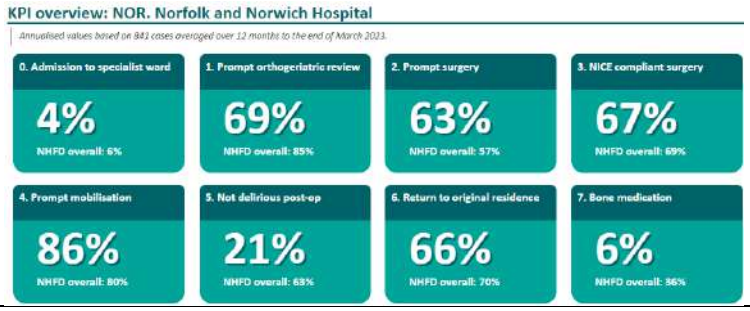
QP3 - Elective Recovery: Reduce outpatient waiting list backlog	
Rationale	The NHS was set a target to reduce outpatient follow-ups by a minimum of 25% against 2019/20 activity levels by March 2023 to release time for new appointments and additional procedure lists. One of the main challenges facing children and young people currently are significant backlogs in paediatric elective care. Long waits are likely to impact their ability to access education and lead full and active lives, exacerbating existing inequalities • 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 • Norfolk & Waveney Integrated Care System – Quality Priority 2 & 4
How we will do this	Focussing on challenged specialities: • Paediatric outpatient pathways • Spinal Surgery, Ear, Nose & Throat (ENT), Trauma & Orthopaedics (T&O), Gynaecology, Dermatology, Ophthalmology & Respiratory Medicine
Improvement measures	QP3a: No adult patient waiting longer than 52 weeks for first outpatient attendance by 31 March 24 QP3b: Paediatrics should wait no longer than 18 weeks for 1st attendance
Executive Lead and Delivery Leads	Chief Operations Officer Divisional Operational Directors

Clinical Effectiveness

QP4 – New priority - Elective Recovery: Improving Surgical pathways and outcomes	
Rationale	Prolonged waiting times for elective care with increased risk of harm whilst waiting. Long waits before accessing planned care can have life-long consequences on the development of children and young people (CYP). One of the main challenges facing children and young people currently are significant backlogs in paediatric elective care. Long waits are likely to impact their ability to access education and lead full and active lives, exacerbating existing inequalities. • 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 • Norfolk & Waveney Integrated Care System – Quality Priority 2 & 4
How we will do this	Focussing on: • Children and Young People's Elective Recovery Toolkit (Feb 2023)

	• Actions to reduce head and neck cancer backlog and waiting times • Critical care availability (and flow) Looking divisionally at future ward capacity to increase cohort numbers to limit impact on HDU capacity and surgical delays • Safety restrictions on staffing levels and bed capacity for tracheostomy/laryngectomy patients
Improvement measures	QP4a: Cancer performance measures, 62 day target for 1st treatment QP4b: Reduction in cancelled theatre lists due to critical care bed capacity
Executive Lead and Delivery Leads	Chief Operating Officer Deputy Director of Operations within Surgery

QP5 – New priority - Non elective Pathways Fractured neck of Femur (#NOF)	
Rationale	A hip fracture is one of the most common serious injuries affecting older people that requires them to be admitted to hospital, have emergency anaesthesia and surgery, followed by weeks of rehabilitation in hospital and the community. The National Hip Fracture Database (NHFD) is an online platform that uses real-time data to drive Quality Improvement (QI) across all 163 hospitals that look after patients with hip fractures in England and Wales. KPI overview for our Trust is included below Whilst a lot of work has been done on the overarching pathway, there remains elements outstanding that need to be addressed. • Strategic commitment 1, 4 • Norfolk & Waveney Integrated Care System – Quality Priority 2 & 4
How we will do this	The purpose of this Quality Priority is to address the key areas of current under performance in the #NOF pathway, and achievement of Best Practice Tariff **National Hip Fracture Database (NHFD) key performance indicators (KPIs) (2022) 5 out of 8 KPIs are below average,** Admission to specialist ward Prompt orthogeriatric review % Not delirious post op% Return to original residence % Bone medication % **2 are average** Prompt surgery% NICE compliant surgery % **1 is above average** Prompt mobilisation %
Improvement measures	Baseline data taken from NHFD annualised values based on 841 cases averaged over 12 months to the end of March 2023. QP5a: To achieve scores that are average or above average across all KPIs QP5b: Mortality rate (March 23: 2.3%)

	QP5c: Best Practice Tariff achievement Target 100% 
Executive Lead and Delivery Leads	Medical Director Consultant Geriatrician, Consultant Orthopaedic Surgeon, Operational Manager, Earsham Ward Sister, Matron

QP6 – Improving Non elective Pathways and Patient Flow	
Rationale	Crowding within the Emergency Department (ED) increases delays in evaluation and essential care which is associated with increased mortality, , medical errors, increased length of stay, worse outcomes, reduced patient satisfaction, over testing and overtreating of patients, along with increased exposure to violence and increased stress on staff. The current ambulance handover delay position, and associated patient risk with this, has long been recognised as unacceptable to the ED, therefore, this has been on the risk register for some time. • 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 • Norfolk & Waveney Integrated Care System – Quality Priority 2 & 4
How we will do this	• Improving patient flow by improving efficiency and effectiveness of the Red to Green process. • Developing a robust and reactive escalation process: using the national OPEL and resilience framework to enable a robust “seasonal plan” to react to internal and external pressures. • Same Day Emergency Care (SDEC)/ Early Assessment Unit – Surgery (EAUS)/ Minors Assessment Unit (MAU) capacity/capability. • Internal ED Flow.
Improvement Measures	QP6a: 4 hour standard QP6b: 60 Minute Ambulance handovers QP6c: Reduction in use of escalation beds QP6d: Virtual Ward activity QP6e: Reduce criteria 2 reside (C2R) to ≤80 Pts (P1-3). QP6f: Proportion of Red to Green Days
Executive Lead and Delivery Leads	Chief Operations Officer (COO): Deputy COO – Non-Elective Care; Chief Of Division (COD) Medicine COD Surgery, Emergency and critical care: Operations Director – Transformation and Integration

QP7 - Shared Decision Making (SDM) and Personalised Care	
Rationale	Achieving high quality shared decision-making conversations 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 • Norfolk & Waveney Integrated Care System – Quality Priority 1, 2 & 3
How we will do this	Focus on the following areas for 2023-24: • Identify clinical champions for SDM • To strengthen links with ICS • To identify delivery lead for SDM • Decision support tools Cancer, Cardiology and MSK • Gap analysis and actions to meet NICE guidance for SDM.
Improvement measures	QP7a: Evidence of Decision Support Tools uploaded to the Beat QP7b: Delivery of CQUIN for 23/245: The level of patient satisfaction with shared decision-making conversations –improvement to mean score between baseline data collection (in Q2) and subsequent data collection (in Q4), OR on maintenance of a score of 75% or above across the two collections. QP7c: Evidence of SDM resources for patients available on the Trust Website
Executive Lead and Delivery Leads	Medical Director Deputy Medical Director Associate Director Patient Engagement and Experience

QP8 - Improving equity of access to services	
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 • Norfolk & Waveney Integrated Care System – Quality Priority 2, 3 & 4
How we will do this	• Completion of Diversity, Inclusion and Belonging (DIB) strategy to launch in Q2 • Completion of review of Health Inequalities alignment with wider equality, diversity and inclusion (EDI) work for ongoing reporting/governance • EDS2022 self-assessment completed by using data gathered from variety of sources and feedback. Published to Trust website 2022/23 (nnuh.nhs.uk)

	• To address the areas for improvement identified in it is proposed that our new Diversity, Inclusion and Belonging strategy will capture direct actions which will be progressed over the next five years (alongside of local action plans via Local Divisional Equality and Diversity Group (LEDG)
Improvement measures	QP8a: DIB Strategy launched Q2 2023 QP8b: Governance Structure agreed for DIB incorporating Health Inequalities. QP8c: A performance measurement framework agreed for monitoring improvements against the actions identified in the DIB
Executive Lead and Delivery Leads	Chief Nurse Associate Director Patient Engagement and Experience

QP9 – New priority - Improving equitable experience of services	
Rationale	Together, we will develop services so that everyone has the best experience of care and treatment • Strategic commitment 1, 3 • Norfolk & Waveney Integrated Care System – Quality Priority 2, 3 & 4
How we will do this	Publish 5 year DIB strategy – Yr 1 objectives: • Implement the Accessible Information Standard (AIS) standards policy • Reach out, engage and develop partnerships with seldom heard community groups • Improve how we collate demographic data from our patients • Investigate the development of an expanded EDI training package for staff
Improvement measures	QP9a: Establish pilot areas for testing implementation of the policy and use of Reasonable Adjustments QP9b: Implement an engagement programme/plan to target seldom heard communities (link to Health Inequalities) QP9c: Develop information for communities to explain importance of collecting demographic information and for staff to ask QP9d: Track the number of staff who access EDI training
Executive Lead and Delivery Leads	Chief Nurse Associate Director Patient Engagement and Experience

Staff Experience

QP10 - People Plan to improve staff experience	
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 • Norfolk & Waveney Integrated Care System – Quality Priority 1
How we will do this	We need to make transformational, sustained improvement into how our staff feel about working at NNUH. • Improvements in staff shortages • Improvements in staff facilities • Improvements in Manager support and appreciation • Improvements in staff wellbeing • Improvements in addressing poor behaviours • Improvements in working and care environment • Improvements in digital health (new addition)
Improvement measures	QP10a: Staff vacancy rate (≤5%). QP10b: Improve key staff survey results in 2024. QP10c: Improve quarterly Pulse survey take up and score
Executive Lead and Delivery Leads	Chief People Officer Director of Workforce

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
Executive Lead and Delivery Leads	Medical Director Deputy Chief Operations Officer Elective Deputy Chief Nurse Elective Recovery Associate Medical Director
Progress during 2022/2023	All patients on a waiting list move have a P code assigned, this is reviewed/confirmed at the weekly Patient Treatment List (PTL) meetings with the individual specialities. Clinical Harm Incident Group meets weekly and reviews patients who have been admitted as an emergency or have died whilst on an elective wating list. The group also reviews patients who have breached 104 days on a cancer pathway Clinical harm information presented at the elective clinical harm group and clinical safety and effectiveness sub board. This priority has gone to business as usual (BAU) monitoring and will no longer be a quality priority.

Safe record keeping and results management – 1 - 3 years	
Rationale	Documentation and management of results are a theme from Structured Judgement Reviews and Serious Incidents Quality of discharge information a theme from patient complaints and feedback from primary care partners • Strategic commitment 1, 3 & 5. • Norfolk & Waveney Integrated Care System – Quality Priority 2 & 4
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
Executive Lead and Delivery Leads	Medical Director Chief Clinical Information Officer Deputy Medical Director Associate Medical Director Primary Care
Progress during 2022/2023	• Scanning and Digitisation of Patient Health Records has now reached 462,719 (138.6 million images) over the programme lifetime. • Destruction of 233,158 scanned records has been undertaken as of Jan 2023. • Integration of document feeds from electronic data transfer (EDT) (Clinic Letters) and ORSOS (Theatre Records) • Trust-Wide Deployment to Adult Services (Excl. Ophthalmology) complete and successfully transferred to BAU with post implementation reviews undertaken in partnership with the system vendor, IMMJ Systems. • eLearning Packages developed by Applications Support & Training Team, facilitating training for new clinical starters. • Health Records recruitment and training of Health Records Training resource completed – this resource will help maintain BAU processes and upskill new admin starters on electronic document management (EDM) processes This priority has gone to BAU monitoring and will no longer be a quality priority.

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 • Norfolk & Waveney Integrated Care System – Quality Priority 2 & 4

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)
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
Progress during 2022/2023	• The following metrics are behind trajectory but have seen improvement in the last quarter towards trajectory– Initial assessment <15mins, total time in ED <12 hours, average time in ED (non-admit), 4 hour standard, SDEC activity as a total of emergency presentations in ED, virtual ward activity, GP streaming. • 7/16 metrics have seen progression towards trajectory • As an aside in terms of numbers of hours lost on ambulance hand over delays beyond 30 mins, this improved in December and January from lowest 4 Trusts in to top 4 Trusts

Fig1: 4 hour standard

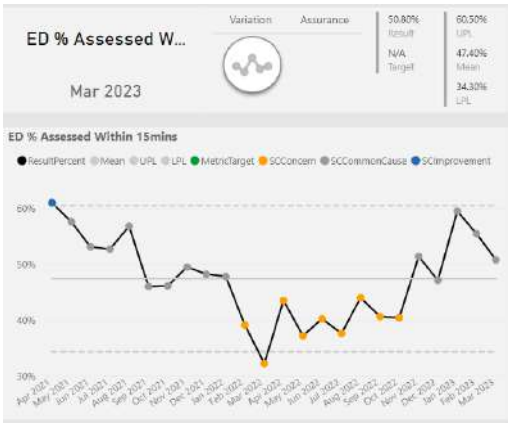
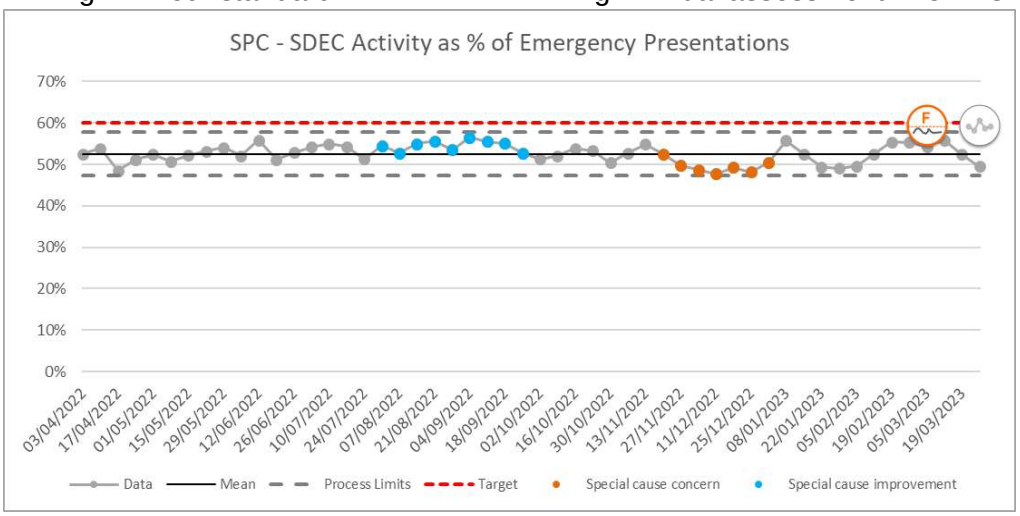


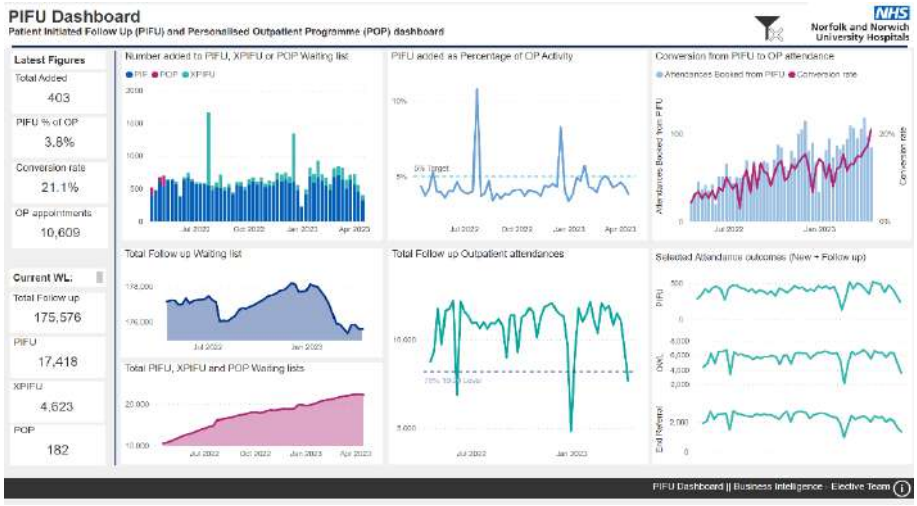
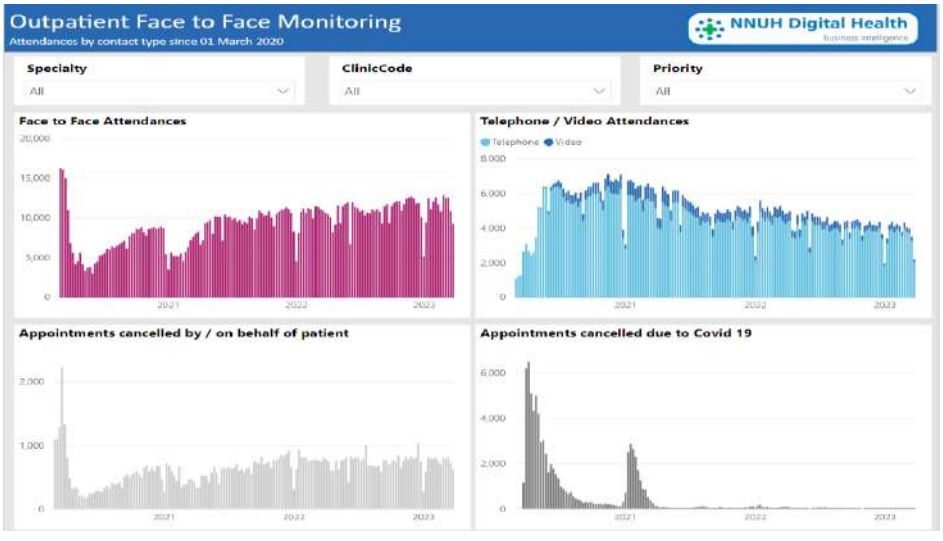
Fig 2: Initial assessment <15mins



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. • Norfolk & Waveney Integrated Care System – Quality Priority 2, 3 & 4
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
Executive Lead and Delivery Leads	Chief Nurse Director of Midwifery Service Director Obstetrics
Progress during 2022/2023	• Ockenden 1 immediate and essential actions (IEA's) 1-6 have been through the evidence group process. This has highlighted what has been achieved and actions to improve compliance. Due to the release of Ockenden 2, Kirkup 2022, and review of Clinical Negligence Schemes for Trusts (CNST), it was agreed a new process was required for compliance to recommendations as the themes through all national recommendations are similar. • Maternity are working with the Quality Team (QI) team in developing a master document with all recommendations from all reports where themes can be reviewed and compliance achieved and crossmatched to save repetition and time. • Work continues to achieve compliance where further evidence required for NNUH sign off. There are 19 actions which require further evidence to be black from the IEA's presented.

Clinical Effectiveness

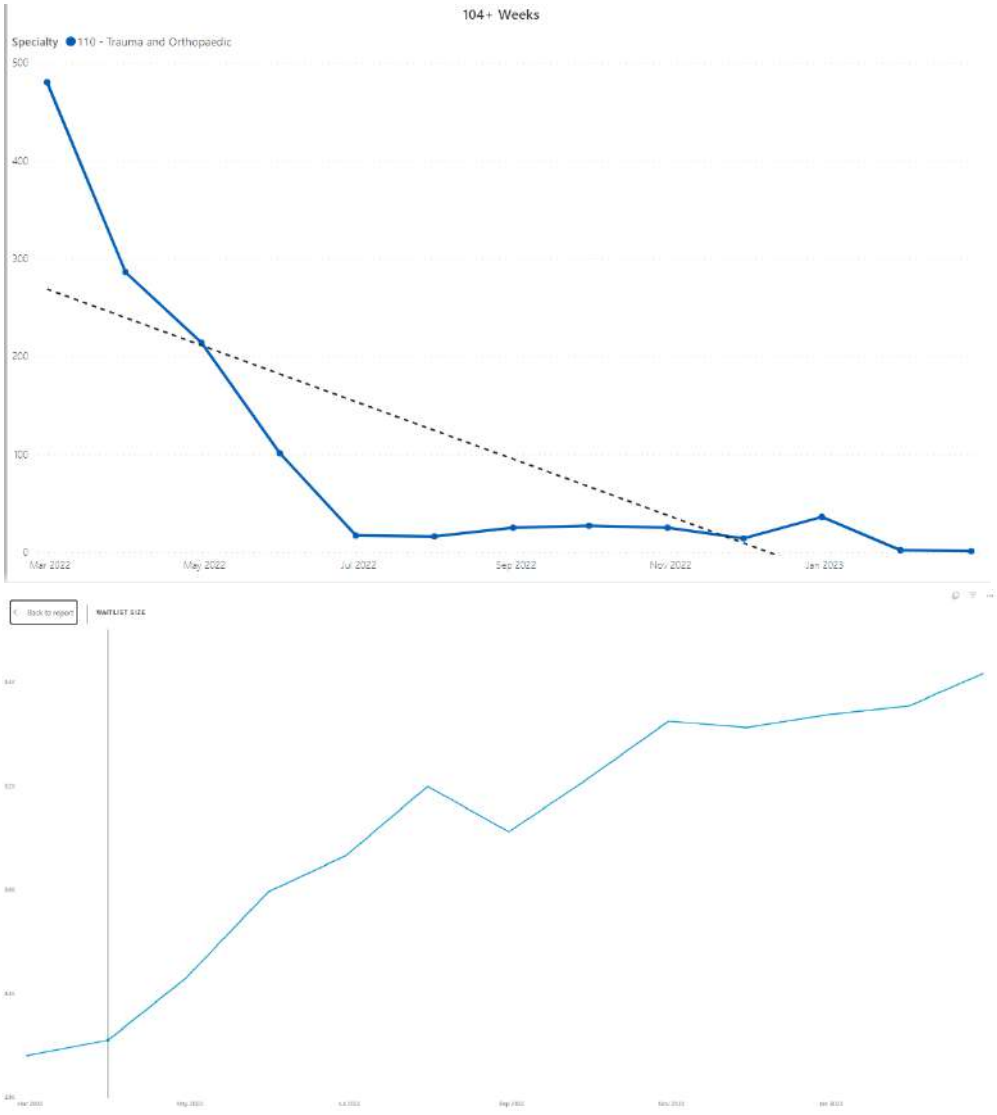
Reduce waiting list backlog (Personalised Outpatient Programme)	
Rationale	NHS target to reduce outpatient follow-ups by a minimum of 25% against 2019/20 activity levels by March 2023 to release time for new appointments and additional procedure lists • Strategic commitment 1 • Corporate Risk Register 1 • Risk Register: 363, 513, 694, 908, 948, 1299, 1407, 1410, 1599, 1504, 1636, 1637, 1670, 1826, 1856, 1877 • Business Assurance Framework: 1.3 • Norfolk & Waveney Integrated Care System – Quality Priority 2 & 4
How we will do this	• Introduction of a Personalised Outpatient Programme • Implement 2 new IT systems:

	○ Infinity – a referral task management platform linked to the Patient Administration system ○ DrDoctor – a cloud based platform for 2 way communication between the hospital and patients
Executive Lead and Delivery Leads	Chief Operations Officer Operations Director – Transformation and Integration
Progress during 2022/2023	 • 18,000+ patient initiated follow up (PIFU) patients now able to request an appointment through DrDoctor. • 42 PIFU pathways live on Infinity, some to include questionnaires. • Notifications Pilot Project progressing to go live in May enabling to contact patients with SMS/email for appointment confirmations, and will then roll out Trust wide. • Integration work with DrDoctor/Wayfinder for the NHS app. • Quick Book facility through DrDoctor in Audiology, Medical Illustration, phlebotomy and Andrology in May. Phlebotomy will save patients having to call to make a blood test appointment and can book via this function (approx. 200 per day). Audiology has seen a take up of 90% of patients booking via Quick Book. • Lab integration project through Infinity/Trust in progress. 

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. • Norfolk & Waveney Integrated Care System – Quality Priority 2 & 4
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
Executive Lead and Delivery Leads	Operational Lead Respiratory Respiratory Matron Medical Lead (to be confirmed)
Progress during 2022/2023	Project re-commenced. Ice referrals up and running from Feb 2023. Referral criteria created. This priority has gone to BAU monitoring and will no longer be a quality priority.

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 • Norfolk & Waveney Integrated Care System – Quality Priority 2 & 4
How we will do this	Provide a dedicated orthopaedic centre comprising of two new laminar theatres and a dedicated bed base.
Executive Lead and Delivery Leads	Director of Strategy Project Manager Deputy Director of Operations within Surgery
Progress during 2022/2023	• Equipment list finalised. Long lead time equipment ordered. Other equipment to be reviewed for budget and ordered.

- Lead in contract for NANOC1 not yet confirmed with Octagon delaying opening of the unit. Likely now opening not before October.
- Business case for expanding NANOC to 5 days operating (1.5 days backfill) being competed this quarter.
- Outline plans for an additional Orthopaedic elective centre (“NANOC 2”) being developed by Director of strategy & Major projects with Surgical division and external consultants (scoping stage).
- Established strategic initiatives (in conjunction with BCG) around LoS in Orthopaedics and increased provision of day case procedures (not yet in delivery phase)
- Set to not achieve 78-week position by 31/03/23 by approx. 120 cases (down from 4000)
- 104 week position over last 12 month demonstrates significant recovery (top graph) but not linked to NANOC. Overall orthopaedic waiting list size continues to increase (9.4k – bottom graph)



This priority has gone to BAU monitoring and will no longer be a quality priority.

Shared Decision Making (SDM) and Personalised Care – 1-3 years	
Rationale	Achieving high quality shared decision-making conversations 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 • Norfolk & Waveney Integrated Care System – Quality Priority 1, 2 & 3
How we will do this	• Focus on the following areas for 2022/23: Primary immune deficiencies, Bone marrow transplant, Palliative chemotherapy, Cardiology COPD
Executive Lead and Delivery Leads	Medical Director Deputy Medical Director Associate Director Patient Engagement and Experience
Progress during 2022/2023	Set up draft content for SDM on The Beat, user testing to review content and ease of navigation, ideal location etc.prior to the launch of The Beat at the end of March The approach/content mirrors the SDM Implementation Model.

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 • Norfolk & Waveney Integrated Care System – Quality Priority 2, 3 & 4
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
Executive Lead and Delivery Leads	Chief Nurse Associate Director Patient Engagement and Experience
Progress during 2022/2023	• **EDS2022** self-assessment completed by using data gathered from variety of sources and feedback using the **engagement plan**. Published to website - Norfolk and Norwich University Hospitals NHS Foundation Trust » Equality Delivery System – EDS2 2022/23 (nnuh.nhs.uk) For Domain 1 this was also submitted to the Integrated Care Board (ICB) for the ICB submission. In summary the assessment showed Domain 1: Commissioned or Provided Services Patients (service users) have required levels of access to the service – Developing/ Achieving Individual patients (service users) health needs are met – Developing/ Achieving

	When patients (service users) use the service, they are free from harm – Developing/ Achieving Patients (service users) report positive experiences of the service – Developing/ Achieving • Our new **Diversity, Inclusion and Belonging strategy** will capture direct actions from the EDS2002 report which will be progressed over the next five years (alongside of local action plans via LEDGes). Engagement and feedback from stakeholders has helped influence the strategy which is due to launch in quarter 1 of 2023/2024. • **Health Inequalities** – core stakeholders (internal) met to review Core20+5 requirements and associated mapping across to all other EDI (Equality, Diversion and Inclusion) work streams/strategy. • Work is continuing on the implementation of The **Accessible Information Standard (AIS)** (Trust Docs ID: 20348) which was published in December 2022. There are 2 pilot sites (Audiology and Ophthalmology) with a focus on PAS alerts to enable the identification, recording and flagging of patients communication needs. • **Transgender patients update** – risk identified and taken to HMB. This is to be added to the risk register to enable next steps to finding appropriate digital solutions. • **Norfolk & Waveney (N&W) Carers ID Passport** roll out has been successful and feedback from carers at NNUH has been positive so far. In line with this the team have been working on the review of the NNUH Carers passport and working in partnership with carers guidance with the Carers Forum and the nursing and clinical colleagues. • NNUH was reaccredited for the **Carer Friendly Tick Award Health** in April 2023 with excellent feedback from the reviewing panel. • **Military Community** working group- Veteran aware reaccreditation being worked towards, the working group has the support of an Executive Lead in the Chief Nurse. The Military Community Working Group is co-chaired by a senior member of our Patient Panel who also has extensive history and lived experience in the armed forces and veteran leads from the workforce. The working group is supported by the Patient Experience team in an administrative capacity. • The **INTRAN** policy and resource/information is being reviewed by a working group joined by colleagues from various departments and teams. The review is to be completed by June 2023.

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 • Norfolk & Waveney Integrated Care System – Quality Priority 2 & 4

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)
Executive Lead and Delivery Leads	Chief Nurse Chief Of Division Clinical Support Services Divisional Director Clinical Support Services
Progress during 2022/2023	• Patients on the unit are medically optimised but waiting for packages of care or Inpatient beds for rehabilitation. Suitable patients on the discharge list are identified by ward team who notify Home First Unit. • Average length of stay on the unit is approx. 7 days, the median length is approx. 2 days. Of 83 Inpatient patients requiring rehabilitation beds on the unit, only 2 went onto rehabilitation, the rest went home with packages of care. • Patients are being discharged with 1 carer rather than the 2 initially required when came onto the unit. • The nursing staff on the unit are trained in re-enablement; ward cleaners, ward clerks etc. are also included and trained in interactions with patients which is showing to make an impact on the patients (not requiring rehabilitation beds and reduction in carers required). • There is a stakeholder development group to work with older people's medicine (OPM) colleagues and complete assessments in patient's own homes.

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 • Norfolk & Waveney Integrated Care System – Quality Priority 1
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.
Progress during 2022/2023	A total of 24 individual workstreams commenced during 2022/23 to deliver improvement actions, which have been reported monthly. During the 12-month period, 15 of the 24 actions were completed as 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 • Norfolk & Waveney Integrated Care System – Quality Priority 1
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
Executive Lead and Delivery Leads	Chief People Officer Head of Facilities/Estates
Progress during 2022/2023	• Agreed refurbishments/improvement plan (July 2022) • Refurbishment programme communicated (August 2022) • Revised travel to work options and parking offering published (September 2022)
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 • Norfolk & Waveney Integrated Care System – Quality Priority 1
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
Executive Lead and Delivery Leads	Chief People Officer Director of HR and Head of Corporate HR Management
Progress during 2022/2023	• Meaningful PDR discussion with your line manager (90% of staff by end September 2022) • A wellbeing conversation as part of your PDR (90% by end September 2022)
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 • Norfolk & Waveney Integrated Care System – Quality Priority 1 & 4
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
Executive Lead and Delivery Leads	Chief People Officer Director of HR
Progress during 2022/2023	• Achieving an average of 55 days from placing job ad to completing employment checks (June 2022) • At least 25% of job ads include options for flexible working (June 2022)
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 • Norfolk & Waveney Integrated Care System – Quality Priority 1
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
Executive Lead and Delivery Leads	Chief People Officer Director of HR and Head of HR Corporate Development
Progress during 2022/2023	• A monthly programme of senior management visits to ward and specialty areas (from June 2022) • Introducing divisional oversight for approving flexible work requests to ensure greater equity (September 2022) • Schwartz Rounds reintroduced, increase Professional Nurse Advocate and Professional Midwifery Advocate roles and promotion of other wellbeing support (end September 2022) • A monthly programme of “Rest & Restore” days (ongoing to March 2023) • Practical cost-of-living support and information (June 2022) • Agreed divisional actions for areas reporting high incidence of bullying or feeling unable to speak up in the Staff Survey (June 2022) • “No excuse for abuse” campaign launched (June 2022) • Protocol to withdraw patient care where behaviour is unacceptable (July 2022).

An Act of Kindness

Hospital beds donated to Eastern Ukraine

The Norfolk and Norwich University Hospital and Medstrom Ltd have been working together to recycle and rehome outgoing hospitals beds to support those affected by the war in Ukraine.

In excess of 50 beds have transited through charitable organisations and Ukrainian NGOs across the Polish border, to reach hospitals in some of the hardest-hit regions in Eastern Ukraine. Due to destruction of key medical infrastructure, there was a severe shortage of hospital beds and mattresses to support the wounded and patients who have been transferred. These donated beds have been greatly received by healthcare staff, providing essential equipment to improve patient care and outcomes.

The hospital beds were only recently removed from the Trust, who were undergoing a rolling programme to replace equipment used across the hospital.

Stacy Hartshorn (**pictured to the right**), project lead for the bed replacement programme at NNUH, said: *"We are grateful to Medstrom for organising for our older beds to be sent to help the people of Ukraine. The beds were in use for our patients until the day they were removed so we know these will be a great addition to whichever hospital they are deployed into. We are privileged in our Trust to be at the end of a bed replacement programme where all of our bed frames have been replaced with high specification standard and low-rise frames, which has afforded us this opportunity for donation."*

Rachel Apsey, Commercial Director for Medstrom, added: *"This is an incredible achievement from everyone involved and I'm proud that Medstrom could support NNUH with this project. The logistical organisation, transport and volunteer time should all be recognised, but we all had one clear objective in mind; providing the necessary equipment, as quickly as possible, to help those throughout Ukraine. We will continue to do our utmost to support with further donations."*

Part 2.2 - Board Assurance Statements

Photo of old hospital (Eye Infirmary and ENT between 1968 and 1976) taken from public domain

Review of services

During 2022/2023 the Norfolk and Norwich University Hospitals NHS Foundation Trust provided and/or sub-contracted 81 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 81 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 2022/2023.

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

During 2022/23 53 of the 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 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 2022/23 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.]

Table 1: National Clinical Audit in Alphabetical Order

National Clinical Audit (Alphabetical order)	Eligible Y/N	Took part Y/N	Participation Rate Cases Submitted	Completed/ In-progress/ Ongoing
Breast and Cosmetic Implant Registry	Y	Y	15 (100%)	Ongoing
Case Mix Programme	Y	Y	1627/1627 (100%)	Ongoing
Child Health Clinical Outcome Review Programme	Y	Y	Transition Study: 15/28 (54%) Testicular Torsion Study: 3/3 (100%)	Ongoing
Cleft Registry and Audit NEtwork Database	N	n/a	n/a	n/a
Elective Surgery: National PROMs Programme	Y	Y	Hips: 505/521 (97%) Knees: 521/549 (95%)	Ongoing
Emergency Medicine QIPs:				
a. Pain in children	Y	Y	228/228 (100%)	Completed
b. Assessing for cognitive impairment in older people	Y	n/a	n/a	Deferred to 2023/2024
c. Mental health self harm	Y	Y	n/a	Audit extended into 2023/2024
Epilepsy 12 - National Clinical Audit ofSeizures and Epilepsies for Children and Young People	Y	Y	79/79 (100%)	Ongoing
Falls and Fragility Fracture Audit Programme:				
a. Fracture Liaison Service Database	Y	N	n/a	n/a
b. National Audit of Inpatient Falls	Y	Y	0/19 (0%)	Data being submitted for 21-22 anticipated submissions for 22-23 will commence shortly
c. National Hip Fracture Database	Y	Y	748/748 (100%)	Ongoing
Gastro-intestinal Cancer Audit Programme:				
a. National Bowel Cancer Audit	Y	Y	569/569 (100%)	Ongoing
b. National Oesophago-gastric Cancer	Y	Y	184/184 (100%)	Ongoing
Inflammatory Bowel Disease Audit	Y	Y	16/16 (100%)	Ongoing
LeDeR - learning from lives and deaths of people with a learning disability and autistic people (previously known as Learning Disability Mortality Review Programme)	Y	Y	15/15 (100%)	Ongoing
Maternal and Newborn Infant Clinical Outcome Review Programme	Y	Y	Maternal deaths: 1/1 (100%)	Ongoing

			Late Fetal Loss: 10/10 (100%) Terminations: 10/10 (100%) Stillbirths: 16/16 (100%) Early Neonatal Deaths: 11/11 (100%) Late Neonatal Deaths (includes. Transfers in): 7/7 (100%	
Medical and Surgical Clinical Outcome Review Programme	Y	Y	Epilepsy Study: 3/5 (60%) Crohn's Disease Study: 3/5 (60%) Community Acquired Pneumonia Study: 2/5 (40%)	Ongoing
Mental Health Clinical OutcomeReview Programme	N	n/a	n/a	n/a
Muscle Invasive Bladder Cancer Audit	Y	Y	11/11 (100%)	Completed
National Adult Diabetes Audit:				
a. National Diabetes Core Audit	Y	Y	Data collection starts in April for 2022-23 audit	Ongoing
b. National Diabetes Foot care Audit	Y	Y	260/260 (100%)	Ongoing
c. National Diabetes Inpatient SafetyAudit	Y	Y	33/33 (100%)	Ongoing
d. National Pregnancy in Diabetes Audit	Y	Y	50/50 (100%)	Ongoing
National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme:				
a. Adult Asthma Secondary Care	Y	Y	186/186 (100%)	Ongoing
b. Chronic Obstructive PulmonaryDisease Secondary Care	Y	Y	457/457 (100%	Ongoing
c. Paediatric Asthma Secondary Care	Y	Y	15/15 (100%)	Ongoing
d. Pulmonary Rehabilitation- Organisational and Clinical Audit	N	n/a	Trust does not have Pulmonary Rehabilitation service	n/a
National Audit of Breast Cancer inOlder Patients	Y	Y	573/573 (100%)	Completed
National Audit of CardiacRehabilitation	Y	Y	2780/2915 (95%)	Ongoing
National Audit of Cardiovascular Disease Prevention (Primary Care)	N	n/a	n/a	n/a
National Audit of Care at the End ofLife	Y	Y	50/50 (100%)	Complete
National Audit of Dementia	Y	Y	75/80 (94%)	Complete
National Audit of Pulmonary Hypertension	N	n/a	n/a	n/a
National Bariatric Surgery Registry	N	n/a	n/a	n/a
National Cardiac Arrest Audit	Y	Y	40/40 (100%)	Ongoing
National Cardiac Audit Programme:				
a. National Congenital Heart Disease	N	n/a	n/a	n/a

b. Myocardial Ischaemia National Audit Project	Y	Y	788/868 (91%)	Ongoing
c. National Adult Cardiac Surgery Audit	N	n/a	n/a	n/a
d. National Audit of Cardiac Rhythm Management	Y	Y	Pacemaker: 1444/1444 (100%) Electrophysiology: 641/661 (97%)	Ongoing
e. National Audit of PercutaneousCoronary Interventions	Y	Y	1305/1320 (99%)	Ongoing
f. National Heart Failure Audit	Y	Y	601/601 (100%)	Ongoing
National Child Mortality Database	Y	Y	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 Early Inflammatory Arthritis Audit	Y	Y	23 cases submitted percentage not known	Ongoing
National Emergency Laparotomy Audit	Y	Y	229/229 (100%)	Ongoing
National Joint Registry	Y	Y	828/828 (100%)	Ongoing
National Lung Cancer Audit	Y	Y	380/380 (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	978/978 (100%)	Ongoing
National Ophthalmology AuditDatabase	Y	Y	1777/1777 (100%0	Ongoing
National Paediatric Diabetes Audit	Y	Y	297/297 (100%)	Ongoing
National Perinatal Mortality ReviewTool	Y	Y	34/34(100%)	Ongoing
National Prostate Cancer Audit	Y	Y	427/427 (100%)	Ongoing
National Vascular Registry	Y	Y	441/441 (100%)	Ongoing
Neurosurgical National Audit Programme	N	n/a	n/a	n/a
Out-of-Hospital Cardiac ArrestOutcomes	N	n/a	n/a	n/a
Paediatric Intensive Care Audit	N	n/a	n/a	n/a
Perioperative Quality Improvement Programme	Y	Y	4 cases submitted Data submissions from NNUH only commenced January 2023	Ongoing
Prescribing Observatory for Mental Health:	N	n/a	n/a	n/a

a. Improving the quality of valproate prescribing in adult mental health services	N	n/a	n/a	n/a
b. The use of melatonin	N	n/a	n/a	n/a
Renal Audits:				
a. National Acute Kidney Injury Audit	Y	Y	6180/6180 (100%)	Ongoing
b. UK Renal Registry Chronic Kidney Disease Audit	Y	Y	849/849 (100%)	Ongoing
Respiratory Audits:				
a. Adult Respiratory Support Audit	Y	Y	Data being collected not yet submitted	Ongoing
b. Smoking Cessation Audit- Maternityand Mental Health Services	Y	n/a	Audit did not commence	n/a
Sentinel Stroke National Audit Programme	Y	Y	687/687 (100%)	Ongoing
Serious Hazards of Transfusion UK National Haemovigilance Scheme	Y	Y	26/26 (100%)	Ongoing
Society for Acute Medicine Benchmarking Audit	Y	Y	115/115 (100%)	Complete
Trauma Audit and Research Network	Y	Y	471/672 (70%)	Ongoing
UK Cystic Fibrosis Registry	Y	Y	Paediatrics:57/57 (100%) Adults: 89/89 (100%)	Ongoing
UK Parkinson's Audit	Y	Y	OPM: 22/22 (100%)	Complete

The reports of published national clinical audits or confidential enquiries were reviewed by the provider in 2022/23. These are reported through department's local governance teams and the Clinical Effectiveness Operational Group. Some examples of actions undertaken following review are given below.

Table 2: Example of actions following review:

National Audit Title	Keys Successes	Key Concerns	Key Actions
National Audit of Cardiac Rehabilitation	All patients who have a cardiac event invited to the Cardiac Rehabilitation Programme at discharge. Involvement with the East of England Cardiac Rehabilitation Steering Group Committee. Working with Service Managers to develop new clinics. Cardiac Rehabilitation programme at NNUH given green fully certified status from the National Certification Programme for Cardiac Rehabilitation.	Need to review patient assessment protocols and routine practice assessment. Need to ensure that all patients taking part in Cardiac Rehabilitation exercise have a baseline exercise test.	Implementation the Co-op Dartmouth Quality of Life Assessment; and Introduced assessments for patients who are physically frail.

National Audit of Percutaneous Coronary Interventions (PCI) (Coronary Angioplasty) (Part of the National Cardiac Audit Programme)	86.66% of elective Percutaneous Coronary Interventions for stable symptoms were discharged on the same day as the procedure (Standard >75%). Trust had 100% use of drug-eluting stents where a stent was deployed to treat a ST-Elevated Myocardial Infarction (STEMI) (Standard >90%).	65% of use of intracoronary imaging during Percutaneous Coronary Intervention procedures to treat unprotected Left Main Stem disease (Standard >75%).	Continue open and honest communication with the East of England Ambulance Service NHS Trust regarding delayed Call-to-balloon and Door-to-balloon times. Submit business cases for Cardiac Catheter Laboratories refurbishment. Secured non-recurrent funding for the Non-ST-Elevated Myocardial pathway improvement project.
National Diabetes Core Audit (Part of the National Adult Diabetes Audit)	70% of patients had timely reviews. Well established operational structures to deliver streamlined annual reviews. Well established intermediate care services.	Need for support with data entry, phlebotomy and medication reconciliation.	Clinic letter templates changed to clearly reflect care processes; Support for data entry on the Diamond Diabetes System has been escalated.
National Hip Fracture Database (NHFD) (part of the Falls and Fragility Fracture Audit Programme)	Performance at or above national average for prompt mobilisation following surgery, time to surgery, and NICE compliant surgery. Steady increase in the rate of cases where surgery is supervised by Consultant Surgeon and Anaesthetist. Greater engagement from Site and Divisional Management in regards to direct admit capabilities of Ortho-Medical Unit. When discharge destination is available, Orthogeriatric Team are able to discharge within 12 days of surgery.	Performance below national average for direct admission to specialist ward, prompt orthogeriatric review, post operative delirium assessment, and return to original residence. Decrease in attainment of Best Practice Tariff (39.9%). Mortality rate remains worse than national average. Phlebotomy priority for Ortho-Medical Unit increases likelihood of delay to surgery and receipt of post operative indicators.	Increase provision of dedicated Orthogeriatric Consultant care to support the return to the pre-covid model of excellent Older People's Medicine care.
National Bowel Cancer Audit (NBOCA)	Excellent performance in relation to surgical quality, length of stay, and mortality, as recognised by a recent Get It Right First Time (GIRFT) visit.	Poor quality of data entry, with the reported case ascertainment figures for the Trust.	Divisional leadership team coordinating a Division-wide review of data entry requirements for national audits to determine the level of investment in resources required to improve data submissions.

National Emergency Laparotomy Audit (NELA)	100% of cases had pre-operative risk assessment. Good performance in general, with high numbers of procedures and a low mortality rate.	Low input from Geriatrician. Appropriate timing to theatre. Presence of both Consultant Surgeon and Anaesthetist when risk >5%	Opening of the new Orthopaedic Centre to improve accessibility of emergency theatres during daylight hours. Reinforced standards with Surgeons and Anaesthetists via Governance meetings.
Muscle Invasive Bladder Cancer Audit (British Association Of Urological Surgeons (BAUS))	Good outcomes reported for cystectomy. Patients offered all options for muscle invasive disease.	Median length of time to bladder cancer diagnosis 61 days vs 41 days nationally.	Cancer diagnostic pathway being reviewed as part of diagnostic delay and cancer pathway work.
National Vascular Registry (NVR)	Trust is the 9th busiest Aortic Centre in UK for elective infrarenal Abdominal Aortic Aneurysms (AAA) and 2nd busiest for Ruptured Abdominal Aortic Aneurysms (RAAA). Our practice of a large proportion of open surgery is evidence based and in line with the latest National Institute of Health and Clinical Excellence (NICE) guidelines. Our elective AAA is amongst the best in the UK. The adjusted mortality rate is excellent for both elective AAA repairs and RAAA. All elective AAA patients have a pre-op computerised tomography (CT) and are discussed at Vascular Multi-Disciplinary Team (MDT) Meeting. When compared to previous years, we have improved on the documentation of various parameters. For Carotid Endarterectomy (CEA) cases, the Trust's time from symptom to surgery continues to be good, with a median time of 10 days. 60% of symptomatic patients achieved the Get It Right First Time (GIRFT) target of 7 days from symptom to referral, and 80% received their surgery within the NICE target of 14 days.	Documentation of multi-disciplinary assessment could improve, for AAA cases. There is further improvement that could be achieved in respect of time from assessment to surgery so that the Trust sits within the best 10 Trusts. Of CEA cases, the adjusted stroke and/or mortality rate had increased to 4.8% compared to national average of 2.2%, which will be monitored over the next 2 years to ensure it remains below the acceptable upper limit.	No specific targeted clinical actions identified from the report. Results highlighted importance of accuracy and completeness of data entry to the Registry and continued monitoring of in-hospital mortality rates via monthly Governance Meetings. The results highlight the importance of the provision of adequate extended recovery, Critical Care bed capacity and the recruitment and retention of ward-based staff to enable the Vascular Department to continue to provide excellent patient care and achieve excellent patient outcomes.

National Neonatal Audit Programme (NNAP)	Neonatal Intensive Care Unit (NICU) exceeded 3 of the national audit standards. NICU exceeded the national average rates in a further 7 standards.	Below national standard in 3 areas.	Both the audit and benchmarking data are reviewed quarterly and a rolling action plan is in place with ongoing initiatives to raise standards. These include: education; case reviews; audits and ad-hoc data quality reviews. Improvements have been achieved over the 2022 calendar year such that local performance now exceeds the national average.
National Maternal And Newborn Infant Clinical Outcome Review Programme (MBRRACE)	The Trust was compliant to 16/18 recommendations.	The National Maternity Early Warning Score system to monitor pregnant women in all hospital settings and the National Patient Group Direction allowing prescription of aspirin for pregnant women at risk of pre-eclampsia not fully implemented in the Trust.	The Modified Early Obstetric Warning Scores (MEOWS) recording system to be made available electronically Trustwide and discussion of Midwives utilising a Patient Group Directive for Aspirin being undertaken.
National Inflammatory Bowel Disease (IBD) Registry, Biological Therapies Audit	Good performance against key performance indicators (KPIs).	Assessment of disease activity was based on PGA (Physician Global Assessment) but never on the Paediatric Crohn's Disease Activity Scores (PCDAI) or the Paediatric Ulcerative Colitis Activity Index (PUCAI). Transfer of patients to adult services resulted in appearance of incomplete data sets at 12 month follow-up.	Incorporation of a template (paper based initially then electronic) for recording disease activity scores at every patient visit. Trust's electronic patient record to include disease activity score as a key element. Patients transferred to adult services are taken off the Paediatric database.
National Paediatric Diabetes Audit (NPDA)	Least hospital readmissions compared to national and regional figures. Paediatric Diabetes service offers excellent service to patients.	Quality dietetic and psychology time for patients.	Improve process of collecting data by effective use of information technology systems, for example DIAMOND.
Surgical Site Infection Surveillance Service	Annualised Surgical Site Infection rate was below the United Kingdom Health Security Agency (UKHSA) threshold.	There was a need for data entry support for the orthopaedic elements to enable continuous surveillance	Recruitment of a data entry person in Orthopaedic Department to facilitate Surgical Site Infection

	Improved electronic recording of C section wound surveillance provided access to 100% of cases as paper forms were no longer required. This provided improved oversight of infection rates.	for all categories to obtain more accurate figures. Due to staffing pressures, demands on services and acuity of admissions some surveillance information may not have been collated. The Covid-19 pandemic and increased prevalence of winter viruses, increased the workload of the Infection Prevention & Control Team. This delayed analysing and reporting of Surgical Site Surveillance.	data entry along with other audits in the department. Surgical Site Infection Surveillance results were taken to Clinical governance meetings and fed back to the clinicians for discussion and learning. These were also discussed at Hospital Infection Control Committee (HICC) meeting quarterly with divisional and governance leads.
LeDeR - Learning from Lives and Deaths of People with a Learning Disability and Autistic People	Overall improvements in quality of care and suitability of care packages.	Poor discharge arrangements. Lack of reasonable adjustments in acute settings and delays in treatment, diagnosis and onward referral.	Introduction of bespoke training to individual areas. Regular meetings with Community Learning Disability Teams. Meeting with Complex Discharge Team leads to highlight concerns and establish a working pathway. A review of End of Life care for people with Learning Disabilities in the Norfolk and Norwich University Hospital, in collaboration with the Norfolk and Waveney Integrated Care Board. A specific audit of ReSPECT and reasonable adjustments to be completed.

Case study

Mark Andrews – Lead Consultant

NNUH Doctor awarded a National Diploma in Obstetric Medicine

An NNUH Doctor has become the only Consultant in the country to be awarded a National Diploma in Obstetric Medicine.

Dr Mark Andrews has a specialty in renal (kidney) disease. He is the first Consultant in the country to complete Obstetric Medicine training at consultant level following an NHS initiative to improve medical care in maternity services, by funding training in medical problems in obstetrics for existing Consultant specialists.

NNUH has also become home to one of two Maternal Medicines Centres in the East of England and Dr Andrews is leading this service with fellow Obstetric Consultant Fran Harlow.

As part of the national strategy to create these centres of excellence, NHS England funded the training of 12 Consultant Physicians in Obstetric Medicine. Dr Andrews had had experience of Obstetrics and “high risk pregnancy” as it was called, while a Medical Registrar in Nottingham. Since that time, he has continued an interest within his own specialty of renal (kidney) disease and has long experience of the management of kidney disease in pregnancy.

This experience meant he was an ideal candidate, and he became the first person to complete the year-long part-time programme at Guy’s and St Thomas’s Hospital and University College London Hospital. Dr Andrews remains the only person in the country to be awarded the prestigious Diploma in Obstetric Medicine.

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 2022/2023 that were recruited during that period to participate in research approved by a research ethics committee was 4014.

Commissioning for Quality and Innovation (CQUIN)

A proportion of NNUH income in 2022/23 was conditional on achieving quality improvement and innovation goals agreed between NNUH and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for NNUH and for the following 12- month period are available electronically at https://www.england.nhs.uk/nhs-standard-contract/cquin/2022-23-cquin/.

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 2022/23.

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 2022/23:

- **Unannounced focused inspection of Medical care (including older people's care) at the Norfolk and Norwich University Hospital.**

Table 3: CQC Ratings of Medical care (including older people's care), reported January 2023

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	**Requires Improvement**	**Requires Improvement**	**Good**	**Not rated**	**Not rated**	**Requires Improvement**

There were no changes in the level of ratings given during this inspection to Medical Care (including older people's care).

During 2022/23, the Norfolk and Norwich University Hospitals NHS Foundation Trust did not receive a Trust Well Led inspection by the Care Quality Commission, therefore, the inspection of Medical care (including older people's care) 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 4: CQC 'Must Do' and 'Should Do' Recommendations for Medical care (including older people's care) reported January 2023

Area	Level	Ref	Recommendation
CORE SERVICES			
Medical care (including older people's care)	**Must Do**	**Med 2022.a**	The trust must ensure that patients' physiological observations are reassessed and recorded in line with trust policy. (Regulation 12(2)(a))
		Med 2022.b	The trust must ensure that risk assessments relating to the health, safety and welfare of people using services are completed and reviewed in accordance with trust policy. (Regulation 12(2)(a))
		Med 2022.c	The trust must ensure that resuscitation equipment is checked in accordance with trust policy. (Regulation 12(2)(e))
		Med 2022.d	The trust must ensure that patients have drinks and call bells within reach. (Regulations 14(4)(a) and 9 (1))
		Med 2022.e	The trust must ensure that work to improve the support that patients receive to meet their nutritional and hydration needs continues. (Regulation 14(4))
		Med 2022.f	The trust must ensure that intentional rounding is carried out and recorded in accordance with trust policy. (Regulation 12 (2)(b))
	Should Do	**Med 2022.g**	The trust should ensure that nursing and healthcare assistant staffing levels continue to be regularly monitored and adjusted when required. Work to increase staffing levels in order to meet establishment levels should continue (Regulation 18(1))

		Med 2022.h	The trust should ensure that monitoring of compliance and risk assessment of the trust policy for the use of additional beds in bays continues. (Regulation 15(1)).
		Med 2022.i	The trust should ensure that actions identified following the completion of local audits are implemented. Action plans should be updated when actions have been implemented. (Regulation 17 (2))
		Med 2022.j	The trust should continue to work closely with all system partners to tackle the capacity pressures on urgent and emergency care in the health and social care system in Norfolk and Waveney.
		Med 2022.k	The trust should continue work to improve Friends and Family Test response rates.
		Med 2022.l	The trust should continue work to improve the time of day that patients are discharged.
		Med 2022.m	The trust should work to reduce the number of patient moves for non-clinical reasons, particularly during night-time hours.

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 2023 in taking such action

Table 5: Progress on CQC 'Must Do' and 'Should Do' Recommendations for Medical care (including older people's care) reported January 2023

Area	Level	Ref	Recommendation
CORE SERVICES			
Medical care (including older people's care)	**Must Do**	**Med 2022.a**	The Trust observation system WebV has been upgraded to allow retrospective observation. PowerBI where metrics are viewed has also been updated to show easily the results of observations. A QI project has begun to review and improve the remaining actions.
		Med 2022.b	All superseded risk assessments have been removed from the Trust. Singular risk assessments are available to all staff. The new risk assessment booklet began trials on the 31/3/2023.
		Med 2022.c	Tendable audits for checking resus equipment have been updated from the 31/3/2023. This should improve consistency with documentation.
		Med 2022.d	Tendable audits will include checking intentional rounding from 31/3/2023. WebV will be explored for future recording.
		Med 2022.e	Weekly project meetings are taking place. Meal service observations were added to Tendable on 31/3/2023. New fluid balance chart will be trialled from 31/3/2023.
		Med 2022.f	Review of the intentional rounding documentation and Tendable audits.
	Should Do	**Med 2022.g**	Continue with 3 x daily Safer Staffing meetings, monitoring red flag data and care hours per patient per day (CHPPD) Continue with the Trust recruitment and retention programme
		Med 2022.h	There are effective, real time risk assessments in place as business as usual

			Revised additional patients in corridors and 7th patient in a bay SOP is now uploaded on Trust Docs
		Med 2022.i	Monitor actions from Tendable audits via monthly performance meetings with the Divisional Senior Nursing team Action planning training for staffing using Tendable Clear historical actions prior to September 2022
		Med 2022.j	Daily update and review regarding patient's criteria to reside status Continue long length of stay patient review with system partners
		Med 2022.k	Continue roll out SMS messaging for friends and family responses Focus volunteers to areas where SMS unlikely to be used Add friends and family questions to the care assurance process
		Med 2022.l	Relaunch of Red2Green process Executive review of red days in planning phase QI project discharge bloods
		Med 2022.m	Improving Red2Green process to identify discharges earlier in the day Trial of risk assessment for selecting boarding patients

As of the 31st of Marc 2023 there are **25** open recommendations from our previous inspections, please note this does not include the recommendations above.
The breakdown of the recommendations is as follows:

Green – On track to meet outcome date.	**6**
Amber – At risk of not meeting outcome date.	**8**
Red - Will not meet the outcome date or has already passed outcome date.	**5**
Blue – Recommendation is complete but requires further monitoring from Quality Programme Board (QPB).	**6**

Once a recommendation has been agreed as complete it is turned **Black** and is archived. Since January 2022, 29 recommendations have been turned black.

Data Quality

The Norfolk and Norwich University Hospitals NHS Foundation Trust submitted records during 2022/2023 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data.

Table 6: Records of published data Month 9 December 2022

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%	99.8%	100%	99.5%
Accident & emergency care	99.4%	98.6%	100%	99.1%

- Completed Referral to Treatment (RTT) Audit Programme for 2022/23

- Reviewed effectiveness of Key Systems Audit programme with plan to move to a different way for working for 2023/24
- Referral to Treatment and Data Quality web pages reviewed and updated, providing guidance documents and SOPs to further support staff with policy, process and progressing patient pathways.
- Policies reviewed and updated to provide further clarity and understanding.
- Provided RTT training and coaching to Operational Managers, Admin Managers and RTT Validators to support at specialty level
- Introduced 40 Data Quality Metrics to support robust management of patient pathways
- To use benchmarking tools such as the SUS dashboard and DQMI Dashboards to ensure the NNUH are meeting national averages and proactively work with stakeholders to ensure resolution in areas of weakness if identified.
- Introduced multiple PAS enhancements and SOP's to support NHSE guidelines i.e. introduction of C1 patient unavailability
- Worked with the development team to introduce Robotic Process Assurance (RPA) to undertake repetitive duties to keep data clean i.e., automatic discharge of PIFU referrals once the target date has expired
- Supported with multiple validation objectives to support recovery and NHSE directives, used findings to deliver learning and coaching via the Referral to Treatment Operational Management Group Meetings (RTTOMG)
- The trust was visited by the NHS Elective Care IST Review team in April 2022 who reported a high level of confidence in the data quality of the PTL. The DQ team provide a service the Elective Care IST would describe as best practice.

Information Governance Data Security & Protection Toolkit Attainment Levels

Norfolk and Norwich University Hospital Foundation Trust's Data Security & Protection Toolkit overall score for 2022-23 was of a "Standards Met" assurance status and is graded satisfactory.

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 2022/23 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:

- Completion of Referral to Treatment (RTT) action plans will enhance performance in RTT within specialties

- Information Asset Administrators IAAs to produce/review Key Systems Policy & Procedures document, (master copy produced collaboratively with Digital Health, Data Quality & Information Governance
- Monthly Data Quality 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.
- 40 Data Quality Metrics have been introduced which will highlight under performance in key areas to support the management of patient pathways and RTT validation
- New post introduced in Data Quality to support the robust management of how activity/data is recorded, tariff generated, and preparation work for EPR
- Introduce the new standard staff induction for team members with manage patient pathways
- Continue to provide RTT training and coaching to Operational Managers, Admin Managers and RTT Validators to support as part of their induction programme.
- Train on DQ metric processes

Charity Café opens at Cromer Hospital

A new café has opened at Cromer Hospital, funded by the Norfolk & Norwich Hospitals Charity, offering hot and cold food, to eat in or takeaway, and accessible without entering the main hospital building.

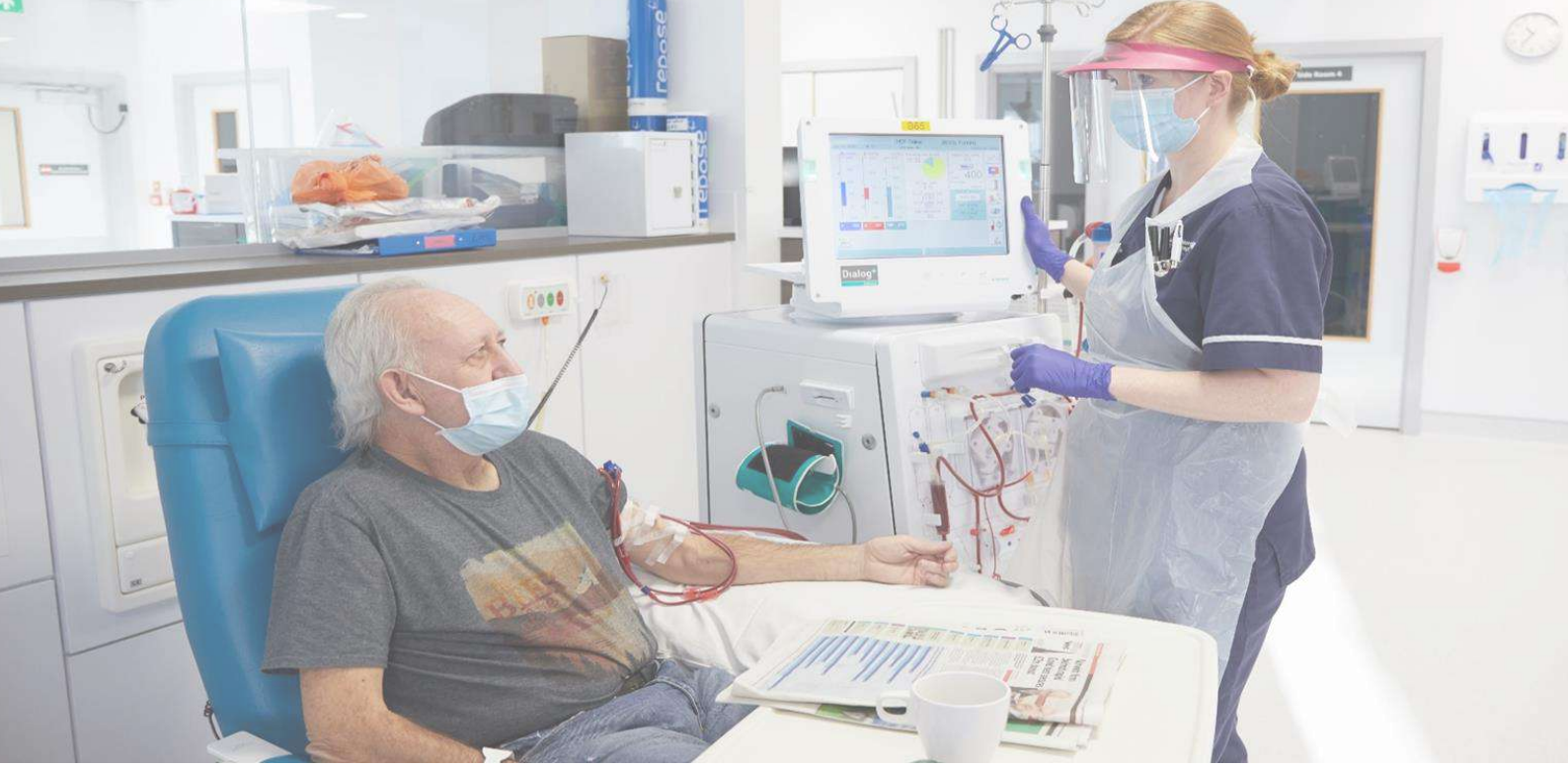
The café is called “Mardle”, a name suggested by Sharon Grimwood, Cromer Minors Injury Unit (MIU) Receptionist.

It is run by the Balanced Food Co, with proceeds to be reinvested into further improvements at Cromer Hospital with staff offered a discount.

John Paul Garside, Charity Director, said: “*We are really excited to have been able to provide this wonderful facility for Cromer Hospital and are keen to see the proceeds from the café go towards further developments for NHS patients in North Norfolk*”.

To find out more about the N&N Hospitals Charity or to make a donation please visit:

www.nnhospitalscharity.org.uk



Learning from Deaths

During the financial year 2022/23 2,842 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:

623 in the first quarter, of which 7 were patients with Learning Difficulties, 6 had a Severe Mental Illness, 8 were Still Births and 1 was a Neonatal Deaths.

711 in the second quarter, 7 were patients with Learning Difficulties, 3 had a Severe Mental Illness, 3 were Still Births and 3 were Neonatal Deaths.

761 in the third quarter, 14 were patients with Learning Difficulties, 8 had a Severe Mental Illness, 5 were Still Births and 4 were Neonatal Deaths.

747 in the fourth quarter, 4 were patients with Learning Difficulties, 13 had a Severe Mental Illness, 3 were Still Birth and 8 were Neonatal Deaths.

Table 7: Summary of In-Hospital deaths and deaths within 30 days of discharge for the financial year 2022/23

Financial Year 2022/2023	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	17874	272	623	895	7	6	8	1
Q2	18078	267	711	978	7	3	3	3
Q3	18927	297	761	1058	14	8	5	4
Q4	18364	263	747	1010	4	13	3	8
Total	73243	1099	2842	3941	32	30	19	16

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

Table 8: Medical Examiner reviews and escalations

Financial Year 2022/2023	Total Number of Deaths Reviewed by the Medical Examiner Service	Total Number of Deaths Escalated to SJR by the Medical Examiner Service	Total Number of Deaths Escalated to Local Mortality Meetings by the Medical Examiner Service
Q1	667	2	10
Q2	769	4	49
Q3	825	2	36
Q4	820	2	41
Total	3081	10	136

(In Q4 28 of the total deaths reviewed were community cases.
No escalations to SJR/M&M of deaths within 30 days of discharge.)

The Medical Examiner Service has scrutinised 100% of all inpatient deaths in 2022/2023 and the service is continuing to expand into the community. The statutory phase of the Medical Examiner Service is expected in late 2023, whereby all non-coronial deaths in all settings will be reviewed by a Medical Examiner. The service currently has some engagement with several GP practices and community providers to begin the community roll-out.

Learning Disabilities

The Trust takes seriously the learning gained from LeDeR (Learning from Lives and Deaths - people with a learning disability and autistic people) and other mortality-related projects. It is well-evidenced that people with learning disabilities die younger than a 'general population', and often due to potentially preventable reasons, with a higher proportion dying in hospital.
The local Integrated Care Board, with whom the learning disability team works closely, approached the Trust to share positive feedback about its 'learning from deaths' programme, and with a view to expanding the Trust's model to other local acute hospital Trusts.

The Trust's model for learning from deaths for learning disabilities (and other Complex Health focuses) incorporates several key approaches:

- Structured Judgment Review (SJR)
- Parallel internal learning disability specialist mortality review (exploring issues of health inequality, diagnostic overshadowing, bias and discrimination)
- Escalation to SJR Scrutiny Panel for patients with learning disabilities where concerns have been identified (10 in the past year, 5 of which highlighted concerns and significant learning)
- Transparent process inviting external LeDeR reviewers to panel to encourage cross-agency learning
- Engagement with regional LeDeR steering group, and associated working groups
- Regular learning disability report summarising internal and external mortality-related learning to the Trust's Learning from Deaths committee

The learning disability team is currently engaged in several working groups associated with LeDeR learning, including: respiratory care, end of life care, acute care, and will continue this work in the coming year, also aiming to turn its focus on to other key areas as identified via the LeDeR process.

Child Death Overview Panel Reviews (CDOP)
CDOP reports data in line with the National Child Mortality Database annual reporting period (1st March to the 28th February). By the end of the 2022/2023 reporting period, 17 deaths were reviewed at the Child Death Overview Panel Review Group in relation to the 18 child deaths reported during 2022/2023. These reviews may include children who died elsewhere such as children who were under paediatric follow up but died at home and who were transferred to other hospitals for intensive care and died on PICU. The outstanding case is on the agenda for the next upcoming panel meeting.

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

Following the completion of the SJR, a scrutiny panel may be held with input from relevant expert and specialist teams and, where appropriate, external stakeholders. The scrutiny panel will review the SJR findings to identify key learning and areas of focus for improvement which may ultimately help all patients. The panel will also agree the appropriate governance response, and thank teams for any notable practise highlighted in the review.

An SJR scrutiny panel will be held when any of the following criteria are met:

- Overall care score is Poor or Very Poor
- Quality of care score indicates Avoidability
- Regulation 28 from the Coroner
- Patient was homeless
- Paediatric patients who have an SJR completed
- Escalation of concerns following a local Learning Disabilities or Severe Mental Illness review
- Escalation of outstanding practice identified through the SJR or following a local Learning Disabilities/Severe Mental Illness review

Table 9: Case record reviews completed during the 2022/2023 reporting period, including a breakdown by vulnerable group.

Financial Year 2022/23	Total Number of SJR's completed 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	39	7	12	0
Q2	39	12	12	0
Q3	79	13	10	1
Q4	51	17	12	1
Total	208	49	46	2

A collaboration led by MBRRACE-UK developed and established a national standardised Perinatal Mortality Review Tool (PMRT) building on the work of the DH/Sands Perinatal Mortality Review 'Task and Finish Group'.

The PMRT was released in January 2018, used by all NHS maternity, and neonatal units in England, Wales and Scotland, as well as being wholly integrated within the MBRRACE-UK programme of work.

The tool supports:

- Systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care;
- Active communication with parents to ensure they are told that a review of their care and that of their baby will be carried out and how they can contribute to the process;
- A structured process of review, learning, reporting and actions to improve future care;
- Coming to a clear understanding of why each baby died, accepting that this may not always be possible even when full clinical investigations have been undertaken; this will involve a grading of the care provided;
- Production of a clinical report for inclusion in the medical notes;

- Production of a report for parents which includes a meaningful, plain English explanation of why their baby died and whether, with different actions, the death of their baby might have been prevented;
- Other reports from the tool which will enable organisations providing and commissioning careto identify emerging themes across a number of deaths to support learning and changes in the delivery and commissioning of care to improve future care and prevent the future deaths which are avoidable;
- Other reports for use by the Child Death Review process and the PMRT will link with the soon to be commissioned National Child Mortality Database;
- Production of national reports of the themes and trends associated with perinatal deaths to enable national lessons to be learned from the nation-wide system of reviews;
- Parents whose baby has died have the greatest interest of all in the review of their baby's death. Alongside the national annual reports a lay summary of the main technical report will be written specifically for families and the wider public. This will help local NHS services and baby loss charities to help parents engage with the local review process and improvements in care.

Table 10: Case Record Review - Perinatal Mortality Review Tool (PMRT) –

Financial Year 2022/23	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	8	3
Q2	1	4
Q3	6	8
Q4	6	6
Total	21	21

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 11: Serious Incidents reported and investigations completed in relation to the deaths which occurred during the 2022/2023 reporting period:

Financial Year 2022/23	Total Number of Serious Incidents reported in relation to the deaths which occurred during the report period	Total Number of SI Investigations completed
Q1	7	7
Q2	4	3
Q3	18	16
Q4	2	1
Total	31	27

Total number of case record reviews and investigations in 2022/2023

By the end of Quarter 4, 117 case record reviews and 27 investigations have been carried out in relation to the 2,842 in-patient deaths reported during the 2022/2023 financial year, however, all in-patient deaths are scrutinised by the Medical Examiners Service.

In 3 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: 7 in the first quarter; 17 in the second quarter; 51 in the third quarter; 42 in the fourth quarter.

Of the 144 deaths reviewed, 41 representing 1.4% of patient deaths during 2022/2023 (2842) 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 0.8% of patient deaths during 2022/2023 (623)
Quarter 2: 4 representing 0.6% of patient deaths during 2022/2023 (711)
Quarter 3: 22 representing 2.9% of patient deaths during 2022/2023 (761)
Quarter 4: 10 representing 1.3% of patient deaths during 2022/2023 (747)

This number has been estimated using the following:

1. Case record reviews:

Table 12: SJR Case record reviews completed in relation to deaths which occurred during the 2022/2023 reporting period, where the death was judged to be more likely than not due to problems in care

Financial Year 2022/2023	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	0	0	0%
Q2	11	2	18%
Q3	21	4	19%
Q4	29	9	31%
Total	61	15	25%

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.

12: PMRT Case record reviews completed in relation to Neonatal/Post Neonatal deaths which occurred during the 2022/2023 reporting period, where the death was judged to be more likely than not due to problems in care

Financial Year 2022/2023	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	0	0	0%
Q2	1	0	0%
Q3	6	1	16.6%
Q4	6	0	0%
Total	13	2	15%

(Care provided by local hospital, not NNUH, therefore this will not be included in the figures above)

Table 13: PMRT Case record reviews completed in relation to Still Births which occurred during the 2022/2023 reporting period, where the death was judged to be more likely than not due to problems in care

Financial Year 2022/2023	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	0	0	0%
Q2	2	0	0%
Q3	8	1	12.5%
Q4	6	0	0%
Total	16	1	6%

2. Serious Incident Investigations:

Table 14: Investigations completed in relation to patients who have died during the 2022/2023 reporting period where the death was judged to be more likely than not due to problems in care

Financial Year 2022/2023	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	7	5	71%
Q2	3	2	67%
Q3	16	16	100%
Q4	1	1	100%
Total	27	25	93%

Thematic analysis of the 27 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; Dedicated pages on the Trust Intranet The Beat, Grand Rounds, SJR panel meetings, Local Mortality and Morbidity meetings, Governance Meetings and Trust wide OWLS (Organisation Wide Learning).

Table 15: Learning from Case Record Reviews – SJRs

	Themes identified through case record review	Update/ Action
1	Diagnosis	This was the top theme from the SJR process this year. Main sub-themes include: - Lack of timely recognition that a patient is - approaching end of life - Lack of a clear plan and oversight of - complex patients - Failures/delays to obtaining senior reviews These are inter-related themes and discussions at SJR scrutiny panels often reveal that they are underpinned by resource constraints including staffing shortfalls and lack of bed availability. These increase the risk of multiple patients moves/handovers and fragmentation of care. The constraints are well-recognised and kept under close review The AMBER care bundle is being trialled on specific wards as a means of enabling clinical teams to recognise patients at risk of dying and better communicate their concerns with them and their families and, where possible, to realise their preferences for place of care and death.
2	Non-compliance with the Mental Capacity Act	This is a recurrent theme coming through the SJR process and is a trust wide concern. The main sub-theme is no mental capacity assessment undertaken. Other themes include best interest decision meetings not held and no evidence that best interest decision making included balancing of risks and benefits to the individual. These cases often come through the SJR scrutiny panel where there is an opportunity to discuss SJRs in detail. It is common to find that assessments and best interest decisions have been made but not documented appropriately in the case-notes

		The action plan to address this issue is undergoing a refresh with the appointment of a new MCA lead. Focused training sessions are being made available and there will a review of MCA associated documentation to ensure these are concise and clear.
3	Communication and coordination	The main sub-themes are sub-optimal communication between teams, inadequate handover communication within or between teams and sub-optimal communication with patients/families. There are also specific concerns relating to ready identification of responsible Consultant/team & lack of joint handover processes between medical & nursing staff Several initiatives have been rolled out in the past year to improve communication between teams Trust wide including the roll out of the Alertive tool and the roll out of internal professional standards. The Alertive initiative requires the mapping out key roles and responsibilities within specialties/departments, enabling the redesign and strengthening processes in support of improved communication. Work is being undertaken to improve handover communication between nursing and medical staff. The Trust continues work to improve communication with patients and families via measures such as relative liaison staff. Discussions at SJR scrutiny panels and LFD committee suggest that patients who are outliers or those subject to multiple moves are at greatest risk of poor communication with the clinical team.
4	Gaps in documentation	This is a recurrent theme coming through case record reviews as well as other mortality reviews including Medical Examiner reviews. The main sub-themes are gaps in medical and gaps in nursing documentation. The Trust is still using paper case notes so there is a higher risk of poor legibility, misfiling, mishandling, loss, or damage Direct feedback is provided to speciality teams and this is a regular item of discussion at Learning From Deaths Committee to raise awareness The financial plan for a shared electronic patient record across the 3 acute trusts in Norfolk and Waveney has been approved and the procurement process has started. EPR implementation with the associated training, should help reduce the risk of poor documentation and record keeping. There

		are also several initiatives taking place that will support improvements in documentation including an electronic discharge letter (EDL) improvement workstream as well as a nursing documentation improvement workstream to streamline current requirements

Table 16: Learning from Case Record Reviews – PMRT

	Themes identified through investigations	Update/ Action
1	Preterm birth	Occasional missed opportunities to predict and prevent preterm birth. Themes reminder presentation already undertaken at Maternity Governance. LMNS focus in next Clinical Safety & Quality Oversight Group Meeting to ensure improvements in offer across the LMNS, as NNUH take the preterm babies from the local units in the LMNS due to the level 3 NICU provision. Change in skin prep for the extreme preterm babies to protect skin integrity.
2	Fetal Anomaly	2x quartiles include fetal anomalies that were predicted to have poor outcomes but families have chosen to continue these pregnancies in any case.
3	Access to Triage	Birmingham Triage criteria and methods being instigated – pilot being undertaken and removal of Medicom/CallEast being considered to avoid this extra layer.
4	Ongoing concern regarding staffing to offer appropriate care appointments and 1:1	Ongoing recruitment drive to ensure backfill for maternity and longterm sick leave.

The main themes identified through the Serious Incident investigations are listed below. This learning will be used to inform our Patient Safety Incident Response Plan (PSIRP) and our focused future quality improvement work to minimise recurrence.

Table 17: Learning from investigations

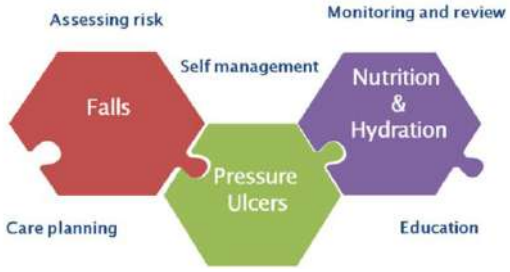
	Themes identified through investigations	Comments
1	Delay in diagnosis	NNUH will transition to the new National Patient Safety Incident Investigation Framework from September 2023. This will replace the existing Serious Incident Framework. All NHS providers are required to publish a Patient Safety Incident Response Plan (PSIRP) on their website. This sets out the level of review and investigation that will be undertaken for patient safety incidents. The highest patient safety risks will have a systems investigation called a Patient Safety Incident Investigation (PSII) conducted by a Patient Safety Incident Investigator. Alongside two national PSII priorities, Provider Trusts will identify their highest risk patient safety areas for PSII. Insight from SJR is being utilised along with other incident and complaint information to inform the local priorities for PSII.
2	Sub optimal care of deteriorating patient – monitoring and escalation of vital signs	
3	Suboptimal communication with families	A Family Liaison Support Officer role was put in place during Covid pandemic to primarily support the emotional wellbeing of the patient, providing a creative and practical means to maintain a 2-way communication with family, loved ones and carers. In addition, the role also supports ward teams to ensure that patient/family concerns are listened to, recorded and acted upon and will regularly liaise with ward colleagues to escalate patient and family concerns and questions requiring a response from a clinical / medical colleague. This role is funded until March 2024 and is being evaluated with a view to embedding it into the establishment.

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 five commonly occurring themes across all three domains as shown (*to the right*) -



Reducing Harm from Falls Quality Improvement Programme

The falls improvement programme is being rolled out across the Trust and builds on the learning from local and national improvement work. The Tendable © audits are being used at ward level to identify areas for improvement.

Fig 1.0 (above). shows the monthly compliance scores for the Tendable Falls Audit.

5 Lowest Scoring Questions

Question	Score
3f. Has the Post Falls Hot Debrief been completed and uploaded to Datix?	36.1%
2a. Has the patient had a lying and standing blood pressure documented as per procedure on WebV ?	56.4%
2b. Is there documented evidence that the Safety Sides Matrix has been completed?	71.2%
3c. Has the Multi-Disciplinary Team Standard Assessment and Falls Prevention Actions for all Adult Inpatients been reassessed and updated following the fall?	75.0%
2. If required, has Part 2 of the Multifactorial Falls Risk Assessment been completed in full and is dated and signed by the assessing staff member.	77.1%

Fig 2.0 (above) is an example of the lowest scoring questions that identifies areas for improvement

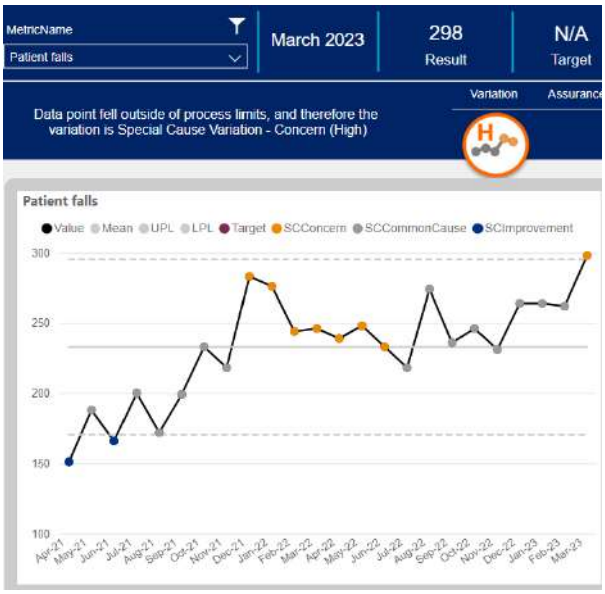


Fig 3.0 (above) The number of inpatient falls per month

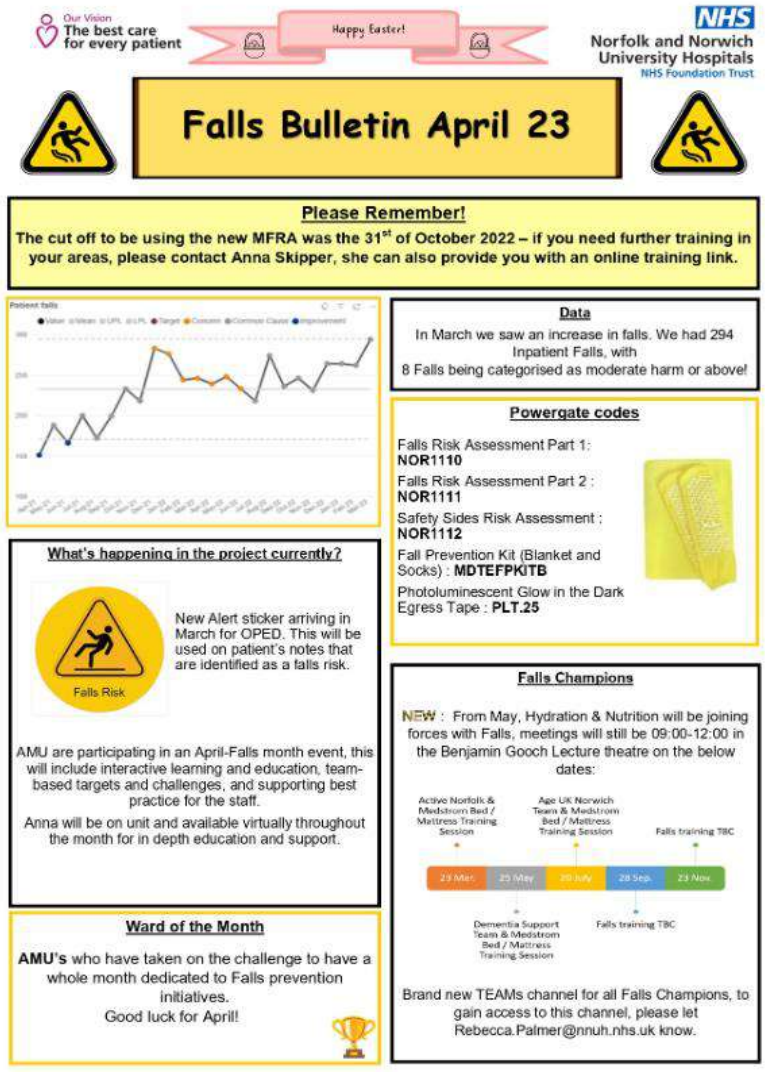
Fig 4.0 The rate of falls per 1000 bed days causing moderate harm and above

Falls Prevention & Management Lead Initiatives

- Introduction of new MFRA & Safety Sides Risk Assessments with rolling training across the MDT/Trust
- Ward MDT Educational Training on Falls Prevention
- Bespoke MFRA created for CCC & Kidney Units
- Refreshed Tenable AIMS Falls & New ED AIMS Falls
- Falls Alertive Group created to respond to multiple fallers
- Think Yellow rolled out Trust Wide
- Assistive Technology Trial underway
- ICS Collaborative working
- Collaborative working with Medstrom on Ultra-Low Bed Training
- Development of Falls Champion Training
- Creation of Physiological Falls Category on Datix

Falls Steering Group

This group is 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.



Example of monthly Falls Bulletin

Pressure Ulcer Improvement Challenge

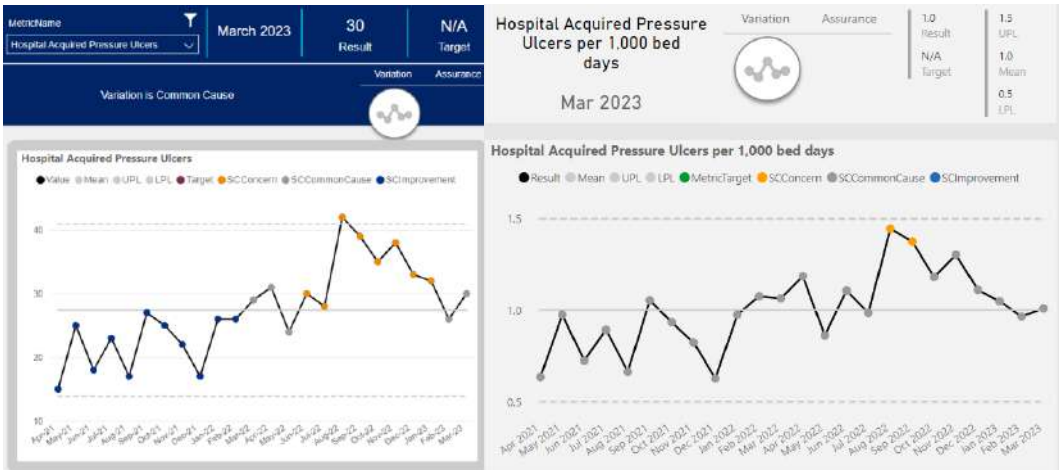
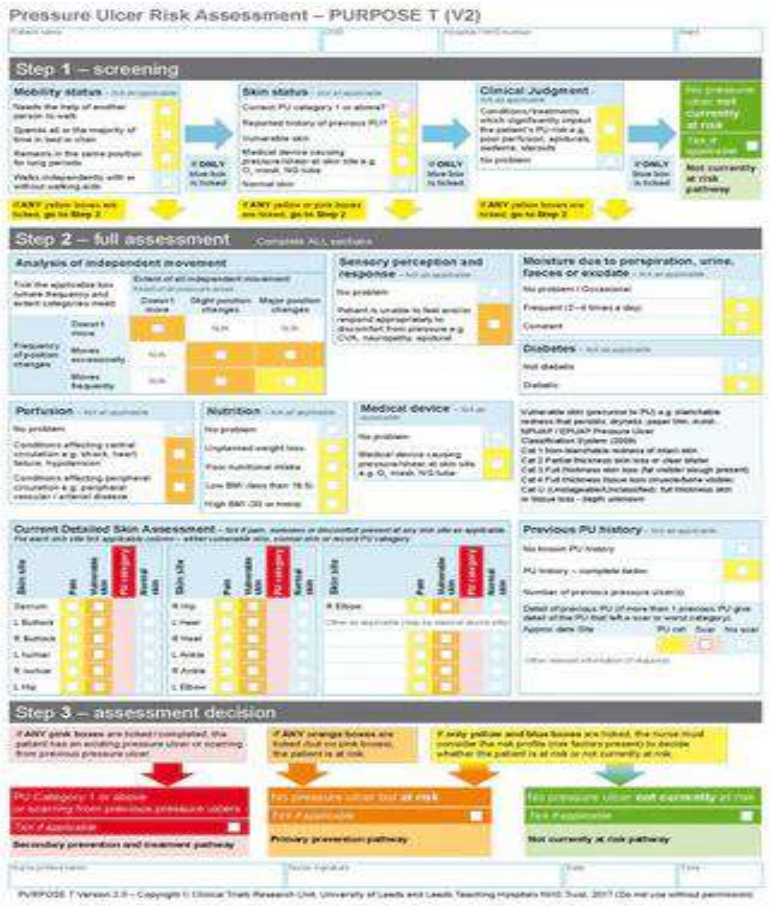


Fig 5.0 The number of Cat 2-4 Hospital Acquired Pressure Ulcers (HAPU)

Fig 6.0 The rate of HAPU per 1000 bed days

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 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.

NICE recommends the use of BAPEN's interactive e-learning resource on nutritional screening using 'MUST' for staff working in hospitals, to aid implementation on the new NICE Quality Standard for Nutritional Support of Adults.

Staff are able to access the MUST e-learning training to improve compliance with MUST screening assessments. MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (undernutrition), or obese. It also includes management guidelines which can be used to develop a care plan.

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

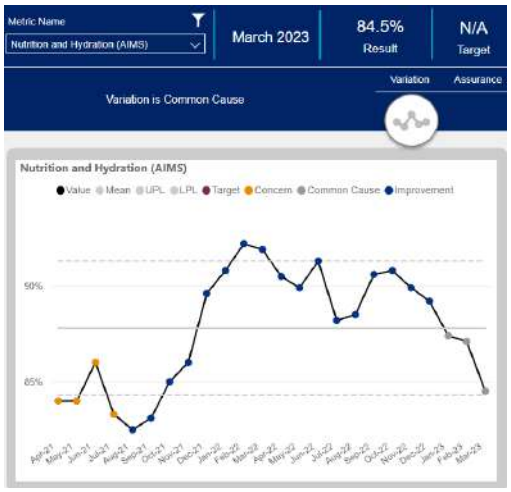


Fig 7.0. shows the monthly compliance scores for the Tendable Nutrition Audit.

5 Lowest Scoring Questions

Question	Score
4.2. Is there documented evidence that shakes/soups have been offered?	54.2%
5.2. Is there documented evidence that shakes/soups have been offered?	54.4%
7.2 Has the chart been totalled at midnight?	54.7%
5.3. Has the High Calorie/Protein diet sign been displayed?	56.1%
4.3. Has the High Calorie/Protein diet sign been displayed?	65.5%

Fig 8.0 is an example of the lowest scoring questions that identifies areas for improvement

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

Update on Case Record Reviews and Investigations for 2021/2022

75 case record reviews and 9 investigations were completed after 1st April 2022 which related to in-patient deaths which took place before the start of the reporting period.

Of the 84 deaths reviewed, 16 representing 0.7% of in-patient deaths before the reporting period (2,397) 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 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.

35 representing 1.5% of the in-patient deaths (2,397) during 2021/2022 are judged to be more likely than not to have been due to problems in the care provided to the patient.

Spotlight on the Voluntary Department

Sally Dyson – Volunteer Manager of the Year 2022

Congratulations to Sally Dyson who won Volunteer Manager of the Year at the Helpforce Champions Awards 2022.

The Helpforce Awards, which were held on 4th November 2022, celebrated the very best of volunteering in healthcare. Sally, who has been Voluntary Services Manager at the hospital since 2004, deservedly won the Manager of the Year award.

Sally and her team in Voluntary Services have grown our volunteer workforce to more than 700 and provide 3,000 hours of help per week throughout the Trust. There are 45 different volunteering roles across seven sites.

Sally said: *"I'm delighted to win this award, which is wonderful recognition of our volunteer programme at NNUH and my amazing team in Voluntary Services who make it all happen. By embedding volunteers into our clinical infrastructure right across the Trust, we are able to support our hard-working staff to focus on clinical priorities, help to improve quality and productivity, support strategic objectives and attract our future workforce. Volunteers are able to assist older people with hydration and nutrition, provide therapeutic and dementia activities, sit with patients at end of life, support their pathway through ED, drive patients home and settle them in on their day of discharge and provide welfare calls post discharge."*

Norfolk High Sheriff praises NNUH Volunteers

The High Sheriff of Norfolk, David McLeavy Hill DL, visited the hospital on 26th January 2023 and was "extremely impressed" by the work of our volunteers.

David was appointed High Sheriff in April 2022 and helps support the voluntary sector and charities across our county. He met CEO Sam Higginson and other members of the Executive team before touring the hospital accompanied by Sally Dyson, Voluntary Services Manager.

He talked with volunteer drivers and those who support discharge and patients with dementia, as well as, volunteers in the Emergency Department, Butterfly volunteers and those who help run Hospital Radio.

"It was wonderful to see how many volunteers are involved in the life of the hospital and how well their activities are organised," said David. "Their enjoyment, passion and dedication are clear in everything they do and their help is invaluable. I've heard some great stories by chatting to volunteers and I've been extremely impressed by how well they're integrated in the operation of the hospital."

"Our volunteers work tirelessly and it was such a treat for them to receive recognition and praises from the High Sheriff of Norfolk, we can't thank him enough," said Sally.

Part 2.3 - Reporting against core indicators

Photo of old hospital taken from public domain

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 Oct 21 – Sep 22 Published by NHS Digital	National Average	Best performer	Worst performer	NNUH Nov 20-Oct 21	NNUH 19/20
SHMI value and banding	1.2340 Band 1	0.9995	0.6454	1.2340	1.1860 Band 1	1.1688 Band 2

Location: https://digital.nhs.uk/data-and-information/publications/statistical/shmi/2023-02/shmi-data > SHMI data at trust level

Latest version available covers October 2021 to September 2022, published 9th February 2023

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this data is as described for the following reasons: NNUH has a comprehensive mortality surveillance programme in place. Investigation of our 'higher than expected' SHMI by SJR cohort review has not shown that our SHMI is being driven by poor quality care. In addition, there is no signal from the Medical Examiner office that the NNUH is an outlier for potentially preventable deaths. SHMI appears to be driven by 3 factors:

1. *Data Quality relating to our continued use of paper case notes and fragmented IT systems*
2. *Removal of SDEC (same day emergency care) activity from the APC data set/SHMI denominator**
3. *Palliative care – NNUH has high palliative care activity and this is not factored in by the SHMI model*

*Please note that NNUH is an SDEC pilot site whereby the Trust captures SDEC activity as emergency care (ECDS) rather than in the admitted patient care (APC) data set. It has recently been acknowledged by NHS Digital that removal of SDEC from the APC data set by SDEC pilot sites is associated with an increase in SHMI.

% of patient deaths with palliative care						
Indicator	NNUH Nov 21 – Oct 22 Published by NHS Digital	National Average	Best performer – Lowest %	Worst performer – highest %	NNUH Nov 20 – Oct 21	NNUH Nov 19 – Oct 20
% of patient deaths with palliative care coded at either diagnosis or specialty level for the reporting period	55%	40%	12%	65%	54%	52%
Location: Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation, England, November 2021 - October 2022 - NDRS (digital.nhs.uk)> interactive data visualisation > page 7 (contextual indicators: Palliative Care) **Latest version available** covers November 2021 – October 2022, published 9th March 2023.						

PROMS –						
Indicator	2021/2022				NNUH 20/21	NNUH 19/20
	NNUHFT	National Average	Best performer	Worst performer		
Patient reported outcome scores for groin hernia surgery	No data available	No data available	No data available	No data available	No data available	No data available
Patient reported outcome scores for varicose vein surgery	No data available	No data available	No data available	No data available	No data available	No data available
Patient reported outcome scores for hip replacement surgery	No data available	No data available	No data available	No data available	0.444 2020/21	0.452 2019/20
Patient reported outcome scores for knee replacement surgery	No data available	No data available	No data available	No data available	0.271 2020/21	0.309 2019/20
At the time of publication, the data for 2021/2022 has not been released by NHS Digital due to merging with Education Health England and NHS England						

28 day readmission rates						
Indicator	2022/2023 (NNUH reported based on the NHS Outcomes Framework Specification)				NNUH 21/22	NNUH 20/21
	NNUHFT (Apr 22 – Mar 23)	National Average	Best performer	Worst performer		
28 day readmission rates for patients aged 0-15	Average rate 7.09%	No data published	No data published	No data published	Average rate 10.9%	Average rate 15%
28 day readmission rates for patients aged 16 or over	Average rate 9.27%	No data published	No data published	No data published	Average rate 11.2%	Average rate 8%
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	2021/2022 NHS Digital				NNUH 20/21	NNUH 19/20
	NNUHFT	National Average	Best performer	Worst performer		
Trust's responsiveness to the personal needs of its patients during the reporting period.	No data available	No data available	No data available	No data available	72.9	67.1
At the time of publication, the data for 2021/2022 has not been released by NHS Digital due to merging with Education Health England and NHS England						

% Staff employed who would recommend the trust						
Indicator	2022 NHS Staff Survey Results				NNUH 2021	NNUH 2020
	NNUHFT	National Average	Best performer	Worst performer		
NHS Staff Survey Q23d – "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation."	47.3%	61.9%	86.4%	39.2%	60%	72.2%

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

The 2022 results represent a difficult period where we have seen decline in our staff experiences. Data from the 2022 staff survey has provided the Trust with strong evidence that there is significant work to be done to improve our staff experiences working at the trust.

The results reflect the continued and sustained pressure we face across our Trust. We recognise we have more work to do to improve staff experience and the actions we have already launched will take longer to embed throughout our organisation.

We are still recovering from the impact of the Covid-19 pandemic and we're putting a lot of work in across the Trust, as well as with our system partners, to improve flow and discharge to reduce the pressure on our inpatient wards and emergency areas. We are making progress on recruitment and reducing our vacancy rate as well as investing in staff facilities, the opportunity for more colleagues to work flexibly and a strong focus on wellbeing as part of our NNUH People Promise.

We are reviewing our results to identify necessary actions to make improvements. We will work together, both internally and with the wider healthcare system, to make transformational changes

We are reviewing our results with corporate People Promise priority action plans, and leaders/ managers are also reviewing their local action plans, to ensure improvements are identified. We want to deliver improvements to the way in which we work, care for patients and care for each other, in wanting to improve our staff experience of working at the trust.

% of patients assessed for Venous Thromboembolism (VTE)						
Indicator	2022/2023 (Trust data)				NNUH 21/22	NNUH 20/21
	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	99.35%	No data available	No data available	No data available	No data available	No data availabl e
VTE data collection was paused due to the Covid-19 pandemic and has not been restarted; therefore no official publication of data is available. Data presented has been collected from the Digital Health – Business Intelligence Team at NNUH.						

C difficile						
Indicator	2021/2022 NHS Digital				NNUH 20/21	NNUH 19/20
	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	13.68	16.46	0	53.6	14	8.6

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 2022

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 United Kingdom Health Security Agency (UKHSA)

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.*difficile*, in order to contain the spread of infection, and our Infection Prevention & Control team works in a targeted way to quickly contain any Periods of Increased Incidence. Clinical cleaning processes are in place to contain any suspected infections and avoid an outbreak entirely if at all possible.

Patient Safety Incidents						
Indicator	2021/2022 NHS Digital				NNUH 20/21	NNUH 19/20
	NNUHFT	National Average (Rate)	Best performer (Rate)	Worst performer (Rate)		
Number and rate of patient safety incidents per 1,000 bed days	No data available	No data available	No data available	No data available	Rate 118.7 (n32,917)	Q1/2 Rate 49.7 (n8069) Q3/4 Rate 52.5 (n8585)
Number and percentage of patient safety incidents per 1,000 bed days resulting in severe harm or death	No data available	No data available	No data available	No data available	Rate 0.25 (n69)	Q1/2 Rate 0.2 (n39) Q3/4 Rate 0.3 (n41)
At the time of publication, the data for 2021/2022 has not been released by NHS Digital due to merging with Health Education England and NHS England						

Review of Implementation of 7 Day Services

Acute Service providers are not required to submit a board assured self-assessment return or provide any monitoring reports to NHS England or NHS Improvement, against Version 2 of the Seven Day Services Clinical Standards.

The Norfolk and Norwich University Hospital (NNUH) has embedded 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.

Reports are submitted to the Quality Programme Board, in line with the Board Assurance Framework regarding these standards.

Review of Speak Up Policy

The National Speak Up Policy has undergone a review. Following publication in June 2022, we have been raising awareness within the organisation of the National guidance. We are currently sharing this work with key stakeholders and staff networks to improve understanding. This is providing us with an opportunity to myth bust any preconceptions and update users on best practice.

We are looking to adopt the National Speak Up policy in full before the deadline of 31st Jan 2024, submitting the paper through our appropriate governance channels. The policy underpins the NHS people promise that we each have a voice that counts. It outlines; how staff can speak up, how we will listen and what will happen next. It also outlines making a protected disclosure. Users are signposted to appropriate support, both internal and external to the organisation.

Freedom to Speak Up (FTSU) Guardian Service

The Freedom To Speak Up Guardian Service consists of a network that is well established in our vertical framework with NED oversight. Our focus is now on

horizontal growth across the organisation with Guardians and Champions, aiming to continually reduce barriers of support to users.

- Designated NED – Sandra Dineen
- Executive Lead – Paul Jones, Chief People Officer
- Lead of Service – Frances Dawson
- Guardians – Aligned to each division
- Champions – Aligned to departments

We are active in the National and East Regional FTSU networks and Communities of practice (COP's). This provides opportunity for sharing practice and learning from other NHS organisations, without boundaries.

Rota Gaps

Health Education England (HEE) allocate junior doctors to our organisation, and as such we continue to work 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 a Guardians of Safe Working Hours, who acts as a champion 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. The roll-out of Health Roster is underway. When this is complete we will be able to review rota gaps corporately, by division and specialty, allowing granular oversight and increased potential to manage our rota gaps proactively.

A bespoke Medical & Dental Workforce Improvement Programme was executed in 2022-2023. This intense programme has resulted in improved performance across a number of workstreams and subjects related to our medical and dental workforce, such as junior doctor rostering, work schedules, induction, 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.

Additionally, a bespoke group of stakeholders relevant to junior doctor employment and educational experience has been established to provide a 12-month forward look of aspects relevant to employment and educational experience. Group representation spans medical workforce, PGME, office of the Medical Director, operational services, in addition to other co-opted membership.

Spotlight on the International Recruitment Programme

NNUH International Recruitment receives Pastoral Care Quality Award

NHS England and NHS Improvement International Recruitment Programme team have recognised the high quality of our international recruitment by awarding us their Pastoral Care Quality Award.

This award scheme requires Trusts to assess the quality of pastoral care they provide to their internationally recruited nurses and midwives and to collate a portfolio of evidence. In the past year, we have recruited 137 international nurses and are expecting another 79 to join us within the coming months.

Lisa Dennis, International Recruitment Programme Lead said –
"*I am truly thrilled that in September 2022 our Trust received this award. We take great pride in ensuring internationally recruited colleagues arrive safely, have their induction and a positive experience.*

They are supported and valued as part of team NNUH as they train to gain their Nursing and Midwifery Council (NMC) registration and adapt to their new roles in the UK. I'm very passionate about the welfare and experiences of our nurses and midwifes and always ensure we go above and beyond in supporting our new workforce to not only stay with us but also to progress in their personal development.

We value the experiences of our new colleagues and ensure they are welcomed at the airport and settled into their accommodations and we look after all their needs. We have a great training programme that covers all the essential learning and skills for their exams and ensure that nurses are well prepared for clinical practice."

Internationally Recruited Buddy Network

A team of 24 internationally recruited nurses have recently come forward to form part of our Internationally Recruited Buddy Network. This network aims to support new overseas nurses and provide a friendly welcome to our Trust. The network also helps new staff preparing for their OSCE exam. The network will also provide help to colleagues once they're sent to work in different wards.

Frimpomaa Akoto, Pre-registered Nurse in Interventional Radiology and Buddy Network member, joined our hospital just over one year ago, having previously worked in Ghana said:

"Coming to a new workplace is always challenging, but even more if this is also in a different country. I remember when I arrived the country was in lockdown and I had to self-isolate for two weeks. It also took me a while to adapt to the new system at the hospital and do all the training. I remember preparation for the OSCE exam was intense but that was not the only challenge: I did not know anything about Norwich and having our colleagues from the Practice Development and Education (PD&E) team to ask the simplest questions, such as which areas of the city are nice to go for a walk, made a huge difference. But I believe for the new cohort of international nurses it would be even better, now that the buddy network is well established."

In the last five years our Trust recruited 246 international nurses and our PD&E team has provided pastoral care support before and after their arrival in Norwich.




Part 3 - Overview of the Quality of Care

(All photos taken from the public domain)



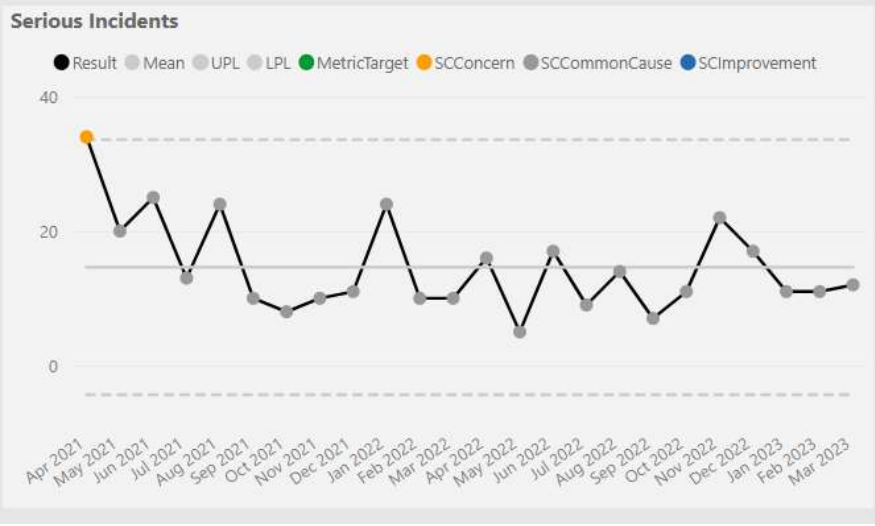

Patient Safety

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 2023, 176 Serious Incidents were externally reported to the national StEIS (Strategic Executive Information System). 14 Serious Incidents that were reported onto StEIS were declared void and removed from the system, but continued to be investigated by the relevant teams.

Fig 1.0 Serious Incidents Reported April 2021 – March 2023 ; extract from Integrated Performance Report (IPR)



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 reinforce a just and learning culture, reporting through the daily Serious Incident Group. There has been an 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, 44 Serious Incident cases where patients and families are undergoing varying levels of support according to individual needs and wishes. The Bereavement Midwife team are supporting 13 families at the time of this report.

Patient Safety

Never Events (NEs)

'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 five never events during the period covered by this Quality Account

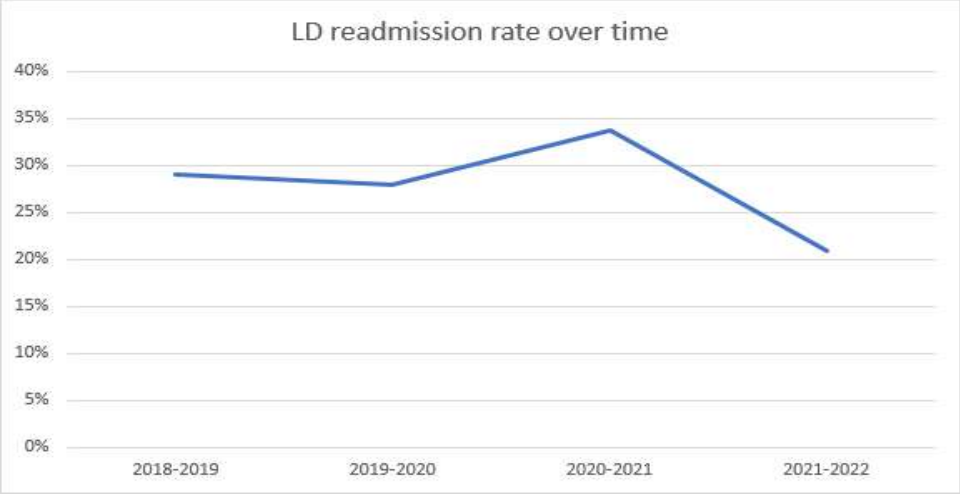
April 2022	Foreign body unintentionally left in situ
May 2022	Foreign body unintentionally left in situ
January 2023	Misplaced naso gastric tube
February 2023	Operation/procedure on wrong patient/ wrong part of body
February 2023	Operation/procedure on wrong patient/ wrong part of body

Learning Disability Readmission Rate reduction

The Trust has been submitting data to the NHS Benchmarking Network annually since 2018. The submission comprises patient and staff feedback in addition to service data covering key areas.

One metric that is measured is hospital readmission rate (within 30 days of discharge), which evidence suggests is typically higher for patients with learning disabilities. The Norfolk and Norwich University Hospital has reported a high readmission rate for people with learning disabilities consistently since 2018, both in comparison to other Trusts and to a 'general population'.
The most recent data submission (2021-2022) demonstrated that this rate has been significantly reduced:

- 18/19 – LD readmission rate **29%** (compared to general population rate 13%)
- 19/20 – LD readmission rate **27.9%** (compared to general population rate 13.7%)
- 20/21 – LD readmission rate **33.7%** (compared to general population rate 14.5%)
- 21/22 – LD readmission rate **20.9%** (compared to general population rate 14.9%)



Readmission rate for people with learning disabilities, which evidence suggests is often potentially preventable, was identified as a key focus of the learning disability and autism team and several improvement steps were taken, including:

- Thematic review of 'failed' discharges
- Close engagement with the Complex Discharge team
- A proactive strategy for identifying potentially complex discharges alongside Complex Discharge team
- Establishment of cross-agency forums with community services

In addition, the team are now able to identify with more clarity where in the Trust readmissions are concentrated by division/ward/specialty, which enables targeted support for those areas.

Whilst a certain disparity in readmission rate is to be expected – people with learning disabilities are more likely to have Long Term Conditions which require frequent admission – the team believes it is a positive step towards ever-improving equity between patient groups.

In the coming year, the team intends to focus further on those areas in which potentially preventable readmission rate is high and aim to sustain the improvement trend already noted.

Future Planned Projects…

The learning disability & autism team, in collaboration with the Patient Experience team, is in the process of developing a suite of initiatives aimed at making patient engagement more accessible and gaining enhanced patient feedback.

Informed by the Ask, Listen, Do approach (NHS England), the initiatives are expected to involve inviting patients and their families/carers to the hospital to assess the hospital environment. This will be using a modified version of the PLACE framework, which will be more accessible, and will enable feedback to be offered in a wider variety of ways.

The teams will then be able to use information gathered via this approach to co-produce improvement actions and monitor progress.

After Action Review (AAR)

Baseline: what increased the focus After Action Review
The new Patient Safety Incident Response Framework (PSIRF) published by NHS England in August 2022 signals a significant shift from the existing incident investigation approaches. It recommends a decrease in the number of lengthy Patient Safety Incident Investigations using Root Cause Analysis and an increase the use of other more agile and inclusive approaches including After Action Review (AAR).

AAR is a structured, facilitated discussion of an event or incident, led by a trained "AAR Conductor," which provides a safe reflective environment where psychological safety is actively created and maintained throughout. Learning during the AAR is the main focus, and, as a group learning process, the interactions between members of the team are available to learn from and improve. This has a strong effect on team performance and patient safety.

All AARs follows a four-question model:

1. What was expected?
2. What actually happened?
3. Why was there a difference?
4. What are we learning?

The journey so far this year (April 2022 – March 2023) including successes and challenges
The first cohort of 32 AAR conductors have been trained and are starting to use the AAR model to identify learning following a patient safety incident.

What you are aiming to achieve over the next 12 months and beyond.
AAR is a highly adaptable process, and as we adopt PSIRF we will be incorporating AAR into our range of standard responses to patient safety incidents.

In June, 9 conductors will be undertaking the Train the Trainer programme in preparation for rolling out AAR training across the Trust.

Case Study

Update on the Anti-Spiking Campaign

An Anti-Spiking Campaign pilot, launched by NNUH Specialist Biomedical Scientist Michelle Frost in Norwich, has been rolled out further across the region, with kits now also available in venues in Great Yarmouth and King's Lynn.

In last years Quality Account, we introduced Michelle Frost, Specialist Biomedical Scientist, who along with the Toxicology team, have created the Anti-Spiking Campaign. It is believed that the spiking of drinks – adding drugs or substances to a person's drink – or injecting them without their prior knowledge or agreement, has become more prevalent across the country, with a number of incidents reported in Norwich and the whole of the UK.

The aim of the Anti-Spiking Campaign was 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.

We have caught up with Michelle and the team to see what they have been doing since last year:

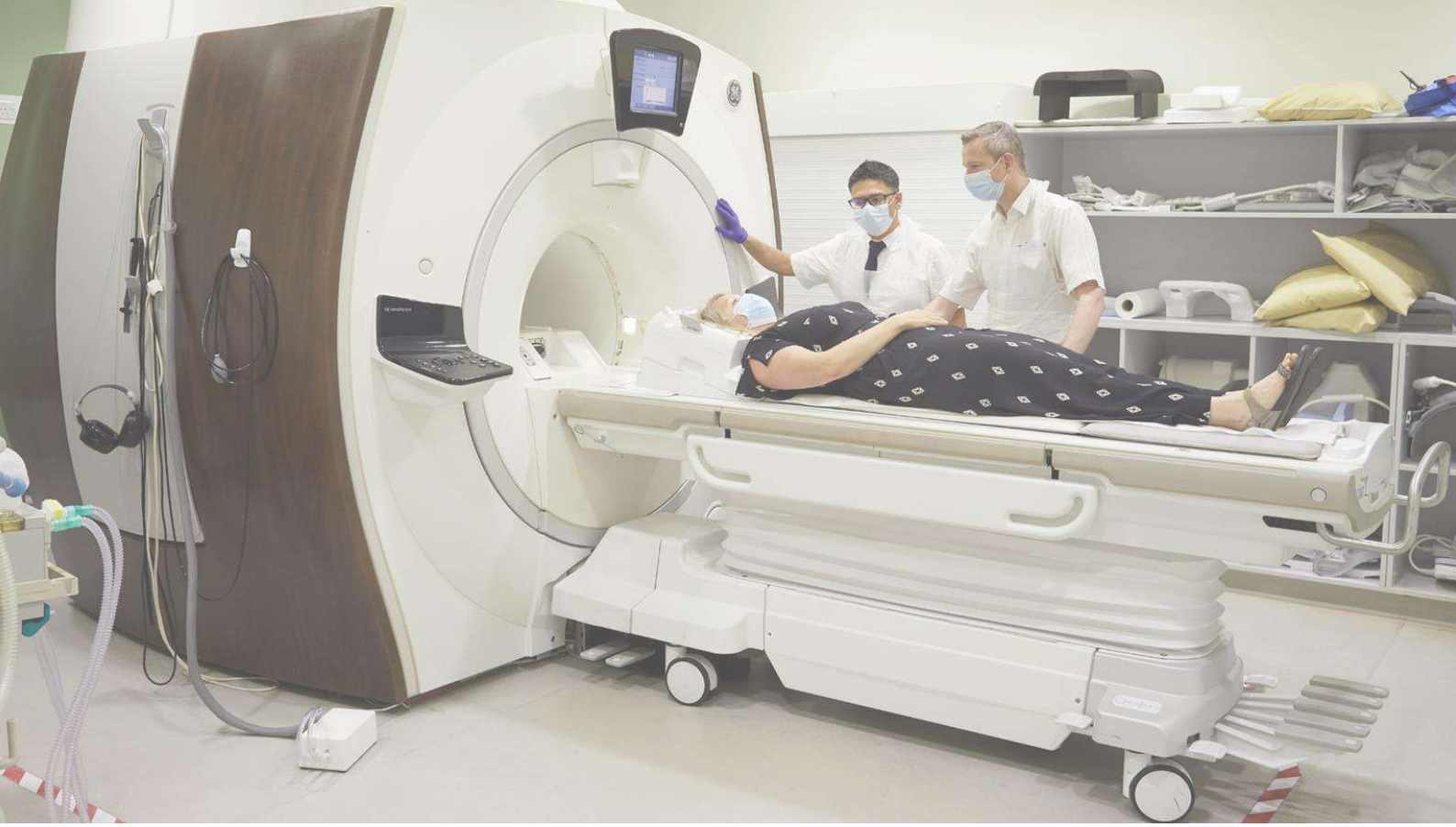
NNUH anti-spiking campaign extended across Norfolk towns

The Norfolk Police and Crime Commissioner has funded the kits, which are now available in Britannia Pier, The Empire, Empire Lounge, Peggotty's and Uptown Bar all in Great Yarmouth, and the Ocean Rooms in Gorleston.

The SOS bus in King's Lynn also now holds the kits, and after a meeting in King's Lynn, a further 12 venues have also signed up to have the kits. This is in addition to the 17 venues and the SOS bus in Norwich holding the kits, allowing the initiative to cover a wide area to keep people safer over the spring and summer period. Campaign creator Specialist Biomedical Scientist Michelle Frost has confirmed that Leeds and Reading Festival are providing the anti-spiking kits for festival-goers.

Michelle said: "*This really is now starting to take off with more venues coming on board. It means we can make sure that people going out can feel safe and we can really start to find out the true extent of this problem. The NNUH will be delivering enhanced patient care to festival goers at both Reading and Leeds for their annual festival. The kits will allow anyone who thinks they may have been spiked, through either the spiking of drinks – adding drugs or substances to a person's drink – or through injection, to personally access a full toxicology analysis. Drinks can also be tested to find out if they contain unconsented substances. Results will be sent back to kit users within seven days."*

She added: "*It's brilliant to know that we can help with patient care, even remotely. It also shows just how committed the organisers of Reading and Leeds Festival are about people's safety. I would like to thank them for taking our kits. I am so excited about this. It means it's official – we've gone national*."



Clinical Effectiveness

Virtual Ward

Baseline: what increased the focus on the virtual ward
On the 13th January 2021 all NHS Trusts were asked by NHS England/Improvement to set up a virtual ward (VW) to support inpatients with COVID. Within Digital Health we had already purchased and piloted a number of remote monitoring kits and were able to launch our VW at pace, on the 3rd February 2021 we admitted our first patients. Our initial focus was COVID, but we knew we wanted to use the VW to support recovery.

Since its launch, the VW has gained national recognition as being an exemplar acute hospital VW, winning 3 local and national awards and supporting up 40 patients at one time.

In 2022, Integrated Care Systems (ICS) across England were asked to deliver VW capacity equivalent to 40 to 50 VW 'beds' per 100,000 (equivalent to the delivery of up to 24,000 VW beds), by December 2023.

There is a requirement for the Norfolk & Waveney ICS VW, which NNUH is part of, to meet the following trajectory:

- 173 virtual wards beds by April 2023
- 368 virtual wards beds by April 2024

Ongoing work with our community providers and the other 2 acute NHS hospitals in Norfolk and Waveney present a significant opportunity to optimise and scale up the

current setup. The NNUH itself has been asked to support the trajectory by expanding our VW to support up to 60 VW 'beds'.

What you are measuring success on
Success for the VW will be:

- Offloading bed capacity and reducing readmission by about 15-45%
- New flexible way of working and more time for 1:1 patient interaction
- Treatment costs reduced by 20-30%
- Patients are three times more likely to be satisfied, and lower incidence of complications
- Sets a platform for integrated Virtual Care across the ICS, to improve patient flow through the whole system

The journey so far this year (April 2022 – March 2023) including successes and challenges

The Virtual Ward was designed initially for 20 patients VW 'beds', however in 2022 this was doubled to support 40 patients VW 'beds', with recruitment in place to extend this to support 60 patients VW 'beds' by June 2023. Our major challenge has been active referrals from teams so that flow is not solely reliant on the VW driving referrals and transfers.

Two major milestone have recently been reached, the VW welcomed their 2,000th patient and shortly after reached more than 16,000 bed days saved within NNUH.

The VW team have also received a lot of recognition over the last year:

- Winners of the Healthcare Financial Management Association (HFMA) 'Delivering Value with Digital Technology Award' 2022
- Highly Commended in the 'Digitising Patient Care Award' at the Health Service Journal (HSJ) Awards 2022
- Finalists at the HSJ partnership awards 2023 for the 'Best Healthcare Provider Partnership with the NHS' for the work with Homelink and QEHKL, JPUH, N&W ICB.
- Winners of the special award for Innovation in the NNUH annual staff awards

Other achievements include:

- Publication in the British Journal of Nursing (Volume 31, Issue 20) 'Successful implementation of round-the-clock care in a virtual ward during the COVID-19 pandemic'
- Publication in BioMed Central Pregnancy and Childbirth (Article 550 (2022)) 'Remote care and triage of obstetric patients with COVID-19 in the community: operational considerations'

- ‘Rapid Service’ evaluation paper – gold standard and being used as a template for service excellence
- Recognition as a potential ‘low carbon model of care’ and contributing to the NHS’ commitment to delivering a ‘net zero health service’

What you are aiming to achieve over the next 12 months and beyond.
Our current focus is to:

- Maintain current 40 bed ward, with focus on ensuring consistent pathways while recruitment of staff to support expansion
- Optimise Length of Stay in the VW
- Launch the use of Hoveton Isolation Ward to free up physical beds sooner
- Increase active referrals from teams

Longer term

- Introduce new remote monitoring technology in line with Norfolk and Waveney
- Reach about a 10% increase in transfers, with their stays in the VW helping to save about 10 more acute beds (about 30 total)
- Integrate new specialties and care to transfer additional patients into the home, maintaining a 60 bed ward
- Reach about 140 more patients, with their stays in the virtual ward helping to save about 20 more acute beds (about 50-55 total)

Future ambitions

- To have a single ICS wide VW hub so that no matter where you are in across the ICS as a patient you have equal access to the same care.
- Integrated community and acute VW
- Standardised approach

Maternity Reviews

Baseline: what increased the focus on the whole of the maternity reviews
NHS Maternity services across the whole of England have been under the spotlight following the release of reports from independent reviews of Maternity services such as Ockenden (Shrewsbury and Telford Hospital NHS Trust 2020 and 2022) and Kirkup (Morecambe Bay 2015 and East Kent 2022). These reports identified essential and immediate actions not only for the individual NHS Trusts being reviewed but everyone delivering NHS Maternity services.

As well as the independent review reports requirements, regional NHS England visits and the Maternity Incentive Scheme have added to the ask for compliance and evidence of a safe Maternity service.

What you are measuring success on

- Good CQC Overall Rating for Maternity Services
- Meeting the requirements to obtain the Maternity Incentive Scheme

The journey so far this year (April 2022 – March 2023) including successes and challenges
The NNUH Maternity Services have been reviewing themselves against the action plans for each of the recommendations produced by the independent review reports, regional visits and the Maternity Incentive Scheme, providing evidence against each where they have been met or demonstrating the journey in order to meet the requirement.

The evidence for compliance is collated and then reviewed by the specialist Maternity evidence group which is attended by multidisciplinary colleagues across the Trust for increased independent scrutiny and RAG rated with any recommendations and timelines.

Green – On track to meet outcome date.
Amber – At risk of not meeting outcome date.
Red - Will not meet the outcome date or has already passed outcome date.
Blue – Recommendation is complete but requires further monitoring from Quality Programme Board (QPB).
Black – Recommendation is agreed as complete.

The implementation of maternity evidence group has highlighted areas for improvement in meeting the requirements and but also identified where we are excelling; this has been useful in creating a robust evidence repository for any regulatory body or request when required.

The challenge has been the level of resource required to collate the evidence of compliance for our Maternity service due to the amount of similar repetition of

recommendations/themes in the sperate action plans and the limitation of a monthly evidence group all whilst maintaining a high standard of care to our patients.

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

Due to the increasing ask from national reports and reoccurring themes, NNUH maternity services are working collaboratively with the Quality Improvement Team to produce an overarching Maternity Action plan which will include all the data and recommendations from all the various audits, reports and inspections which will be cross referenced. This should reduce the number of meetings required, remove duplication of work to meet the similar requirement for several individual action plans and allow the Maternity teams to focus on identifying and implementing improvements.

In addition, the action plan will be shared widely with maternity staff via open forums and updates at maternity meetings to ensure staff are aware of progress and our position within national recommendations.

We are waiting on the CQC to conduct an inspection of the NNUH Maternity Services in the next few months as part of their aim to inspect all NHS Maternity services in England.

Orthopaedics Knee Replacement Research

Baseline:
The Trust is currently conducting research in Orthopaedics on knee replacement.

Within this research we are focusing on a number of different areas:

- Comparing pre-existing implants to more modern implants
- Looking at rehabilitation before and after knee replacement
- Looking at novel diagnostic tests for infection
- Looking at novel painkillers to try and decrease the number of patients having knee replacement.

The reason why we are doing this is:
Comparison of implants
Our findings so far has demonstrated that a pre-existing implant (Genesis 11) is equal, if not superior, in the outcome of surgery to more modern designs.

The importance of this research is:

- Patients can feel reassured that they will get a knee replacement that is supported by quality evidence.
- That more modern designs do not necessarily deliver better performance.
- This is a benefit for Surgeons who will understand that their patients are being treated with the best possible designs.
- The old designs are cheaper than more modern designs and this is a saving for the NHS and this helps Implant Companies in focusing their research efforts.

Rehabilitation and prehabilitation
We have found that the use of novel devices and not using face to face physiotherapy, which reduces costs to the NHS, can continue to improve outcomes of patients following hip and knee replacements.

Novel diagnostics
We are looking at novel diagnostics to try and diagnose infection and differentiate it from other types of joint pain. The focus on this research is on patients coming to the Emergency Department or General Practice who can have a quick diagnostic test which can differentiate between different types of knee pain. Tests currently do not allow this, meaning patients are often admitted to hospital, thereby taking a bed and more resources. If we can develop a diagnostic that will allow patients to be discharged safety from the Emergency Department where they do not have an infection, meaning that the patient can have the right treatment at the right time and avoid an unnecessary admission.

New painkillers
We are looking at trialling new painkillers to treat patients with arthritis with the view that this will reduce the number of patients requiring joint replacement. This is currently at the set-up phase.

The journey so far this year (April 2022 – March 2023)
The successes of this research work are:

1. In the first trial we have published a paper which has changed our practice and we continue to work with knee implant companies to develop better techniques.
2. The paper which was published is now undergoing NICE review and a further ethical review which could see changes across the whole of the UK.
3. The research is undergoing ethical review

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

1. Start a trial looking at better implant insertion to try and improve outcomes.
2. Look at methods of decreasing our waiting list by focusing on prehabilitation and rehabilitation which we hope will decrease length of stay in hospital and improve patients recovering in the Community.
3. Improve pain relief for patients who have arthritis already.

Spotlight on our Oncology Team

NNUH becomes brain cancer centre of excellence

Our Oncology Department is one of six NHS brain cancer centres that have been granted excellence status by the Tessa Jowell Brain Cancer Mission. The East of England service, including Cambridge University Hospitals and Ipswich Hospital teams, has been working collaboratively to provide exceptional treatment and care for all patients, regardless of their location. This initiative is part of the Tessa Jowell Brain Cancer Mission is to ensure that all patients have access to outstanding care.

Our team, which treats approximately 100 new patients annually with brain cancer, has been commended for its exemplary excellence in clinical service and patient-centred approach. Pinelopi Gkogkou, Consultant Clinical Neuro-Oncologist, expressed her pride in being part of an amazing team that has developed an excellent multi-disciplinary approach for patients. Patients can feel confident in knowing that they will receive high-quality care throughout their treatment at the Trust as part of the East Anglia Network.

Pinelopi Gkogkou, Consultant Neuro- Oncologist and Brain Cancer Lead, said: "*When I started here seven years ago, it was a single-handed service. Now I am proud to be part of an amazing team that has developed an excellent multi-disciplinary approach for our patients, and I am delighted that our high-quality holistic care has been recognised*." Pinelopi added: "*This achievement acknowledges the hard work and dedication of Norfolk and Norwich Brain team; Caroline Barry, Palliative Medicine Consultant, Jeff Cochius, Consultant Neurologist responsible for Seizure Service, Janak Saada, Neuroradiologist Lead, Dr Andrew Ho, Neuro-Oncologist and Hannah Hendry, CNS- Neuro-Oncology and many others*."

The excellence status was awarded by a panel of experts including Health Care Professionals and Academics and this is a tangible way of providing reassurance for patients and their families and carers.

Patients in Norfolk have the opportunity to participate in Study ERIC-Qol (IRAS: 300115), which aims to quantify radiation-induced neuro-cognitive dysfunction, anxiety, and Quality of Life (QoL) in patients with high-grade gliomas. The hospital has high recruitment numbers to national studies related to brain tumors and aims to continue recruiting more patients to national and international studies in the near future.

Looking forward, our goal is to involve all healthcare professionals who play a role in brain tumor care, such as clinicians, nurses, palliative care specialists, psychologists, and neuro-rehabilitation colleagues in the community. We plan to concentrate on the entire patient journey, from the point of diagnosis to end-of-life, by organizing presentations, workshops, and educational resources in collaboration with the Tessa Jowell academy and the University of East Anglia. Moreover, our clinical nurse specialist, Ms. Hendry, is collaborating with the Brain Tumour charity to introduce a new support group. This group is designed to provide education, support, and enjoyable activities while also promoting inclusivity and support for families. Patients will have the opportunity to express their thoughts and feelings through this group.

Patient Experience

We identified 4 Key Priorities for 2019-2023; these are set out below, with progress to date in March 2023. There has been some interruption in achieving all we set out to in 2019 due to COVID. Therefore, we are going to continue to work on these priorities through 2023 alongside conducting a review of the Patient Engagement and Experience Strategy which may amend our priories going forward.

The Trust developed its NNUH Caring with Pride Trust Strategy, publishing during 2022. This included extensive Stakeholder engagement and Participation from staff, partners and the Patient Panel as well as reaching out to local communities, especially those less well heard – detail of the Strategy and how is was developed is available here - https://www.nnuh.nhs.uk/about-us/caring-with-pride/

The NNUH Caring with Pride Strategy and Patient Engagement and Experience Strategy have aligned to ensure 'Our Commitment to Patients' is a central tenet and objective for the trust as a whole.

We said we would….	2021-2022	2022-2023
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.	Created 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 Patient Panel have continued to go from strength to strength and have been working closely with Trust staff on a range of projects including improving how we respond to concerns and complaints, a shared consent process for the three acute hospitals in Norfolk and Waveney, ensuring carers are supported appropriately, taking part in our new Care Assurance process - we have

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 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	Rebooted and re-energised the Carers' Forum **+** supported the Norwich Maternity Voices Partnership (MVP) to embed more fully into the Women & Children division **+** Children & Young People's voices amplified **+** supported Division for Clinical Support Services to develop its own Patient Forum – embarking on embedding the patient & carer voice within Medicine Division and across Emergency & Urgent Care Patient Panel members actively engaged with committees and groups - HICC, Health & Safety, Quality Improvement, Transforming Outpatients, Nutritional Steering Group, Digital Transformation, Acute Integration consent Policy work stream Developing Toolkits, training and support offer to support embedding patients and service users into any service redesign/improvement projects New volunteering strategy developed & focus on innovative roles to support patients and families – at mealtimes, in discharge planning and settling in at home – despite Covid pandemic limitations, the volunteer team have diversified and responded to support transportation of chemotherapy, ensuring equipment and patients were safely transported home etc. Partnerships and relationships developed with external partners to connect with those less well heard groups and ensure their voices are amplified Enhance working with Healthwatch Norfolk, initiating the visits on regular basis to listen to patients and families, then during the pandemic, continuing to liaise virtually, especially in relation to the feedback via their website. Strong partnership working developed and enhanced during the pandemic with acute partners at JPUH and QEHKL as well as system partners	published a short report covering their work since launching https://issuu.com/nnuhinformation/docs/patient_panel_report_2019_to_2022 The Carers Forum meet bi-monthly and have continued to work on improving identification of and recognition of carers. We are awaiting re- accreditation for the Carer Friendly Award Tick-Health from Caring Together. The Forum and team supported the system wide Co-Production of a Carers Identity Passport, now in use across Norfolk and Waveney. The first Patient Safety Partner (PSP) has been recruited to for NNUH as part of an ICB wide recruitment drive for a pool of committed system-wide PSPs. Involvement toolkit has been developed and will be available on the Trust intranet (BEAT). End of Life **Butterfly** Volunteering has strengthened during the year with additional volunteers recruited, post Covid. Volunteer **drivers** continued throughout Covid and are now re-building their capacity to support safer discharges – coupled with a new innovation – Post Discharge 'Safety Net' volunteer follow up calls - they ask a series of questions around meal and shopping provision, mobility, personal care and medications. Any concerns and queries are forwarded to a dedicated coordinator who can provide "in-house" support and advice or signpost to community-based services. The **Older People's Medicine** (OPM) volunteers have also been able to expand and strengthen – they provide assistance at mealtimes, a wide range of enrichment activities, interactive games which encourage movement

	NCH&C and the CCG. This enabled greater consistency around e.g. visiting arrangements and a joint tender for new FFT provider – putting in place the building blocks for greater collaborative working.	and memory box activities to stimulate memory and reminiscence. OPM volunteers are able to support in the Older People's Emergency Department where they will meet, reassure and accompany patients to further investigations for the duration of their visit. They also offer support to the dementia support team by calling patients' next of kin to discuss and complete 'This is Me' booklets. These booklets provide staff and visitors with information about the patients' background, likes and dislikes and enable a more person-centred approach to care and support. Volunteers now support patients in all areas of the **emergency department**. They sit with patients who may be alone, anxious, elderly, confused, homeless or even those at end of life. They will assist staff in a wide range of tasks such as providing refreshments, stocking up clinical areas, taking telephone calls, finding wheelchairs, carrying out basic admin tasks and collecting patient feedback. We have also recently launched a new project within the Emergency Department which enables our volunteers to support our **mental health team**. Research provides evidence that dogs can have a positive effect on our patients' wellbeing and assist a speedier recovery. The companionship of a dog and their handler can decrease loneliness, stimulate conversation, encourage movement and social interaction. The hospital is supported by twelve **Pets as Therapy** volunteers who visit ten different wards. Feedback from the wards is extremely positive, the PAT dogs lift the mood of some of

		our long stay patients - they allow our patients with dementia to reminisce about having a dog of their own and staff morale is always greatly improved. A new Military Community Working Group has been set up in order to improve experiences of care for patients, staff and carers who have a military background. Supported by an Executive Lead the group is led by 2 staff (volunteer) veteran leads and a patient panel member, the priority for the group this year has been to support the Veteran Aware (VA) reaccreditation award. Healthwatch Norfolk visits continued to several areas within the hospital, with continued guidance and advice from our infection prevention and control colleagues. Feedback collected from the visits and via the website is shared at the Patient Engagement and Experience Group sub-board quarterly.
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 recruited and developed a range of opportunities to connect and give feedback despite the pandemic via virtual means – Care Opinion, Healthwatch website, Facebook, Twitter, Zoom meetings; QR codes and web links for surveys – coming soon – SMS PALS recruited additional team members, opened up their office and reached out to wards pre-pandemic – during the pandemic they have enhanced their support to families needing to connect to loved ones through 'letters to loved ones', supporting the Relatives' Liaison Team and ensuring messages get through to patients on wards. They have developed Zoom opportunities for face to face meetings and calls and devised support for those wanting to make formal complaints.	Engagement Team have been working with creating a presence in the local communities through various engagement activities and participation in public events gathering feedback. More opportunities for feedback for patients and carers opened through the introduction of SMS for FFT in ED and Outpatients. Plans underway to introduce similarly for other appropriate areas in the hospital. NNUH has engaged with the new PHSO framework as an early adopter and work was carried out to align our processes to the changes in the framework. The team continue to have training and support in aligning to these changes. This has also meant close working with the Business Intelligence team to update reporting systems and divisional teams to ensure all concerns and

	PALS developed and are now piloting 'let's resolve it together' training to support staff to feel confident and empowered to rectify concerns on the spot. PALS and Complaints will merge into one front door service during the coming year ensuring the new Parliamentary and Health Service Ombudsman framework is enacted – the service will be co-designed with colleagues and Patient Panel members.	complaints are managed in a timely manner and where appropriate learning gained to inform improvements in service provision. The Patient Panel Complaints Sub-group continues to meet regularly to review and support the improvements for PALS and Complaints.
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 reviewed at 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.	The Divisions have been strengthening their local patient and carer engagement - Clinical Support Services Division have their own patient panel, promoting co-production in quality improvement projects; Medicine Division have a Patient Panel 'partner' embedded and supporting their improvement initiatives and Maternity have continued to develop and strengthen their relationship with Maternity Voices Partnership (MVP). Patient stories continue to be reviewed at Patient Engagement and Experience Governance Sub-Board (PEEG) and other key committees with regular updates on further improvements made from the learning. IPR for FFT data completed, work underway for PALS and Complaints data with the Business Intelligence team to update reporting systems and divisional teams to ensure all concerns and complaints are managed in a timely manner and where appropriate learning gained to inform improvements in service provision. Using the **Equality Delivery System** as a tool to measure how we are performing against key equality priorities, work with divisions and communities has continued. With the launch of the new EDS2022 the team focussed on the patient focused

		domain 1 and chose maternity and cancer services as the 2 services to grade, including contributing evidence to the system wide EDS submission. The work on EDS2022 has informed the development of the Trust's **Diversity Inclusion and Belonging Strategy** which will launch in the coming year. The **Accessible Information Standard Policy** was finalised and reasonable adjustments guidance devised for staff to enable the Trust to support patients with a communication need. 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	The impact from Covid-19 has meant that recruitment for the faculty was put on hold however two positions have now been recruited to. Patient Panel members are being involved within the recruitment of positions which involve improvement to services at the NNUH.	2 Patient Panel member supported the creation of the ICS wide QI faculty. The Faculty has been strengthened during the year with the support of the NNUH QI Team and wider participation as the ICB develops. Two NNUH projects have taken part in ICB wide QI Co-Production initiative, funded through NHSE which are contributing to the development of the N&W model of working for QI Co-Production.

Case Study – Working Together

The HEAR (Help, Educate Awareness, Respond) Campaign

Each year nearly 2 million people in the UK suffer some form of domestic abuse - 1.3 million female victims (8.2% of the population) and 600,000 male victims (4%). The charity Refuge recorded an average of 13,162 calls and messages to its National Domestic Abuse Helpline (NDAH) every month between April 2020 and February 2021, this constitutes a 60% increase in comparison to monthly calls and messages at the start of 2020.

The HEAR pledge

To mark the second anniversary of Norfolk County Councils HEAR (Help, educate awareness, respond) campaign, The Norfolk and Norwich University Hospital Foundation Trust signed the pledge in support of breaking the silence around domestic abuse. This was facilitated by Angela Johnson, Named Nurse for Safeguarding Children. The campaign calls on employers to break the silence around domestic abuse and HEAR help and provide support to their staff on this important issue.

The trust signed the HEAR pledge to promote awareness that the workplace is a safe environment and will provide support where appropriate. The pledge is supported by the Women's Staff Network and Domestic Abuse Champions.

The Trust have 11,570 employees. We feel it is extremely important that we provide access to the right support to both our employees as well as our patient groups. Angela Johnson said, "*We are committed to recognising and responding to domestic abuse whilst providing a safe environment to do so. As part of that commitment Rebecca Fish, Ward Sister and Domestic Abuse Champion has designed posters to be displayed around the hospital to make support more accessible*".

Posters are displayed across the Trust, and we are encouraging all teams to support the campaign by printing their own posters to place on the back of toilet doors and changing facilities in both staff and public areas of their department. This would enable vulnerable people to discretely scan the QR code and access the help they need by taking them directly to the Norfolk County Council homepage.

Staff Experience

NHS Staff Survey

The NHS Staff Survey 2022 launched at NNUH on 4th October 2022 and closed on 25th November 2022. The response rate for the Trust was 51% with 4,347 staff sharing their views, exceeding the 2021 49% response rate. The 2022 response rate was also above the national acute trust 44% median response rate (benchmarked with 124 acute trusts).

2022 Staff Survey - benchmark results

The NHS Staff Survey is aligned to the NHS People Promise which describes 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. The NHS Staff Survey therefore tracks 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 – 124 acute trusts

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

In comparison to 2021:

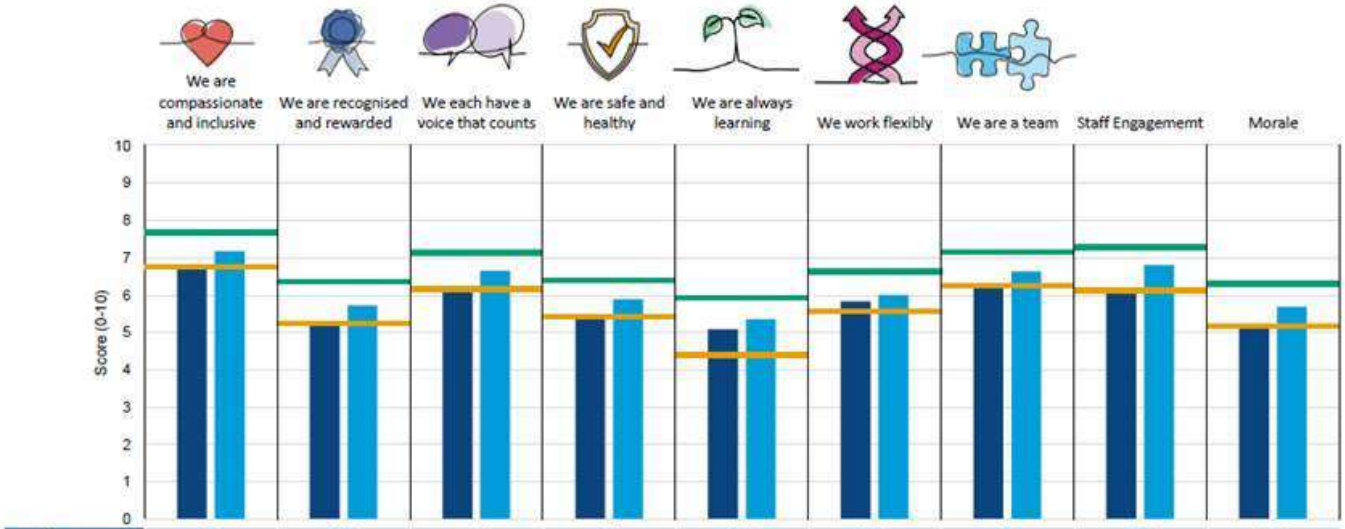
- One theme score improved
- Two theme scores remained the same
- Six theme scores were worse

The nine themes have 21 sub-scores which make up the overall theme score. From these scores compared to 2021:

- 5 improved: Compassionate leadership, Development, Appraisals, Support for work-life balance, Line management
- 4 remained the same: Autonomy and control, Burnout, Involvement and Stressors.
- 12 scores worsened: Compassionate culture, Diversity and equality, Inclusion, Raising concerns, Health and safety climate, Negative experiences, Flexible working, Team working, Motivation, Advocacy, Thinking about leaving and Work pressure.

Appraisal was the NNUH most improved score, and **Advocacy** was the NNUH most worsened score in the 2022 survey.

NNUH 2022 theme scores compared to the benchmark of 124 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 Engagememt	Morale
Your org	6.8	5.3	6.2	5.4	5.1	5.8	6.3	6.1	5.2
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	4574	4565	4550	4571	4423	4557	4571	4578	4578

Next Steps
The results are extremely disappointing for the trust. It has been a particularly difficult year for the hospital in terms of capacity, escalation, flow/ discharge, and pressures on our services and this has evidently had a negative impact on our staff experiences.

We recognise the wealth of studies which evidence staff experience impacting on patient care and organisational outcomes.

We have firm foundations in the commitments in our NNUH People Promise on which to build and will continue to focus on delivering the key changes we identified from staff feedback, that are needed to make NNUH a great place to work.

We are making progress on recruitment and reducing our vacancy rate as well as investing in staff facilities, the opportunity for more colleagues to work flexibly and a strong focus on wellbeing as part of our NNUH People Promise.

Each Division will examine their own results to identify actions they feel require escalation to our corporate People Promise action plan and those they will take forward themselves.

The Executive Board are focused to deliver the commitments we made in our People Promise to ensure that NNUH is somewhere our staff enjoy working and can thrive, safe in the knowledge that they're supported to deliver the best care for every patient.

Our staff listening doesn't end with staff survey and we will continue to hear the views from staff from various channels such as the National Quarterly Pulse Survey, Connected, through our Staff Side, Staff Network and Staff Council representatives and local teams.

Case Study

Preventing Falls – 'Think Yellow'

The Emergency Department have reduced patient falls by using the 'Think Yellow' initiative.

The Emergency Department (ED) has a fast-paced environment, with a high turnover of patients. Unfortunately, this means that sometimes it can be difficult to have a constant oversight of all patients that are at risk of a fall. ED carried out an 'ED Specific Falls Risk Assessment' in 2020 Initially the compliance with this risk assessment was good and there was a reduction in falls.

Sadly, since December 2021, the ED have reported 5 moderate and above harm incidents in relation to in-patient falls. Patients with a fractured neck of femur have an increase in mortality and morbidity.

Stacey Butcher, ED Governance/Risk Facilitator, along with support from ED colleagues, implemented an ED specific Fall Reduction Initiative – 'Yellow Visual Cueing Falls awareness kits in ED'.

The yellow falls kits contain a small fleece blanket with a pair of yellow double tread falls prevention slipper socks. The socks have been designed to migrate with the patient throughout their stay at the hospital and can go home with the patient upon discharge.

There is a scoring system in place, which staff complete to identify if a patient requires the yellow kit.

Since using the yellow kits, for those patients within the ED there has been a significant reduction of falls that have resulted in Moderate or above harm to patients.

This initiative is now being used within the wider hospital.

Score 1 for each of the following risks (maximum score is 5):

1	Presenting due to a fall	
2	Acutely unwell (i.e. respiratory compromised, DKA, heart problems etc)	
3	Patients with confusion due to dementia or delirium with any of the following features: Agitation Wandering Inability to use the call bell reliably Challenging behaviour Reduced safety awareness and disorientation	
4	Likely to attempt to mobilise on their own and unsafe to do so	
5	Alcohol or drug misuse causing challenging behaviour	
	Total score	/5

If scores two or more provide a yellow kit

Statement from Healthwatch Norfolk

Healthwatch Norfolk Statement – NNUH Quality Account 2021/22

Alex Stewart
Chief Executive
Healthwatch Norfolk

June 2022

Statement from the Integrated Care Board (ICB)

Improving lives together
Norfolk and Waveney Integrated Care System

NHS
Norfolk and Waveney
Integrated Care Board

NHS Norfolk and Waveney ICB
Floor 8
County Hall
Martineau Lane
Norwich
Norfolk
NR1 2DH

Date: 31/05/2023

Sam Higginson,
Norfolk and Norwich University Hospitals NHS Foundation Trust,
Colney Lane,
Norwich,
NR4 7UY

Dear Sam,

Norfolk and Waveney Integrated Care Board (ICB) acknowledges the receipt of the draft 2022/2023 Quality Account from the Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUHFT) and welcomes the opportunity to provide this statement.

Based on the information and data available within the draft report NHS Norfolk and Waveney Integrated Care Board (ICB) supports NNUHFT in the publication of its Quality Account for 2022/2023. We are satisfied that it incorporates the required mandated elements.

The ICB recognises the challenges experienced by the Trust over the last contractual year and the significant pressures the workforce has faced. We acknowledge that the level of quality of care, patient and staff experience has been impacted throughout the year and thank the Trust and staff for their sustained commitment in caring for those using your services. We support the Trust and welcome your commitment to improve staff experience in line with the People Promise, with a focus on recruitment, staff facilities and engagement.

The Trust has worked in collaboration with system partners within the Integrated Care System (ICS) to strengthen and enhance integrated working practice, focussing resources where our patients need them most. This has been evident in the work that is starting to join projects and services with the James Paget University Hospital NHS Foundation Trust and The Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust.

The ICB recognises the positive progress and improvements against the 2022/2023 priorities and appreciates the challenges and constraints that have affected the progression of others. The ICB supports the refresh of six existing priorities, and four

new priorities for 2023/2024. The focus will be patient safety and experience, clinical effectiveness and staff experience aligning with the Trust strategy 'Caring with Pride'.

The ICB acknowledges the Trust's clear focus and commitment to patient safety through a culture of openness and engagement with patients and relatives. We note this was recognised by the Care Quality Commission (CQC) following their unannounced visit in November 2022 and is a new Trust priority for 2023/2024. The ICB acknowledges the work undertaken in progressing their Patient Safety Incidence Response Plan (PSIRP) aligned to the Patient Safety Incident Response Framework (PSIRF) guidance and is confident the Trust is on trajectory for the implementation date of 01 September 2023.

The ICB recognises the work that the Trust has undertaken to assess maternity services against the national recommendations and the development of a safety assurance processes. The ICB anticipates working collaboratively with the Trust to support on-going developments in Local Maternity and Neonatal systems (LMNS), including the three-year delivery plan for Maternity and Neonatal services and the NHS Long Term plan. We thank staff for their hard work and dedication that resulted in a positive recent peer review of these services and appreciate the ongoing efforts to focus on the recommendations made for further improvement.

The ICB appreciates that many quality improvement initiatives have been rolled out across the Trust as part of The Essential Care Improvement Programme. We recognise the significant work that has taken place around falls, pressure ulcers and nutrition and hydration, all with an aim to improve patient experience and prevent harm. We also recognise the efforts made to improve patient flow and bed capacity with the relaunch of Red to Green and the expansion and optimisation of the Virtual Ward.

The Care Quality Commission has undertaken an inspection to Medical Care including older people's care which requires improvement. The ICB looks forward to working collaboratively with you to address the recommendations.

The ICB recognises the challenges ahead and values the commitment from all staff within the Trust. The ICB believes the report capture key elements of safety, clinical effectiveness, and patient experience and well led Trust and demonstrates the Trust's commitment to continuous improvement and quality.

On behalf of NHS Norfolk and Waveney ICB, I would like to personally thank you, the individuals involved in developing and producing this account and all the staff. I look forward to building on our joint working relationship to ensure safe, effective care for our patients and local population during 2023/24.

Yours Sincerely

Karen Watts
Director of Nursing and Quality
NHS Norfolk and Waveney Integrated Care Board

Feedback from Governors

Comment on the Quality Account from Erica Betts, Lead Governor, NNUH:

'Thank you to the team for producing another comprehensive document this year, which while covering a lot of data, includes many interesting stories about initiatives and innovations in the Trust. It has been a difficult year with many pressures on performance and staff. Progress is being made but it is slow and there is clearly still much to do to improve both the staff and patient experience, which we know are intrinsically linked. It is good to see that these challenges are recognised in this report.'

Comment on the Quality Account from Jackie Hammond, Governor, NNUH:

'Overall, the QA demonstrates the breadth of work carried out by NNUH staff and the collaboration with other providers and voluntary organisations across the county.

It is a weighty tome, but this reflects the many achievements and patient and service excellence set against a backdrop if huge pressures affecting the NNUH and the NHS in general.'

‘Sponge on a string’ pilot launched by Endoscopy Unit

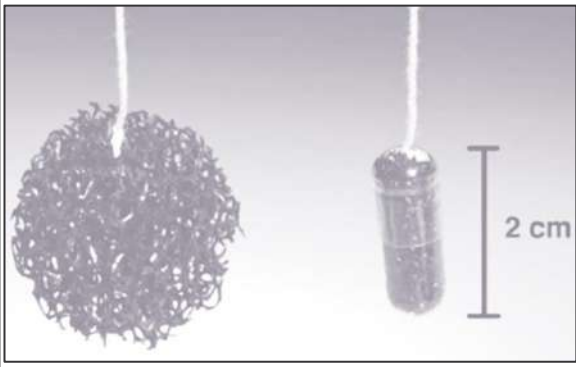
A ‘sponge on a string’ pilot has started in our Gastroenterology Department as a new diagnostic test for patients referred from primary care with symptomatic gastro-oesophageal reflux disease.

The first Cytosponge clinic has taken place at the Quadram Institute, which is being offered as a less invasive alternative to endoscopy.

The Cytosponge **(in the right-hand side picture)** consists of a spherical sponge within a dissolvable capsule attached to a string. The Cytosponge is swallowed, the capsule dissolves and the sponge expands within the stomach. Using the string, the sponge is retrieved and collects approximately one million cells lining the oesophagus. The sponge is then sent for histological and biomarker analysis, and with high accuracy can diagnose Barrett’s oesophagus, which is a condition where some of the cells in the oesophagus grow abnormally and can lead to oesophageal cancer.

By offering Cytosponge to patients, it is hoped that most patients with reflux symptoms can safely avoid more invasive investigations and that endoscopy can be prioritised for those most in need.

Tracy Mcdonnell, Lead Nurse for Endoscopy Services, said: “*We are excited to be taking part in this NHS England funded pilot for the next 12 months, which is supported by Norfolk and Waveney ICB and we will initially carry out one clinic a week*. *It is less invasive than a gastroscopy procedure and can be done in a clinic room. The feedback during trials from patients who have endoscopy regularly is that they prefer Cytosponge to gastroscopy*.”



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
Chairman

Date: <>.06.2023

Sam Higginson
Chief Executive

Date: <>.06.2023

HIPEC programme hailed as success

Two years ago the hospital started the UK's first gynaecology hyperthermic intraperitoneal chemotherapy (HIPEC) programme and the only colorectal HIPEC programme in the East of England. It is used to treat advanced ovarian or bowel cancer, which has already spread to the abdominal cavity.

In that time the multidisciplinary team has completed 40 cases with good outcomes for the patients. This has been achieved by the efforts of a vast multi-disciplinary team. HIPEC is a procedure carried out following the completion of complex surgery to remove all visible disease in the abdomen and pelvis. After the initial procedure has been completed, a 40-42°C solution is washed through the patient, in an attempt to kill off any cells the surgeons have not been able to see.

Patients must meet very strict criteria to be eligible; their cancer must be advanced but not spread to other organs and they need to be assessed fit enough to undergo this extensive surgery.

Nikos Burbos, Consultant Gynaecologist Surgeon and Adam Stearns, Consultant Colorectal Surgeon, have led the collaboration and are encouraged by the results they have recorded. Nikos said: "*At the moment we are treating around 20 of our most advanced ovarian cancer patients a year. These are people who have the most aggressive form of cancer, but who we feel benefit from this procedure. "We require highly specialised anaesthetists to be alongside the patient throughout. These are trailblazing anaesthetists who we have on board here*."

Our experience here means we are the only established centre in the UK to offer this service to ovarian cancer patients as part of the standard care. Recently, two other centres in England have started treating patients with ovarian cancer, The Christie in Manchester and the Royal Marsden in London. The development of this service has been more than 10 years in the making and requires a huge level of collaboration across multiple teams including nurses, HCAs, pharmacy, oncologists, anaesthetists, intensive care team and various surgical specialties.

Adam said: "*This has been an enormous team effort and we want to celebrate this achievement. This would not have been possible without the generous support of the Norfolk and Norwich Hospitals Charity and the Friends of NNUH, who gave £50,000, as well as donations from Norfolk businesses insurance specialists Alan Boswell, and charity supporter David Geiss*."

Julie Cooper, Head of Grants said: "*The Norfolk and Norwich Hospitals Charity are delighted to have been able to fund the purchase of the HIPEC, thanks to money transferred from the Friends of the Hospital when they closed their charity. This is yet another example of our local community donating to support improvements at our hospitals, over and above what the NHS must fund, and we are very grateful to everyone who has made this possible*."

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.
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.
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
LeDeR	Learning from Lives and Deaths - people with a learning disability and autistic people
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
MLBU	Midwifery Led Birthing Unit
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
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
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.
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

Photo taken from: https://www.royal.uk/

In Rememberance: Her Majesty the Queen

The NNUH were deeply saddened to hear of the passing of Her Majesty the Queen.

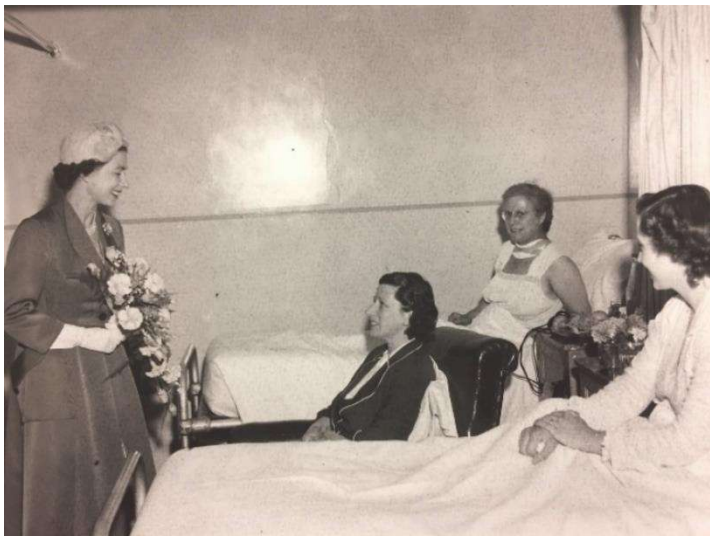


Photo from 1957 at the old NNUH

NNUH Chief Executive Sam Higginson and Chair Tom Spink said: "*On behalf of everybody at NNUH, we'd like to send our sincerest condolences to the Royal Family at this difficult time."*

Photo taken from 1957

"For many of us, Queen Elizabeth II has been our only monarch and head of state and she will be fondly remembered for her unwavering dedication, long service and influence across the country and the Commonwealth."

"The Queen played a hugely important role in the official opening of the new NNUH hospital in 2004 and we are extremely sad to hear of her passing."

The Queen officially opened the NNUH on 5th February 2004, which at the time had 989 beds and replaced the former Norfolk and Norwich and West Norfolk Hospitals.

Photo of the Queen opening the new NNUH in 2004

Annex 4 -Acronyms A-Z

A&E	Accident and Emergency Department (See ED)
AAA	Abdominal Aortic Aneurysm
AAR	After Action Review
ACU	Acute Cardiac Unit
AIS	Accessible Information Standard
APC	Admitted Patient Care
BAPM	British Association of Perinatal Medicine
BAU	Business As Usual
BAUS	British Association of Urological Surgeons
Bliss	Baby Life Support Systems
BSIR	British Society of Interventional Radiology
C.difficile (C.diff)	Clostridium difficile
CAPE	Carer and Patient Experience Committee
CCC	Critical Care Complex
CCG	Clinical Commissioning Groups
CEA	Carotid Endarterectomy
CEO	Chief of Operations
CG NICE	Clinical Guideline from NICE
CHD	Congenital Heart Disease
CHKS	Caspe Healthcare Knowledge Systems
CHPPD	Care hours per patient per day
CNST	Clinical Negligence Schemes for Trusts
CMP	Case Mix Programme
CMT	Core Medical Trainee
CPR	Cardiopulmonary Resuscitation
COD	Chief of Division
COO	Chief Operations Officer
COP	Communities of Practice
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CQUIN	Commissioning for Quality Improvement and Innovation
C2R	Criteria 2 reside
CRM	Cardiac Rhythm Management
CT	Computerised Tomography
CYP	Children and Young Persons
D2A	Discharge to Assess
DIB	Diversity, Inclusion and Belonging
DNACPR	Do not attempt Cardiopulmonary Resuscitation
DQ	Data Quality
DQMI	Data Quality Maturity Index
DVT	Deep Vein Thrombosis
EADU	Emergency Admission and Discharge Unit
EAUS	Early Assessment Unit – Surgical
ECG	Electrocardiogram
ED	Emergency Department (See A&E)

EDI	Equality, Diversion and Inclusion
EDL	Electronic Discharge Letter
EDM	Electronic Document Management
EDS	Equality Delivery System
EDS2	Equality Delivery System 2
EDT	Electronic Data Transfer
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
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
HCA	Healthcare Assistant
HDU	High Dependency Unit
HEAR	Help, Educate Awareness, Respond
HEE	Health Education England .
HES	Hospital Episode Statistics
HFACS	Human Factors Analysis and Classification System
HICC	Hospital Infection Control Committee
HIPEC	Hyperthermic Intraperitoneal Chemotherapy
HSCIC	Health and Social Care Information Centre
HSMR	Hospital Standardised Mortality Ratio
HTA	Human Tissue Authority
IBD	Inflammatory Bowel Disease
ICB	Integrated Care Board
ICS	Integrated Care Systems
IEA	Immediate and Essential Actions
IG	Information Governance
IGT	Information Governance Toolkit
IMI	Innovative Medicines Initiative
IPR	Integrated Performance Report
IR	Interventional Radiology
IS	Information Services
IT	Information Technology
JPUH	James Paget University Hospitals NHS Foundation Trust
KPIs	Key Performance Indicators
KF	Key Finding
KLOE	Key Lines of Enquiry
LD	Learning Disability

LEDG	Local Divisional Equality and Diversity Group
LMNS	Local Maternity and Neonatal System
MASH	Multi-Agency Safeguarding Hub
MAU	Minors Assessment Unit
MBRRACE	National Maternal and Newborn Infant Clinical Outcome Review Programme
MDT	Multi-Disciplinary Team
MEOWS	Modified Early Obstetric Warning Score
M&M	Morbidity and Mortality
MINAP	Myocardial Ischaemia National Audit Project
MRI	Magnetic Resonance Imaging
MSK	Musculoskeletal
MTPJ	Metatarsophalangeal Joint
MVP	Maternity Voices Partnership
N/A	Not applicable
NAD	National Audit of Dementia
NAOGC	National Oesophago-Gastric Cancer Audit
NBOCAP	National Bowel Cancer Audit
NCA	National Clinical Audits
NCE	National Confidential Enquiry
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
NCH&C	Norfolk Community Health and Care NHS Trust
NCIR	Norfolk Centre for Interventional Radiology
NC2R	No Criteria To Reside
NDA	National Diabetes Audit
NDAH	National Domestic Abuse Helpline
NDFA	National Diabetes Footcare Audit
NE	Never Event
NED	National Endoscopy Database
NELA	National Emergency Laparotomy Audit
NG	NICE Guidance
NGO	Non-Governmental Organisation
NHFD	National Hip Fracture Database
NHS	National Health Service
NHS E	NHS England
NHSLA	National Health Service Litigation Authority
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health Research
NNAP	National Neonatal Audit Programme
NNUH	Norfolk and Norwich University Hospital NHS Foundation Trust
NMC	Nursing and Midwifery Council
#NOF	Fractured neck of Femur
NOFERP	Neck of Femur Enhanced Recovery Programme
NPDA	National Paediatric Diabetes Audit
NPSA	National Patient Safety Agency

NRLS	National Reporting and Learning Service
NVR	National Vascular Registry
N&W	Norfolk & Waveney
OSCE	Objective Structured Clinical Examination
OPM	Older People Medicine
PAF	Patient Assurance Framework
PALS	Patient Advice and Liaison Service
PAT	Patient Assessment and Triage
PCDAI	Paediatric Crohn's Disease Activity Scores
PCI	Percutaneous Coronary Interventions
PCNL	Percutaneous nephrolithotomy
PCSP	Personalised Care Support Plans
PDR	Personal Development Review
PE	Pulmonary Embolism
PEEG	Patient Engagement and Experience Governance Sub-Board
PGA	Physician Global Assessment
PHSO	Parliamentary and Health Service Ombudsman
PICA	Net Paediatric Intensive Care Audit Network
PIFU	Patient Initiated Follow Up
PLACE	Patient-Led Assessments of the Care Environment
PMRT	National Perinatal Mortality Review Tool
PoC	Point of Care
PODs	Patients' own drugs
PD&E	Practice Development and Education
PROMs	Patient Reported Outcome Measures
PSEC	Patient Safety and Effectiveness Committee
PSI	Patient Safety Incident
PSIIs	Patient Safety Incident Investigations
PSP	Patient Safety Partner
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plan
PTL	Patient Treatment List
PUCAI	Paediatric Ulcerative Colitis Activity Index
QI	Quality Improvement
QIR	Quality Incident Report
QoL	Quality of Life
QS	NICE Quality Standard
RAAA	Ruptured Abdominal Aortic Aneurysm
RAG	Red/Amber/Green
RCA	Root Cause Analysis
RCP	Royal College of Physicians
RCPCH	Royal College of Paediatrics and Child Health
ROP	Retinopathy of prematurity
RPA	Robotic Process Assurance
RTT	Referral to Treatment

RTTOMG	Referral to Treatment Operational Management Group Meetings
SAFER	Senior review, All patients, Flow, Early discharge, Review
SCEC	Surgery, Critical and Emergency Care
SDEC	Same Day Emergency Care
SEND	Special Educational Needs and Disability
SHMI	Summary hospital level mortality indicator
SHOT	Serious Hazards of Transfusion
SJR	Structured Judgement Review
SI	Serious Incident
SMR	Structured Medication Reviews
SOP	Standard Operating Procedure
SRO	Senior Responsible Owner
STP	Sustainability and Transformation Plan
STEMI	ST-Elevated Myocardial Infarction
StR	Specialty Registrar
SUS	Secondary Users Service
T&O	Trauma and Orthopaedic
TACO	Transfusion Associated Circulatory Overload
UEA	University of East Anglia
UKHSA	United Kingdom Health Security Agency
UKRETS	UK Registry of Endocrine and Thyroid Surgery
VA	Veteran Aware
VC	Virtual Clinic
VTE	Venous Thromboembolism
VW	Virtual Ward
WESB	Workforce and Education Sub-Board
WTE	Whole Time Equivalent

How to contact us

Write to us:

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Colney Lane
Norwich
NR4 7UY

Website: http://www.nnuh.nhs.uk

Email: communications@nnuh.nhs.uk

If you are worried about your care, or your families care, or have some positive feedback to share, please contact our Patient Advice Liaison Service and Complaints Team on:

Telephone Number: 01603 289036

Email: **palsandcomplaints@nnuh.nhs.uk**

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REPORT TO TRUST BOARD			
Date	June 2023		
Title	2023 -24 Quality Priorities		
Author **Exec lead**	Barbara Hercliffe – Head of Patient Safety Improvement: Nancy Fontaine – Chief Nurse		
Purpose	For discussion and agreement		
Relevant Strategic Objective(s)	1. Our Patients: Together, we will develop services so that everyone has the best experience of care and treatment. 2. 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 3. Our Partners: Together, we will join up services to improve health and wellbeing of our diverse communities 4. Our Services: Together, we will provide nationally-recognised, clinically-led services that are high quality, safe and based on evidence and Research 5. Our Resources: Together we will use public money to maximum effect.		
Are there any quality, operational, workforce or financial implications of the decision requested by this report?	Quality	Yes☐ No✓	
	Operational	Yes☐ No✓	
	Workforce	Yes☐ No✓	
	Financial	Yes☐ No✓	

This paper provides a summary of the proposed Quality Priorities for 2023 – 2024 with associated actions and metrics for monitoring progress through Evidence Group and Quality Programme Board.

Please note that we are awaiting confirmation of the % improvements to be ratified by the teams, this will be completed before the end of June

Recommendation:

Trust Board is requested to approve the proposed Quality Priorities for 2023-24 for inclusion in the Quality Account for 2023 -24. The confirmed improvement targets will be shared once ratified by the teams.

Background

NNUH aims to deliver and assure patients they are receiving the very best quality of care. Foundation Trusts (FTs) are required by the Health Act 2009, and in the terms set out in the National Health Service (Quality Accounts) Regulations 2010 ('the quality accounts regulations), to publish Quality Accounts each year.

The Quality Account contains an overview of our agreed Quality Priorities, including the commitments for the forthcoming year and lookback reports on achievements from the current year. The Quality Priorities are aligned to our strategic commitments, and associated threats to support continuous improvement and to reduce some of our highest risks. *(Ref Page 15)* There is also alignment to ICS Quality Priorities (*Ref Page 16)*

We are required to have at least three priorities for improvement for each of the following domains, Patient Safety, Clinical Effectiveness, and Patient Experience.

Quality Priorities all have an Executive lead as well as an operational lead. Clear, measurable target objectives will be defined to provide assurance and focus on continuous improvement.

Progress is monitored against each Quality Priority through' Business As Usual' governance structures (Page 14) and assurance via quarterly Evidence Groups and Quality Programme Board,. The 10 Quality Priorities for 2023-24 contained in this paper, were proposed by Hospital Management Board (HMB), 6 are existing priorities from 2022-2023 that have been refreshed, and there are 4 new priorities *

Patient Safety

- Implement the Patient Safety Incident Response Framework (PSIRF) *
- Provide personalised safe care to women, people, babies and their families
- Reducing waiting times for Outpatient appointments

Clinical Effectiveness

- Improving Elective Surgical pathways *
- Improve #Neck of Femur pathways and outcomes *
- Improving Non elective Pathways / Flow and RTG

Patient Experience : we have also added Staff Experience

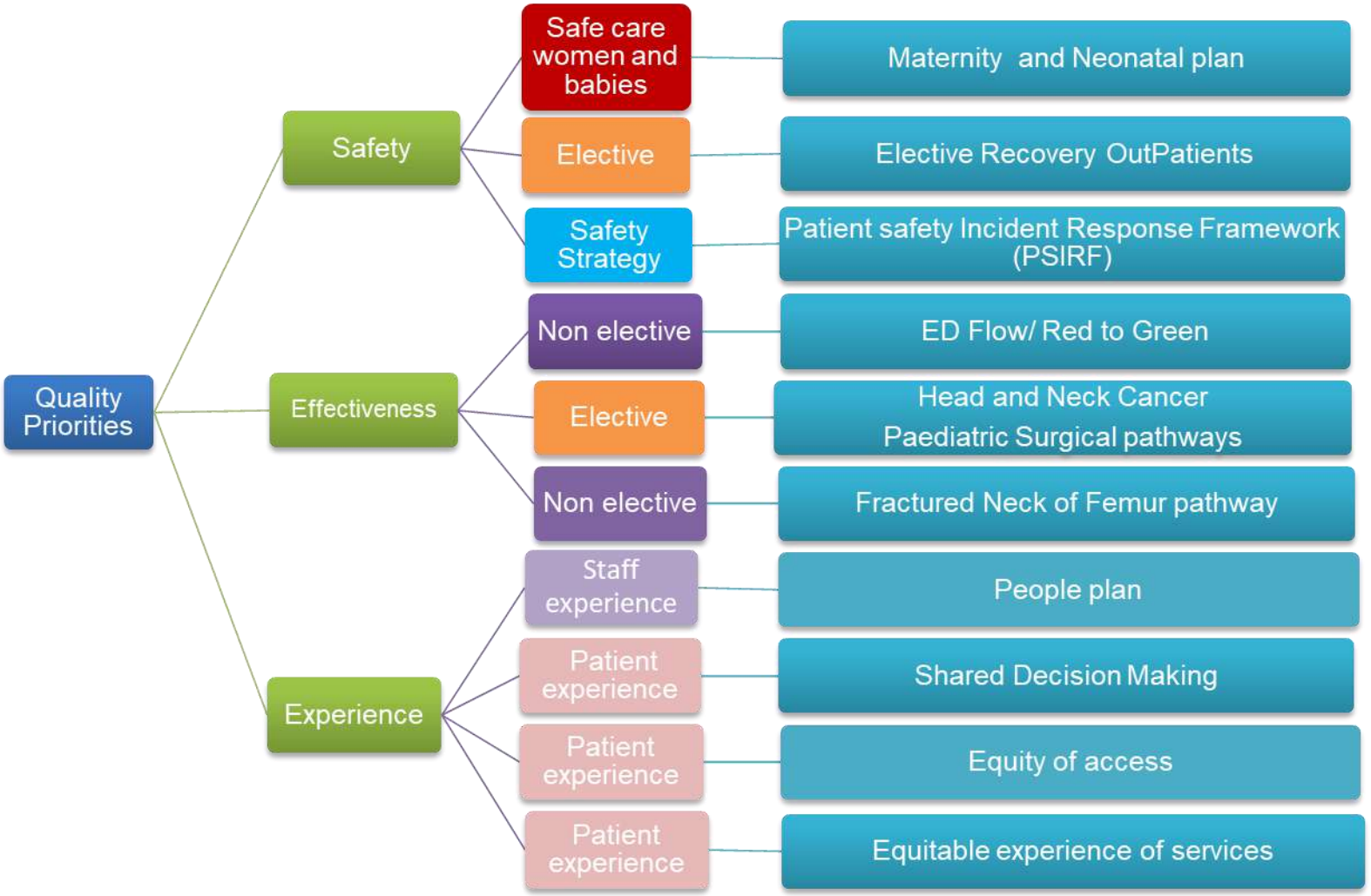
- Shared Decision Making and Personalised Care
- Improving equity of access to services
- Improving experience of care *
- Improve Staff Experience

The following 2022 – 23 Quality Priorities will be absorbed as 'business as usual' in 2023-24

- Improve surveillance of patients who have delayed surgical treatment - (Harm review process)
- COPD pathway improvements
- Safe record keeping and results management
- Orthopaedic pathways
- Home First Model

Pages 4-13 outline in more detail the proposed 2023-24 Quality Priorities

Driver Diagram Quality Priorities



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Patient Safety

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QP1 Embed our patient safety culture through the implementation of the Patient Safety Incident Response Framework (PSIRF) and the application of system-based approaches to learning.			
Rationale	PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety. This is replacing the current Serious Incident Framework. • NHS Patient Safety Strategy • Strategic commitment 1, 2, and 4 • Risk Register: 2211 and 567 • Norfolk & Waveney Integrated Care System – Quality Priority 2 & 4		
How we will do this	• Write and publish a Patient Safety Incident Response Plan (PSRIP) • Revise governance structures to support PSIRF • Ensure sufficient resource is in place to manage PSIRF and meet national requirements via business case • Train staff in new learning response methods e.g. After Action Review • Write new Incident Management and Investigation Policy • Update the Learning from Deaths Policy to include the link with PSIRF • Ensure processes within Datix (incident reporting system) are revised to support PSIRF • Communicate PSIRF to staff and patients including carers and families • Go live with PSIRF in September 2023 in line with other ICS providers • Revise regular reports to Board sub Committees to reflect PSIRF requirements • Remove inappropriate related performance measures from all dashboards / performance frameworks	**Improvement measures** QP1a By November 2023, 100% of Serious Incident Investigations (RCA) completed to conclusion. ** QP1b Revised Governance processes signed off and in place by September 2023 QP1c Increased use of Learning Response Tools (After Action Review and Patient Safety Incident Investigations (PSIIs).Monthly tracker QP1d Number of staff trained in conducting Learning Responses , ➢ 5% staff trained in AAR : Governance teams trained in MDT Thematic Review QP1e 90% of staff have completed level 1 (essentials of patient safety) 85% of staff completed level 2 (access to practice) of the patient safety syllabus. * QP1f Required resource is obtained and essential posts recruited to meet requirements QP1g PSII meet national standards for investigation QP1h The patient safety incident response policy is published on the website.	
BAU assurance	• Clinical Safety and Effectiveness Sub Board	**Data source**	ESR for training records * Datix SI dashboard **
Executive Lead and Delivery Leads	Chief Nurse / Associate Director of Quality & Safety (Patient Safety Specialist)		

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QP 2 Safe Personalised Care for service users of Maternity and Neonatal services			
Rationale	Central to Better Births is the principle that maternity care should be personalised and safe. Care should be centred on the woman, her baby and her family; based around her needs and decisions, where there has been genuine choice informed by unbiased information. This is essential to ensuring that women receive the best care possible The concerns raised in the recent Ockenden and Kirkup reports have highlighted the importance of positive, learning cultures underpinned by relational leadership Creating the conditions for a positive safety culture in teams across the NHS is crucial to ensure that women and families using NHS services receive high quality care and better outcomes • Strategic commitment 1. • Norfolk & Waveney Integrated Care System – Quality Priority 2, 3 & 4		
How we will do this	• Co production and implementation of Personalised Care Support Plans (PCSP) • Participation in the Perinatal Culture and Leadership Programme • Deliver SCORE culture survey as a means to tangibly understand current culture within teams and identify key themes that can be used to enhance team working.	**Improvement measures** QP2a: Progress tracked against the delivery plan for PCSP QP2b: By March 2024 each person has a sharable PCSP which records what matters to them, their outcomes and how they will be achieved QP2c: Achieve SCORE Survey response rates between 40% and 60% QP2d: Improvement plans are agreed, tailored to survey results and feedback.	
BAU Assurance	Maternity Safety Board Maternity Evidence Group	**Data Source**	Score Survey Results
Executive Lead and Delivery Leads	Chief Nurse Director of Midwifery Service Director Obstetrics		

Patient Safety

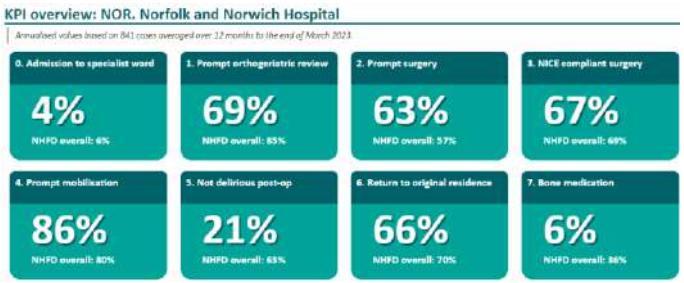
QP 3 Elective Recovery: Reduce outpatient waiting list backlog			
Rationale	The NHS was set a target to reduce outpatient follow-ups by a minimum of 25% against 2019/20 activity levels by March 2023 to release time for new appointments and additional procedure lists One of the main challenges facing children and young people currently are significant backlogs in paediatric elective care. Long waits are likely to impact their ability to access education and lead full and active lives, exacerbating existing inequalities • 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 • Norfolk & Waveney Integrated Care System – Quality Priority 2 & 4		
How we will do this	Focussing on challenged specialities : • Paediatric OP pathways • Spinal Surgery, ENT, T&O , Gynaecology, Dermatology, Ophthalmology & Respiratory Medicine	**Improvement measures** QP3a: No adult patient waiting longer than 52 weeks for first OP attendance by 31 March 24 QP3b: Paediatrics should wait no longer than 18 weeks for 1st attendance	
BAU assurance	Divisional Performance meetings Use of Resources	**Data source**	Metrics from Power BI IPR dashboard
Executive Lead and Delivery Leads	Chief Operations Officer Divisional Operational Directors		

Effectiveness

QP4 Elective Recovery : Surgical pathways and outcomes			
Rationale	Prolonged waiting times for elective care with increased risk of harm whilst waiting. Long waits before accessing planned care can have life-long consequences on the development of children and young people (CYP). One of the main challenges facing children and young people currently are significant backlogs in paediatric elective care. Long waits are likely to impact their ability to access education and lead full and active lives, exacerbating existing inequalities. • 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 • Norfolk & Waveney Integrated Care System – Quality Priority 2 & 4		
How we will do this	Focussing on : Children and Young People's Elective Recovery Toolkit (Feb 2023) Actions to reduce head and neck cancer backlog and waiting times Critical care availability (and flow) Looking divisionally at future ward capacity to increase cohort numbers to limit impact on HDU capacity and surgical delays Safety restrictions on staffing levels and bed capacity for tracheostomy/laryngectomy patients	**Improvement measures** QP4a: Cancer performance measures , 62 day target for 1st treatment QP4b: Reduction in cancelled theatre lists due to critical care bed capacity	
BAU assurance	directorate, divisional and trust level scrutiny and management of waiting times	**Data source**	Power BI Integrated Performance Report
Executive Lead and Delivery Leads	Chief Operating Officer Deputy Director of Operations within Surgery		

Effectiveness

QP5 Non elective Pathways Fractured neck of Femur #NOF

Rationale	A hip fracture is one of the most common serious injuries affecting older people that requires them to be admitted to hospital, have emergency anaesthesia and surgery, followed by weeks of rehabilitation in hospital and the community. The National Hip Fracture Database (NHFD) is an online platform that uses real-time data to drive Quality Improvement (QI) across all 163 hospitals that look after patients with hip fractures in England and Wales. KPI overview for our Trust is included below Whilst a lot of work has been done on the overarching pathway, there remains elements outstanding that need to be addressed. Strategic commitment 1, 4 Norfolk & Waveney Integrated Care System – Quality Priority 2 & 4		
How we will do this	The purpose of this Quality Priority is to address the key areas of current under performance in the #NOF pathway, and achievement of Best Practice Tariff **NHFD KPIs (2022) 5 out of 8 KPIs are below average,** Admission to specialist ward Prompt orthogeriatric review % Not delirious post op% Return to original residence % Bone medication % **2 are average** Prompt surgery% NICE compliant surgery % **1 is above average** Prompt mobilisation %	**Improvement measures** Baseline data taken from NHFD annualised values based on 841 cases averaged over 12 months to the end of March 2023. QP5a: To achieve scores that are average or above average across all KPIs QP5b: Mortality rate (March 23 : 2.3%) QP5c: Best Practice Tariff achievement Target 100% 	
BAU Assurance	Medical Divisional Board	**Data source**	Submitted data to NHFD Best Practice Tariff data
Executive Lead and Delivery Leads	Medical Director Consultant Geriatrician, Consultant Orthopaedic Surgeon, Operational Manager, Earsham Ward Sister, Matron		

Effectiveness

QP6 Non elective pathways and patient flow			
Rationale	Crowding within the ED increases delays in evaluation and essential care which is associated with increased mortality, medical errors, increased length of stay, worse outcomes, reduced patient satisfaction, over testing and overtreating patients, alongwith increased exposure to violence and increased stress on staff. The current ambulance handover delay position, and associated patient risk with this, has long been recognised as unacceptable to ED, therefore, this has been on the risk register for some time.(717) • 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 • Norfolk & Waveney Integrated Care System – Quality Priority 2 & 4		
How we will do this	• Improving patient flow by improving efficiency and effectiveness of the Red to Green process, • Developing a robust and reactive escalation process: using the national OPEL and resilience framework to enable a robust "seasonal plan" to react to internal and external pressures, • SDEC/EAUS/MAU capacity/capability • Internal ED Flow • Patents managed on Virtual Ward	**Improvement measures :** QP6a: 4 hour standard QP6b: 60 Minute Ambulance handovers QP6c: Reduction in use of escalation beds QP6d: Virtual Ward activity QP6e: Reduce C2R to ≤80 Pts (P1-3). QP6f: Proportion of Red to Green Days , increase in the proportion of reported green days	
BAU assurance	Site meetings: Divisional Performance Meetings: UEC Improvement Programme meetings	**Data source:**	Power BI , Inpatient flow and beds module Red to Green Dashboard / Flow Dashboard /Virtual Ward Emergency Department ED Dashboard and Standards
Executive Lead and Delivery Leads	Chief Operations Officer (COO): Deputy COO – Non Elective Care; Chief Of Division (COD) Medicine COD Surgery, Emergency and critical care :Operations Director – Transformation and Integration		

Patient Experience

QP7 Shared Decision Making and Personalised Care			
Rationale	Achieving high quality shared decision-making conversations 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 • Norfolk & Waveney Integrated Care System – Quality Priority 1, 2 & 3		
How we will do this	Focus on the following areas for 2023-24 • Identify clinical champions for SDM • To strengthen links with ICS • To identify delivery lead for SDM • Decision support tools Cancer, Cardiology and MSK • Gap analysis and actions to meet NICE guidance for SDM .	**Improvement measures** QP7a: Evidence of Decision Support Tools uploaded to the Beat QP7b: Delivery of CQUIN for 23/245 :The level of patient satisfaction with shared decision making conversations – improvement to mean score between baseline data collection (in Q2) and subsequent data collection (in Q4), OR on maintenance of a score of 75% or above across the two collections. QP7c: Evidence of SDM resources for patients available on the Trust Website	
BAU assurance	PEEG	**Data source**	CQUIN Survey questionnaires
Executive Lead and Delivery Leads	Medical Director Deputy Medical Director Associate Director Patient Engagement and Experience		

Patient Experience

<table>
<tr><th colspan="4">QP8 Improving equity of access to services</th></tr>
<tr><td>Rationale</td><td colspan="3">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
• Norfolk & Waveney Integrated Care System – Quality Priority 2, 3 & 4</td></tr>
<tr><td>How we will do this</td><td>• Completion of Diversity, Inclusion and Belonging (DIB) strategy to launch in Q2
• Completion of review of Health Inequalities alignment with wider EDI work for ongoing reporting/governance
• EDS2022 self-assessment completed by using data gathered from variety of sources and feedback. Published to Trust website 2022/23 (nnuh.nhs.uk)
• To address the areas for improvement identified in it is proposed that our new Diversity, Inclusion and Belonging strategy will capture direct actions which will be progressed over the next five years alongside of local action plans via LEDG</td><td colspan="2">Improvement measures
QP8a: DIB Strategy launched Q2 2023
QP8b: Governance Structure agreed for DIB incorporating Health Inequalities.
QP8c: A performance measurement framework agreed for monitoring improvements against the actions identified in the DIB</td></tr>
<tr><td>BAU assurance</td><td>PEEG and EDGE</td><td>Data Source</td><td></td></tr>
<tr><td>Executive Lead and Delivery Leads</td><td colspan="3">Chief Nurse
Associate Director Patient Engagement and Experience</td></tr>
</table>

Our Vision
The best care for every patient

Patient Experience

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

QP 9 Improving equitable experience of services			
Rationale	Together, we will develop services so that everyone has the best experience of care and treatment • Strategic commitment 1, 3 • Norfolk & Waveney Integrated Care System – Quality Priority 2, 3 & 4		
How we will do this	Publish 5 year DIB strategy – Yr 1 objectives: • Implement the AIS standards policy • Reach out, engage and develop partnerships with seldom heard community groups • Improve how we collate demographic data from our patients • Investigate the development of an expanded EDI training package for staff	**Improvement measures** QP9a: Establish pilot areas for testing implementation of the policy and use of Reasonable Adjustments QP9b: Implement an engagement programme/plan to target seldom heard communities (link to Health Inequalities) QP9c: Develop information for communities to explain importance of collecting demographic information and for staff to ask QP9d: Track the number of staff who access EDI training	
BAU assurance	PEEG and EDGE	**Data Source**	
Executive Lead and Delivery Leads	Chief Nurse Associate Director Patient Engagement and Experience		

Our Vision
The best care for every patient

Staff Experience

NHS
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NHS Foundation Trust

QP 10 People Plan Improve Staff Experience			
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 • Norfolk & Waveney Integrated Care System – Quality Priority 1		
How we will do this	We need to make transformational, sustained improvement into how our staff feel about working at NNUH. • Improvements in staff shortages • Improvements in staff facilities • Improvements in Manager support and appreciation • Improvements in staff wellbeing • Improvements in addressing poor behaviours • Improvements in working and care environment • Improvements in digital health (new addition)	**Improvement Measures** QP10a: Staff vacancy rate (≤5%). QP10b: Improve key staff survey results in 2024. QP10c: Improve quarterly Pulse survey take up and score	
BAU assurance	• People and Culture Committee	**Data source**	Power BI data sets
Executive Lead and Delivery Leads	Chief People Officer Director of Workforce		

Governance and reporting

Quality and Safety Committee									
Quarterly Quality Programme Board									
Quarterly Evidence Group Progress updates and items for escalation to QPB									
BAU Programme Monitoring									
CSEB	Maternity Governance / Divisional Board Bi monthly to QSC	Trust Access Group	UEC Board	Medicine Divisional Board	UEC Board	Monitored via PEEG and EDGE			People and Culture Committee
QP1 PSIRF	QP2 Safe Care Mothers and Babies	QP3 Elective recovery : Outpatients	QP4 Elective recovery: Surgical pathways	QP5 Non Elective: Fractured Neck of Femur pathways	QP6 Non elective: Emergency pathways and Flow	QP7 Shared Decision making	QP8 Equity of access to servcies	Q9 Patient experience	Q10 People Plan Staff experience

Strategic Commitments and Associated Threats

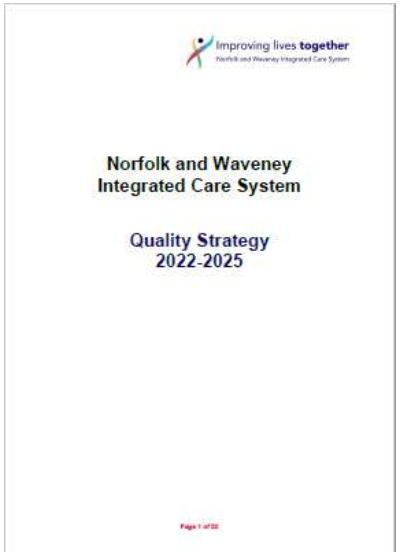
Our Vision
The best care for every patient

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

1.	**Our Patients - Together, we will develop services so that everyone has the best experience of care and treatment**
1.1	**If** we do not nurture and promote a culture in which the quality of patient experience is at the core of our decisions and a priority of all our staff **then** we will not achieve our aspirations & Journey to Outstanding
1.2	**If** the number and profile of patients requiring care on an unplanned basis is not matched by our operational capacity and efficient resilient systems and processes **then** this may cause delays in care, use of escalation areas, increased patient moves, poor continuity of care, diminished patient experience and failure to achieve expected performance standards
1.3	**If** the Trust is unable to provide planned care without lengthy delay **then** this will lead to diminished patient experience, increased risk, reduced staff satisfaction and failure to achieve the Trust's performance targets
2	**Our Team - Together, we will support each other to be the best we can be, to be valued and proud of our hospital for all**
2.1	**If** the Trust does not have an open, caring and positive employment culture **then** it will not be a place where people of diverse backgrounds want to work
2.2	**If** inadequate resource and focus is given to supporting staff health, well-being, morale, empowerment & resilience **then** this will have a negative impact on recruitment and retention, staff will not perform at their best and will not identify the Trust as a good place to work or to be cared for
2.3	**If** we do not adequately plan and anticipate our future workforce needs and educate and train sufficient specialist staff **then** this may lead to pressure on staffing levels and we will be unable to maintain and develop services for patients and will incur additional costs in seeking to attract staff educated elsewhere
2.4	**If** we do not give appropriate respect and support to education (undergraduate and post-graduate) **then** we will not deliver our responsibilities as a teaching hospital, generate a supply of specialist staff to meet our population health needs or enable our staff to realise their potential
2.5	**If** we do not ensure adequate capacity, capability and effectiveness of leadership, communication and management through our divisional and clinical structures **then** efficiency, performance and staff experience will suffer and staff will not be supported to realise their potential
3	**Our Partners - Together, we will join up services to improve the health and wellbeing of our diverse communities**
3.1	**If** our services are not adequately aligned with and supported by those in primary and community care **then** there will be fractured clinical pathways & inadequate alternatives to acute care resulting in excessive emergency demand
3.2	**If** our services are not adequately aligned with & supported by community provision (mental health, social care, EOL and community health) **then** there will be delays in discharge and disjointed post-discharge care
3.3	**If** progress in the N&W response to the challenges of system redesign is inadequate **then** this will result in uncertainty for individuals and services and will fail to deliver the efficiencies & transformational changes necessary to establish and maintain high-quality & sustainable services
3.4	**If** our response to system redesign does not adequately include 'vertical' collaboration with community services and primary care **then** we will not optimise improvement and efficiency opportunities and will fail to achieve 'Place-Based' services
4	**Our Services - Together, we will provide nationally recognised, clinically led services that are high quality, safe, and based on evidence and research**
4.1	**If** we do not achieve clinical outcomes that compare well against recognised benchmarks (e.g. HSMR/SHMI, TARN, SSNAP, GIRFT etc) **then** this may undermine our reputation and development as a provider of high quality and sustainable specialist services
4.2	**If** we do not develop our research infrastructure, partnerships, culture and performance **then** we will not achieve our obligations and potential as a University Hospital and as partner in QIP and NRP
4.3	**If** there is inadequate networking, resourcing and capacity (physical & people) for our specialist services **then** we will be limited in our ability to provide tertiary and specialist care (e.g. in major trauma, thrombectomy, maternity, oncology and paediatrics)
4.4	**If** we do not promote and oversee a culture, system and processes of clinical innovation, clinical audit and clinical governance **then** we will not achieve services that are recognised as safe, efficient and inspiring
4.5	**If** the Trust is not adequately prepared and resilient to withstand the impact of crisis and pandemic disruption **then** we may be diverted from achievement of our Vision and Strategy
5.	**Our Resources - Together, we will use public money to maximum effect**
5.1	**If** we do not deliver against our Financial Strategy **then** this will threaten our financial sustainability and ability to improve the services we are providing
5.2	**If** we do not embed enhanced business planning, data and financial management, operational efficiency and sustainable improvement & transformation processes **then** we will fail to comply with financial regulatory requirements and achievement of sustainable high quality clinical services
5.3	**If** we do not address the relative immaturity and fragility of the Trust's digital infrastructure **then** this may lead to inefficiency and risks to cyber security, operational resilience and clinical quality
5.4	**If** we do not give adequate attention to the imperatives of environmental sustainability **then** we will diminish our reputation, miss key targets and fail to realise potential economic & efficiency benefits

ICS Quality Priorities

1. Well-led through a culture of compassionate leadership.
2. Focussed on improving care quality and outcomes.
3. Using insights around health inequalities and population health to achieve fair outcomes.
4. Ensuring services are safe and sustainable, for now and for future generations.

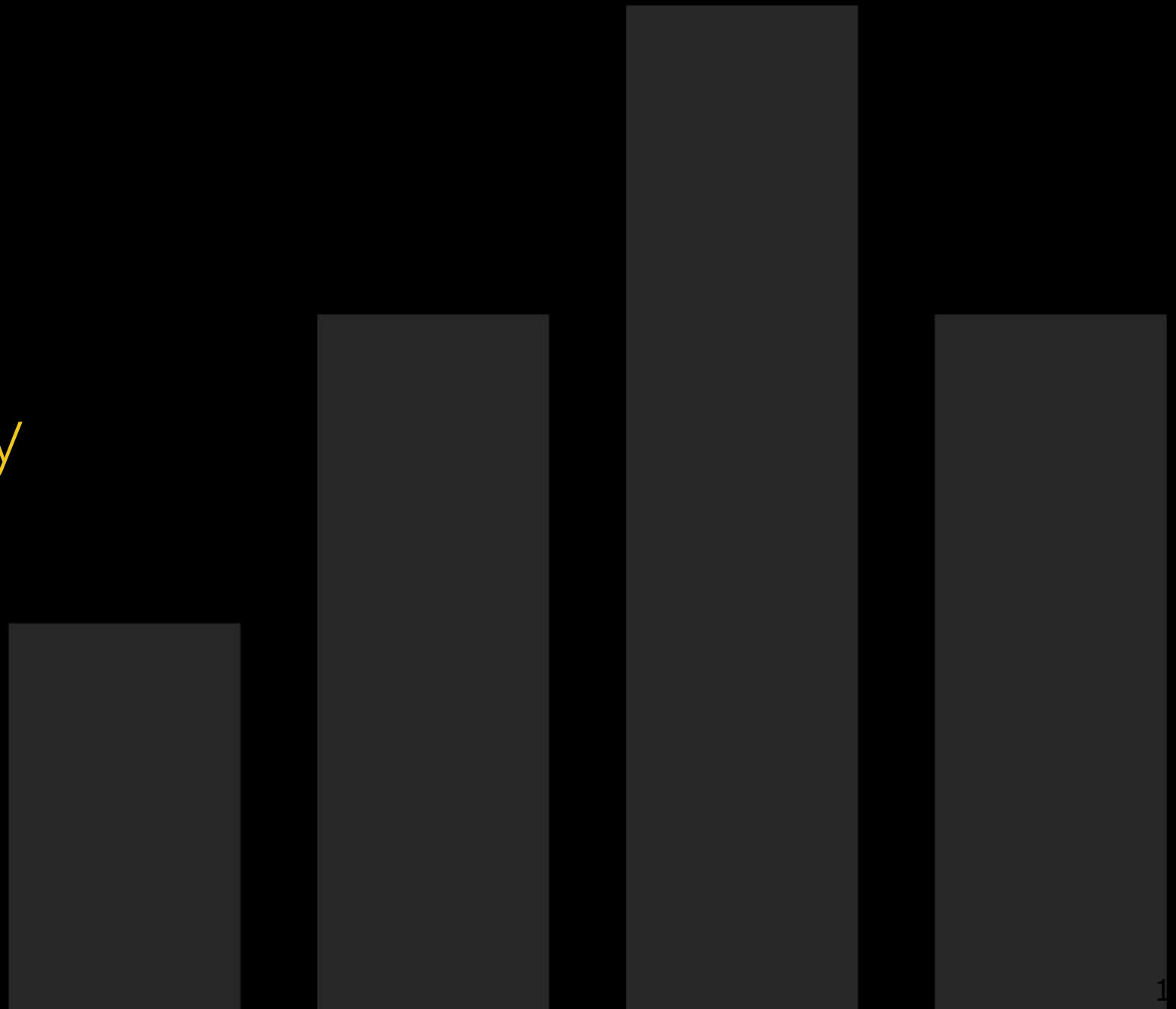


Taken from the ICS whole system Quality Strategy which outlines ICS quality priorities for 2022-25

Microsoft | Power BI

Quality & Safety

View in Power BI



Last data refresh:
24/05/2023 07:31:18 UTC

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24/05/2023 07:53:50 UTC

Quality Summary

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

NNUH Digital Health
business intelligence

Topic	Metric Name	Date	Result	Variation	Assurance
Saving Babies Lives	SGA detected Antenatally	Apr 2023	116%	Improvement (High)	No Target
Safer Staffing	Safe Staffing Fill Rates	Apr 2023	87.30%	Improvement (High)	Not capable
Patient Safety	Incidents	Apr 2023	1,869	Improvement (Low)	No Target
Patient Experience	Compliments	Apr 2023	432	Concern (Low)	No Target
Patient Experience	Friends & Family Score	Apr 2023	93.40%	Improvement (High)	Not capable
Patient Concerns	PALS % Closed within 48 hours - Trust	Apr 2023	33.5%	Concern (Low)	No Target
Patient Concerns	PALS Contacts - Trust	Apr 2023	248	Concern (Low)	No Target
Palliative Care	Palliative Care IP Referrals Accepted	Apr 2023	173.0	Concern (Low)	No Target
Complaints	Complaints (Trust)	Apr 2023	100	Concern (High)	No Target
Children & Midwifery Safeguarding	Safeguarding Children	Apr 2023	14	Concern (High)	No Target

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

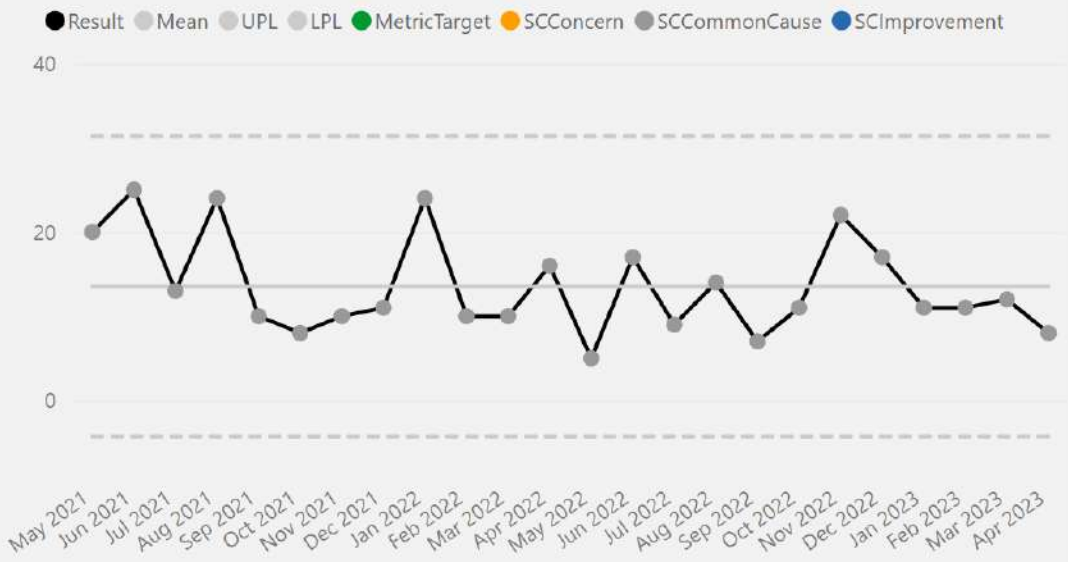
Serious Incidents

Apr 2023

Variation	Assurance

8 Result	31 UPL
N/A Target	14 Mean
	-4 LPL

Serious Incidents



Analytical Commentary

Variation is Common Cause

Assurance Commentary

There were 8 Serious Incidents reported in April:
4 Patient Falls (2 fractured neck of femur; 2 Subdural haemorrhage).
1 treatment delay (Ophthalmology), 1 Surgical /Invasive procedure, 2 HCAI Norovirus ward closures.

100% of Duty of Candour letters were sent out within the 10 day target (15/15)

There are 35 ongoing internal RCA investigations and 5 Maternity cases being investigated by HSIB.

Improvement Actions

The Serious Incident Group (SIG) meets daily to discuss incidents in a supportive environment, promoting psychological safety to reinforce a just and learning culture.
Governance teams continue to support Duty of Candour compliance.
In preparation for our new learning response to safety incidents as we transition to PSIRF, 32 staff have received After Action Review conductor training, 9 will attend Train the Trainer course in June. AAR training will be rolled out across the Trust from July

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Duty of Candour Compliance	Apr 2023	100%		Common Cause		Unreliable
Incidents	Apr 2023	1,869		Improvement (Low)		No Target

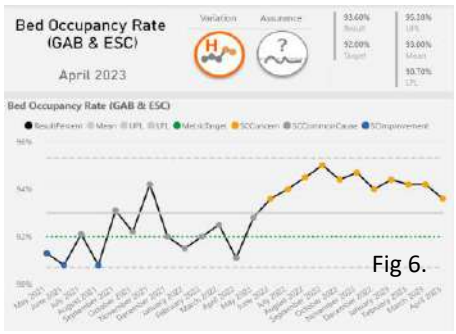
Essential Care Measures – March 2023

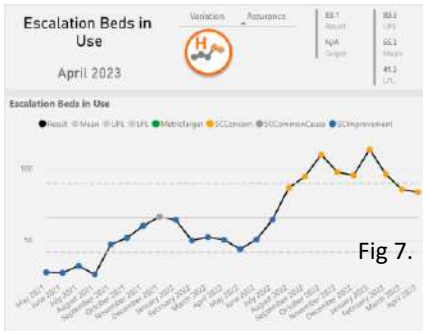
Patient Falls

Safe Staffing Fill Rates

Safe Staffing: Care Hours per Patient Day

Hospital Acquired Pressure Ulcers





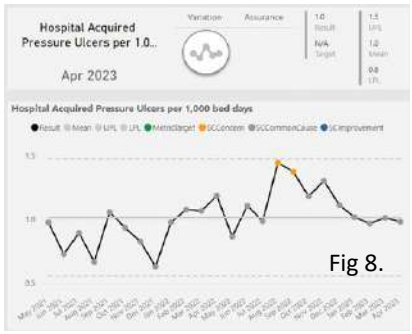


Fig 1 Our Trust-wide falls data is showing predictable variation between 174 and 301 falls per month . Since December 2021 the number of falls show common cause variation and no signals of improvement or deterioration.
Fig 4:The number of HAPU was showing a special cause of concern between June 2022 and January 2023, the last 3 months of data has reverted to common cause
Fig 5: Rate of patient falls per 1000 bed days causing moderate harm and above is between 0 and 0.4. (Between 0 and 12 falls per month, mean of 5) the data continues to show common cause variation and no signals of improvement or deterioration.
Fig 6 & 7: Bed occupancy was 93.6% , above the target of 92%, with 83 escalation beds in use and 190 super stranded patients.
Fig 8: The rate of HAPU per 1000 bed days remains within the predicted range of between 0.5 and 1.5.

To manage unprecedented increase in emergency admissions and in response to 3rd wave of Covid the Trust had to make the very difficult decision to increase the 6 bedded bays to take a 7th patient on 30/12/2021**. Risk No: 1856** - Additional patients in the 6 bedded bays or twin bedded rooms
You can also see from the Safe Staffing Fill Rates (fig 2) that this date also correlates with the special cause reduction in safer staffing levels. Since September 2021 there is also a special cause of concern for Care Hours Per patient Day (Fig 3.) **Risk No: 886**: Ability to meet safer staffing levels

Pressure Ulcers

NNUH Digital Health
business intelligence

Hospital Acquired Pressure Ulcers per 1,000 bed days

Apr 2023

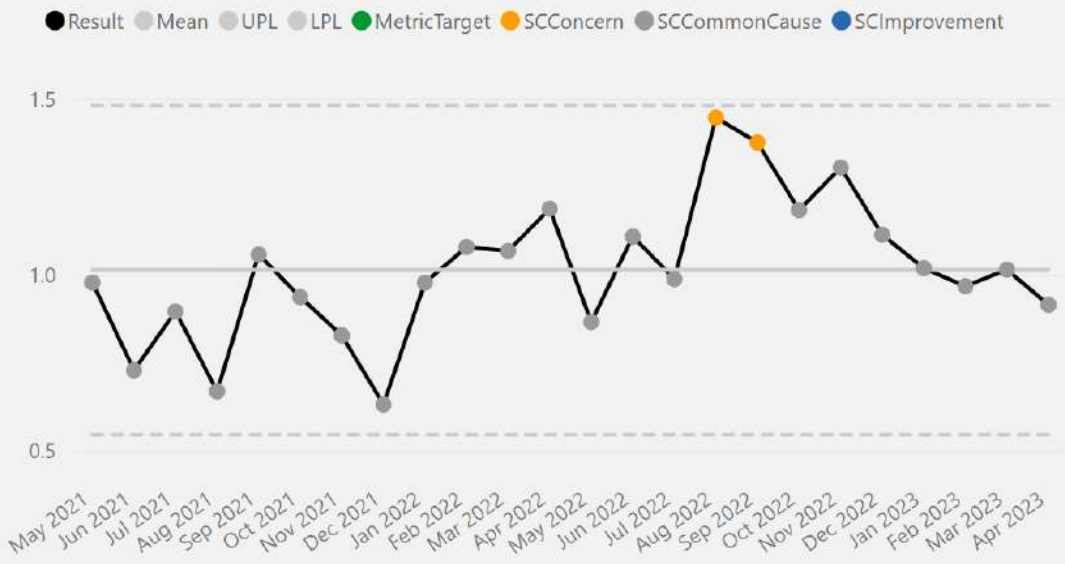
Variation | Assurance

0.9 Result	1.5 UPL
N/A Target	1.0 Mean
	0.5 LPL

Analytical Commentary

Variation is Common Cause

Hospital Acquired Pressure Ulcers per 1,000 bed days



Assurance Commentary

Rate of Hospital Acquired Pressure Ulcers (HAPU) per 1000 bed days showing common cause variation since October 2022.
The mean monthly number of Cat 2-4 HAPU remains at 28, without a hoped for reduction due to ongoing bed pressures on the wards.
Several wards are providing specific pressure ulcer related training days for staff. The Education Team have provided a well attended study morning across the Trust for Healthcare workers to increase confidence in correct equipment selection and identification of pressure damage.

Improvement Actions

The Tissue Viability Service continue to provide support, advice and guidance to clinical areas where and when required.
To support all ward specific study days.
Provide training sessions to new staff as part of the induction process.
Participating in the Pressure Ulcer Risk Assessment CQUIN for 2023 - 2024

Patient Falls

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business intelligence

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

Apr 2023

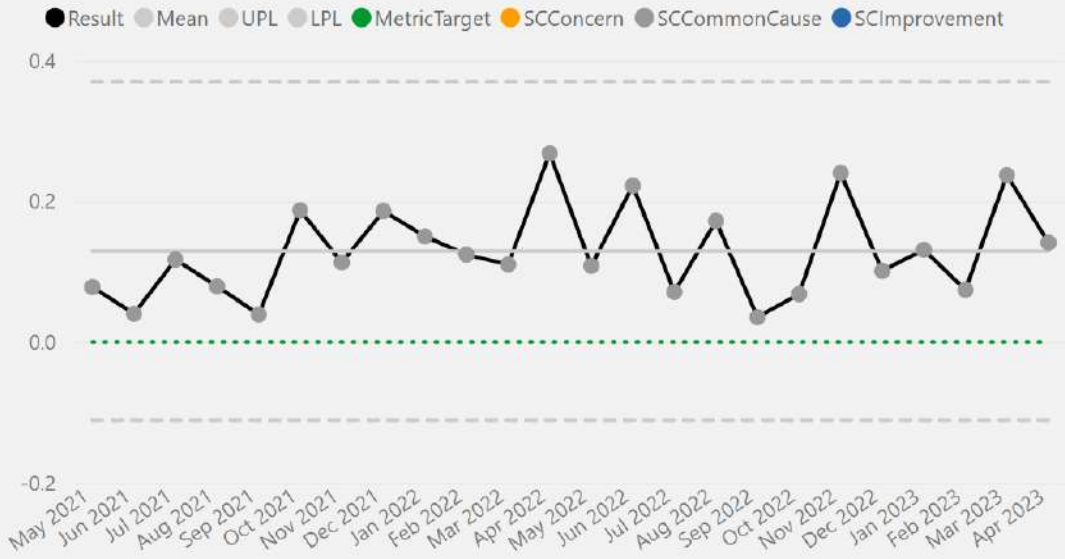
Variation | Assurance

0.1 Result	0.4 UPL
0.0 Target	0.1 Mean
	-0.1 LPL

Analytical Commentary

Variation is Common Cause

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



Assurance Commentary

Variation remains common cause with a random variation between the upper process limit of 0.4 and lower process limit of 0.0 .
Currently at 0.1 falls per thousand bed days causing moderate harm and above harm. Operational and clinical pressures remain high with the majority of falls being unobserved as a result.
There has been a slight improvement in Care Hours Per Patient Day which may have contributed to an in month reduction of Trust wide falls for April.

Improvement Actions

New bespoke MFRA designed for CCC fully approved and being integrated into Metavision. Kidney Unit MFRA to be approved by NMCP Board. Assistive Technology trial provider agreed and project moving forwards with Finance & Clinical Engineering. MDT approach to Falls Prevention continues Trust wide with hybrid training across all wards continuing for risk assessments and all falls initiatives. ED Falls AIMS audit live. Int Nurses, HCA, Student Nurse and Housekeepers training booked for 2023. Refresh of QI Programme planned with ward education on Life QI, starting with Kimberley/Brundall wards.

Patient Experience

NNUH Digital Health
business intelligence

Friends & Family Score

Apr 2023

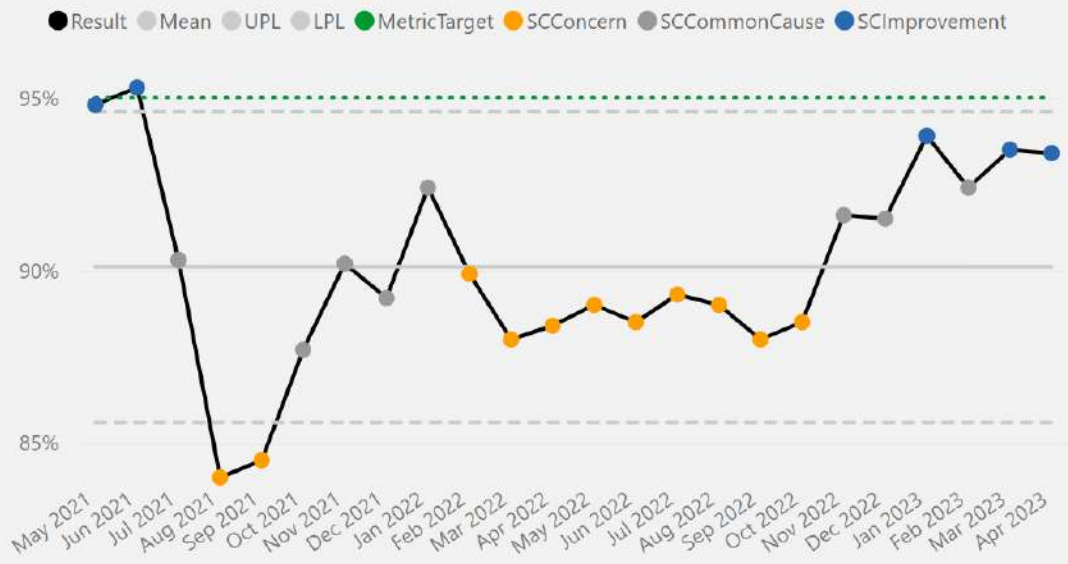
Variation	Assurance
H	F

93.40% Result
95.00% Target
94.60% UPL
90.10% Mean
85.60% 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 (High)

Friends & Family Score



Assurance Commentary

Overall FFT score remains within usual limits, with a slight increase to 93.4% for April 2023.
3460 FFT responses were received in April, we are seeing special cause variation in our FFT scores with six months showing an improvement.

Top positive themes within reviews for April continue to be staff attitude, implementation of care, waiting times and communication.

Negative themes see environment included. However, we continue to hear more positive themes than negative.

Improvement Actions

Testing for SMS for CSS to be completed following discussions with the external provider regarding SMS allocation available within the contract.
Medicine Division is a priority to increase completion of Inpatient FFT surveys. A plan is being finalised to increase volunteer support for collection; promote the use of QR codes and other methods of collecting feedback to support accessibility. Mapping the requirements for appropriate use of SMS is to be completed with Medicine Division support.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Compliments	Apr 2023	432		Concern (Low)		No Target

Patient Concerns

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business intelligence

PALS % Closed within 48 hours - Tr...

Apr 2023

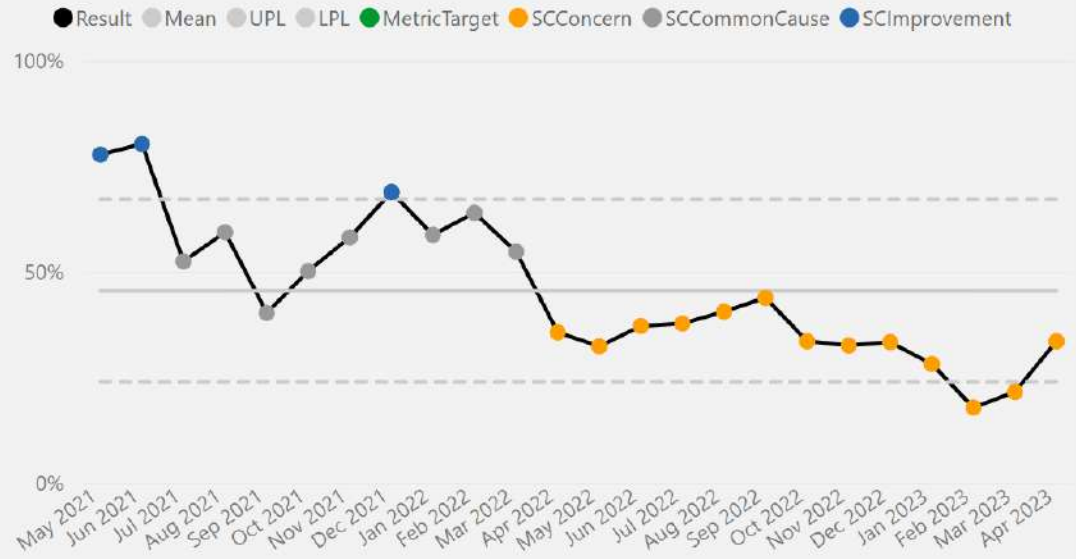
Variation	Assurance
	

33.5% Result	67.1% UPL
N/A Target	45.5% Mean
	23.9% LPL

Analytical Commentary

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

PALS % Closed within 48 hours - Trust



Assurance Commentary

213 Level 1 PALS matters were raised in April, with a breakdown of: 136 enquiries, 74 signposting, 2 Best Wishes and 1 suggestion.

Appointments including delays and cancellations remained the top subject for PALS along with communication and Clinical Treatment Surgical.

PALS current KPI to manage Level 1 cases in a 2 day timeframe was 35% which is an improvement.

PALS Band 4 Assistant vacancy was successfully recruited to, and the new staff member is currently undergoing training.

Staff sickness levels have remained low.

Improvement Actions

Recruitment of a Band 3 admin post was successful, predicted start date for the end of the month.
Review of the 2 day wait time KPI has been completed and signed off at HMB/PEEG. Changing to 100% closed within 7 days and 90 % within 5 days.
PowerBI changes have been requested with the BI team, with a plan to complete update in May to reflect new KPI reporting commencing June.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
PALS Contacts - Trust	Apr 2023	248		Concern (Low)		No Target

Complaints

NNUH Digital Health
business intelligence

Complaints (Trust)

Apr 2023

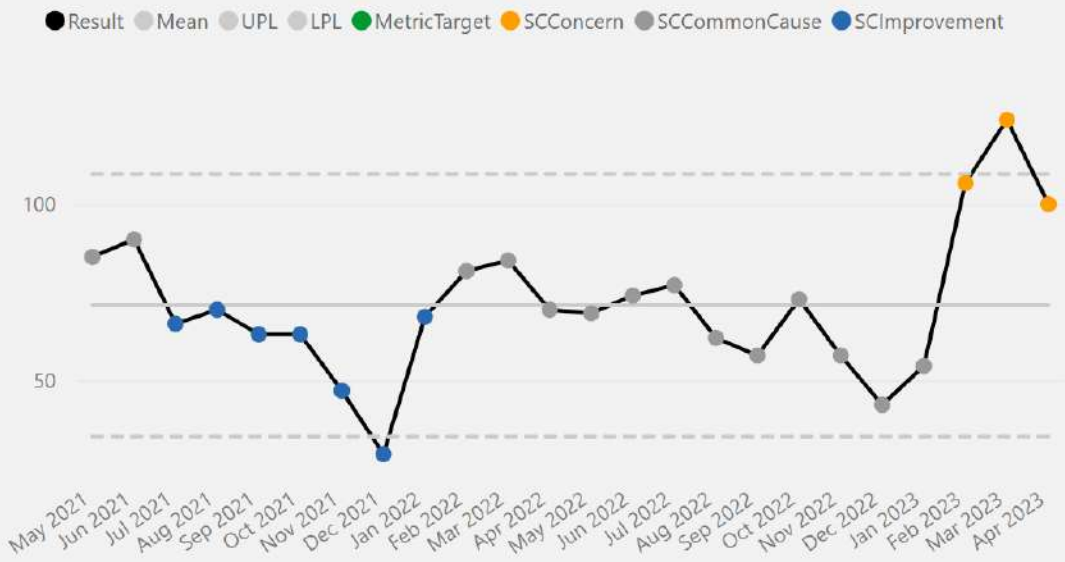
Variation | Assurance

100 Result
N/A Target
109 UPL
71 Mean
34 LPL

Analytical Commentary

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

Complaints (Trust)



Assurance Commentary

The total number of complaints received in April was 100; 64 level 2 and 36 Level 3.

The number of complaints reported takes into account the new Parliamentary and Health Service Ombudsman (PHSO) framework. This framework now includes lower-level complaints (64 for this month). Some of these would have previously been categorised as PALS Concerns and not included as a complaint.

Top themes were - Access to treatment or drugs, Clinical Treatment and Appointments including delays and cancellations.

Improvement Actions

Additional temporary resource now in place to support managing caseloads and completion of responses within timeframes.
Initial discussions have taken place with the Communications Team to support the upgrade work to the BEAT and external communications. Draft pages for internal and external communications are scheduled to be prepared by the end of June.

Supplementary Metrics

Metric Name	Date	Result	Variation	Assurance
Complaints - Acknowledgement	Apr 2023	90%	Common Cause	Unreliable
Complaints - Response Times - Trust	Apr 2023	85%	Common Cause	Unreliable
Post-investigation enquiries	Apr 2023	6	Common Cause	Capable

Palliative Care

NNUH Digital Health
business intelligence

Palliative Care Seen Within 48 Hours

Apr 2023

Variation	Assurance
	

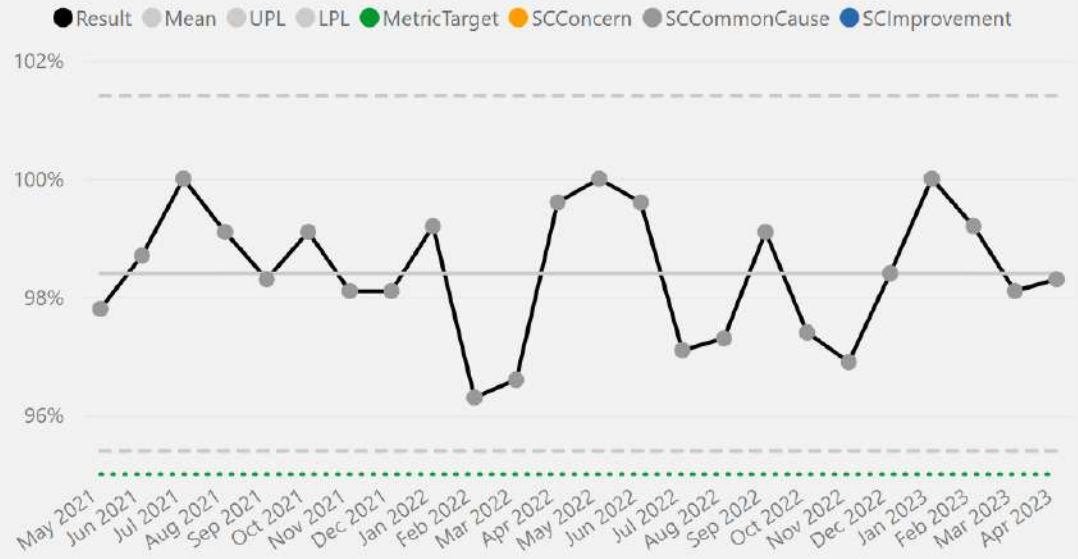
98.3% Result
95.0% Target

101.4% UPL
98.4% Mean
95.4% LPL

Analytical Commentary

Variation is Common Cause

Palliative Care Seen Within 48 Hours



Assurance Commentary

Data entry issues remain. Operational Managers are reviewing data collection processes.

Improvement Actions

To continue to review and resolve the resource issues previously identified to address the backlog of data entry which is impacting on the reported number of referrals made to the team and the number of those seen by the team who have died within the Trust.

Supplementary Metrics

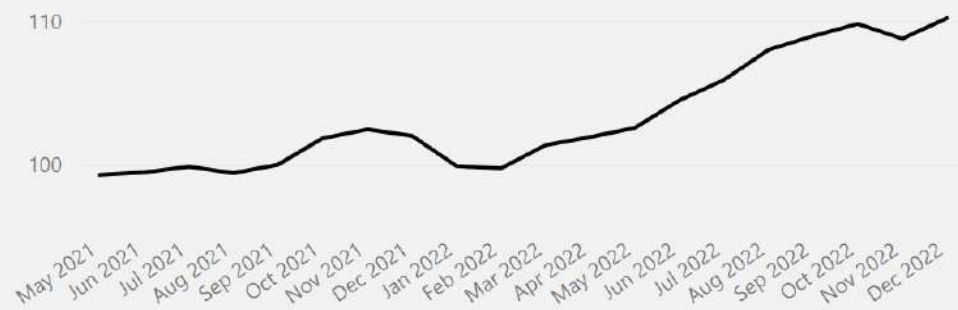
Metric Name	Date	Result		Variation		Assurance
Palliative Care Died in Trust and Seen by SPCT	Apr 2023	44.1%		Common Cause		No Target
Palliative Care IP Referrals Accepted	Apr 2023	173.0		Concern (Low)		No Target

Mortality Rate

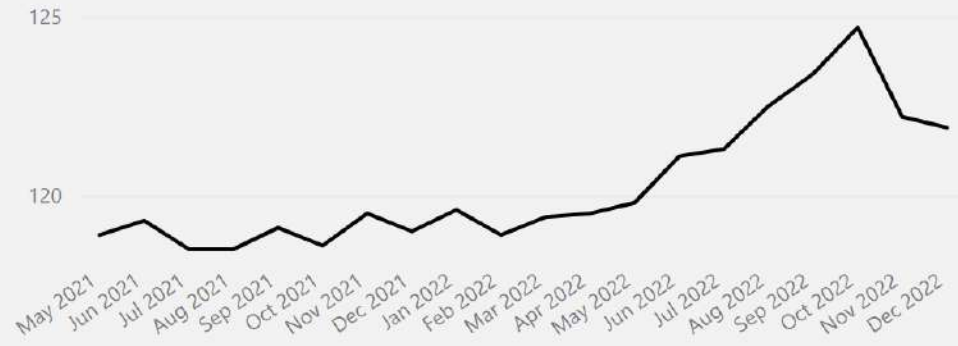
NNUH Digital Health
business intelligence

MetricName	Date	Result
HSMR	Dec 2022	110.24
SHMI	Dec 2022	122

HSMR



SHMI



Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Crude Mortality Rate	Mar 2023	5.40%		Common Cause		No Target

Assurance Commentary

HSMR/SMR & SHMI remain higher than expected showing an upward trajectory over time. Performance including Crude mortality remains similar to the figures reported last month. Recently NNUH has positively moved to 8th place within the 13 acute non-specialist Trusts in the East of England region, from 10th.
A new process has been introduced which uses reports and guidance from Dr Foster Intelligence to allow NNUH to focus and prioritise the multiple mortality alerts to resources available.
For example HSMR identified 5 diagnosis groups with a higher than expected banding, only 3 groups are notable with a large number of potential 'excess' deaths to review.
These include septicaemia (except in labour) 60 patients, which the coding team are already reviewing. Congestive heart failure (24 patients), which has been reviewed and is feeding into the ICB improvement work.
Other perinatal conditions (10 patients), a review is being undertaken with the Perinatal Mortality Review Tool (PMRT) Neonatal Intensive Care Unit (NICU) Lead to understand this data as it may be linked to coding.
It was recommended to monitor the other two alerts (Urinary Tract Infection & Acute Myocardial Infarction).

Improvement Actions

To continue work with BI/DFI/HED and the commissioning team
To continue using the Doctor Foster Intelligence (DFI) reports to focus resources for mortality alerts and to complete the actions for each focused alert.

To continue to work with the Royal College of Physicians to undertake the external review

To continue to seek engagement with clinical teams to complete SJRs to address the SJR backlog. To continue efforts to increase the pool of available chairs for SJR scrutiny panels to address the SJR scrutiny panel backlog.

Safer Staffing

NNUH Digital Health
business intelligence

Safe Staffing Fill Rates

Apr 2023

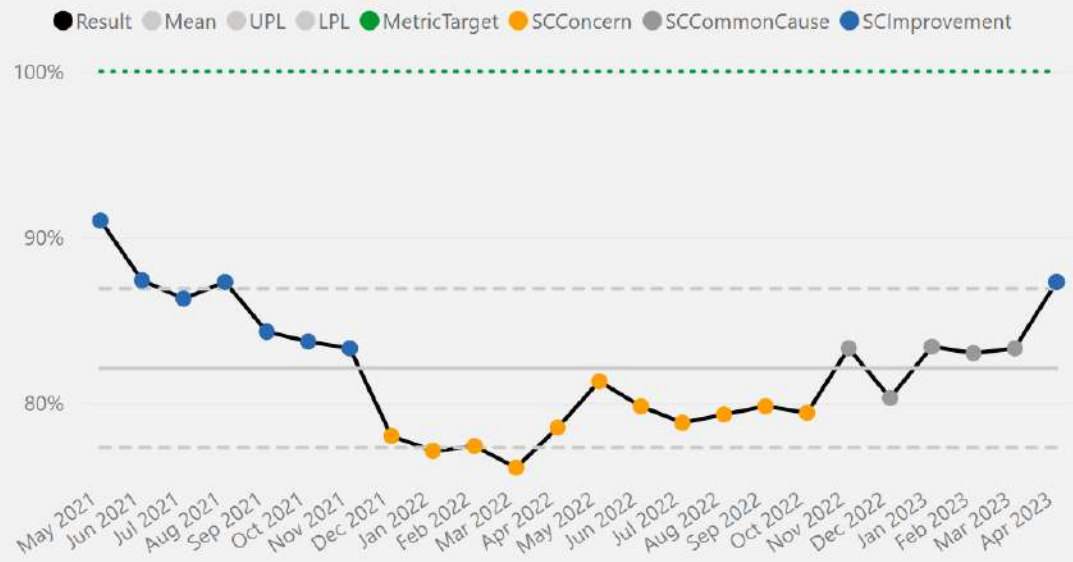
Variation	Assurance
H	F

87.30% Result
100.00% Target
86.90% UPL
82.10% Mean
77.30% LPL

Analytical Commentary

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

Safe Staffing Fill Rates



Assurance Commentary

The Trust-wide RN/M vacancy rate increased to 12.8 (n= 344.2) from 12.1% (n=323.2) in March with a reported turnover rate of 0.8% (18.5 WTE leavers & 9.89 WTE new starters). Trust-wide, there were 12 areas with an RN/M vacancy rate above 20%. The average Trust-wide RN/M fill rate has increased from 88.9% in March to 91.7% in April. The RN/M fill rate didn't fall below 75% in any inpatient area. The Trust-wide HCSW vacancy rate decreased to 18.2% (n=252.6) from 20.4% (n= 291.4) in March, with a reported turnover rate of 1.4% (14.3 WTE leavers & 26.92 WTE new starters; of which 18.64 WTE are in Medicine Division). There were 13 inpatient areas across the Trust with HCSW vacancy rates above 20%. The HCSW average Trust-wide fill rates have increased to 82.2% in April. The HCSW fill rate fell below 75% in 8 areas. The Trust wide CHPPD increased from 6.5 to 6.9 in April which is now above the average of 6.5 over the last 12 months. Red flags decreased to 1,559 with 84% remaining open. The number of falls remains a concern, with 114 rereported patient falls; 71 of these were unobserved.

Improvement Actions

The organisation is on track to employ 100 newly qualified nurses in September with 90 offers to date with 44 in SCEC, 21 in Medicine and 25 in Paediatrics along with 11 international nurses to arrive in April; 8 nurses training at the hub who will arrive with us the end of May; totalling 81 Nurses up to the end of April. The staff redeployment standard operating procedure is in draft which aligns with the Boards structure around the four pillars of retention.

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 2023	10	83	7
CPE positive screens	Apr 2023	0	N/A	0
E. Coli trust apportioned	Apr 2023	2	96	4
HOHA Trajectory C. Difficile Cases	Apr 2023	0	57	2
Hospital Acquired MRSA bacteraemia	Apr 2023	0	0	0
Klebsiella trust apportioned	Apr 2023	3	48	2
MSSA HAI	Apr 2023	6	N/A	3
Pseudomonas trust apportioned	Apr 2023	1	26	1

Assurance Commentary

C. difficile total for April 2023 = 10 cases, 6 x HOHA 6 x trajectory. 4 x COHA 3 x non trajectory, 1 x trajectory
Gram negative surveillance; E. coli 6 cases - sources: 2 urinary tracts
Klebsiella 3 cases- sources 1x urinary tract, 1 hepatobiliary & 1 x unknown
Pseudomonas 1 case – source skin/soft tissue
C.diff supportive measures - Guist ward commenced 09.02.2023 and concluded on 20.04.2023. Mulbarton commenced 26.04.2023. 2 HOHA cases - ongoing
COVID-19 (SARS CoV-2) - 5 outbreaks reported in April.
Updated government guidance relating to Covid -19 patient testing and isolation published 30th March 2023 for implementation from April 1st, 2023.

Hospital Acquired MRSA bacteraemia

E. Coli trust apportioned

C. difficile Cases Total

MSSA HAI

Klebsiella trust apportioned

CPE positive screens

Pseudomonas trust apportioned

Improvement Actions

C.difficile Post Infection Review (PIR) meetings held monthly with clinical staff and Norfolk & Waveney ICB to identify any lapses in care. Delay in sampling remains the main concern to date. Lapses are disseminated in Organisational Wide Learning and is now integrated within datix, providing access to Givisional Governance teams, ensuring actions and learning is discussed and disseminated appropriately.
Surveillance undertaken on each Healthcare Associated Gram-negative Blood Stream Infection to ascertain the potential sources. To continue to provide supportive action to wards where required.
COVID-19 outbreak reporting/monitoring continues as required by NHS England.
Updated processes for COVID – 19 patient testing and isolation in line with new government guidance, agreed at Hospital Management Board 9th May 2023 and communicated and implemented trust wide 24th May 2023.

Maternity: Mothers

NNUH Digital Health
business intelligence

Mothers Delivered

Apr 2023

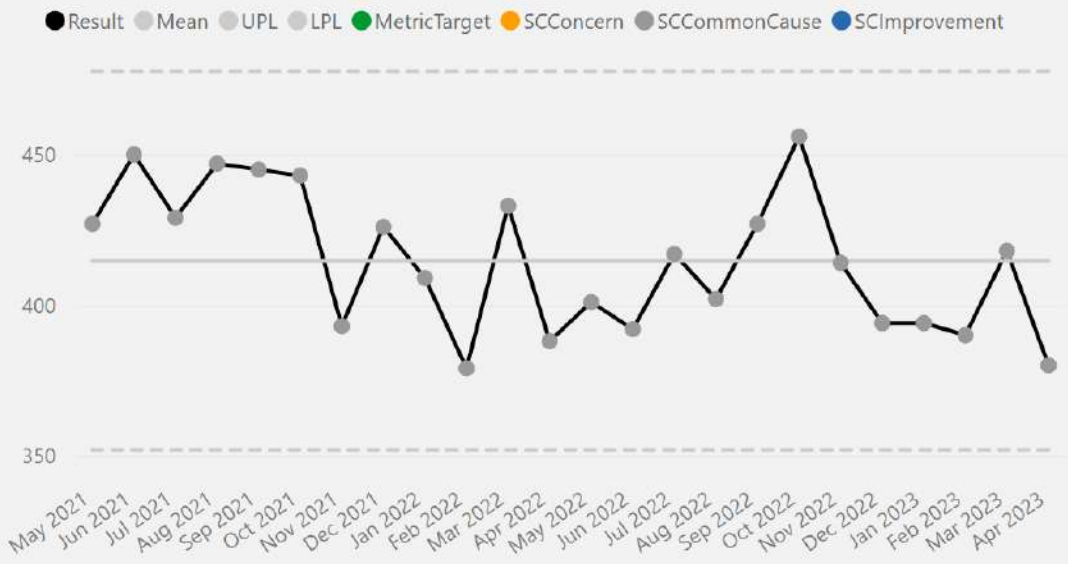
Variation | Assurance

380 Result
N/A Target
478 UPL
415 Mean
352 LPL

Analytical Commentary

Variation is Common Cause

Mothers Delivered



Assurance Commentary

380 mothers delivered - 312 on delivery suite, 50 in MLBU and 18 at home. Reduction in 3/4th degree tears continues. Reduction in PPH noticed. 4 babies born before arrival (BBA) noted - all reviewed and unavoidable.

Improvement Actions

The variable spike in 3/4th degree tears remain within the national average but are being reviewed. These incidents are all discussed weekly at our Risk and Governance meeting and actions / learning shared with the wider team. The Digital Health team will be reviewing data from our BAME /non-English speaking service users to ascertain if there is any increase in adverse outcomes.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
1:1 Care in Labour	Apr 2023	99.3%		Common Cause		No Target
3rd & 4th Degree Tears	Apr 2023	2.6%		Common Cause		Unreliable
Births Before Arrival	Apr 2023	4		Common Cause		No Target
Post Partum Haemorrhage ≥1500mls	Apr 2023	2.1%		Common Cause		No Target

Mothers Delivered
380
Babies Delivered
387

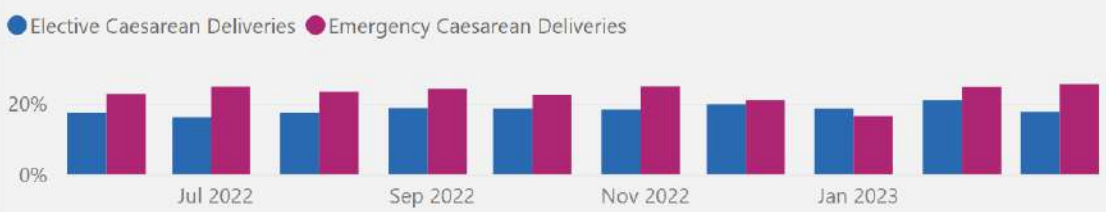
Maternity Activity

NNUH Digital Health
business intelligence

31/05/2022 28/02/2023

Apr 2023	0.00	0.00
Latest Month	Maternal Deaths	Unplanned Admissions to Critical Care

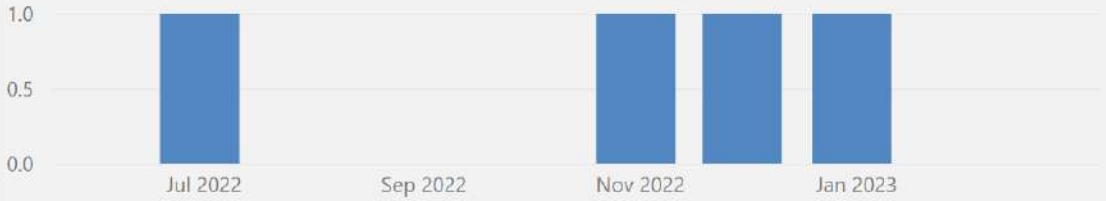
Caesarean Deliveries



Inductions of Labour

Maternal Deaths

Unplanned Adm. to Critical Care



Latest Assurance Commentary

Latest Improvement Actions

The Business Intelligence (BI) Team and the Digital Midwife have undertaken a vast amount of work to be able to provide the requested Robson Group report within the IPR.
Currently there are issues with the data tables in the Euroking system, which mean it is not possible to provide accurate Robson group data directly from the system. A manual review of data from January 2023 is necessary and once the data has been corrected it can be used to populate the IPR, which will need to continue until Euroking are able to resolve the complex issues identified.

Maternity: Babies

NNUH Digital Health
business intelligence

Unplanned NICU ≥37 week Admissions (E3)

Apr 2023

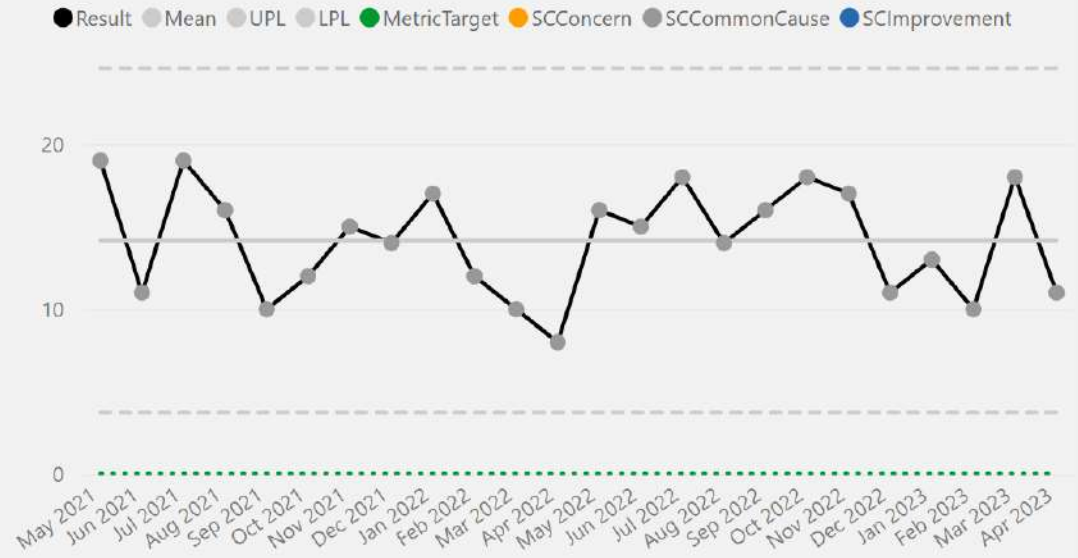
Variation	Assurance
	

11 Result
0 Target
25 UPL
14 Mean
4 LPL

Analytical Commentary

Variation is Common Cause

Unplanned NICU ≥37 week Admissions (E3)



Assurance Commentary

387 babies born in April. No stillbirths.

Improvement Actions

Avoiding Term Admissions Into Neonatal (ATAIN) admissions are reviewed monthly.
The Risk and Governance team has been strengthened to ensure that all admissions to NICU are fully reviewed using a MDT approach and lesson learnt are shared.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Adjusted Still Births	Apr 2023	0		Not Applicable		No Target
Apgar score <7 @5, ≥37 weeks	Apr 2023	4		Common Cause		No Target
Early Neonatal Death	Apr 2023	0		Not Applicable		No Target
Mothers Transferred Out of Unit	Apr 2023	0		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 2023	7.1%		Common Cause		Unreliable
Fetal Growth Restriction	Less Than 3rd centile born > 37+6 weeks	Apr 2023	2%		Common Cause		Not capable
Fetal Growth Restriction	SGA detected Antenatally	Apr 2023	116%		Improvement (High)		No Target
Reducing Preterm Birth	Singleton Births Preterm	Apr 2023	7%		Common Cause		Unreliable
Reducing Preterm Birth	Singleton live births < 34 wks (AN corticosteroids within 7 days PN)	Apr 2023	14%		Common Cause		Unreliable
Effective Fetal Monitoring	CTG Training and Human factors situational awareness compliance	Apr 2023	88%		Common Cause		Unreliable

Assurance Commentary

Smoking cessation recognised as a LMNS and ICB local and regional priority. Supportive collaborative work ongoing to support reduction in smoking at booking and delivery. Areas of Saving Babies Lives Care Bundle (SBLCB) remain under review - awaiting next version which will incorporate diabetes care.

Improvement Actions

To complete a series of audits for CO2 monitoring performance; Risk assessment, prevention, and surveillance of pregnancies at risk of fetal growth restriction (FGR); raising awareness of reduced fetal movement (RFM) and the use of steroids for fetal optimisation. This will ensure our maintenance of the SBLCB compliance for 23/24 and for our Year 5 submission.

Adult Safeguarding

NNUH Digital Health
business intelligence

Safeguarding Adults

Apr 2023

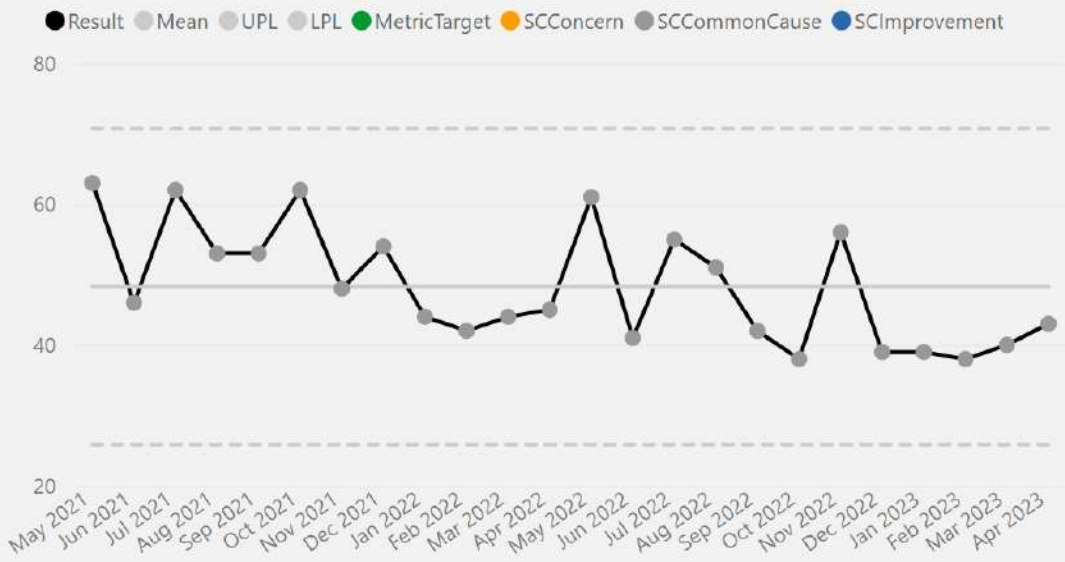
Variation	Assurance

43 Result
N/A Target
71 UPL
48 Mean
26 LPL

Analytical Commentary

Variation is Common Cause

Safeguarding Adults



Assurance Commentary

Bespoke training sessions are being rolled out in the departments to support staff with their understanding of safeguarding and to help build their confidence. There is an increase in concerns raised about staff subject to domestic abuse. Managers are being supported by the safeguarding team and HR to ensure that our staff are safe and have access to appropriate services. Due to this rise, domestic abuse training is being developed as a brief bespoke session to facilitate quick identification of possible abuse in both service users and staff.

Improvement Actions

Monthly meetings with the leads in Norfolk County Council (NCC) Social Care are ongoing, with the last meeting held on 9th May. NNUH Safeguarding Team continues to work collaboratively with NCC management team to provide effective services and support for both service users and staff both on site and in the community. The NNUH safeguarding team and hospital social work team have now set up monthly meetings to support each other with safeguarding adult processes and workload in the trust. The first meeting was held on 18th May.

Children & Midwifery Safeguarding

NNUH Digital Health
business intelligence

Safeguarding Children and Midwife...

Apr 2023

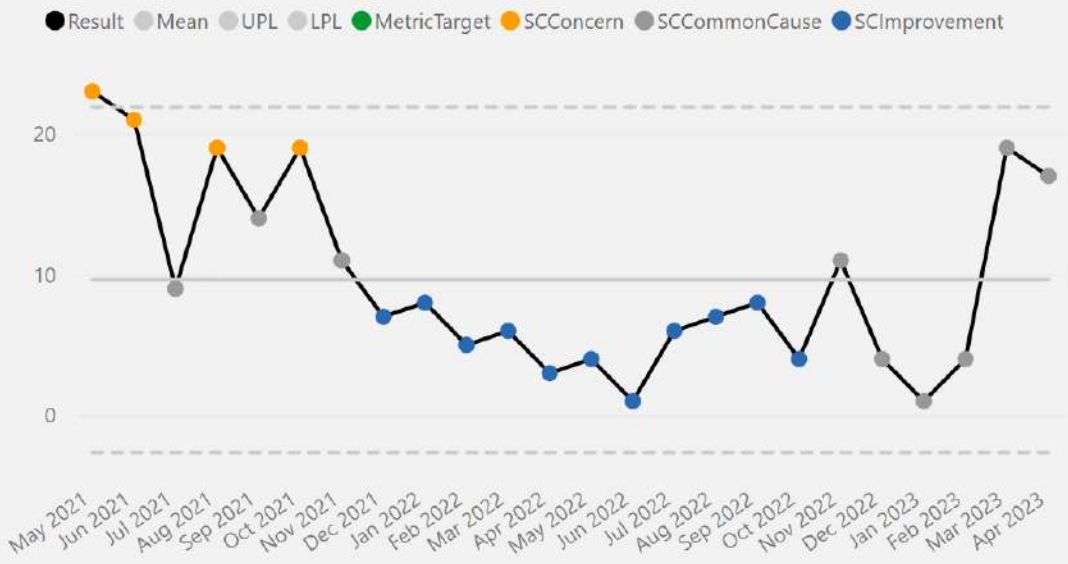
Variation | Assurance

17 Result	22 UPL
N/A Target	10 Mean
	-3 LPL

Analytical Commentary

Variation is Common Cause

Safeguarding Children and Midwifery



Assurance Commentary

We have seen an improvement in compliance in the last 2 months with completion of datixes following a referral of a child or unborn to Children`s Services. These figures reflect the amount of referrals the Trust is making and will help to identify if further support is needed for staff with regards to understanding thresholds to raise concerns for a child or unborn. Mandatory training continues face to face and via e-learning and is being well received. Through feedback, staff report feeling more confident in recognising safeguarding concerns and managing them.

Improvement Actions

The 2023 Section 11 has been disseminated to providers by the Children`s Partnership. This year`s priorities are Protecting Babies, Neglect and Child Exploitation. This self-assessment of the trust will help to identify gaps in our processes and help us to develop our safeguarding children practices. To facilitate this, a staff survey has been included and shared with all staff via Sisters/Matrons and communications to help evaluate and improve the way in which Norfolk keeps children safe. The Safeguarding Lead for Children and Adults will collate this on behalf of the Trust due by September.

Supplementary Metrics

Metric Name	Date	Result	Variation	Assurance
Safeguarding Children	Apr 2023	14	Concern (High)	No Target
Safeguarding Midwifery	Apr 2023	3	Common Cause	No Target

Daily Safety Check

NNUH Digital Health
business intelligence

Daily Safety Check

Apr 2023

Variation	Assurance
	

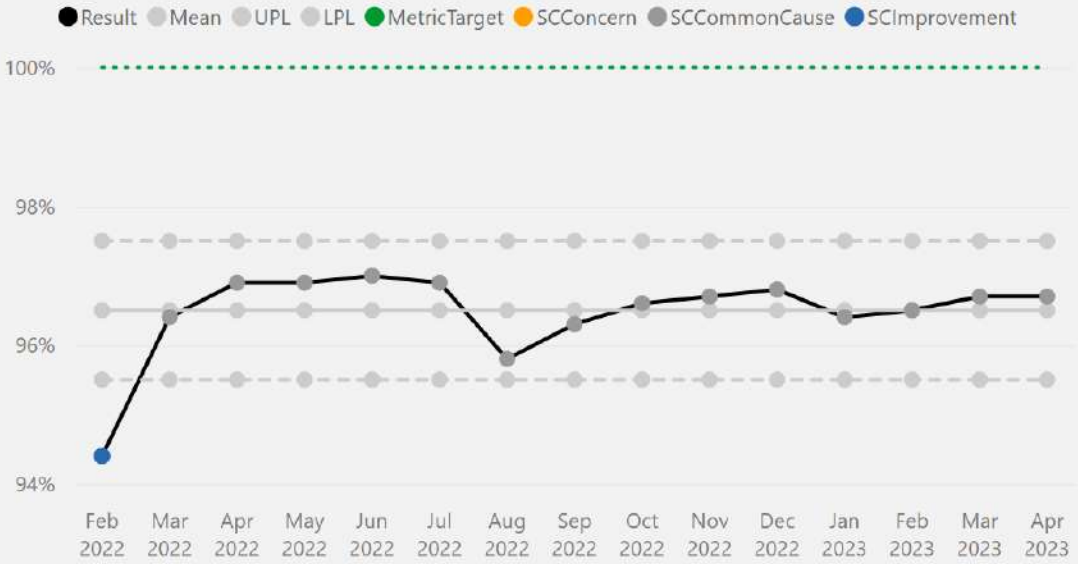
96.7% Result
100.0% Target

97.5% UPL
96.5% Mean
95.5% LPL

Analytical Commentary

Variation is Common Cause

Daily Safety Check



Assurance Commentary

Improvement Actions

Results of Tendable now to be presented by the Divisions at NMCP boards. Review of daily safety check questions to streamline process completed. Once the new Fundementals & documentation audit is live on Tendable, we will review whether the daily safety audit is required.

Documentation

NNUH Digital Health
business intelligence

Documentation

Apr 2023

Variation

Assurance

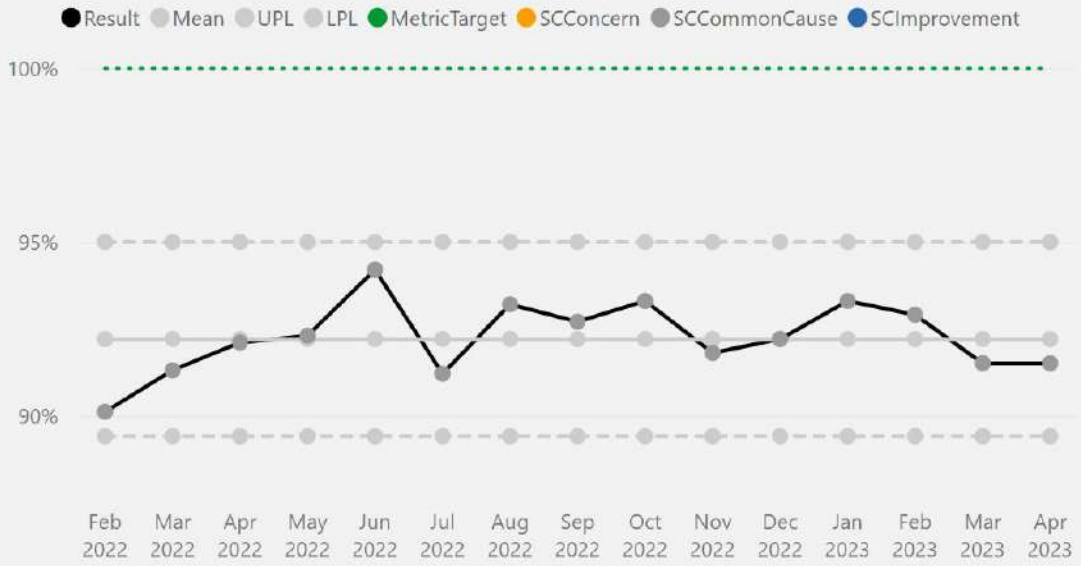
91.5% Result
100.0% Target

95.0% UPL
92.2% Mean
89.4% LPL

Analytical Commentary

Variation is Common Cause

Documentation



Assurance Commentary

Improvement Actions

Data set feedback to Nursing, Midwifery and Clinical Professionals (NMCP). Tendable annual review of questions and trends of non-compliance. Following CQC recommendation, documentation audit being rewritten, new questions presented to NMCP forum in March 2023, awaiting ratification at NMCP board. Trial of new paper risk assessment booklet to be completed in 4 pilot areas by the end of May.

IPC Audit

NNUH Digital Health
business intelligence

IPC Audit

Apr 2023

Variation

Assurance

95.6% Result

100.0% Target

98.1% UPL

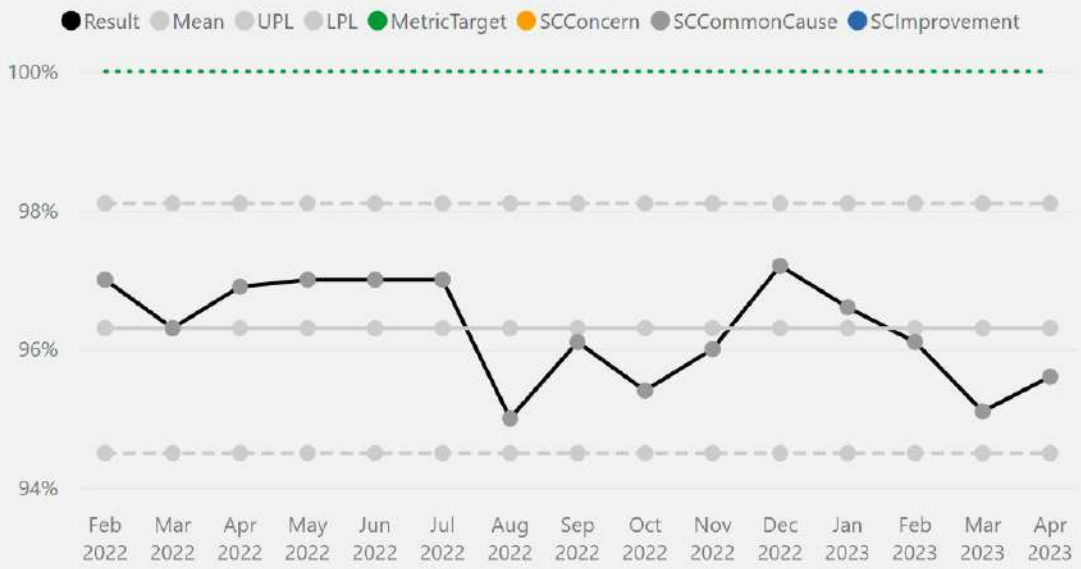
96.3% Mean

94.5% LPL

Analytical Commentary

Variation is Common Cause

IPC Audit



Assurance Commentary

Improvement Actions

Consistent compliance with audit. Review of question set completed to incorporate questions removed from daily safety check. Ice machine question added to audit. Medicine is continuing a monthly DND Quality Dashboard review meeting with specialities.

Falls (AIMS)

NNUH Digital Health
business intelligence

Falls (AIMS)

Apr 2023

Variation | Assurance

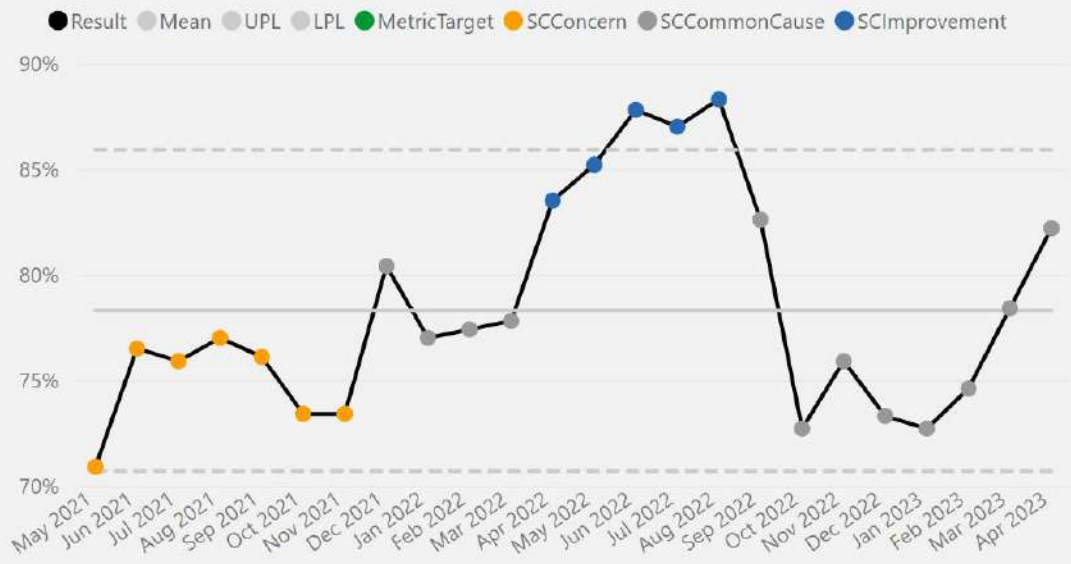
82.2% Result
N/A Target

85.9% UPL
78.3% Mean
70.7% LPL

Analytical Commentary

Variation is Common Cause

Falls (AIMS)



Assurance Commentary

Improvement Actions

Nutrition and Hydration (AIMS)

NNUH Digital Health
business intelligence

Nutrition and Hydration (AIMS)

Apr 2023

Variation | Assurance

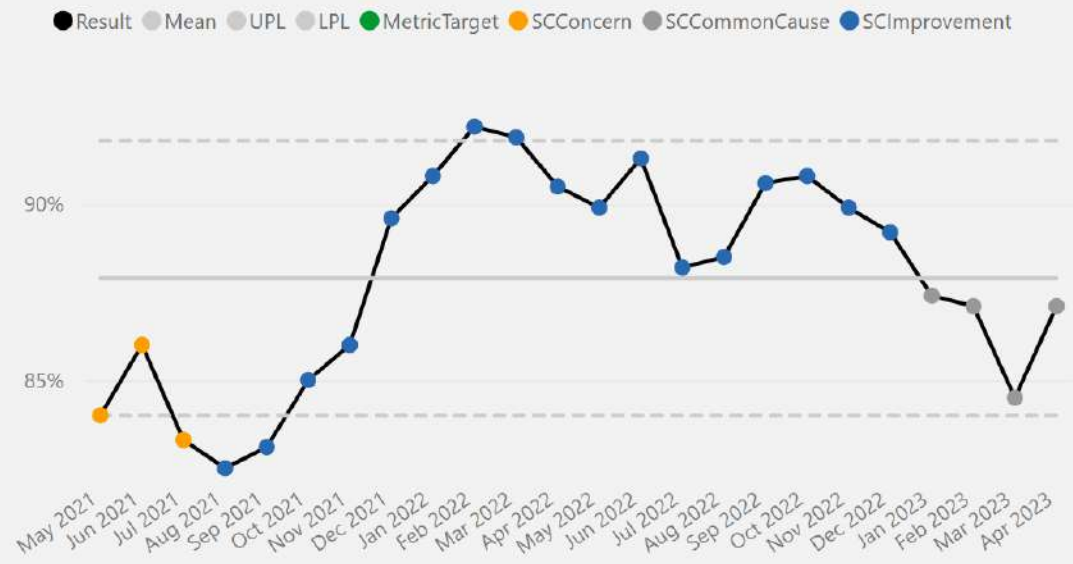
87.1% Result
N/A Target

91.8% UPL
87.9% Mean
84.0% LPL

Analytical Commentary

Variation is Common Cause

Nutrition and Hydration (AIMS)



Assurance Commentary

Improvement Actions

Compliance has improved this month. Lowest scoring question continues to be documented evidence of shakes and soups have been offered. There is poor compliance with the totalling of fluid charts. The new adult inpatient admision and discharge booklet has a risk assessment for the use of fluid charts.

Patient Observation and Escalation (AIMS)

NNUH Digital Health
business intelligence

Patient Observation and Escalation (AIMS)

Apr 2023

Variation | Assurance

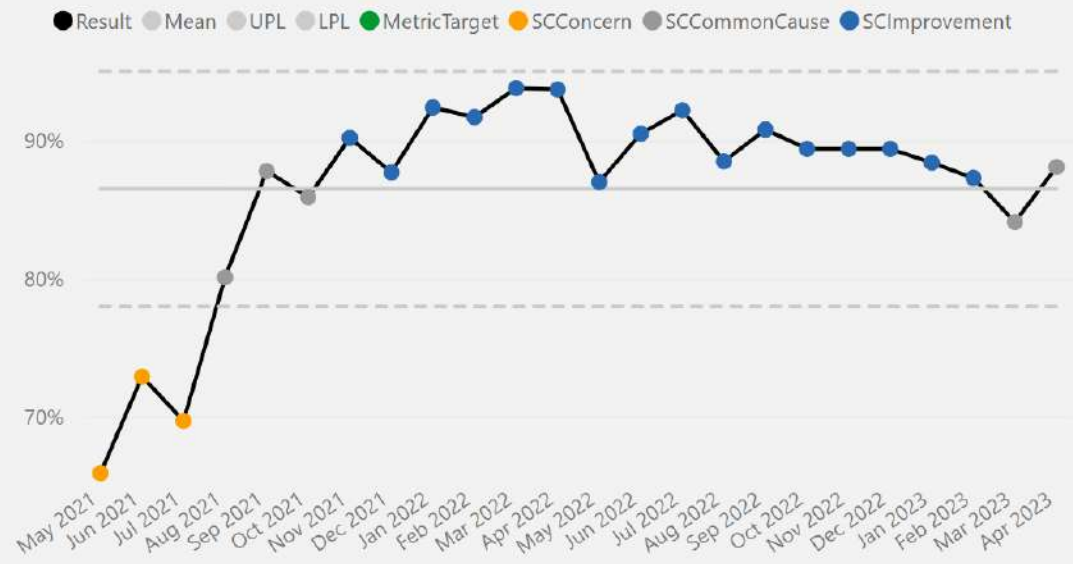
88.1% Result
N/A Target

95.0% UPL
86.5% Mean
78.0% LPL

Analytical Commentary

Variation is Common Cause

Patient Observation and Escalation (AIMS)



Assurance Commentary

Improvement Actions

Improved compliance with audit. Overall score has improved this month. Failure to escalate QI project continues, led by RRT Matron. NEWS2 eLearning introduced on the 8 pilot wards.

Pressure Ulcers (AIMS)

NNUH Digital Health
business intelligence

Pressure Ulcers (AIMS)

Apr 2023

Variation | Assurance

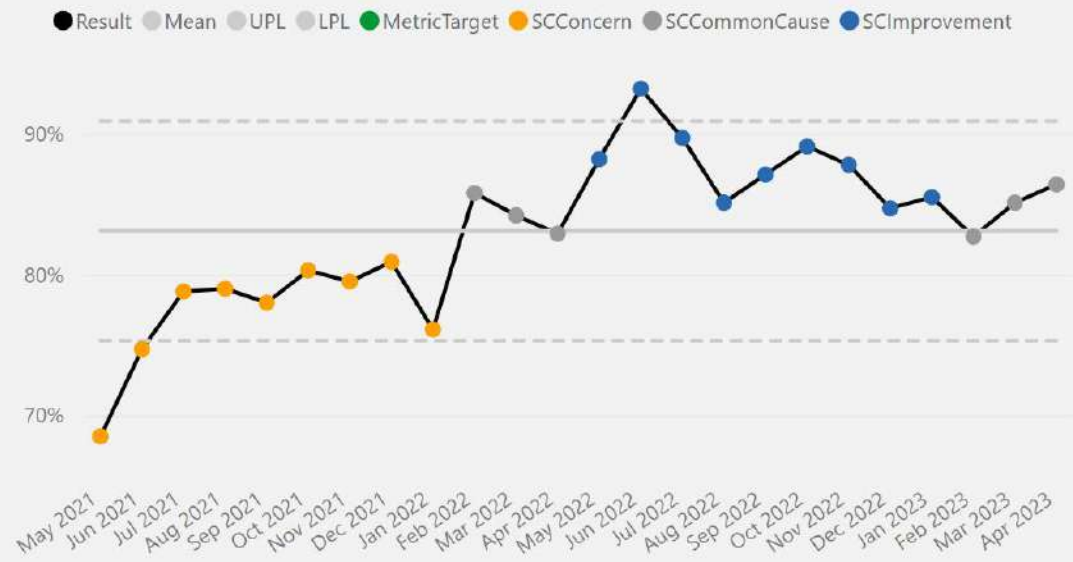
86.4% Result
N/A Target

90.9% UPL
83.1% Mean
75.3% LPL

Analytical Commentary

Variation is Common Cause

Pressure Ulcers (AIMS)



Assurance Commentary

Improvement Actions

Our Vision
The best care for every patient

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

REPORT TO TRUST BOARD	
Date	**7 June 2023**
Title	**Chair's key Issues report from Finance, Investments and Performance Committee meeting on 31.05.23**
Author & Exec Lead	**Mr Tom Spink (Committee Chair)**
Purpose	**For Information**

The Finance, Investments and Performance Committee met on 31 May 2023. Papers for the meeting were made available to Board members for information in the usual way via Admin Control. The meeting was quorate and it was attended by Erica Betts (Public Governor) as Observer.

The Committee endeavoured to conduct its meeting as discussed at the Board development day – to spend less time looking backward and more forward looking, seeking the right KPIs for assurance, with only exceptional, 'not assured' or cross-cutting issues escalated to the Board.

The Committee reviewed reports in accordance with its Terms of Reference, including updates on the current financial and operational position. The following issues were identified to highlight to the Board:

1	Performance & Productivity IPR (inc theatre productivity)	The Committee was updated on operational performance as detailed in the IPR. The Emergency Department has demonstrated that the emergency pathway performs well when there are beds available within the hospital. The Operational Position remains one of Extreme Pressure and elective performance has suffered as a consequence of disruption due to industrial action regarding national pay bargaining. The Hospital is operating at >100% capacity, with additional patients on wards and corridors. The Committee discussed the current position with regard to inpatients with 'No Criteria to Reside' - ie inpatients who no longer need care in the hospital and who are awaiting discharge/transfer to receive ongoing care in the community. This use of the hospital to accommodate patients for months whilst they await transfer may impact quality of care for these patients and is a very poor use of hospital resources, especially when it prevents admission of patients from waiting lists. The Trust's Operational Plan has been established on the assumption that the ICS will put measures in place to reduce the number of No Criteria To Reside patients on Pathways 1-3 to an average of 80. This will still leave over two wards in the hospital permanently occupied by patients waiting to move elsewhere. The Committee requested visibility of the detailed plans from the ICB that all the necessary arrangements are in place to deliver this metric on a consistent basis, so that the Trust can plan its activity accordingly.

2	Financial Performance YTD	The Committee received the regular update regarding financial performance, after one month of the 23/24 financial year, as detailed in the Financial Report. Performance with regard to cost improvement schemes is behind plan and the Committee discussed the need for increased focus in this early part of the year if we are to avoid the need for more difficult cost improvement actions later in the year. The Committee also noted that the planned implementation of an Electronic Patient Record (EPR) will inevitably lead to 'distraction' and reduced activity. This will need to be taken into account in future operational and financial planning.
3	Divisional Performance and Accountability Framework	The Committee received the latest assessment of Divisional performance against the standard framework of metrics across all domains (finance, performance, people & quality & safety). The position is obviously challenged across all domains and it was noted that the summary is generated by divisional self-assessment moderated through review by the Divisional Performance Committee. The PAF is currently showing performance adverse to the Plan. The Plan and associated trajectories are considered robust but followed the planning submission guidance to exclude impact of industrial action. It will be necessary to have a period without industrial action to get a proper perspective on performance.
4	Financial Strategy Refresh	The Committee discussed the draft 'refresh' of the Trust's Financial Strategy. This is subject to a separate paper and is recommended to the Board for approval.

3 Conclusions/Outcome/Next steps

The next Committee meeting is scheduled for 28 June 2023.

Recommendation: The Board is recommended to:

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

REPORT TO TRUST BOARD

Date	**7th June 2023**		
Title	**Activity and Contractual Standards – Performance & Activity IPR**		
Author & Exec Lead	**Chris Cobb – Chief Operating Officer**		
Purpose	**For Information**		
Relevant Strategic Objective	**BAF 1.2 and BAF 1.3**		
Are there any quality, operational, workforce and financial implications of the decision requested by this report? If so explain where these are/will be addressed.	**Quality**	**Yes☐ No✓**	
	Operational	**Yes☐ No✓**	
	Workforce	**Yes☐ No✓**	
	Financial	**Yes☐ No✓**	

1. Background/Context

The attached report provides an update on compliance against the new Operational Priorities 2023-24:

- Urgent and Emergency Care:
  - 78.7% of patients seen in ED within 4 hours: **On Track**
  - Increase Ambulance handover delays under 30 minutes: **Off Track**
  - Reduce General and Acute bed occupancy to 92% or below: **Off Track**
- Elective Care:
  - Eliminate waits of over 65 weeks: **On Track**
  - Increase day case rate to 85%: **On Track**
  - Increase theatre utilisation to 85%: **Off Track**
  - Reduce outpatient follow-up to 75% of 2019/20 baseline: **Off Track**
- Cancer:
  - Reduce the number of patients waiting over 62 days: **On Track**
  - Meet the Cancer Faster Diagnosis Standard (75%): **Off Track**
- Diagnostics:
  - Increase the percentage of patients that receive a diagnostic test within 6 weeks to achieve the 95% target by March 2025: **Off Track**

Recommendations: The Board is recommended to: **Acknowledge** the paper and latest position for information.

Our Vision
The best care for every patient

Integrated Performance Report:

Norfolk and Norwich University Hospitals NHS Foundation Trust

Performance & Activity Domains

April 2023

Key 2023-24 Operational Priorities

- Next Steps on Elective Care – Board Self Certification (October 2022): Fully Compliant
- Elective Care 23/24 Priorities – Board Self Certification (May 2023): Partially Compliant
- Urgent and Emergency Care: –
  - 78.7% of patients seen in ED within 4 hours: On Track
  - Increase Ambulance handover delays under 30 minutes: Off Track
  - Reduce General and Acute bed occupancy to 92% or below: Off Track
- Elective Care: –
  - Eliminate waits of over 65 weeks: On Track
  - Increase day case rate to 85%: On Track
  - Increase theatre utilisation to 85%: Off Track
  - Reduce outpatient follow-up to 75% of 2019/20 baseline: Off Track
- Cancer: –
  - Reduce the number of patients waiting over 62 days: On Track
  - Meet the Cancer Faster Diagnosis Standard (75%): Off Track
- Diagnostics: –
  - Increase the percentage of patients that receive a diagnostic test within 6 weeks to achieve the 95% target by March 2025: Off Track

Board Self Certification

Our Vision
The best care for every patient

Next Steps on Elective Care – Board Self Certification (Oct 2022)

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

NNUH Elective Recovery - Board Self Certification	Comments	Compliance	RAG
a) Has a lead Executive Director(s) with specific responsibility for elective and cancer services.	Yes - Christopher Cobb, Chief Operating Officer	Fully compliant	G
b) That the Board and its relevant committees (FI&P, Safety and Quality etc.) receive regular reports on elective, diagnostic and cancer performance, progress against plans and performance relative to other organisations both locally and nationally.	Full and detailed speciality level trajectories for elective and cancer recovery with daily chasing for both areas.	Fully compliant	G
c) Has an agreed plan to deliver the required 78ww and 62 day trajectories for elective and cancer recovery, and understands the risks to delivery, and is clear on what support is required from other organisations.	Yes - shared weekly with NHSE/I	Fully compliant	G
d) Has received a report on the current structure and performance of Lower GI, Skin and Prostate cancer pathways (including the proportion of colonoscopies carried out on patients who are FIT negative or without a FIT; the proportion of urgent skin referrals for whom a face to face appointment is avoided by use of dermoscopic quality images; and a capacity/demand analysis for MRI and biopsy requirements on the prostate pathway), and agreed actions required to implement the changes outlined in this letter.	Data submitted to E of E Q3 FIT data collection snapshot as requested and shared. Teledermatology pilot commenced in November and early results show an approximate 25% footfall reduction in OPD. Cancer Alliance bid for funding to implement as BAU from September. Prostate capacity and demand modelled and shortfall in capacity. Funding bid for 23/24 to increase Prostate Template Biopsy service.	Fully compliant	G
e) Is pursuing the opportunities, and monitoring the impacts, presented by Outpatient transformation and how this could accelerate their improvement, alongside GIRFT and other productivity, performance and benchmarking data and opportunities.	Trust was a pilot site for POP and is continuing to roll out the programme as part of the Outpatient Transformation programme.	Fully compliant	G
f) Have received a report on Super September and have reviewed the impact of this initiative for their organisation.	Super September was optional. The Trust originally planned to participate but due to issues with out of hours payment rates did not generate activity over and above the usual 78 week additional activity.	Fully compliant	G
g) Have received reports on validation, its impact and has a validation plan in line with expectations in this letter.	All patients 26 weeks and above validated in May with continued validation on a weekly basis.	Fully compliant	G
h) Have challenged and received assurance from the lead Executive Director, and other Board colleagues, on the extent to which clinical prioritisation (of both surgical and diagnostic waiting lists) can help deliver their elective and cancer objectives. This should include receiving a review of turnaround times for urgent suspected cancer diagnostics and agreeing any actions required to meet the backstop maximum of 10 days from referral to report.	Weekly meetings chaired by the Trust COO to review RTT and Cancer waiting time recovery plans with Divisional Leads and Head of Cancer Performance and Elective Access and Performance Manager. Urgent Cancer diagnostics reviewed in this meeting and escalated for action where 10 day backstop might be breached.	Fully compliant	G
i) Discuss theatre productivity at every Trust Board; we suggest with the support of a Non-Executive Director to act as a sponsor.	Included in IPR in Trust Board pack.	Fully compliant	G
j) Routinely review Model Health System theatre productivity data, as well as other key information such as day case rates across Trusts.	Reviewed monthly by Surgery Division and included in IPR.	Fully compliant	G
k) Confirm your SROs for theatre productivity.	Christopher Cobb, Chief Operating Officer and Tim Leary, Chief of Division for Surgery.	Fully compliant	G
i) Ensure that your diagnostic services reach at least the minimum optimal utilisation standards set by NHS England.	Overall diagnostic services meet the standard.	Fully compliant	G

Elective Care 23/24 Priorities Letter (May 2023)

Classification: Official
Publication reference: PRN00496

NHS England

To:
- NHS acute trusts:
  - chairs
  - chief executives
  - medical directors
  - chief operating officers

cc.
- NHS regional directors
- Cancer alliance managing directors
- ICB chief executives

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

23 May 2023

Dear Colleagues,

Elective care 2023/24 priorities

Thanks to your continued focus and effort on elective care and cancer recovery we have managed, through the exceptional efforts of your teams, to drive a significant reduction in the number of long waiting patients over recent months.

Despite a very challenging environment, where ongoing industrial action has seen planned care particularly hard hit, the number of patients waiting over 78 weeks has decreased from 124,911 in September 2021 to 10,737 at the end of March 2023, and the number of patients with urgent suspected cancer waiting longer than 62 days has decreased from a peak of 33,950 last summer to 19,023 at the end of March 2023.

We now look ahead to further reduction in 78 week waits, following the disruption from industrial action and delivering our next ambitions, as set out in Operational Planning Guidance, of virtually eliminating 65 week waits, reducing the 62-day backlog further, and meeting the Faster Diagnosis Standard, by March 2024. This letter sets out our priorities, oversight and support for the year ahead as well as including a checklist for trust boards to assure themselves across the key priorities (annex 1).

First, we should acknowledge the progress made over the last year or so:

- Since the beginning of February 2022, the NHS has treated more than 2m people who would otherwise have been waiting 78 weeks by the end of March 2023 (ie: the "cohort").
- The number of patients waiting 65 weeks has reduced from 165,885 in September 2021 to 95,001 in March 2023.

- The cancer 62 day backlog has reduced year-on-year for the first time since 2017.
- The NHS has seen a record 2.8 million referrals for urgent suspected cancer, with the early diagnosis rate now higher than before the pandemic.
- In February 2023, the NHS achieved the faster diagnosis standard (FDS) for the first time since it was created.

Your leadership, collaboration with colleagues and across providers, innovation and tenacity has led to these improvements for patients and should give confidence for the future, despite the continued complexity of the environment that we are all working in.

Recognising the challenges and the complexity you are all dealing with, we thought it would help to set out the key priorities for the year ahead:

1. **Excellence in basics**
   - Maintaining a strong focus on data quality, validation, clinical prioritisation and maximising booking rates have contributed massively to our progress. We need to retain a clear focus on these things.
2. **Performance and long waits**
   - Continue to reduce waits of over 78 weeks and those waiting over 65 weeks.
   - Make further progress on the 62-day backlog where this is still required in individual providers, whilst pivoting towards a primary focus on achieving the Faster Diagnosis Standard.
   - To support this, we have reviewed and refreshed our tiering approach to oversight, so that we can be sure that we are focusing on those providers most in need of support. This refresh has been communicated to tiered providers.
3. **Outpatients (productivity actions annex 2)**
   - We know there is massive potential in our outpatient system to adjust the approach, engage patients more actively and significantly re-focus capacity towards new patients.
4. **Cancer pathway redesign**
   - In 2023/24 Cancer Alliances have received a funding increase to support implementation of priority changes for lower GI, skin and prostate pathways (included in annex 1). All trusts should now have clear, funded plans in place with their Alliance for implementation.

5. **Activity**
   - Ensure that the increasing volume of diagnostic capacity now coming online is supporting your most pressured cancer pathways. ICBs have been asked to prioritise CDC and acute diagnostic capacity to reduce cancer backlogs and improve the FDS standard, as set out in the letter from Dame Cally Palmer and Dr Vin Diwakar.
   - Generally, we all need to see a step up in activity over the coming months, as we recover from the ongoing impact of industrial action.
6. **Choice**
   - A major contributor to our collective progress over this last year has been the way organisations and systems have worked together to accelerate treatment for long waiting patients. This includes work with the Independent Sector (IS) who have stepped up to help in this endeavour. We know this will continue to be important this year and we encourage all systems and providers to crystalise their plans to work together (including IS) early in the financial year to give us the best chance of success.
   - We expect that patient choice will be an increasingly important factor this year, as set out in the Elective Recovery Plan, with some technological advances to support this. We will communicate this more fully when plans have been finalised.

Moreover, it is crucial that we continue to recover elective services inclusively and equitably.

- Systems are expected to outline health inequality actions put in place and the evidence and impact of the interventions as part of their planning returns. Disaggregated elective recovery data should support the development of these plans.
- A collective effort is needed to continue to address the recovery of paediatric services. Provider, system, and regional-level elective recovery plans should set out actions that will be put in place to accelerate CYP recovery and ensure that elective activity gap between CYP and adults is reduced, a best practice toolkit has now been published to help achieve this.
- Systems are expected to continue to recover specialised service activity at an equitable rate to that of less complex procedures, ensuring a balance between high volume and complex patient care requirements.

Elective Care 23/24 Priorities Letter (May 2023)

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Included with this letter is the board checklist (annex 1). This tool has been designed to be the practical guide for boards to ensure they are delivering against the ambitious objectives set out in the letter above.

Thank you again for all your efforts since the Elective Recovery Plan was published. Together, we have made laudable progress in reducing long waits and transforming services, as set out in the plan. We can all take confidence in this as we move on to the next stages of the recovery plan and continue to improve care for patients. If any support is required with these actions, please let us know.

Yours sincerely,

Sir James Mackey
National Director of Elective Recovery
NHS England

Sir David Sloman
Chief Operating Officer
NHS England

Dame Cally Palmer
National Cancer Director
NHS England

Professor Tim Briggs CBE
National Director of Clinical Improvement
NHS England
Chair
Getting It Right First Time (GIRFT) programme

Annex 1: Board checklist

We ask that boards review the checklist below to assure plans to deliver our elective and cancer recovery objectives over the coming year. There is national support available in each of these areas, please contact england.electiverecoverypmo@nhs.net to discuss any support needs.

The three key performance deliverables and metrics we need to focus on are:

- Virtually eliminate waits of >65w by March 2024
- Continue to reduce the number of cancer patients waiting over 62d
- Meet the 75% cancer FDS ambition by March 2024

	Assurance statement	Support/materials
1	**Excellence in basics**	
	Has any patient waiting over 26 weeks on an RTT pathway (as at 31 March 2023) not been validated in the previous 12 weeks? Has the 'Date of Last PAS validation' been recorded within the Waiting List Minimum Data Set?	
	Are referrals for any Evidence Based Interventions still being made to the waiting list?	Release 3 will be published on 28 May. It focuses on the following specialties: breast surgery, ophthalmology, vascular, upper gastrointestinal surgery, cardiology, urology, and paediatric urology
2	**Performance and long waits**	
	Are plans in place to virtually eliminate RTT waits of over 104w and 78w (if applicable in your organisation)?	
	Do your plans support the national ambition to virtually eliminate RTT waits of over 65 weeks by March 2024?	
3	**Outpatients**	
	Are clear system plans in place to achieve 25% OPFU reduction, enabling more outpatient first activity to take place?	NHSE GIRFT guidance
	Do you validate and book patients in for their appointments well ahead of time, focussing on completing first outpatient appointments in a timely way, to support with diagnostic flow and treatment pathways?	Validation toolkit and guidance NHS England » Validation toolkit and guidance published on 1st December 2022
4	**Cancer pathway re-design**	
	Where is the trust against full implementation of FIT testing in primary care in line with BSG/ACPGBI guidance, and the stepping down of FIT negative (<10) patients who have a normal examination and full blood count from the urgent colorectal cancer pathway in secondary care?	Using FIT in the Lower GI pathway published on 7th October 2022 BSG/ACPGBI FIT guideline and supporting webinar
	Where is the trust against full roll-out of teledermatology?	Suspected skin cancer two week wait pathway optimisation guidance
	Where is the trust against full implementation of sufficient mpMRI and biopsy capacity to meet the best practice timed pathway for prostate pathways?	Best Practice Timed Pathway for Prostate Cancer

	Assurance statement	Support/materials
5	**Activity**	
	Are clear system plans in place to prioritise existing diagnostic capacity for urgent suspected cancer activity?	Letter from Dame Cally Palmer and Dr Vin Diwakar dated 26 April 23.
	Is there agreement between the Trust, ICB and Cancer Alliance on how best to ensure newly opening CDC capacity can support 62 day backlog reductions and FDS performance?	
	How does the Trust compare to the benchmark of a 10-day turnaround from referral to test for all urgent suspected cancer diagnostics?	
	Are plans in place to implement a system of early screening, risk assessment and health optimisation for anyone waiting for inpatient surgery? Are patients supported to optimise their health where they are not yet fit for surgery? Are the core five requirements for all patients waiting for inpatient surgery by 31 March 2024 being met? 1. Patients should be screened for perioperative risk factors as early as possible in their pathway. 2. Patients identified through screening as having perioperative risk factors should receive proactive, personalised support to optimise their health before surgery. 3. All patients waiting for inpatient procedures should be contacted by their provider at least every three months. 4. Patients waiting for inpatient procedures should only be given a date to come in for surgery after they have had a preliminary perioperative screening assessment and been confirmed as fit or ready for surgery. 5. Patients must be involved in shared decision-making conversations.	NHS England » 2023/24 priorities and operational planning guidance NHS England » Revenue finance & contracting guidance for 2023/24 Perioperative care pathways guidance
	Where is the trust/system against the standards of 85% capped Theatre Utilisation and 85% day case rate?	
	Is full use being made of protected capacity in Elective Surgical Hubs?	
	Do diagnostic services meet the national optimal utilisation standards set for CT, MRI, Ultrasound, Echo and Endoscopy?	https://future.nhs.uk/NationalCommunityDiagnostics/groupHome

Assurance statement	Support/materials
Are any new Community Diagnostic Centres (CDCs) on track to open on agreed dates, reducing DNAs to under 3% and ensuring that they have the workforce in place to provide the expected 12 hours a day, 7 day a week service? Are Elective Surgical Hub patients able to make full use of their nearest CDC for all their pre and post-op tests where this offers the fastest route for those patients??	
6 Choice	
Are you releasing any Mutual Aid capacity which may ordinarily have been utilised to treat non-urgent patients to treat clinically urgent and long-waiting patients from other providers? Is DMAS being used to offer or request support which cannot be realised within the ICB or region?	www.dmas.nhs.uk
Has Independent Sector capacity been secured with longevity of contract? Has this capacity formed a core part of planning for 2023/24?	
7 Inclusive recovery	
Do recovery plans and trajectories ensure specialised commissioned services are enabled to recover at an equitable rate to non-specialised services? Do system plans balance high volume procedures and lower volume, more complex patient care	
Have you agreed the health inequality actions put in place and the evidence and impact of the interventions as part of your operational planning return? Was this supported by disaggregated elective recovery data?	
Are children and young people explicitly included in elective recovery plans and actions in place to accelerate progress to tackle CYP elective waiting lists?	CYP elective recovery toolkit

Supporting guidance and materials are available on the Elective Recovery Futures site: https://future.nhs.uk/ElectiveRecovery

Annex 2: Outpatients (OP) productivity action

As set out in the 2023/24 Priorities and Operational Planning Guidance, systems are expected to deliver in line with the national ambition to reduce follow-ups by 25% against the 2019/20 baseline by March 2024. To note this excludes appointments where a procedure takes place. Further technical guidance (that covers other exclusions) is here.

Expected actions

In order to work towards achieving the 25% follow-up reduction target, trusts are expected to focus on the following within the first quarter of the year:

- Embed OP follow-up reduction in trust governance mechanisms
- Engage with clinical leads for specialties about the significance of the 25% follow-up reduction target, building on GIRFT guidance
- Review clinic templates to ensure they are set up to enable a 25% reduction in follow-up appointments
- Validate patients waiting for follow-ups to identify any who do not need to be seen
- Ensure continued and expanded delivery of patient initiated follow up (PIFU) in all major OP specialties, particularly accelerating uptake in specialties with the longest waits (ENT, gynaecology, gastroenterology and dermatology)
- Ensure patients who no longer need to be seen in secondary care are appropriately discharged, in line with clinical guidelines
- Work to reduce appointments that are missed by patients (DNAs), in line with NHS England guidance, including by:
  - Understanding the most common reasons why patients miss appointments, building on available national support
  - Making it easier for patients to cancel or reschedule appointments they don't need eg through sending a response to an appointment reminder
- Local analysis of patients on multiple pathways or those with multiple follow-ups.
- Consider conducting a retrospective clinical review of a sample of OP follow-up activity in at least two specialties with the longest waits, to identify where an alternative pathway of care could have been used (eg discharge, PIFU, appointment met through alternate means).

Payment

Reducing OP follow-ups is incentivised by the NHS payment scheme, where follow-up appointments are covered by a fixed payment element, and first appointments are covered by a variable element.

Support available

Competing priorities will always make it difficult to focus on making these changes. Continued support will be available through:

- Data packs for each tiered trust, and top ten other trusts with high OP follow up reduction opportunity
- Clinically-led conversations with tiered trusts from National Clinical Directors, GIRFT clinical leads, and OP clinical leads
- Operational support to amend clinic templates
- Support to improve equity of access through the national Action on Outpatients programme.

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Elective Care 23/24 Priorities – Board Self Certification (May 2023)

NHS
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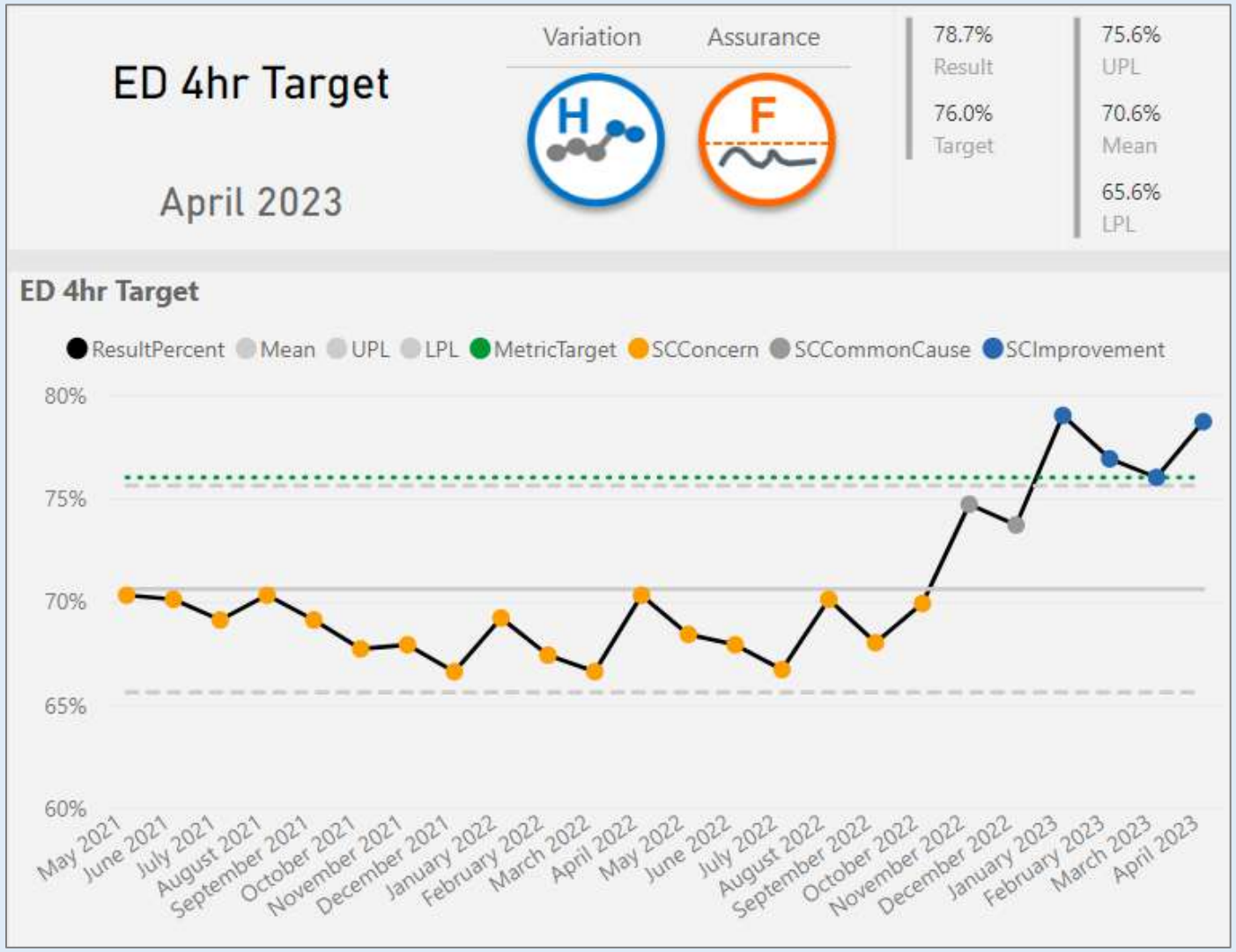
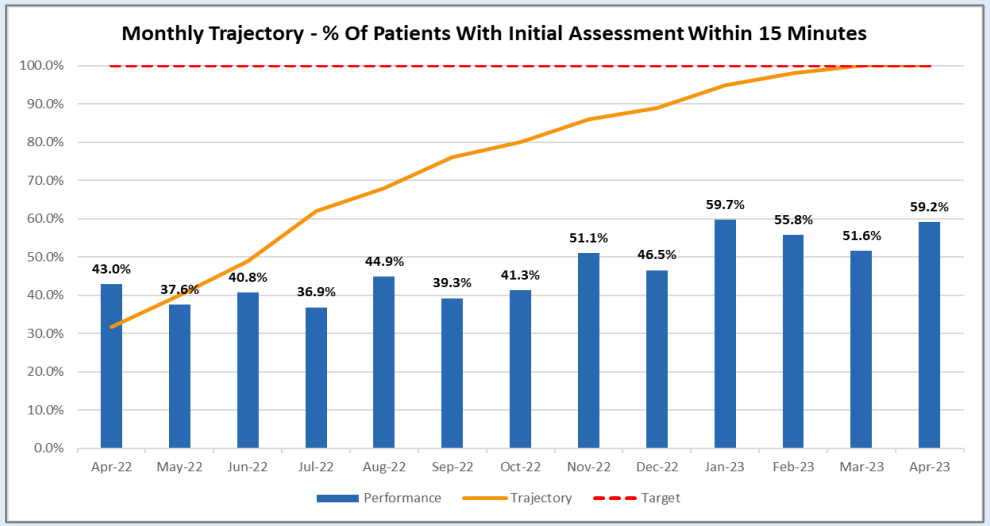
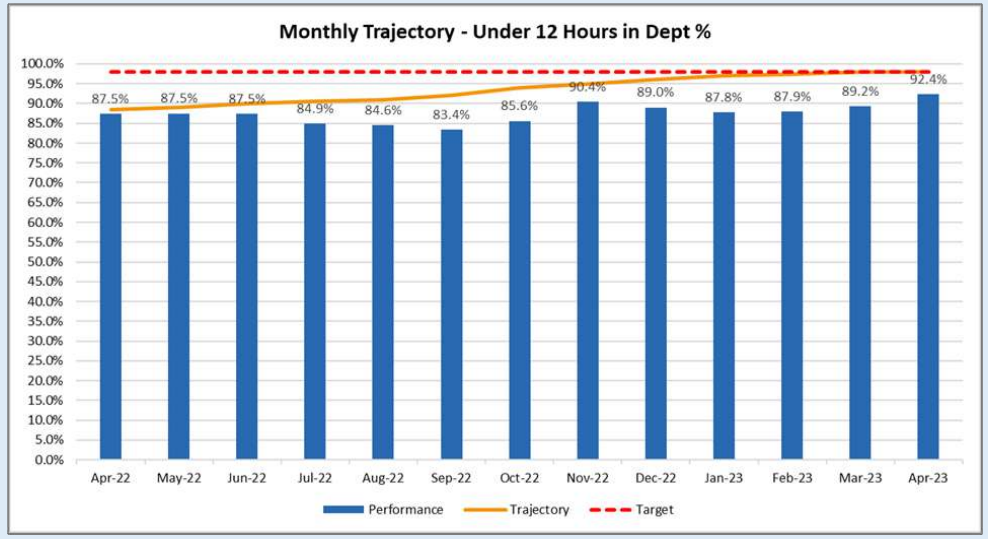
	Assurance statement	Statement	RAG	Additional Comments
1. Excellence in basics	Has any patient waiting over 26 weeks on an RTT pathway (as at 31 March 2023) not been validated in the previous 12 weeks? Has the 'Date of Last PAS validation' been recorded within the Waiting List Minimum Data Set?	We are currently unable to record all validation in PAS, which is a known issue and will be addressed as part of the wider digital strategy. However, validation is now an embedded process that is managed and overseen via the PTL meetings	A	Not 100% we can evidence this and may need to consider resources/ timelines/processes for addressing
	Are referrals for any Evidence Based Interventions still being made to the waiting list?	Yes. These are screened out if any are received and either rejected or a response given via advice and guidance, monitored via DQ	G	
2. Performance and long waits	Are plans in place to virtually eliminate RTT waits of over 104w and 78w (if applicable in your organisation)?	Yes. There are no 104w patients and clear recovery trajectories in place to address 78ww. Industrial action is creating capacity issues in Orthopaedics, Spinal and Gynaecology.	G	
	Do your plans support the national ambition to virtually eliminate RTT waits of over 65 weeks by March 2024?	Yes. However, the activity plan forecast 900 breaches due to insufficient Lamina Flow theatre capacity. Following IA and delay to capital projects we are now forecasting 1300 breaches on 31 March 2024.	A	Further IA in June will increase the number of breaches without additional lamina flow theatre capacity in 23/24
3. Outpatients	Are clear system plans in place to achieve 25% OPFU reduction, enabling more outpatient first activity to take place?	Partially. Due to the large volume of current backlogs we will not fully achieve this size of reduction. However, the ambition is to work towards reducing follow ups and to expand use of PIFU in key specialties.	A	We have joined the national Go Further Faster outpatient programme to provide help and support from GIRFT and the Royal Colleges to 14 key specialties
	Do you validate and book patients in for their appointments well ahead of time, focussing on completing first outpatient appointments in a timely way, to support with diagnostic flow and treatment pathways?	Yes. We do validate and a number of specialities are close to achieving 18w RTT. However, increased focus on time to first appointment would assist in reducing waits by 31 March 24.	A	
4. Cancer pathway re-design	Where is the trust against full implementation of FIT testing in primary care in line with BSG/ACPGBI guidance, and the stepping down of FIT negative (<10) patients who have a normal examination and full blood count from the urgent colorectal cancer pathway in secondary care?	Yes. FIT Testing fully functioning in primary care. Lower GI SOP in place to ensure timely step down of patients from a Cancer Pathway	G	
	Where is the trust against full roll-out of teledermatology?	Teledermatology Pilot completed Q4 22/23. The roll out to high risk BCC two week wait referrals inunderway in Q1 23/24.	A	Clinical team comfortable with a staged roll out of Telederm. Expansion to further 2WW cohorts from Q3 23/24
	Where is the trust against full implementation of sufficient mpMRI and biopsy capacity to meet the best practice timed pathway for prostate pathways?	MPMRI turnaround (Vetting, scanning and reporting) currently at 10 days from request. Template Biopsy capacity currently under the required weekly capacity to meet the timed pathway milestone	A	Cancer Alliance SDF funding secured to recruit to additional resource to deliver a Nurse Led Biopsy service
5. Activity	Are clear system plans in place to prioritise existing diagnostic capacity for urgent suspected cancer activity?	Yes. 2ww will always be prioritised ahead of urgent and routine priority requests. The Radiology Information System (RIS) is designed to show 2ww requests higher up on the scheduling list meaning that they get booked ahead of routine and urgent priority exams. Cancer PTL highlights any requests that are meant to be 2ww but unintentionally requested as routine or priority and these are then escalated for booking within a 2ww pathway.	G	
	Is there agreement between the Trust, ICB and Cancer Alliance on how best to ensure newly opening CDC capacity can support 62 day backlog reductions and FDS performance?	Yes. CDC Capacity being commissioned from the independent sector currently to provide in year addittional capacity	G	
	How does the Trust compare to the benchmark of a 10-day turnaround from referral to test for all urgent suspected cancer diagnostics?	Trust close to meeting 10 day Turnaround for most radiological testing with the exception of Ultrasound/CT guided Biopsy and CTC. Specialty diagnostics which require theatre capacity greatly exceed 10 day waits due to the competing priorities of 78 week patients and Surgical Cancer Treatment	R	
	Are plans in place to implement a system of early screening, risk assessment and health optimisation for anyone waiting for inpatient surgery?	Partially. The system being designed to digitise pre-op will provide automatic screening and risk stratification of patients to improve pre-op process and enable early identification of opportunities for patient optimisation.	A	
	Are patients supported to optimise their health where they are not yet fit for surgery?	Partially. Pre-hab work has commenced with Orthopaedics, utilising digital platforms and education tools. Once established, this will be widened to other areas after pilot outcomes.	A	
	Are the core five requirements for all patients waiting for inpatient surgery by 31 March 2024 being met as follows:			
	1. Patients should be screened for perioperative risk factors as early as possible in their pathway.	Currently being scoped as part of the Pre-op transformation work – system designed will enable identification at point of waiting list addition.	A	
	2. Patients identified through screening as having perioperative risk factors should receive proactive, personalised support to optimise their health before surgery.	Currently being scoped as part of the Pre-op transformation work – pre-hab processes being improved for Orthopaedics.	A	
	3. All patients waiting for inpatient procedures should be contacted by their provider at least every three months.	Process under design with Clinical Harm reviews	A	
	4. Patients waiting for inpatient procedures should only be given a date to come in for surgery after they have had a preliminary perioperative screening assessment and been confirmed as fit or ready for surgery.	This is Trust policy – provisional dates may be scheduled.	A	
	5. Patients must be involved in shared decision-making conversations.	Patients treatment plans are developed and agreed between patients and clinicians	A	
	Is full use being made of protected capacity in Elective Surgical Hubs?	Elective beds continue to be ringfenced	G	
	Do diagnostic services meet the national optimal utilisation standards set for CT, MRI, Ultrasound, Echo and Endoscopy? https://future.nhs.uk/NationalCommunityDiagnostics/groupHome	No. Unable to provide until the DAC is in place which following approval is set to be completed in February 2025 CDC spokes for Central Norfolk ,currently being procured by ICB and anticipated they will be opening in Q4 of 2023/24.	R	
	Are any new Community Diagnostic Centres (CDCs) on track to open on agreed dates, reducing DNAs to under 3% and ensuring that they have the workforce in place to provide the expected 12 hours a day, 7 day a week service? Are Elective Surgical Hub patients able to make full use of their nearest CDC for all their pre and post-op tests where this offers the fastest route for those patients?	No - CDC business cases are in the process of being reviewed for approval for the N&W ICS. The Diagnostic Assessment Centres (DAC) for N&W ICS have Ministerial approval pending HMT approval. Once approved the timetable within the DAC business case will set the time frame for delivery. Elective Hub work will be delivered by a CDC by February 2025. CDC spokes for Central Norfolk, currently being procured by ICB and anticipated to open in Q4 2023/24.	R	
6. Choice	Are you releasing any Mutual Aid capacity which may ordinarily have been utilised to treat non-urgent patients to treat clinically urgent and long-waiting patients from other providers? Is DMAS being used to offer or request support which cannot be realised within the ICB or region?	Yes. Mutual aid in place between sites and providers to support long wait recovery. DMAS being used, however, little appetite from patients to travel out of East Anglia	G	
	Has Independent Sector capacity been secured with longevity of contract? Has this capacity formed a core part of planning for 2023/24?	Yes. Good partnership working in place and part of ongoing recovery capacity	G	
7. Inclusive recovery	Do recovery plans and trajectories ensure specialised commissioned services are enabled to recover at an equitable rate to non-specialised services? Do system plans balance high volume procedures and lower volume, more complex patient care	Yes. Activity plans have been weighted to optimise elective recovery	G	
	Have you agreed the health inequality actions put in place and the evidence and impact of the interventions as part of your operational planning return? Was this supported by disaggregated elective recovery data?	Partially. Reducing HI and Core20 plus 5 are in the Trust quality priorities for this year but currently just high level statement. The Trust reviews the emergency admissions and deaths on elective waiting lists in terms of deprivation deciles at the monthly elective clinical harm group - so far we have not seen any evidence that patients in the more deprived deciles are represented proportionally in larger numbers .	A	Further work required by the equality and diversity group (EDGE)
	Are children and young people explicitly included in elective recovery plans and actions in place to accelerate progress to tackle CYP elective waiting lists?	Partially. Children and young people included in 65w recovery and 52w 1st OP appointment but require specific targets to improve rate of waiting list reduction.	A	

Urgent and Emergency Care

Performance – ED Waiting Times < 4 hours







Commentary

The overall position reflects the extremely challenging situation with the trust remaining in OPEL 4 status. Improvement in ED 4 hour performance compared to March, and remain ahead of target: **Trust only = 65.8% / WIC = 99% / Combined = 78.7%**

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ED Waiting Times <4 hours – National Position (Apr 2023)

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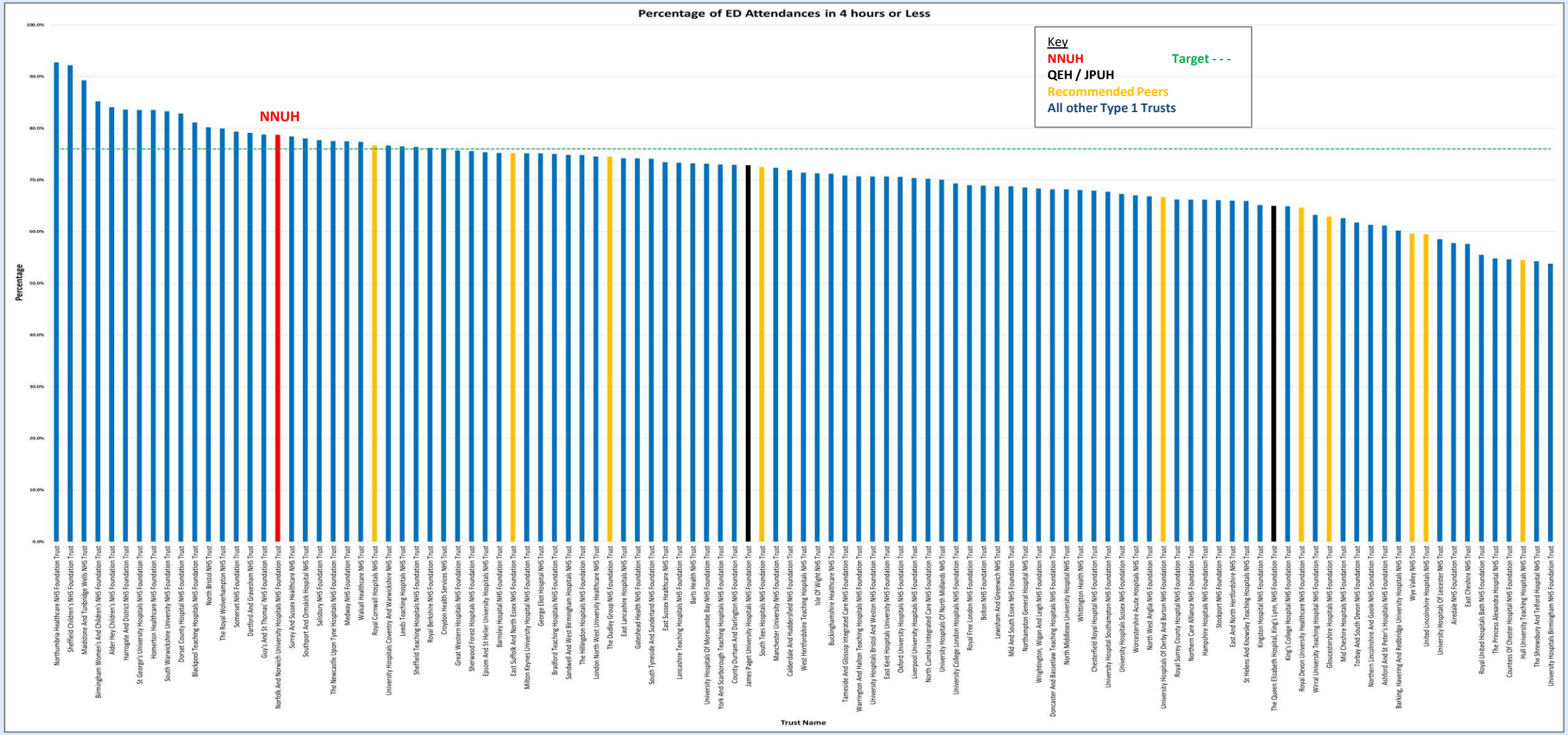

Commentary

In April, NNUH were ranked 17th across all Type 1 NHS Trusts, with 78.7% of ED patients either admitted, transferred or discharged within 4 hours of arrival. This is a reduction on the previous month, though better than the national average of 74.6%, ahead of the national target of 76%, and the best performance among our recommended peers (for most similar attributes).

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Performance – Ambulance Performance < 30 Minutes

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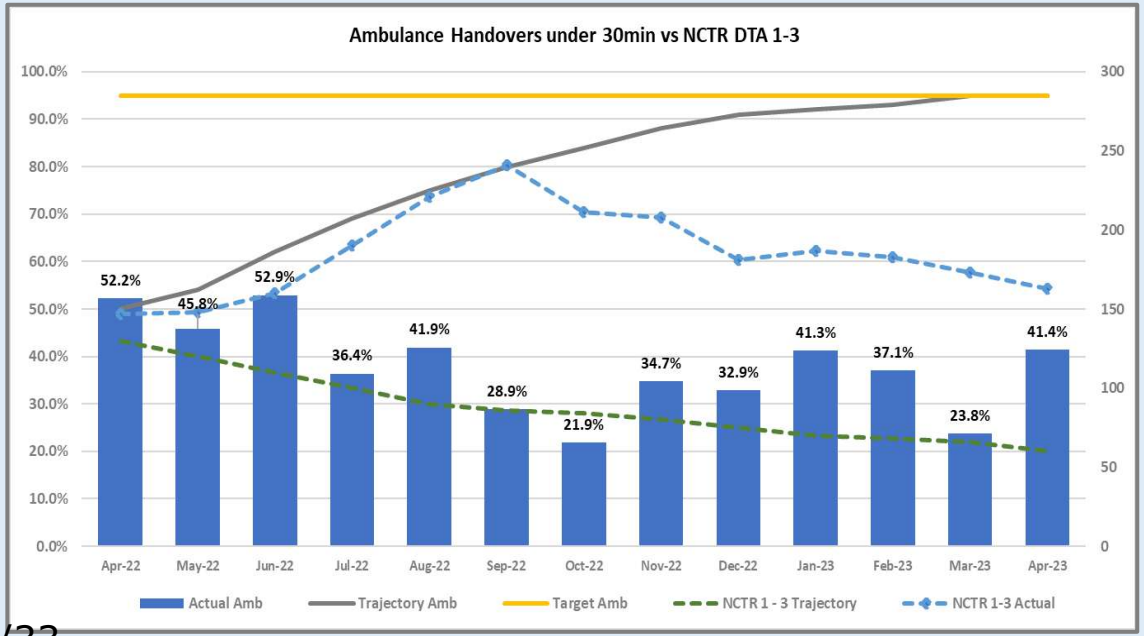
Hospital Name	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Total
Addenbrookes Hospital	71.65%	80.84%	73.26%	64.89%	81.48%	79.01%	65.64%	87.17%	62.39%	87.22%	92.57%	87.15%	93.38%	79.46%
Basildon & Thurrock Hospital	60.36%	59.42%	59.60%	54.01%	54.86%	47.10%	39.49%	47.93%	38.53%	58.16%	54.17%	61.20%	72.62%	55.47%
Bedford Hospital South Wing	81.10%	89.32%	90.66%	86.60%	89.77%	85.42%	87.86%	87.40%	76.62%	86.07%	94.21%	89.61%	97.20%	87.92%
Broomfield Hospital	55.58%	69.47%	73.36%	58.62%	63.22%	59.28%	51.90%	59.34%	32.11%	60.84%	61.95%	73.92%	88.22%	62.89%
Colchester General Hospital	76.50%	82.78%	73.29%	69.63%	74.90%	68.85%	37.67%	39.48%	44.83%	78.06%	82.84%	57.06%	86.11%	69.42%
Hinchingbrooke Hospital	51.95%	54.02%	52.43%	37.95%	57.84%	78.10%	74.66%	85.88%	61.42%	81.96%	81.67%	78.60%	87.81%	69.09%
Ipswich Hospital	72.71%	79.81%	73.40%	68.78%	75.63%	71.34%	52.89%	62.46%	48.21%	67.83%	67.72%	66.21%	74.61%	68.46%
James Paget Hospital	57.76%	67.12%	51.08%	35.67%	33.38%	32.98%	26.39%	38.08%	26.25%	43.36%	42.75%	44.83%	68.78%	44.46%
Lister Hospital	31.25%	38.72%	39.14%	24.19%	34.01%	23.62%	18.90%	22.97%	21.70%	43.06%	42.02%	39.14%	52.82%	34.66%
Luton And Dunstable Hospital	78.61%	82.02%	76.00%	73.65%	77.58%	73.31%	68.50%	72.68%	62.21%	71.24%	76.04%	66.03%	74.05%	73.41%
Norfolk & Norwich University Hospital	51.25%	45.42%	52.14%	35.44%	40.47%	28.24%	21.32%	33.40%	31.17%	39.62%	35.55%	25.55%	43.44%	37.51%
Peterborough City Hospital	33.89%	36.06%	35.89%	29.19%	40.22%	46.09%	41.82%	45.15%	33.41%	47.91%	58.64%	50.72%	56.98%	43.44%
Princess Alexandra Hospital	50.69%	50.00%	54.43%	36.74%	41.97%	36.58%	34.84%	31.81%	32.72%	48.60%	38.63%	39.29%	62.44%	43.88%
Queen Elizabeth Hospital	62.47%	58.09%	45.48%	52.59%	47.63%	42.15%	30.68%	34.81%	27.29%	41.08%	53.83%	43.73%	64.13%	47.32%
Southend University Hospital	45.92%	47.08%	52.02%	52.54%	46.57%	41.49%	37.74%	37.92%	30.34%	58.64%	71.57%	65.10%	75.38%	53.54%
Watford General Hospital	54.01%	46.35%	33.72%	40.27%	45.91%	48.18%	39.27%	39.31%	38.06%	48.16%	56.21%	58.56%	62.63%	49.05%
West Suffolk Hospital	89.28%	90.58%	79.92%	83.68%	82.17%	86.85%	70.12%	68.04%	57.05%	73.26%	71.74%	70.86%	91.57%	78.49%
Total	**61.75%**	**65.44%**	**61.75%**	**55.35%**	**59.81%**	**57.64%**	**48.12%**	**53.51%**	**43.05%**	**61.26%**	**63.92%**	**59.94%**	**73.16%**	**59.42%**

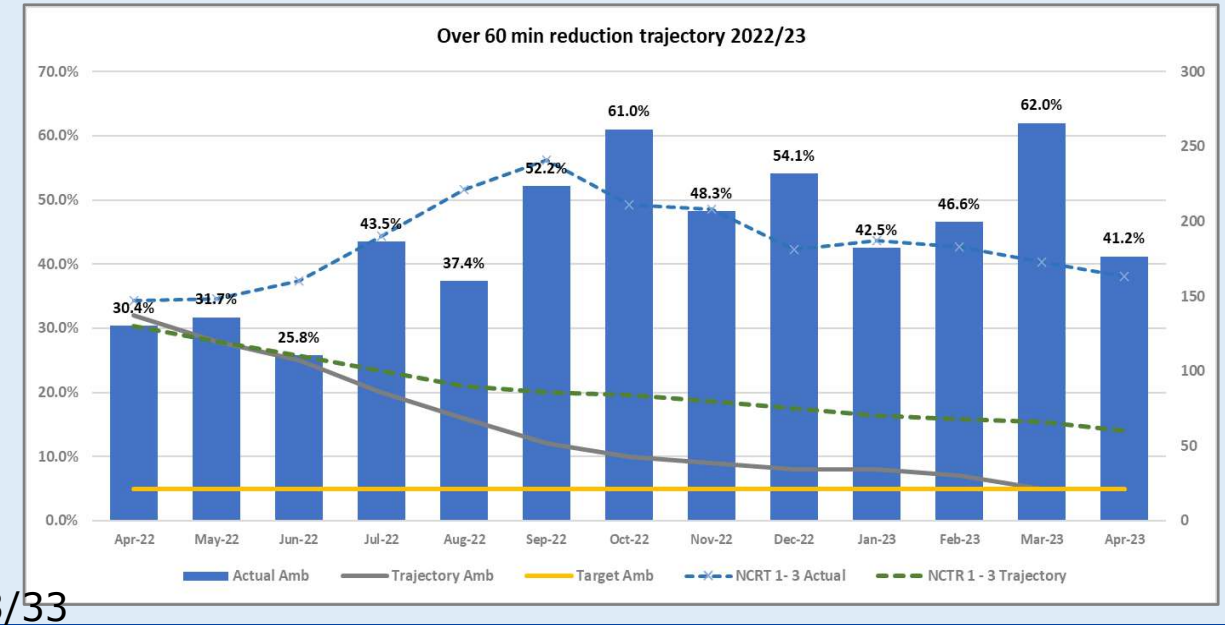


Commentary

Ranking 16th in the region from April 2022 to April 2023 and 17th for the month (April 2023). Improved performance from March and best performance in-month since June 2022.

Performance – Ambulance Performance > 60 Minutes

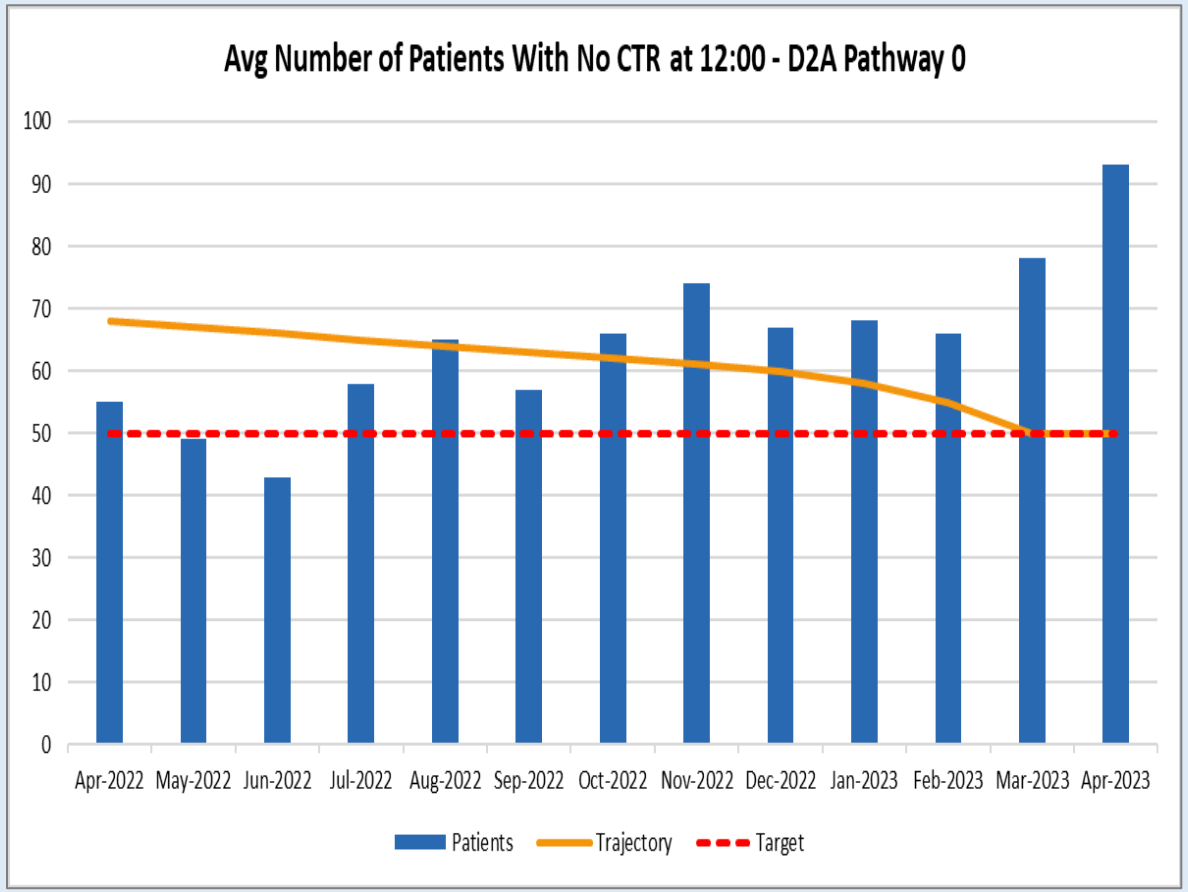
Hospital Name	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Total
Addenbrookes Hospital	13.06%	11.98%	4.53%	9.29%	15.19%	4.46%	8.09%	16.56%	1.78%	23.49%	3.23%	1.16%	3.75%	8.97%
Basildon & Thurrock Hospital	16.13%	18.68%	21.03%	2.11%	2.89%	23.34%	32.00%	38.30%	28.24%	35.35%	21.18%	25.23%	20.87%	21.95%
Bedford Hospital South Wing	4.38%	7.97%	2.59%	2.60%	5.49%	3.10%	6.74%	4.71%	5.55%	14.15%	6.90%	1.96%	5.88%	5.54%
Broomfield Hospital	27.16%	24.47%	13.83%	10.91%	20.90%	16.93%	21.05%	27.88%	18.72%	42.32%	18.41%	15.41%	7.32%	20.41%
Colchester General Hospital	8.60%	6.62%	5.86%	10.47%	13.94%	10.48%	14.08%	40.32%	40.97%	32.36%	5.88%	7.48%	24.54%	17.05%
Hinchingbrooke Hospital	30.65%	19.94%	19.42%	20.69%	38.06%	19.38%	8.07%	9.55%	4.94%	25.19%	9.56%	8.00%	11.11%	17.27%
Ipswich Hospital	14.91%	12.41%	6.65%	10.70%	13.87%	11.71%	14.30%	29.08%	21.33%	32.78%	15.30%	15.82%	16.33%	16.55%
James Paget Hospital	29.66%	23.97%	18.22%	31.79%	47.54%	49.63%	46.15%	58.01%	41.43%	56.72%	34.73%	29.86%	33.43%	38.55%
Lister Hospital	23.72%	36.20%	27.19%	29.72%	46.79%	35.28%	47.23%	52.55%	50.60%	52.81%	26.91%	29.71%	31.70%	37.72%
Luton And Dunstable Hospital	9.21%	8.50%	5.13%	8.38%	13.01%	7.18%	10.43%	16.83%	11.35%	22.29%	12.00%	7.72%	16.36%	11.41%
Norfolk & Norwich University Hospital	38.70%	31.59%	32.17%	27.25%	45.10%	39.67%	53.18%	62.66%	49.92%	56.97%	44.79%	48.47%	59.13%	45.35%
Peterborough City Hospital	38.57%	36.52%	27.61%	31.25%	37.86%	23.14%	20.52%	26.08%	21.47%	33.88%	21.11%	11.98%	16.19%	26.63%
Princess Alexandra Hospital	34.62%	20.87%	21.22%	19.13%	33.68%	27.26%	35.15%	34.84%	39.22%	40.68%	24.84%	36.81%	37.74%	31.24%
Queen Elizabeth Hospital	44.30%	25.14%	27.45%	38.75%	32.97%	36.19%	42.77%	56.08%	52.11%	60.07%	43.43%	28.94%	40.03%	40.63%
Southend University Hospital	35.01%	33.10%	31.62%	23.96%	26.08%	33.70%	38.05%	40.32%	37.15%	47.13%	20.00%	11.08%	12.02%	29.94%
Watford General Hospital	12.36%	11.07%	18.54%	32.95%	28.01%	24.98%	23.50%	28.96%	32.07%	31.84%	18.29%	12.43%	14.78%	22.29%
West Suffolk Hospital	4.98%	2.40%	1.58%	5.70%	6.15%	6.46%	4.66%	14.11%	15.64%	23.10%	12.68%	12.78%	12.96%	9.48%
Total	**21.60%**	**19.02%**	**15.93%**	**18.46%**	**25.26%**	**20.89%**	**23.77%**	**32.21%**	**27.41%**	**37.28%**	**19.80%**	**17.83%**	**21.36%**	**22.80%**

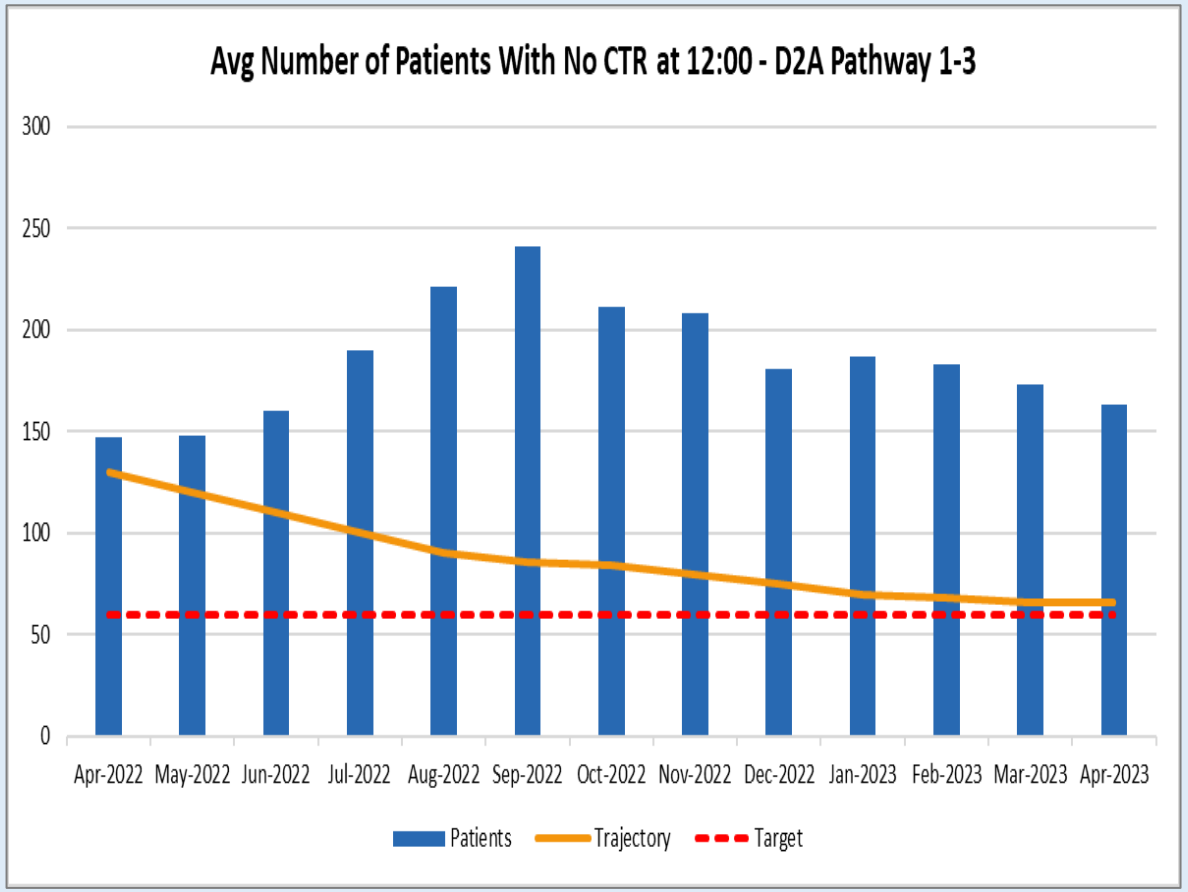


Commentary

Ranking 17th in the region from April 2022 to April 2023 and for the most recent month (April 2023). Improved performance from March and best performance in-month since June 2022.

No Criteria to Reside





Commentary

Both No Criteria to Reside D2A Pathways 0 (P0) and Pathways 1-3 (P1-3) remain behind trajectory, with P0 performance declining in April, and P1-3 performance improving.

Elective Care

Performance – RTT 78-Week Breaches

Specialty		Weekly Averages	07/04/2023	14/04/2023	21/04/2023	28/04/2023	05/05/2023	12/05/2023	19/05/2023	26/05/2023	02/06/2023	09/06/2023	16/06/2023	23/06/2023	30/06/2023	End of June 2023 Position Excluding C1s
Total	Starting Cohort	-	42,547	42,547	42,547	42,547	42,547	42,547	42,547	42,547	42,547	42,547	42,547	42,547	42,547	
	Will Breach	-	2,481	2,404	2,097	1,882	1,602	1,398	1,229	1,060	891	722	553	384	215	208
	Weekly Removals	232	307	77	307	215	280	204	169	169	169	169	169	169	169	
	Target	200	7,931	7,278	6,625	5,972	5,318	4,665	4,012	3,359	2,706	2,053	1,400	746	93	
	Difference	-	-5,448	-4,873	-4,527	-4,089	-3,716	-3,267								
110 - Trauma and Orthopaedic	Starting Cohort	-	6,726	6,726	6,726	6,726	6,726	6,726	6,726	6,726	6,726	6,726	6,726	6,726	6,726	
	Will Breach	-	733	717	635	584	488	435	392	349	305	261	218	175	132	132
	Weekly Removals	60	61	16	82	51	96	53	43	43	44	44	43	43	43	
	Target	63	1,254	1,151	1,047	944	841	738	634	531	428	325	221	118	15	
	Difference	-	-521	-434	-412	-360	-353	-303								
502 - Gynaecology	Starting Cohort	-	4,615	4,615	4,615	4,615	4,615	4,615	4,615	4,615	4,615	4,615	4,615	4,615	4,615	
	Will Breach	-	455	444	383	342	301	246	221	195	170	145	119	93	67	65
	Weekly Removals	42	41	11	61	41	41	55	25	26	25	25	26	26	26	
	Target	36	860	789	719	648	577	506	435	364	293	223	152	81	10	
	Difference	-	-405	-345	-336	-306	-276	-260								
120 - Ear Nose and Throat	Starting Cohort	-	5,228	5,228	5,228	5,228	5,228	5,228	5,228	5,228	5,228	5,228	5,228	5,228	5,228	
	Will Breach	-	272	260	212	180	151	133	114	95	76	57	38	19	1	0
	Weekly Removals	33	58	12	48	32	29	18	19	19	19	19	19	19	18	
	Target	19	975	894	814	734	654	573	493	413	332	252	172	92	11	
	Difference	-	-703	-634	-602	-554	-503	-440								
100 - General Surgery	Starting Cohort	-	2,685	2,685	2,685	2,685	2,685	2,685	2,685	2,685	2,685	2,685	2,685	2,685	2,685	
	Will Breach	-	132	128	115	101	83	77	66	55	44	33	22	11	1	0
	Weekly Removals	11	9	4	13	14	18	6	11	11	11	11	11	11	10	
	Target	11	500	459	418	377	336	294	253	212	171	130	88	47	6	
	Difference	-	-368	-331	-303	-276	-253	-217								
330 - Dermatology	Starting Cohort	-	4,907	4,907	4,907	4,907	4,907	4,907	4,907	4,907	4,907	4,907	4,907	4,907	4,907	
	Will Breach	-	192	181	143	123	91	74	66	55	44	33	22	11	1	0
	Weekly Removals	29	55	11	38	20	32	17	8	11	11	11	11	11	10	
	Target	11	915	839	764	689	613	538	463	387	312	237	161	86	11	
	Difference	-	-723	-658	-621	-566	-522	-464								
160 - Plastic Surgery	Starting Cohort	-	1,228	1,228	1,228	1,228	1,228	1,228	1,228	1,228	1,228	1,228	1,228	1,228	1,228	
	Will Breach	-	78	77	69	59	52	45	40	34	27	21	14	8	1	0
	Weekly Removals	7	6	1	8	10	7	7	5	7	7	7	7	7	7	
	Target	7	229	210	191	172	154	135	116	97	78	59	40	22	3	
	Difference	-	-151	-133	-122	-113	-102	-90								
215 - Paediatric Ear Nose and Throat	Starting Cohort	-	792	792	792	792	792	792	792	792	792	792	792	792	792	
	Will Breach	-	22	21	17	15	11	12	11	10	8	7	5	3	1	0
	Weekly Removals	2	3	1	4	2	4	-1	1	1	2	1	2	2	2	
	Target	2	148	135	123	111	99	87	75	63	50	38	26	14	2	
	Difference	-	-126	-114	-106	-96	-88	-75								

All capacity at NNUH and Independent Sector is fully booked. Mutual Aid in Norfolk not available.

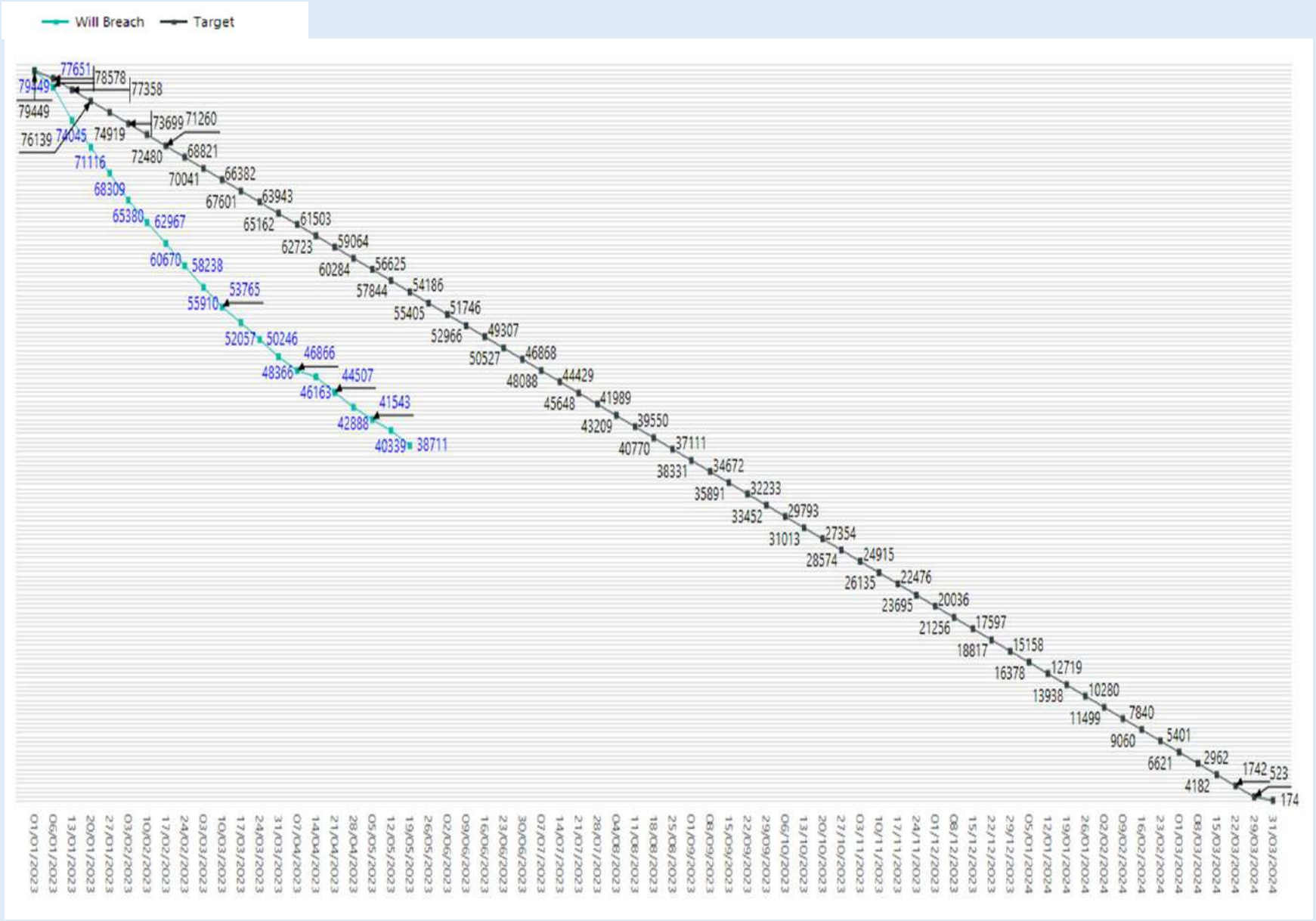
The forecasted 78 week position at the end of June 2023 is 215 patients. This includes 7 C1's (patient choice) and 11 Corneal Grafts. It does not include any activity that will be lost during the Junior Doctors Industrial Action in June.

Orthopaedics
97 Inpatients
56 Day Cases

Inpatient Elective Operations:
43 Hips
41 Knees
13 Other – potential for Independent Sector

Gynaecology
26 Elective Inpatients
29 Day Cases
17 at new outpatient stage.

Performance – RTT 65-Week Breaches



Commentary

For the overarching requirement of 65 week delivery by 31st March 2024, delivery is ahead of trajectory at a Trust level, with 38,711 patients remaining in the cohort against a target of 55,405.

However, the impact of Industrial Action has increased the forecast number of breaches on 1st April 2024 to circa 1,400. The Junior Doctors strike in June will increase this number substantially.

Our Vision
The best care for every patient

Performance – RTT 65-Weeks (Specialty Level Forecast)

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

Specialty		Weekly Averages	14/04/2023 (IA & BH)	21/04/2023	28/04/2023	05/05/2023 (IA & BH)	12/05/2023 (BH)	19/05/2023	26/05/2023	02/06/2023 (BH)	09/06/2023	16/06/2023	23/06/2023	30/06/2023	07/07/2023	14/07/2023	21/07/2023	28/07/2023	04/08/2023	11/08/2023	18/08/2023	25/08/2023	01/09/2023 (BH)	08/09/2023	15/09/2023	22/09/2023	29/09/2023
Total	Starting Cohort	-	79,449	79,449	79,449	79,449	79,449	79,449	79,449	79,449	79,449	79,449	79,449	79,449	79,449	79,449	79,449	79,449	79,449	79,449	79,449	79,449	79,449	79,449	79,449	79,449	79,449
	Will Breach	-	46,163	44,507	42,888	41,543	40,339	38,711	37,869	37,028	36,186	35,345	34,503	33,662	32,820	31,979	31,137	30,296	29,454	28,612	27,771	26,929	26,088	25,246	24,405	23,563	22,722
	Weekly Removals	1359	703	1656	1619	1345	1204	1628	842	842	842	842	842	842	842	842	842	842	842	842	842	842	842	842	842	842	842
	Target	842	61,503	60,284	59,064	57,844	56,625	55,405	54,186	52,966	51,746	50,527	49,307	48,088	46,868	45,648	44,429	43,209	41,989	40,770	39,550	38,331	37,111	35,891	34,672	33,452	32,233
	Difference	-	-15,338	-15,774	-16,174	-16,299	-16,284	-16,692																			
	Future TCIs	4357							1685	858	696	530	300	208	80												
	Provisional TCIs	336							54	36	70	62	50	38	26												
110 - Trauma and Orthopaedic	Starting Cohort	-	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387	9,387
	Will Breach	-	6,830	6,650	6,495	6,322	6,179	6,013	5,882	5,752	5,621	5,490	5,359	5,229	5,098	4,967	4,837	4,706	4,575	4,444	4,314	4,183	4,052	3,922	3,791	3,660	3,529
	Weekly Removals	147	63	180	155	173	143	166	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131	131
	Target	131	7,267	7,123	6,978	6,834	6,690	6,546	6,402	6,258	6,114	5,970	5,826	5,682	5,538	5,393	5,249	5,105	4,961	4,817	4,673	4,529	4,385	4,241	4,097	3,952	3,808
	Difference	-	-437	-473	-483	-512	-511	-533																			
	Future TCIs	827							296	130	137	130	83	46	5												
	Provisional TCIs	6							1	1	0	1	1	2	0												
330 - Dermatology	Starting Cohort	-	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153	8,153
	Will Breach	-	5,468	5,311	5,115	4,979	4,864	4,726	4,623	4,521	4,418	4,315	4,212	4,110	4,007	3,904	3,801	3,699	3,596	3,493	3,390	3,288	3,185	3,082	2,979	2,877	2,774
	Weekly Removals	136	75	157	196	136	115	138	103	103	103	103	103	103	103	103	103	103	103	103	103	103	103	103	103	103	103
	Target	103	6,311	6,186	6,061	5,936	5,811	5,686	5,560	5,435	5,310	5,185	5,060	4,935	4,810	4,684	4,559	4,434	4,309	4,184	4,059	3,933	3,808	3,683	3,558	3,433	3,308
	Difference	-	-843	-875	-948	-957	-947	-960																			
	Future TCIs	302							126	65	56	30	9	13	3												
	Provisional TCIs	5							2	0	0	1	2	0	0												
120 - Ear Nose and Throat	Starting Cohort	-	7,641	7,641	7,641	7,641	7,641	7,641	7,641	7,641	7,641	7,641	7,641	7,641	7,641	7,641	7,641	7,641	7,641	7,641	7,641	7,641	7,641	7,641	7,641	7,641	7,641
	Will Breach	-	5,230	5,071	4,859	4,719	4,595	4,437	4,340	4,243	4,146	4,049	3,952	3,855	3,758	3,661	3,564	3,467	3,370	3,273	3,176	3,079	2,982	2,885	2,788	2,691	2,594
	Weekly Removals	136	23	159	212	140	124	158	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97	97
	Target	97	5,915	5,798	5,680	5,563	5,446	5,329	5,211	5,094	4,977	4,859	4,742	4,625	4,508	4,390	4,273	4,156	4,038	3,921	3,804	3,686	3,569	3,452	3,335	3,217	3,100
	Difference	-	-685	-727	-821	-844	-851	-852																			
	Future TCIs	335							150	105	36	21	10	11	2												
	Provisional TCIs	3							0	0	1	0	0	2	0												
502 - Gynaecology	Starting Cohort	-	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045	7,045
	Will Breach	-	3,987	3,851	3,741	3,603	3,505	3,397	3,323	3,249	3,175	3,102	3,028	2,954	2,880	2,806	2,732	2,659	2,585	2,511	2,437	2,363	2,289	2,215	2,142	2,068	1,994
	Weekly Removals	105	40	136	110	138	98	108	74	74	74	74	74	74	74	74	74	74	74	74	74	74	74	74	74	74	74
	Target	74	5,454	5,346	5,237	5,129	5,021	4,913	4,805	4,697	4,589	4,480	4,372	4,264	4,156	4,048	3,940	3,831	3,723	3,615	3,507	3,399	3,291	3,183	3,074	2,966	2,858
	Difference	-	-1,467	-1,495	-1,496	-1,526	-1,516	-1,516																			
	Future TCIs	383							192	38	76	29	26	21	1												
	Provisional TCIs	111							17	9	25	13	18	13	16												
130 - Ophthalmology	Starting Cohort	-	6,249	6,249	6,249	6,249	6,249	6,249	6,249	6,249	6,249	6,249	6,249	6,249	6,249	6,249	6,249	6,249	6,249	6,249	6,249	6,249	6,249	6,249	6,249	6,249	6,249
	Will Breach	-	3,235	3,079	2,954	2,875	2,819	2,680	2,621	2,562	2,503	2,444	2,385	2,326	2,267	2,208	2,149	2,090	2,031	1,972	1,913	1,854	1,795	1,736	1,677	1,618	1,559
	Weekly Removals	101	49	156	125	79	56	139	59	59	59	59	59	59	59	59	59	59	59	59	59	59	59	59	59	59	59
	Target	59	4,837	4,742	4,646	4,550	4,454	4,358	4,262	4,166	4,070	3,974	3,878	3,782	3,686	3,590	3,495	3,399	3,303	3,207	3,111	3,015	2,919	2,823	2,727	2,631	2,535
	Difference	-	-1,602	-1,663	-1,692	-1,675	-1,635	-1,678																			
	Future TCIs	270							89	63	53	26	22	11	6												
	Provisional TCIs	4							0	2	1	1	0	0	0												
100 - General Surgery	Starting Cohort	-	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482	5,482
	Will Breach	-	2,877	2,779	2,713	2,622	2,531	2,425	2,372	2,320	2,267	2,214	2,161	2,109	2,056	2,003	1,951	1,898	1,845	1,792	1,740	1,687	1,634	1,582	1,529	1,476	1,423
	Weekly Removals	78	15	98	66	91	91	106	53	53	53	53	53	53	53	53	53	53	53	53	53	53	53	53	53	53	53
	Target	53	4,244	4,160	4,075	3,991	3,907	3,823	3,739	3,655	3,571	3,486	3,402	3,318	3,234	3,150	3,066	2,981	2,897	2,813	2,729	2,645	2,561	2,477	2,392	2,308	2,224
	Difference	-	-1,387	-1,381	-1,382	-1,369	-1,376	-1,396																			
	Future TCIs	173							55	29	24	25	13	19	8												
	Provisional TCIs	22							0	0	5	7	3	5	2												
101 - Urology	Starting Cohort	-	3,771	3,771	3,771	3,771	3,771	3,771	3,771	3,771	3,771	3,771	3,771	3,771	3,771	3,771	3,771	3,771	3,771	3,771	3,771	3,771	3,771	3,771	3,771	3,771	3,771
	Will Breach	-	1,838	1,747	1,671	1,609	1,571	1,496	1,463	1,431	1,398	1,366	1,333	1,301	1,268	1,236	1,203	1,171	1,138	1,106	1,073	1,041	1,008	976	943	911	878
	Weekly Removals	68	67	91	76	62	38	75	33	33	33	33	33	33	33	33	33	33	33	33	33	33	33	33	33	33	33
	Target	33	2,919	2,861	2,803	2,746	2,688	2,630	2,572	2,514	2,456	2,398	2,340	2,282	2,225	2,167	2,109	2,051	1,993	1,935	1,877	1,819	1,761	1,704	1,646	1,588	1,530
	Difference	-	-1,081	-1,114	-1,132	-1,137	-1,117	-1,134																			
	Future TCIs	176							56	41	32	21	8	9	9												
	Provisional TCIs	76							13	7	18	15	12	9	2												
191 - Pain Management	Starting Cohort	-	2,334	2,334	2,334	2,334	2,334	2,334	2,334	2,334	2,334	2,334	2,334	2,334	2,334	2,334	2,334	2,334	2,334	2,334	2,334	2,334	2,334	2,334	2,334	2,334	2,334
	Will Breach	-	1,622	1,579	1,528	1,505	1,471	1,422	1,391	1,360	1,329	1,298	1,267	1,237	1,206	1,175	1,144	1,113	1,082	1,051	1,020	989	958	927	896	866	835
	Weekly Removals	38	30	43	51	23	34	49	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31
	Target	31	1,807	1,771	1,735	1,699	1,663	1,628	1,592	1,556	1,520	1,484	1,449	1,413	1,377	1,341	1,305	1,269	1,234	1,198	1,162	1,126	1,090	1,054	1,019	983	947
	Difference	-	-185	-193	-207	-194	-182	-206																			
	Future TCIs	181							76	45	34	17	7		2												
	Provisional TCIs	1							0	0	0	1	0		0												
160 - Plastic Surgery	Starting Cohort	-	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358	2,358
	Will Breach	-	1,564	1,528	1,485	1,454	1,418	1,387	1,356	1,325	1,294	1,263	1,232	1,201	1,170	1,139	1,108	1,077	1,046	1,015	984	953	922	891	860	829	798
	Weekly Removals	31	7	36	43	31	36	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31	31
	Target	31	1,825	1,789	1,753	1,717	1,681	1,644	1,608	1,572	1,536	1,500	1,463	1,427	1,391	1,355	1,319	1,282	1,246	1,210	1,174	1,138	1,101	1,065	1,029	993	957
	Difference	-	-261	-261	-268	-263	-263	-257																			
	Future TCIs	82							28	12	13	15	8	4	2												
	Provisional TCIs	40							6	6	10	5	9	2	2												
320 - Cardiology	Starting Cohort	-	3,528	3,528	3,528	3,528	3,528	3,528	3,528	3,528	3,528	3,528	3,528	3,528	3,528	3,528	3,528	3,528	3,528	3,528	3,528	3,528	3,528	3,528	3,528	3,528	3,528
	Will Breach	-	1,750	1,620	1,565	1,500	1,438	1,325	1,296	1,267	1,239	1,210	1,181	1,152	1,123	1,095	1,066	1,037	1,008	979	951	922	893	864	835	807	778
	Weekly Removals	82	64	130	55	65	62	113	29	29	29	29	29	29	29	29	29	29	29	29	29	29	29	29	29	29	29
	Target	29	2,731	2,677	2,623	2,569	2,514	2,460	2,406	2,352	2,298	2,244	2,190	2,135	2,081	2,027	1,973	1,919	1,865	1,810	1,756	1,702	1,648	1,594	1,540	1,485	1,431
	Difference	-	-981	-1,057	-1,058	-1,069	-1,076	-1,135																			
	Future TCIs	229							73	47	40	40	15	8	6												
	Provisional TCIs	0							0	0	0	0	0	0	0												

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Specialty		Weekly Averages	14/04/2023 (IA & BH)	21/04/2023	28/04/2023	05/05/2023 (IA & BH)	12/05/2023 (BH)	19/05/2023	26/05/2023	02/06/2023 (BH)	09/06/2023	16/06/2023	23/06/2023	30/06/2023	07/07/2023	14/07/2023	21/07/2023	28/07/2023	04/08/2023	11/08/2023	18/08/2023	25/08/2023	01/09/2023 (BH)	08/09/2023	15/09/2023	22/09/2023	29/09/2023
108 - Spinal Surgery	Starting Cohort	-	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799	1,799
	Will Breach	-	1,377	1,368	1,338	1,316	1,299	1,280	1,252	1,224	1,197	1,169	1,141	1,113	1,085	1,057	1,030	1,002	974	946	918	890	863	835	807	779	751
	Weekly Removals	16	0	9	30	22	17	19	28	28	28	28	28	28	28	28	28	28	28	28	28	28	28	28	28	28	28
	Target	28	1,393	1,365	1,337	1,310	1,282	1,255	1,227	1,199	1,172	1,144	1,116	1,089	1,061	1,034	1,006	978	951	923	896	868	840	813	785	757	730
	Difference	-	-16	-3	-1	-6	-17	-25																			
	Future TCIs	116							33	12	28	19	14	6	4												
	Provisional TCIs	4							2	0	1	1	0	0	0												
140 - Oral Surgery	Starting Cohort	-	2,250	2,250	2,250	2,250	2,250	2,250	2,250	2,250	2,250	2,250	2,250	2,250	2,250	2,250	2,250	2,250	2,250	2,250	2,250	2,250	2,250	2,250	2,250	2,250	2,250
	Will Breach	-	1,290	1,238	1,181	1,114	1,045	910	890	870	851	831	811	791	772	752	732	712	692	673	653	633	613	593	574	554	534
	Weekly Removals	68	26	52	57	67	69	135	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20
	Target	20	1,742	1,707	1,673	1,638	1,604	1,569	1,535	1,500	1,465	1,431	1,396	1,362	1,327	1,293	1,258	1,224	1,189	1,155	1,120	1,086	1,051	1,016	982	947	913
	Difference	-	-452	-469	-492	-524	-559	-659																			
	Future TCIs	280							121	52	36	38	23	5	5												
	Provisional TCIs	12							6	1	0	3	1	0	1												
301 - Gastroenterology	Starting Cohort	-	3,015	3,015	3,015	3,015	3,015	3,015	3,015	3,015	3,015	3,015	3,015	3,015	3,015	3,015	3,015	3,015	3,015	3,015	3,015	3,015	3,015	3,015	3,015	3,015	3,015
	Will Breach	-	1,205	1,146	1,088	1,043	971	900	880	861	841	822	802	783	763	743	724	704	685	665	646	626	607	587	567	548	528
	Weekly Removals	59	49	59	58	45	72	71	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20	20
	Target	20	2,334	2,288	2,241	2,195	2,149	2,103	2,056	2,010	1,964	1,917	1,871	1,825	1,779	1,732	1,686	1,640	1,593	1,547	1,501	1,455	1,408	1,362	1,316	1,269	1,223
	Difference	-	-1,129	-1,142	-1,153	-1,152	-1,178	-1,203																			
	Future TCIs	130							46	26	19	18	11	7	3												
	Provisional TCIs	0							0	0	0	0	0	0	0												
400 - Neurology	Starting Cohort	-	2,473	2,473	2,473	2,473	2,473	2,473	2,473	2,473	2,473	2,473	2,473	2,473	2,473	2,473	2,473	2,473	2,473	2,473	2,473	2,473	2,473	2,473	2,473	2,473	2,473
	Will Breach	-	1,222	1,126	1,024	966	922	848	829	810	791	772	753	734	715	696	677	658	639	620	601	582	563	544	525	506	487
	Weekly Removals	69	40	96	102	58	44	74	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19	19
	Target	19	1,914	1,876	1,838	1,801	1,763	1,725	1,687	1,649	1,611	1,573	1,535	1,497	1,459	1,421	1,383	1,345	1,307	1,269	1,231	1,193	1,155	1,117	1,079	1,041	1,003
	Difference	-	-692	-750	-814	-835	-841	-877																			
	Future TCIs	126							69	20	14	13	6	2	2												
	Provisional TCIs	0							0	0	0	0	0	0	0												
215 - Paediatric Ear Nose and Throat	Starting Cohort	-	1,165	1,165	1,165	1,165	1,165	1,165	1,165	1,165	1,165	1,165	1,165	1,165	1,165	1,165	1,165	1,165	1,165	1,165	1,165	1,165	1,165	1,165	1,165	1,165	1,165
	Will Breach	-	815	801	777	758	756	725	709	693	678	662	646	630	615	599	583	567	552	536	520	504	489	473	457	441	426
	Weekly Removals	15	1	14	24	19	2	31	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16
	Target	16	902	884	866	848	830	812	795	777	759	741	723	705	687	669	651	634	616	598	580	562	544	526	508	491	473
	Difference	-	-87	-83	-89	-90	-74	-87																			
	Future TCIs	57							20	15	4	4	2	8	4												
	Provisional TCIs	2							1	0	0	0	1	0	0												
340 - Respiratory Medicine	Starting Cohort	-	1,463	1,463	1,463	1,463	1,463	1,463	1,463	1,463	1,463	1,463	1,463	1,463	1,463	1,463	1,463	1,463	1,463	1,463	1,463	1,463	1,463	1,463	1,463	1,463	1,463
	Will Breach	-	824	800	776	761	726	708	692	676	660	644	628	612	596	580	564	548	532	516	500	484	468	452	436	420	404
	Weekly Removals	22	17	24	24	15	35	18	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16
	Target	16	1,133	1,110	1,088	1,065	1,043	1,020	998	975	953	930	908	886	863	841	818	796	773	751	728	706	683	661	638	616	594
	Difference	-	-309	-310	-312	-304	-317	-312																			
	Future TCIs	69							21	16	12	6	7	5	2												
	Provisional TCIs	1							0	0	1	0	0	0	0												
171 - Paediatric Surgery	Starting Cohort	-	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082	1,082
	Will Breach	-	641	608	604	581	566	551	539	527	515	503	491	479	467	455	443	431	419	407	395	383	371	359	347	335	323
	Weekly Removals	17	13	33	4	23	15	15	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12
	Target	12	838	821	804	788	771	755	738	721	705	688	672	655	638	622	605	588	572	555	539	522	505	489	472	456	439
	Difference	-	-197	-213	-200	-207	-205	-204																			
	Future TCIs	63							20	15	9	10	3	4	2												
	Provisional TCIs	23							4	4	1	7	2	2	3												
257 - Paediatric Dermatology	Starting Cohort	-	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808	808
	Will Breach	-	591	580	563	552	542	533	521	510	498	487	475	463	452	440	429	417	406	394	382	371	359	348	336	324	313
	Weekly Removals	10	1	11	17	11	10	9	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12
	Target	12	625	613	601	588	576	563	551	539	526	514	501	489	477	464	452	439	427	415	402	390	377	365	353	340	328
	Difference	-	-34	-33	-38	-36	-34	-30																			
	Future TCIs	29							14	8	2	2	2	1													
	Provisional TCIs	0							0	0	0	0	0	0													
341 - Respiratory Physiology	Starting Cohort	-	901	901	901	901	901	901	901	901	901	901	901	901	901	901	901	901	901	901	901	901	901	901	901	901	901
	Will Breach	-	459	452	446	448	440	429	419	409	399	389	379	369	359	349	339	329	319	309	299	289	279	269	259	249	239
	Weekly Removals	7	11	7	6	-2	8	11	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
	Target	10	697	684	670	656	642	628	614	601	587	573	559	545	532	518	504	490	476	462	449	435	421	407	393	379	366
	Difference	-	-238	-232	-224	-208	-202	-198																			
	Future TCIs	12							8	3			1														
	Provisional TCIs	0							0	0			0														
420 - Paediatric	Starting Cohort	-	1,012	1,012	1,012	1,012	1,012	1,012	1,012	1,012	1,012	1,012	1,012	1,012	1,012	1,012	1,012	1,012	1,012	1,012	1,012	1,012	1,012	1,012	1,012	1,012	1,012
	Will Breach	-	556	537	522	486	465	428	418	408	398	388	378	368	358	348	338	328	318	308	298	288	278	268	258	248	238
	Weekly Removals	24	17	19	15	36	21	37	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10
	Target	10	783	768	752	737	721	706	690	675	659	644	628	613	597	581	566	550	535	519	504	488	473	457	442	426	411
	Difference	-	-227	-231	-230	-251	-256	-278																			
	Future TCIs	89							58	16	9		6														
	Provisional TCIs	0							0	0	0		0														
107 - Vascular Surgery	Starting Cohort	-	799	799	799	799	799	799	799	799	799	799	799	799	799	799	799	799	799	799	799	799	799	799	799	799	799
	Will Breach	-	335	315	285	270	262	248	242	236	230	224	218	212	206	200	194	188	182	176	170	164	158	152	146	140	134
	Weekly Removals	16	6	20	30	15	8	14	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
	Target	6	619	606	594	582	569	557	545	533	520	508	496	484	471	459	447	435	422	410	398	385	373	361	349	336	324
	Difference	-	-284	-291	-309	-312	-307	-309																			
	Future TCIs	37							6	19	4	6	1	1													
	Provisional TCIs	8							0	0	1	5	1	1													

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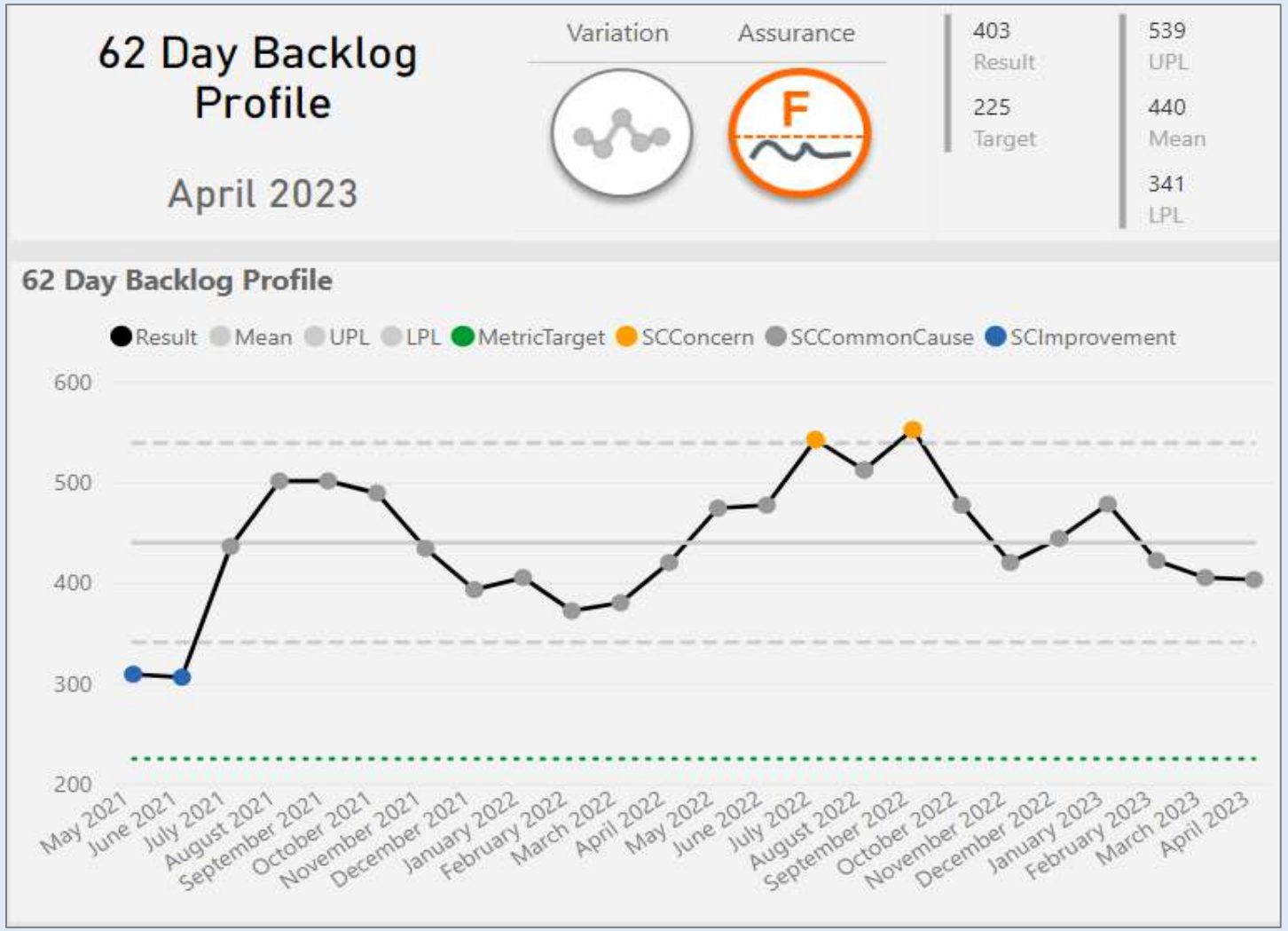
Specialty		Weekly Averages	14/04/2023 (IA & BH)	21/04/2023	28/04/2023	05/05/2023 (IA & BH)	12/05/2023 (BH)	19/05/2023	26/05/2023	02/06/2023 (BH)	09/06/2023	16/06/2023	23/06/2023	30/06/2023	07/07/2023	14/07/2023	21/07/2023	28/07/2023	04/08/2023	11/08/2023	18/08/2023	25/08/2023	01/09/2023	08/09/2023	15/09/2023	22/09/2023	29/09/2023 (BH)
214 - Paediatric Trauma and Orthopaedic	Starting Cohort	-	623	623	623	623	623	623	623	623	623	623	623	623	623	623	623	623	623	623	623	623	623	623	623	623	623
	Will Breach	-	278	277	255	243	240	228	223	218	213	208	203	198	193	188	183	178	173	169	164	159	154	149	144	139	134
	Weekly Removals	10	7	1	22	12	3	12	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5
	Target	5	482	473	463	454	444	434	425	415	406	396	387	377	368	358	348	339	329	320	310	301	291	281	272	262	253
	Difference	-	-204	-196	-208	-211	-204	-206																			
	Future TCIs	33							7	9	4	4	3	3	3												
	Provisional TCIs	0							0	0	0	0	0	0	0												
216 - Paediatric Ophthalmology	Starting Cohort	-	568	568	568	568	568	568	568	568	568	568	568	568	568	568	568	568	568	568	568	568	568	568	568	568	568
	Will Breach	-	224	209	192	185	179	171	167	164	160	156	152	149	145	141	138	134	130	126	123	119	115	112	108	104	100
	Weekly Removals	11	15	15	17	7	6	8	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4
	Target	4	440	431	422	414	405	396	387	379	370	361	353	344	335	326	318	309	300	291	283	274	265	257	248	239	230
	Difference	-	-216	-221	-230	-229	-225	-225																			
	Future TCIs	12							2	3	3	4															
	Provisional TCIs	2							0	0	2	0															
302 - Endocrinology	Starting Cohort	-	539	539	539	539	539	539	539	539	539	539	539	539	539	539	539	539	539	539	539	539	539	539	539	539	539
	Will Breach	-	205	194	163	153	149	136	133	130	127	124	121	118	115	112	109	106	103	101	98	95	92	89	86	83	80
	Weekly Removals	13	10	11	31	10	4	13	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	Target	3	417	409	401	392	384	376	368	359	351	343	335	326	318	310	301	293	285	277	268	260	252	243	235	227	219
	Difference	-	-212	-213	-238	-238	-215	-240																			
	Future TCIs	52							18	12	8	5	5	2	2												
	Provisional TCIs	0							0	0	0	0	0	0	0												
143 - Orthodontic	Starting Cohort	-	291	291	291	291	291	291	291	291	291	291	291	291	291	291	291	291	291	291	291	291	291	291	291	291	291
	Will Breach	-	138	136	133	134	132	132	129	126	123	121	118	115	112	109	106	103	100	98	95	92	89	86	83	80	77
	Weekly Removals	1	2	2	3	-1	2	0	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	Target	3	225	221	216	212	207	203	198	194	190	185	181	176	172	167	163	158	154	149	145	140	136	131	127	123	118
	Difference	-	-87	-85	-83	-78	-75	-71																			
	Future TCIs	7							1		3	1	2														
	Provisional TCIs	0							0		0	0	0														
219 - Paediatric Plastic Surgery	Starting Cohort	-	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251	251
	Will Breach	-	168	164	152	144	136	132	129	126	123	121	118	115	112	109	106	103	100	98	95	92	89	86	83	80	77
	Weekly Removals	7	3	4	12	8	8	4	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	Target	3	194	190	187	183	179	175	171	167	163	160	156	152	148	144	140	137	133	129	125	121	117	113	110	106	102
	Difference	-	-35	-38	-35	-39	-43	-43																			
	Future TCIs	24							10	5	2	6		1													
	Provisional TCIs	14							0	6	4	2		2													
251 - Paediatric Gastroenterology	Starting Cohort	-	175	175	175	175	175	175	175	175	175	175	175	175	175	175	175	175	175	175	175	175	175	175	175	175	175
	Will Breach	-	123	124	122	121	121	120	117	115	112	110	107	104	102	99	97	94	91	89	86	83	81	78	76	73	70
	Weekly Removals	1	1	-1	2	1	0	1	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	Target	3	135	133	130	127	125	122	119	117	114	111	109	106	103	101	98	95	92	90	87	84	82	79	76	74	71
	Difference	-	-12	-9	-8	-8	-4	-2																			
	Future TCIs	4							3		1																
	Provisional TCIs	0							0		0																
421 - Paediatric Neurology	Starting Cohort	-	277	277	277	277	277	277	277	277	277	277	277	277	277	277	277	277	277	277	277	277	277	277	277	277	277
	Will Breach	-	133	125	122	119	113	107	104	101	98	95	92	89	86	83	80	77	74	71	68	65	62	59	56	53	50
	Weekly Removals	5	2	8	3	3	6	6	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	Target	3	214	210	206	202	197	193	189	185	180	176	172	168	163	159	155	151	146	142	138	134	129	125	121	117	112
	Difference	-	-81	-83	-84	-83	-84	-86																			
	Future TCIs	18							5	6	3	1	1		2												
	Provisional TCIs	0							0	0	0	0	0		0												
258 - Paediatric Respiratory Medicine	Starting Cohort	-	245	245	245	245	245	245	245	245	245	245	245	245	245	245	245	245	245	245	245	245	245	245	245	245	245
	Will Breach	-	135	126	122	112	106	100	97	94	91	88	85	82	79	76	73	70	67	64	61	58	55	52	49	46	43
	Weekly Removals	7	5	9	4	10	6	6	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	Target	3	190	186	182	178	175	171	167	163	160	156	152	148	145	141	137	133	129	126	122	118	114	111	107	103	99
	Difference	-	-53	-60	-63	-64	-69	-71																			
	Future TCIs	15							3	10		1		1													
	Provisional TCIs	0							0	0		0		0													
410 - Rheumatology	Starting Cohort	-	819	819	819	819	819	819	819	819	819	819	819	819	819	819	819	819	819	819	819	819	819	819	819	819	819
	Will Breach	-	136	128	126	124	109	99	96	93	90	87	84	81	78	75	72	69	66	63	60	57	54	51	48	45	42
	Weekly Removals	8	8	8	2	2	15	10	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3
	Target	3	634	621	609	596	584	571	559	546	533	521	508	496	483	471	458	445	433	420	408	395	383	370	357	345	332
	Difference	-	-488	-493	-483	-472	-479	-472																			
	Future TCIs	13							5	2		2		3	1												
	Provisional TCIs	0							0	0		0		0	0												
800 - Clinical Oncology	Starting Cohort	-	448	448	448	448	448	448	448	448	448	448	448	448	448	448	448	448	448	448	448	448	448	448	448	448	448
	Will Breach	-	104	105	102	96	87	84	82	80	79	77	75	73	71	69	68	66	64	62	60	58	57	55	53	51	49
	Weekly Removals	4	4	-1	3	6	9	3	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
	Target	2	347	340	333	326	319	312	306	299	292	285	278	271	264	257	251	244	237	230	223	216	209	202	196	189	182
	Difference	-	-243	-235	-231	-230	-232	-228																			
	Future TCIs	27							10	4	2	5	2	4													
	Provisional TCIs	0							0	0	0	0	0	0													
321 - Paediatric Cardiology	Starting Cohort	-	153	153	153	153	153	153	153	153	153	153	153	153	153	153	153	153	153	153	153	153	153	153	153	153	153
	Will Breach	-	85	83	75	74	75	72	70	69	67	66	64	63	61	59	58	56	55	53	52	50	49	47	45	44	42
	Weekly Removals	3	2	2	8	1	-1	3	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
	Target	2	118	116	114	111	109	107	104	102	100	97	95	93	90	88	86	83	81	79	76	74	71	69	67	64	62
	Difference	-	-32	-33	-39	-37	-34	-35																			
	Future TCIs	3								2		1															
	Provisional TCIs	0								0		0															
303 - Clinical Haematology	Starting Cohort	-	227	227	227	227	227	227	227	227	227	227	227	227	227	227	227	227	227	227	227	227	227	227	227	227	227
	Will Breach	-	106	79	70	69	68	67	65	63	61	59	57	55	53	51	49	47	45	43	41	39	37	35	33	31	29
	Weekly Removals	7	1	27	9	1	1	1	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
	Target	2	176	172	169	165	162	158	155	151	148	144	141	137	134	130	127	123	120	116	113	110	106	103	99	96	92
	Difference	-	-79	-93	-89	-96	-94	-91																			
	Future TCIs	24							5	1	7	5	2	1	3												
	Provisional TCIs	0							0	0	0	0	0	0	0												
361 - Renal Medicine	Starting Cohort	-	368	368	368	368	368	368	368	368	368	368	368	368	368	368	368	368	368	368	368	368	368	368	368	368	368
	Will Breach	-	130	120	102	92	82	61	59	57	55	53	51	49	47	45	43	41	39	37	35	33	31	29	27	25	23
	Weekly Removals	13	8	10	18	10	10	21	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
	Target	2	285	279	274	268	262	257	251	245	240	234	228	223	217	211	206	200	194	189	183	178	172	166	161	155	149
	Difference	-	-155	-159	-172	-176	-180	-186																			
	Future TCIs	12							2		1	2	3	4													
	Provisional TCIs	0							0		0	0	0	0													

Performance – Cancer 62-Day Backlog Profile



Commentary

April 2023 Performance

The 62 day backlog reduced in April, with 403 patients waiting over 62 days compared to 405 in March and the lowest figure since March 2022, and has returned to trajectory.

Improvement Actions

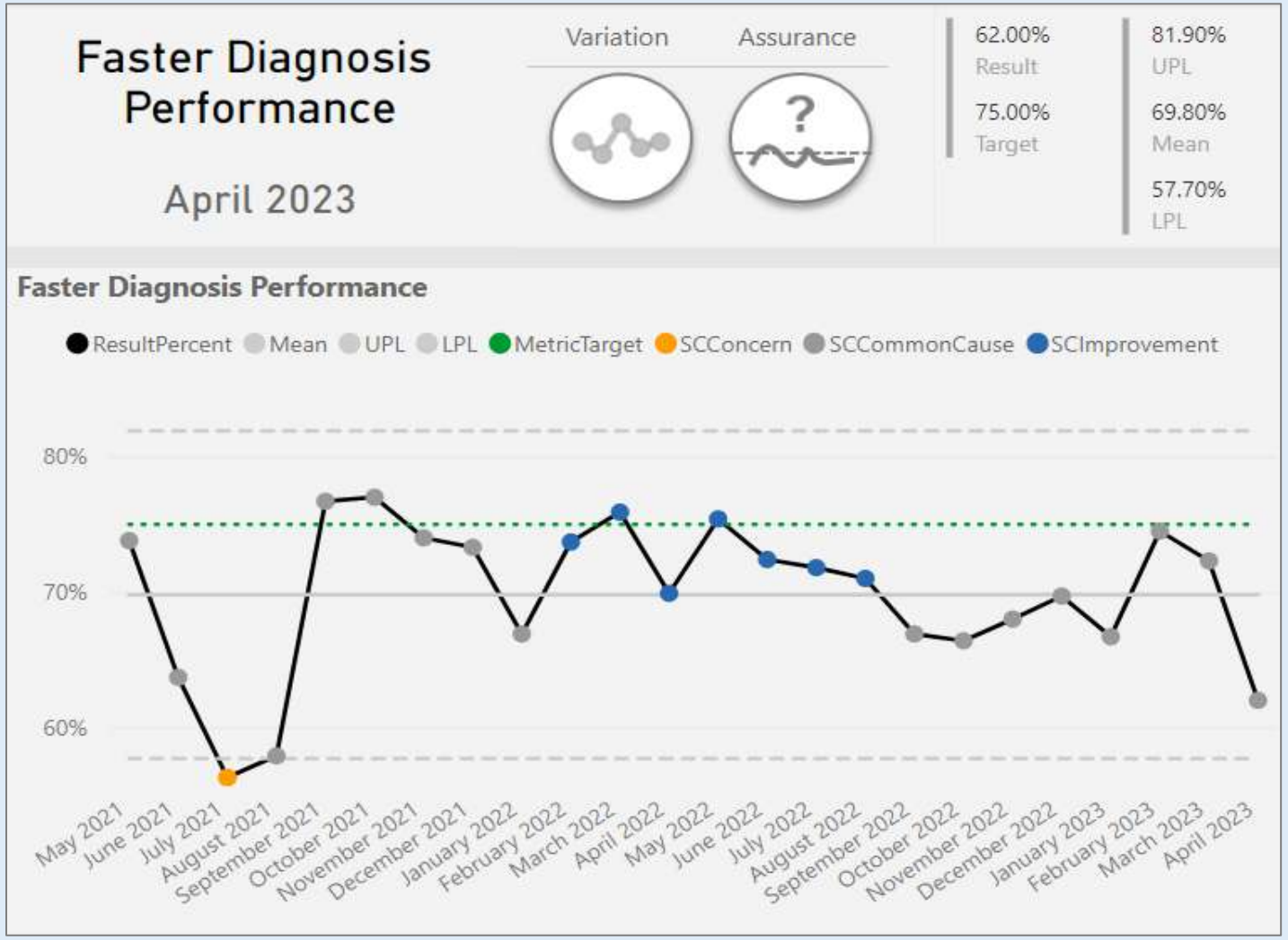
1. Review of Urology weekend robotic operating to support backlog reduction. Current wait for Urology Robotic Surgery is 6 weeks.
2. mpMRI capacity continues to meet levels of demand. Turnaround for Prostate MRI is now 10 days from Radiological request.
3. Implementation of new CWT guidance in Gynaecology to provide minor reduction in the number of patients over 62 days.

Risk To Delivery

There are still significant risks to ongoing recovery performance with constrained capacity, particularly in Urology and Gynaecology cancer pathways, and a reduction in capacity moving into May 2023 due to bank holidays and June 2023 due to Industrial Action.

RED

Performance – Faster Diagnosis Standard



Commentary

April 2023 Performance (provisional)

Cancer performance is reported to NHS Digital a month in arrears. Therefore, April's performance of 62% is provisional and has incomplete data. Performance is expected to increase to circa. 67%. High volume of patients have been waiting in excess of 28 days for their diagnosis, entirely due to delays impacted by Industrial Action. Performance expected to be under 70% in May 23 as teams work through the backlog generated by Industrial Action. Further periods of Industrial Action will restrict the Trust's ability to recover in June.

Improvement Actions

1. Continued data quality review to ensure completeness of information for submission to NHS digital is key to ensuring continued achievement of the standard.

2. Recovery of Two Week Wait standard for Gynaecology and Skin will support improvements to FDS performance. Additional sessions planned for both body sites in May and June.

Risk To Delivery

AMBER

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Lower GI Referrals with a FIT Test

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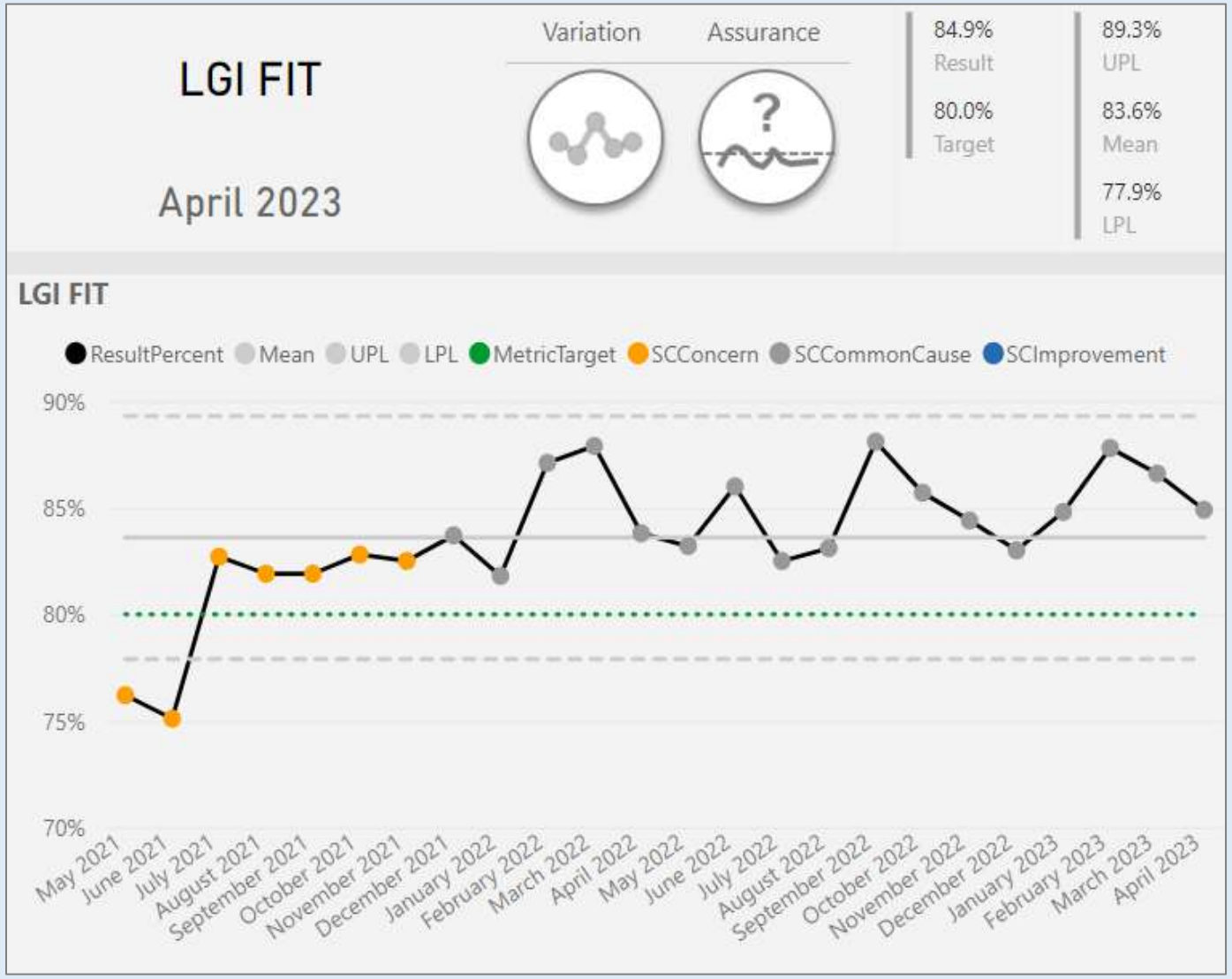


Commentary

April 2023 Performance

Performance remains above 80% target performance for all LGI referrals having an accompanying FIT result, enabling effective triage and straight to test investigations where criteria met.

For those patients with a negative FIT result and meeting inclusion criteria, an additional clinical service, provided by GPs operating via NNPC's Rapid Diagnostic Service for patients with non-specific symptoms pertaining to cancer has been available.

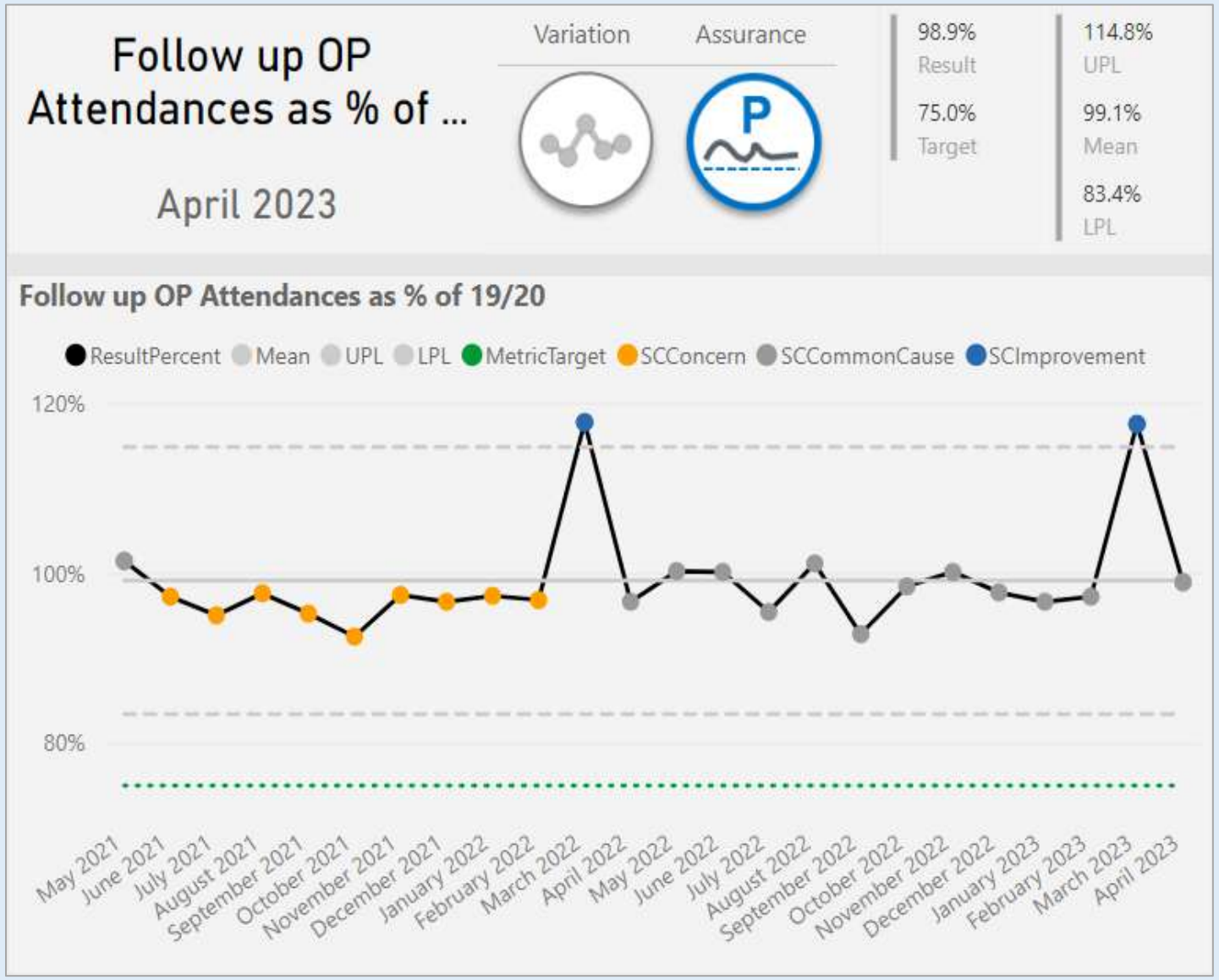
Improvement Actions

1. Extension of Primary Care FIT Negative service provided by North Norfolk Primary Care to support streaming of non-specific symptoms away from the colorectal pathway.
2. Additional Administrative support secured through Cancer Alliance Service Development funding to ensure effective progression of patients on the pathway.

Risk To Delivery

GREEN

Performance – Follow Up Reduction



Commentary

April 2023 Performance

Trust wide performance for April has improved (from 115.8% in March to 98.9% in April), against the target of 75% of 2019/20 follow up activity.

Division	April 2023
Surgery	92.4%
Medicine	108.6%
Women and Children	104.1%
Clinical Support Services	88.9%

Improvement Actions

Due to Industrial Action the risk around additional income from Outpatients is unlikely to be realised in year, so the previously proposed saving stream will not be achievable.

Within the Outpatient Transformation Programme the teams are continuing to focus on PIFU / Advice and Guidance / Targeted DNA reduction.

Follow up activity is closely tracked through the weekly Elective Priorities Divisional meetings with focus on delivery against Commissioned targets.

Risk To Delivery

Due to the size of the follow up backlog, it is unlikely that the Trust will achieve 75% of 2019/20 follow up activity.

RED

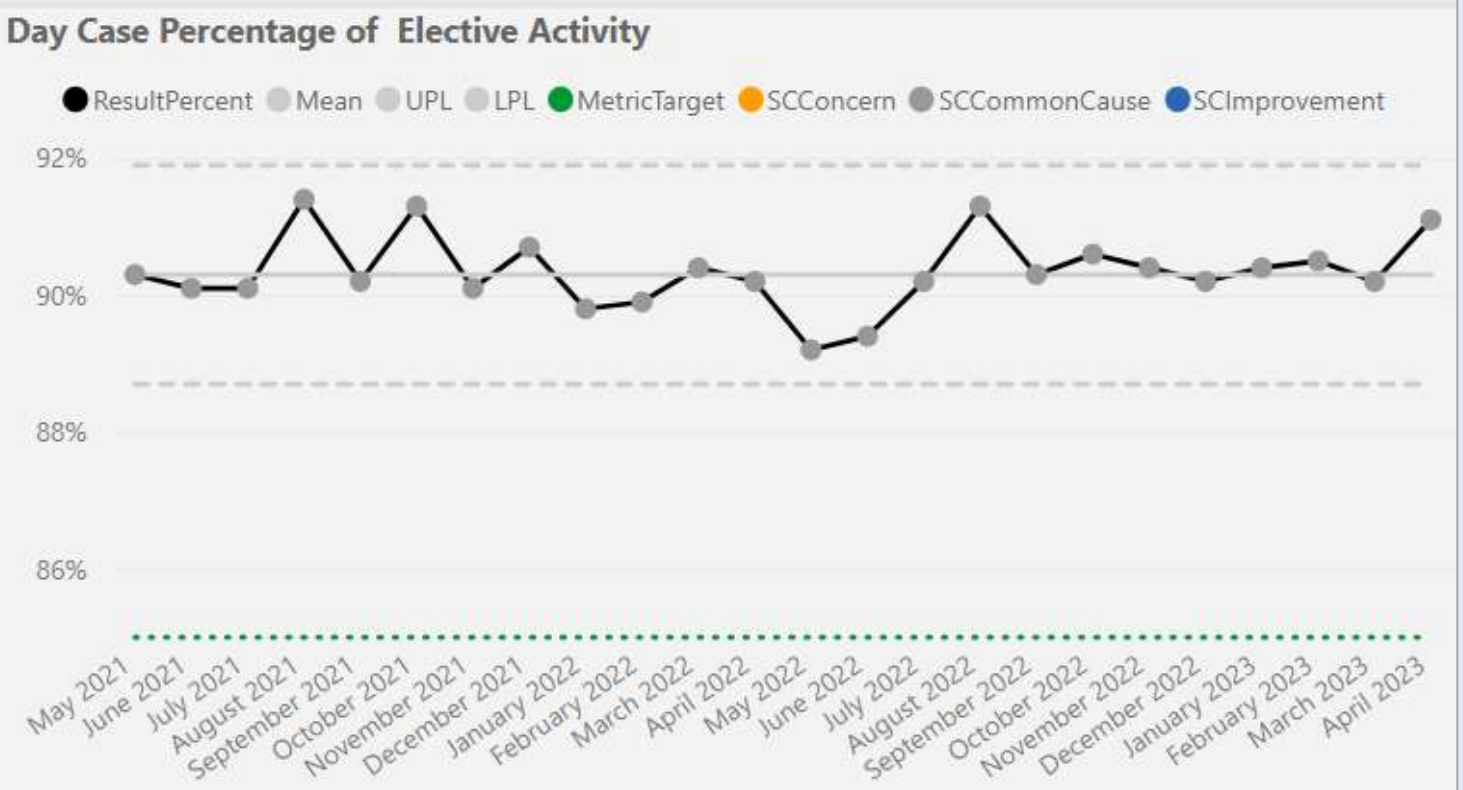
Performance – 85% Day Case

Day Case Percentage of Elective Activity

April 2023

Variation | Assurance

91.1% Result
85.0% Target
91.9% UPL
90.3% Mean
88.7% LPL



Commentary

In April 2023, NNUH delivered 91.1% of elective activity as day cases against the 85% target.

Risk To Delivery

GREEN

Performance – Theatre Dashboard: Utilisation

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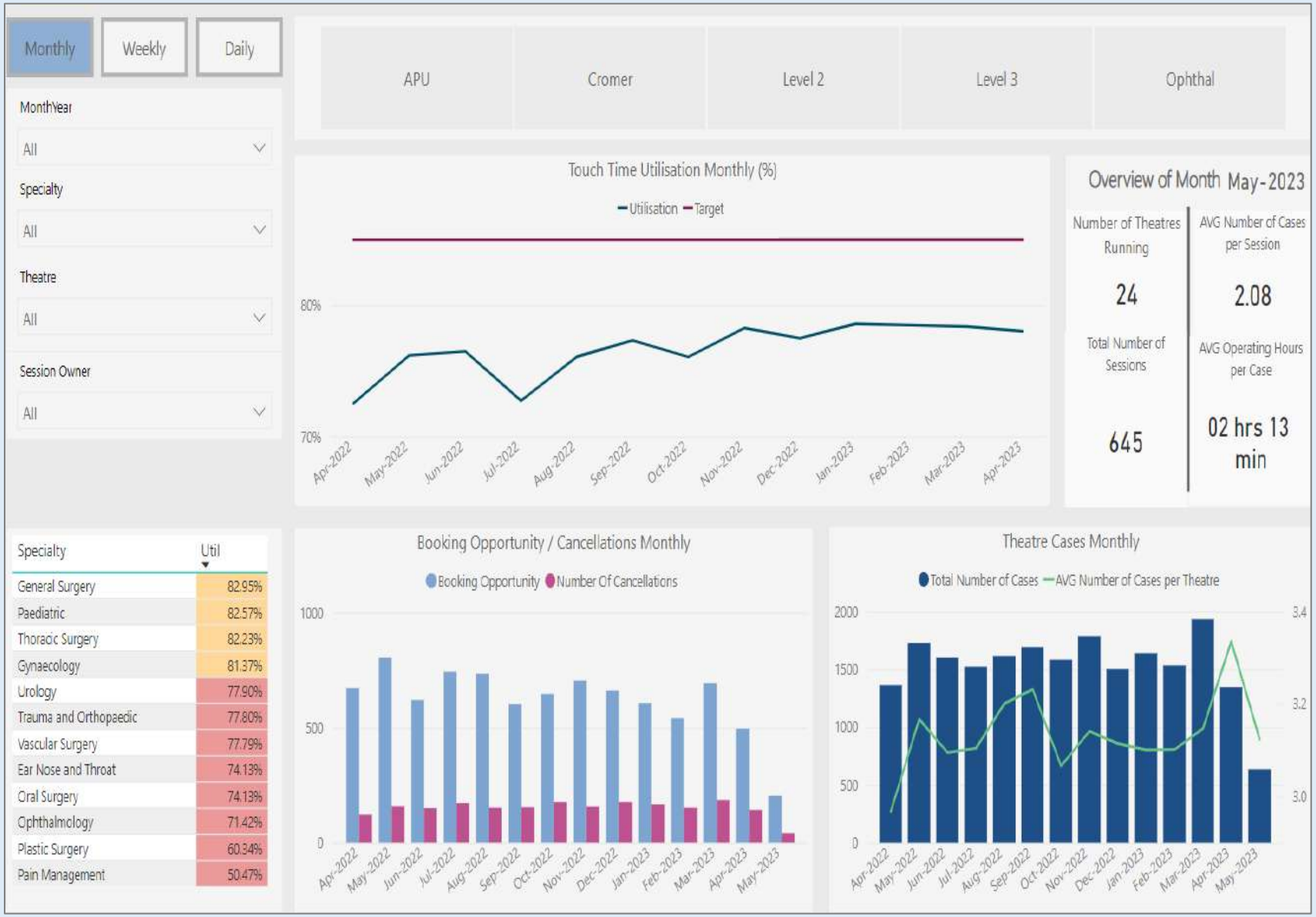


Commentary

April 2023 Performance

The touch time delivery across all theatres showed a slight reduction to 78.01% across April (78.38% in March). Level 3 theatres delivered 82.33%, while Level 2 utilisation was 74.78% for the month.

Utilisation improvements were seen in General Surgery, Trauma and Orthopaedics, and Oral Surgery.

Late starts continued to improve at 18.60% in month.

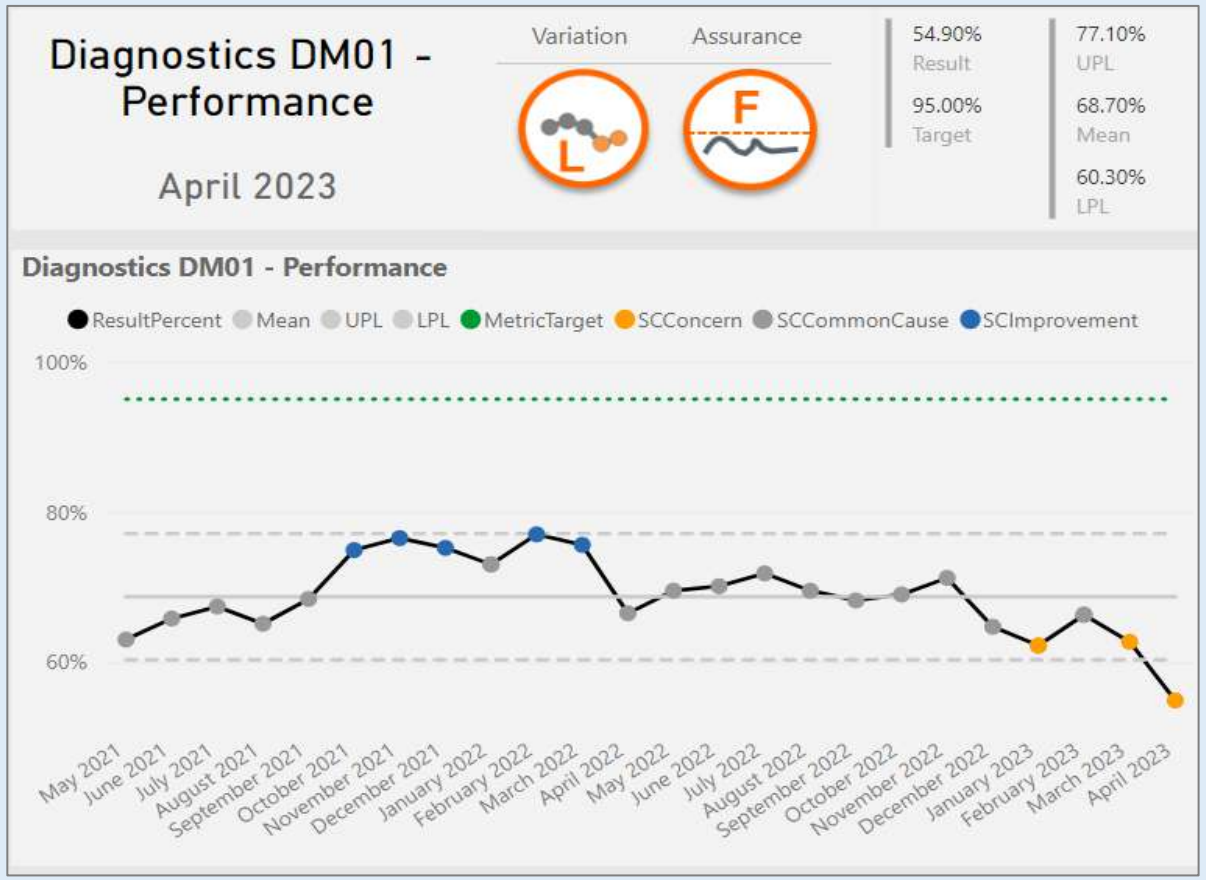
Improvement Actions

1. Work continues on the development of the electronic POA system, which is now in live format and the questionnaire is being tested with patients.
2. Recent server upgrade has disrupted the Theatre tracker. This issue remains unresolved and is impacting on our ability to fully deploy the 6-4-2 process.

Risk To Delivery

AMBER

Diagnostic Test Within 6 Weeks



Commentary

April 2023 Performance

April DM01 performance was impacted by Industrial Action.
Clinical teams continue to actively encourage patients to ensure they attend their appointments in a timely manner. Echocardiography started 2022 with a performance level of 19% against the standard with a backlog of 4,000 patients. The backlog has now been cleared, with specialised procedures left to undertake. There has been some data quality issues which the team are working through to clear.

CT: CT1 and CT3 machine downtime has had a significant impact on activity levels. High levels of staff sickness and vacancy across Radiographer and RDA team resulting in outpatient CT list cancellations. Agency staff being sought.
MRI: High vacancy levels (3.6 WTE) impacted activity levels. Locum sourced and additional locums being sought. 100-150 requests per week to Global routinely.
Ultrasound: Very poor uptake in overtime and additional sessions (compared to historical levels) and high vacancy.

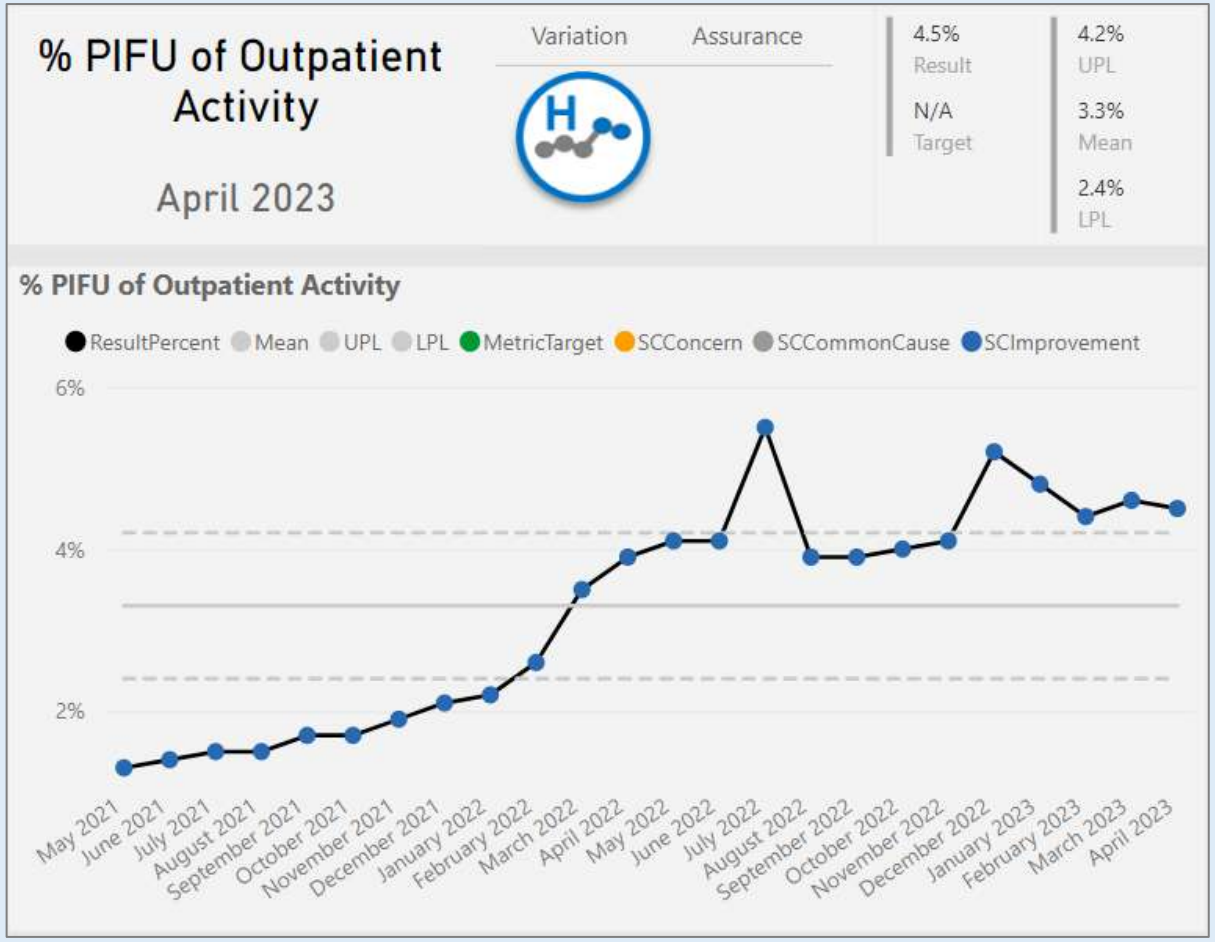
April 2023 Performance									
Specialty	**Radiology**					**Cardiology**	**Gastroenterology**		
Specialty Percentage	**50.71%**					**50.15%**	**87.59%**		
Exam Type	Barium Enema	DEXA Scan	CT	MRI	Ultrasound	Echocardiography	Flexi Sigmoidoscopy	Gastroscopy	Colonoscopy
Exam Type Percentage	**100%**	**77.15%**	**45.44%**	**47.93%**	**54.85%**	**50.15%**	**84.02%**	**90.33%**	**86.32%**

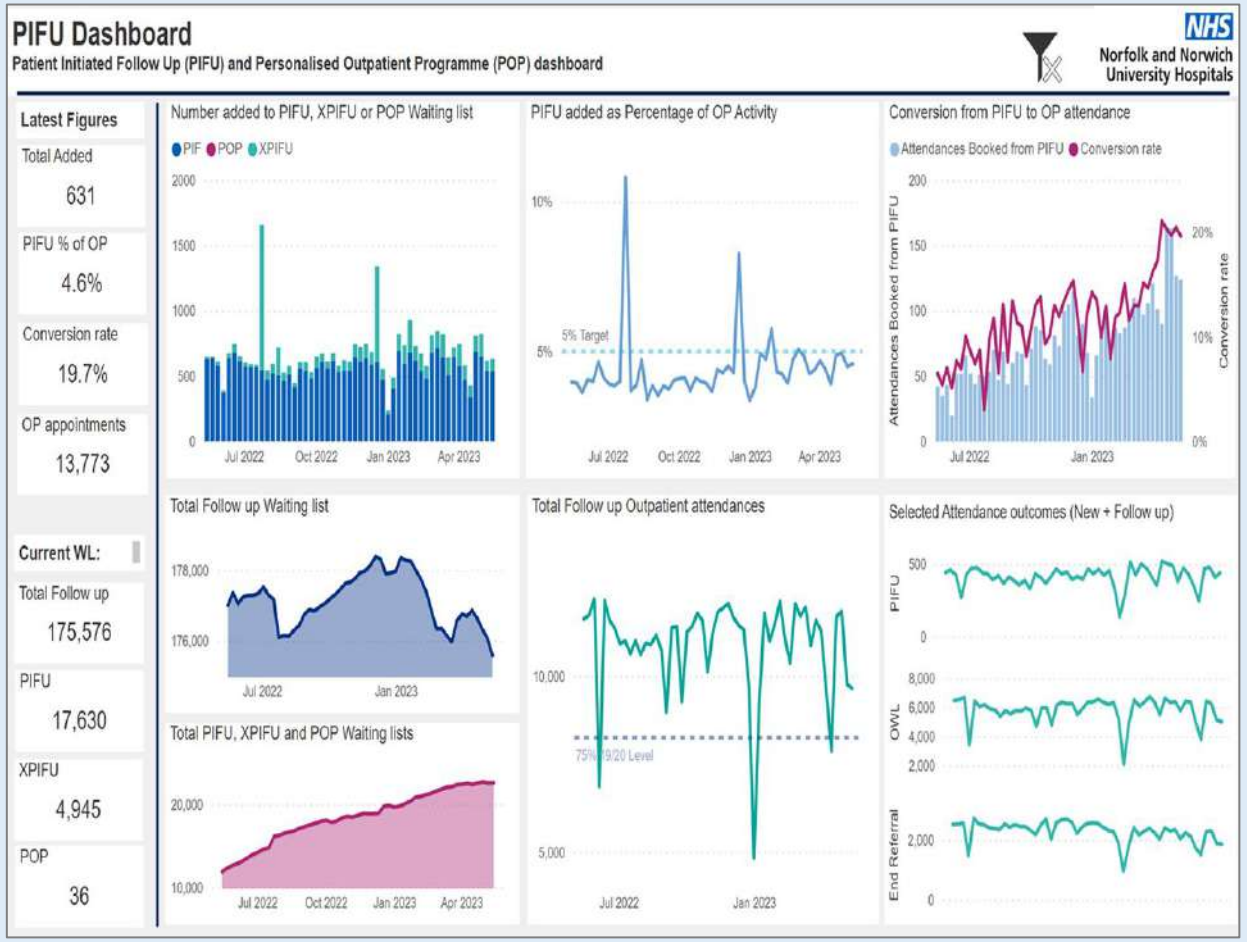
Patient Initiated Follow Up (PIFU)

Commentary

April 2023 Performance

The % of PIFU remained above 4% in April, but there was a slight decrease compared to March (4.6% to 4.5%). The most recent week in May (below right) illustrates an increase from the April average to 4.6%, with a 19.7% conversion from PIFU to Outpatient attendance.





Virtual Ward Activity

Commentary

April 2023 Performance

In April, the number of Virtual Ward transfers in was 87. This is a 23% reduction in month compared to March, but above both January and February 2023. The daily average length of stay of inpatients on the Virtual Ward was 14.41 days in April 2023, compared to 14.65 days in March but higher than the average Virtual Ward length of stay of 10 days since 1st January 2023.

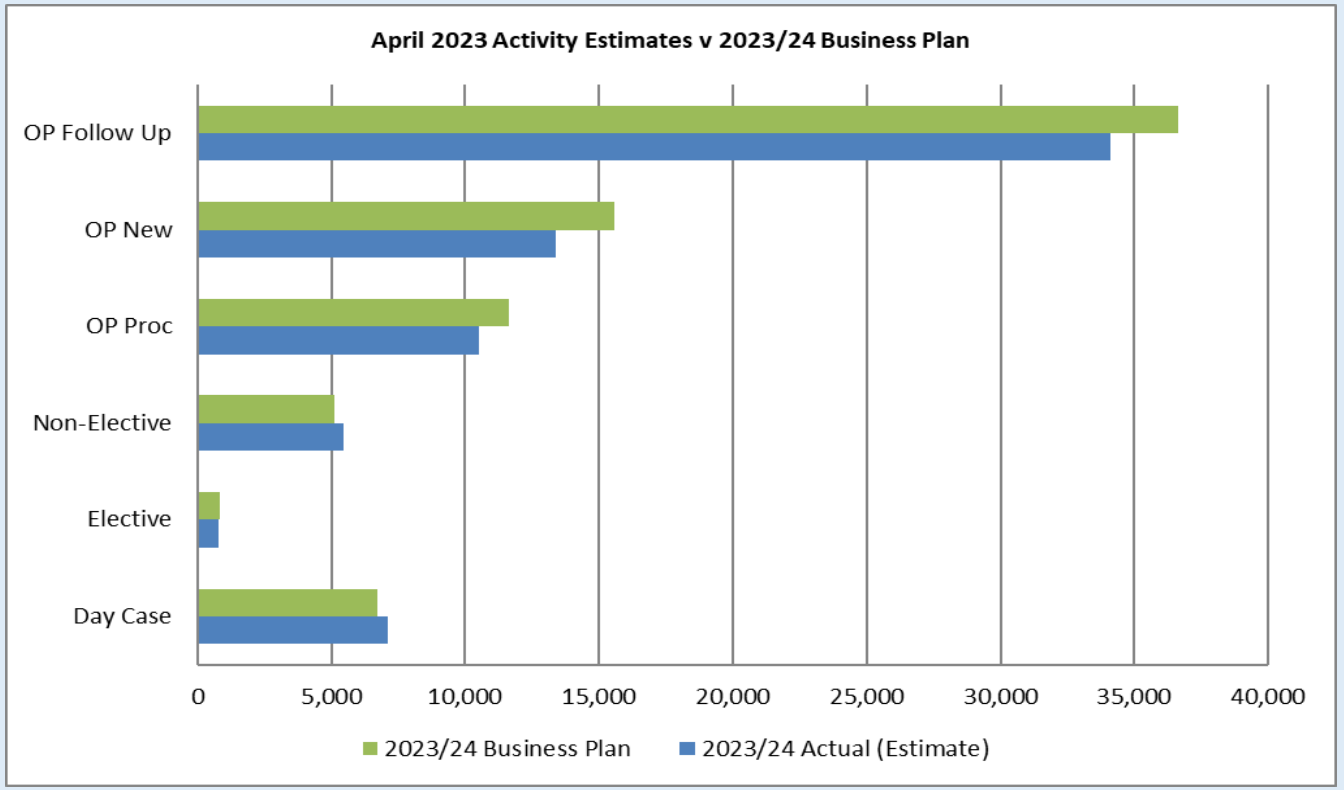
Activity Planning Run Rate

Commentary

April 2023 Performance

April's activity was heavily impacted by Industrial Action. There were 75% less working weekdays in April 2023 (15) compared to 2019/20 (20 working weekdays). The Divisional business plans are based on an uplift against 2019/20. Whilst most specialties were unable to meet their plan, there are some encouraging signs on the admitted pathways when compared against available working days. The table below (left) details some of the specialties that delivered above their plan in April. The graph below (right) summarises the actual activity versus the activity plan. The proceeding slides provide a detailed position for each specialty.

Activity Type	Specialty	Positive Variance
Daycase	Haematology	144
	Trauma and Orthopaedic	9
	Urology	76
Elective	Spinal Surgery	9
	Cardiology	30
Non-Elective	General Medicine	77
	Respiratory	66
	Geriatric Medicine	123



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Activity Planning Run Rate

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Medicine Division	Daycase				Elective				Non Elective				OP - Procedure				OP - New (Exc Procedure)				OP - Follow Up (Exc Procedure)				Total			
	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved
300 General Medicine	0	0	0	0.0%	0	0	0	0.0%	278	202	77	138.0%	0	0	0	0.0%	355	347	8	102.4%	193	191	2	101.2%	**826**	**739**	**87**	**111.8%**
301 Gastroenterology	1,713	1,787	(74)	95.8%	11	9	2	126.7%	242	278	(35)	87.2%	4	9	(5)	48.9%	317	430	(113)	73.7%	475	762	(287)	62.3%	**2,763**	**3,274**	**(511)**	**84.4%**
302 Endocrinology	6	5	1	112.5%	0	1	(1)	0.0%	112	124	(12)	90.6%	0	2	(2)	19.2%	103	173	(70)	59.5%	448	568	(121)	78.8%	**669**	**874**	**(205)**	**76.6%**
303 Clinical Haematology	958	815	144	117.6%	13	15	(3)	83.3%	70	57	13	122.5%	0	0	0	0.0%	365	519	(154)	70.4%	1,859	1,951	(92)	95.3%	**3,264**	**3,356**	**(92)**	**97.3%**
306 Hepatology	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	78	134	(56)	58.2%	371	337	34	110.1%	**449**	**471**	**(22)**	**95.4%**
307 Diabetic Medicine	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	3	(3)	0.0%	183	284	(101)	64.5%	1,741	1,967	(226)	88.5%	**1,924**	**2,254**	**(330)**	**85.4%**
308 Blood and Marrow Transplantation	0	4	(4)	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	1	1	(0)	75.0%	33	42	(9)	78.4%	**34**	**47**	**(13)**	**71.8%**
315 Palliative Medicine	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	191	179	12	106.7%	581	643	(62)	90.4%	**772**	**822**	**(50)**	**93.9%**
320 Cardiology	236	261	(25)	90.4%	55	25	30	220.9%	337	294	43	114.7%	959	1,093	(134)	87.7%	495	789	(294)	62.7%	1,961	2,066	(105)	94.9%	**4,043**	**4,528**	**(485)**	**89.3%**
326 Acute Internal Medicine	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	**0**	**0**	**0**	**0.0%**
328 Stroke Medicine	0	0	0	0.0%	0	0	0	0.0%	124	117	6	105.4%	0	0	0	0.0%	0	0	0	0.0%	28	10	18	271.0%	**152**	**128**	**24**	**118.8%**
329 TIA	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	16	19	(3)	85.1%	56	73	(17)	76.4%	0	0	0	0.0%	**72**	**92**	**(20)**	**78.2%**
331 Congenital Heart Disease Service	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	21	27	(6)	77.4%	61	86	(25)	70.7%	**82**	**113**	**(31)**	**72.3%**
340 Respiratory Medicine	91	76	15	120.0%	7	9	(3)	73.0%	286	220	66	130.1%	306	360	(54)	85.0%	146	297	(151)	49.1%	850	838	12	101.5%	**1,686**	**1,800**	**(114)**	**93.7%**
341 Respiratory Physiology	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	13	0	13	0.0%	64	138	(74)	46.5%	170	244	(73)	70.0%	**248**	**381**	**(133)**	**65.1%**
343 Adult Cystic Fibrosis	0	0	0	0.0%	0	0	(0)	0.0%	0	0	0	0.0%	0	0	0	0.0%	1	0	1	0.0%	41	46	(5)	90.1%	**42**	**46**	**(4)**	**92.0%**
350 Infectious Diseases	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	197	0	197	0.0%	4	0	4	0.0%	**201**	**0**	**201**	**0.0%**
361 Nephrology	59	38	21	156.6%	16	25	(10)	62.1%	105	103	2	101.9%	15	20	(5)	75.4%	44	112	(68)	39.2%	551	775	(224)	71.1%	**790**	**1,074**	**(283)**	**73.6%**
370 Medical Oncology	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	**0**	**0**	**0**	**0.0%**
400 Neurology	128	113	15	113.4%	0	1	(1)	0.0%	104	112	(8)	92.8%	9	11	(2)	80.1%	343	503	(160)	68.3%	805	932	(127)	86.4%	**1,390**	**1,672**	**(282)**	**83.1%**
401 Clinical Neurophysiology	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	284	235	50	121.1%	36	68	(32)	52.4%	2	3	(1)	73.5%	**322**	**306**	**16**	**105.3%**
410 Rheumatology	218	160	58	136.3%	0	0	0	0.0%	0	3	(3)	0.0%	27	31	(4)	88.5%	258	344	(86)	75.0%	1,522	1,798	(276)	84.6%	**2,025**	**2,337**	**(311)**	**86.7%**
430 Geriatric Medicine	24	8	16	300.0%	0	0	0	0.0%	712	589	123	120.9%	0	0	0	0.0%	86	84	2	103.0%	51	59	(8)	85.9%	**873**	**740**	**133**	**118.0%**
653 Podiatry	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	96	89	7	108.3%	389	444	(55)	87.7%	**485**	**532**	**(47)**	**91.1%**
800 Clinical Oncology	1,855	1,560	295	118.9%	20	18	3	115.0%	206	172	34	119.8%	5	6	(1)	90.0%	460	428	33	107.6%	3,256	3,336	(80)	97.6%	**5,802**	**5,519**	**283**	**105.1%**
Total - Medicine (NNUH)	**5,289**	**4,827**	**462**	**109.6%**	**122**	**104**	**19**	**117.8%**	**2,577**	**2,271**	**306**	**113.5%**	**1,640**	**1,788**	**(148)**	**91.7%**	**3,894**	**5,016**	**(1,122)**	**77.6%**	**15,392**	**17,098**	**(1,706)**	**90.0%**	**28,914**	**31,103**	**(2,189)**	**93.0%**

Women and Children's Division	Daycase				Elective				Non Elective				OP - Procedure				OP - New (Exc Procedure)				OP - Follow Up (Exc Procedure)				Total			
	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved
171 Paediatric Surgery	43	30	13	143.3%	10	12	(2)	82.5%	30	42	(12)	72.0%	90	105	(15)	85.4%	116	135	(19)	85.8%	282	180	102	156.5%	**570**	**504**	**66**	**113.1%**
242 Paediatric Intensive Care	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	**0**	**0**	**0**	**0.0%**
251 Paediatric Gastroenterology	18	8	10	226.8%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	10	25	(15)	40.0%	84	120	(36)	70.0%	**112**	**153**	**(41)**	**73.3%**
252 Paediatric Endocrinology	18	14	4	128.6%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	26	20	6	130.0%	93	102	(9)	90.7%	**137**	**136**	**1**	**100.4%**
253 Paediatric Clinical Haematology	0	0	0	0.0%	0	0	0	0.0%	1	0	1	0.0%	0	0	0	0.0%	1	2	(1)	50.0%	21	23	(2)	91.3%	**23**	**25**	**(2)**	**92.0%**
258 Paediatric Respiratory Medicine	1	0	1	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	31	24	7	129.2%	72	90	(18)	80.5%	**104**	**114**	**(10)**	**91.6%**
260 Paediatric Medical Oncology	19	25	(6)	76.0%	0	0	0	0.0%	9	8	1	108.5%	0	0	0	0.0%	4	2	2	200.0%	117	104	13	112.5%	**149**	**139**	**10**	**107.0%**
262 Paediatric Rheumatology	10	8	2	125.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	12	21	(9)	57.1%	112	124	(12)	90.3%	**134**	**153**	**(19)**	**87.6%**
263 Paediatric Diabetic Medicine	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	4	(4)	0.0%	101	123	(22)	82.1%	**101**	**127**	**(26)**	**79.5%**
264 Paediatric Cystic Fibrosis	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	1	(1)	0.0%	23	18	5	127.8%	**23**	**19**	**4**	**121.1%**
321 Paediatric Cardiology	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	31	35	(4)	88.6%	38	60	(22)	63.2%	**69**	**95**	**(26)**	**72.5%**
420 Paediatrics	39	47	(8)	82.8%	2	2	0	127.5%	147	185	(39)	79.2%	0	0	0	0.0%	431	383	48	112.6%	240	251	(11)	95.8%	**859**	**868**	**(8)**	**99.0%**
421 Paediatric Neurology	0	0	(0)	0.0%	0	0	0	0.0%	0	1	(1)	0.0%	0	0	0	0.0%	47	58	(11)	81.0%	93	125	(32)	74.6%	**140**	**184**	**(44)**	**76.1%**
422 Neonatology	0	0	0	0.0%	0	0	0	0.0%	244	223	22	109.7%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	**244**	**223**	**22**	**109.7%**
424 Well Babies	0	0	0	0.0%	0	0	0	0.0%	178	215	(37)	82.8%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	**178**	**215**	**(37)**	**82.8%**
501 Obstetrics	0	0	0	0.0%	60	0	60	0.0%	722	705	17	102.4%	0	0	0	0.0%	473	546	(73)	86.7%	1,453	1,594	(141)	91.1%	**2,708**	**2,845**	**(137)**	**95.2%**
502 Gynaecology	38	57	(19)	66.7%	72	78	(6)	92.6%	191	175	16	109.3%	855	860	(5)	99.4%	593	864	(271)	68.6%	616	675	(59)	91.3%	**2,365**	**2,709**	**(344)**	**87.3%**
503 Gynaecological Oncology	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	6	12	(6)	50.6%	23	44	(21)	51.6%	121	192	(71)	62.9%	**150**	**248**	**(99)**	**60.3%**
505 Fetal Medicine Service	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	42	57	(15)	73.7%	38	48	(10)	79.9%	**80**	**105**	**(25)**	**76.5%**
560 Midwife Episode	0	0	0	0.0%	0	0	0	0.0%	314	244	70	128.5%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	**314**	**244**	**70**	**128.5%**
Total - Women & Children (NNUH)	**186**	**189**	**(3)**	**98.3%**	**144**	**92**	**53**	**157.4%**	**1,836**	**1,798**	**38**	**102.1%**	**951**	**977**	**(26)**	**97.3%**	**1,840**	**2,221**	**(381)**	**82.9%**	**3,505**	**3,829**	**(325)**	**91.5%**	**8,461**	**9,106**	**(645)**	**92.9%**
Women & Children (NNUH) Exc. Maternity	**186**	**189**	**(3)**	**98.3%**	**84**	**92**	**(7)**	**91.9%**	**800**	**849**	**(49)**	**94.3%**	**951**	**977**	**(26)**	**97.3%**	**1,367**	**1,675**	**(308)**	**81.6%**	**2,052**	**2,235**	**(184)**	**91.8%**	**5,439**	**6,017**	**(578)**	**90.4%**

Our Vision
The best care for every patient

Activity Planning Run Rate

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

Surgery Division		Daycase				Elective				Non Elective				OP - Procedure				OP - New (Exc Procedure)				OP - Follow Up (Exc Procedure)				Total			
		Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved
100	General Surgery	133	132	1	100.5%	72	95	(24)	75.1%	275	276	(1)	99.5%	92	104	(11)	89.0%	1,424	1,359	65	104.8%	2,184	2,140	44	102.1%	**4,179**	**4,106**	**73**	**101.8%**
101	Urology	269	193	76	139.7%	93	133	(40)	69.6%	108	119	(11)	91.2%	726	690	36	105.2%	741	805	(64)	92.1%	1,391	1,287	104	108.1%	**3,329**	**3,227**	**101**	**103.1%**
107	Vascular Surgery	34	25	10	138.8%	38	35	3	108.8%	64	47	17	136.0%	24	63	(39)	37.7%	133	162	(29)	82.3%	137	225	(88)	61.0%	**430**	**556**	**(126)**	**77.4%**
108	Spinal Surgery Service	6	13	(7)	47.6%	22	14	9	163.0%	14	13	1	107.1%	0	0	0	0.0%	53	102	(49)	51.8%	243	207	36	117.3%	**338**	**348**	**(10)**	**97.0%**
110	Trauma & Orthopaedics	102	93	9	109.4%	107	128	(20)	84.0%	193	245	(52)	78.6%	24	15	9	157.5%	1,340	1,382	(42)	97.0%	2,021	1,954	68	103.5%	**3,787**	**3,817**	**(30)**	**99.2%**
120	ENT	56	96	(40)	58.2%	29	50	(21)	57.4%	98	85	13	115.6%	738	1,106	(368)	66.7%	334	401	(67)	83.4%	266	407	(141)	65.3%	**1,521**	**2,146**	**(624)**	**70.9%**
130	Ophthalmology	270	292	(22)	92.5%	3	3	1	120.4%	14	14	0	101.2%	3,274	3,190	84	102.6%	771	872	(101)	88.4%	1,664	1,740	(76)	95.6%	**5,997**	**6,110**	**(114)**	**98.1%**
140	Oral Surgery	196	200	(4)	98.1%	9	17	(8)	52.6%	20	30	(10)	66.7%	1	2	(1)	39.0%	375	404	(29)	92.9%	554	520	34	106.6%	**1,155**	**1,173**	**(18)**	**98.5%**
141	Restorative Dentistry	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	8	6	1	123.2%	1	6	(5)	15.8%	22	9	14	258.7%	**31**	**21**	**11**	**151.2%**
143	Orthodontics	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	234	267	(33)	87.8%	5	41	(36)	13.2%	167	261	(94)	64.0%	**407**	**569**	**(162)**	**71.5%**
144	Maxillo-facial Surgery	0	0	0	0.0%	0	0	0	0.0%	2	3	(1)	80.0%	0	31	(30)	1.6%	18	21	(3)	87.0%	119	117	2	101.3%	**139**	**171**	**(32)**	**81.4%**
150	Neurosurgery	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	**0**	**0**	**0**	**0.0%**
160	Plastic Surgery	96	161	(65)	59.8%	39	37	2	104.1%	142	143	(0)	99.7%	386	434	(48)	88.9%	336	272	65	123.8%	490	526	(36)	93.1%	**1,489**	**1,573**	**(84)**	**94.7%**
173	Thoracic Surgery	2	4	(2)	47.6%	26	36	(10)	70.9%	25	21	4	119.5%	0	0	0	0.0%	19	20	(1)	95.0%	75	50	25	151.1%	**146**	**131**	**16**	**112.1%**
180	Accident & Emergency	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	7	12	(5)	58.3%	7	12	(5)	57.4%	**14**	**24**	**(10)**	**57.9%**
190	Anaesthetics	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	393	422	(29)	93.2%	**393**	**422**	**(29)**	**93.2%**
191	Pain Management	102	98	4	103.6%	0	0	0	0.0%	0	0	0	0.0%	53	51	2	103.6%	133	165	(32)	80.6%	512	457	55	112.1%	**800**	**771**	**29**	**103.7%**
192	Critical Care Medicine	0	0	0	0.0%	0	0	0	0.0%	37	49	(12)	75.3%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	**37**	**49**	**(12)**	**76.0%**
214	Paediatric Trauma and Orthopaedics	11	16	(5)	68.8%	13	8	5	156.4%	4	6	(2)	71.8%	7	9	(3)	72.2%	191	240	(49)	79.5%	375	343	32	109.3%	**601**	**623**	**(22)**	**96.5%**
215	Paediatric Ear Nose and Throat	15	12	3	125.0%	14	10	4	142.9%	6	0	6	0.0%	43	47	(5)	90.1%	38	42	(3)	91.9%	56	61	(5)	91.4%	**171**	**172**	**(0)**	**99.8%**
216	Paediatric Ophthalmology	3	10	(7)	30.0%	0	0	0	0.0%	0	0	0	0.0%	24	35	(11)	68.5%	103	99	4	103.7%	271	344	(73)	78.8%	**401**	**488**	**(87)**	**82.1%**
217	Paediatric Maxillo-facial Surgery	9	6	3	150.0%	0	0	0	0.0%	6	0	6	0.0%	0	0	0	0.0%	1	0	1	0.0%	0	0	0	0.0%	**16**	**6**	**10**	**266.7%**
219	Paediatric Plastic Surgery	7	15	(8)	46.7%	2	2	0	131.4%	7	2	5	350.0%	16	23	(7)	69.8%	16	26	(10)	61.8%	26	24	2	109.8%	**75**	**92**	**(17)**	**81.2%**
254	Paediatric Audiological Medicine	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	245	241	4	101.6%	127	102	26	125.1%	41	58	(17)	70.0%	**413**	**401**	**12**	**102.9%**
257	Paediatric Dermatology	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	14	15	(1)	90.9%	15	20	(5)	74.1%	28	29	(0)	98.3%	**57**	**64**	**(7)**	**89.0%**
304	Clinical Physiology	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	123	128	(4)	96.6%	26	20	6	128.3%	32	42	(10)	75.4%	**181**	**190**	**(9)**	**95.3%**
310	Audiological Medicine	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	137	102	36	135.1%	32	45	(13)	71.0%	226	207	19	109.3%	**395**	**354**	**42**	**111.9%**
317	Allergy	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	1	0	1	0.0%	5	0	5	0.0%	**6**	**0**	**6**	**0.0%**
330	Dermatology	283	305	(22)	92.7%	0	0	0	0.0%	3	2	1	141.2%	1,579	2,016	(436)	78.4%	151	263	(112)	57.4%	567	506	60	111.9%	**2,583**	**3,092**	**(509)**	**83.5%**
658	Orthotics	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	56	136	(80)	41.1%	138	174	(36)	79.4%	**194**	**311**	**(116)**	**62.6%**
840	Audiology	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	136	196	(59)	69.7%	113	141	(28)	80.1%	298	305	(7)	97.8%	**547**	**641**	**(94)**	**85.3%**
Total - Surgery & Emergency (NNUH)		**1,594**	**1,671**	**(77)**	**95.4%**	**467**	**568**	**(101)**	**82.2%**	**1,018**	**1,055**	**(36)**	**96.6%**	**7,886**	**8,771**	**(885)**	**89.9%**	**6,561**	**7,157**	**(596)**	**91.7%**	**12,307**	**12,424**	**(117)**	**99.1%**	**29,833**	**31,646**	**(1,813)**	**94.3%**

Clinical Support Services Division		Daycase				Elective				Non Elective				OP - Procedure				OP - New (Exc Procedure)				OP - Follow Up (Exc Procedure)				Total			
		Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved	Estimate	Plan	Var	% Achieved
311	Clinical Genetics	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	**0**	**0**	**0**	**0.0%**
650	Physiotherapy	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	12	32	(20)	36.1%	575	584	(9)	98.5%	1,460	2,035	(575)	71.8%	**2,047**	**2,651**	**(604)**	**77.2%**
651	Occupational Therapy	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	38	42	(4)	91.5%	242	283	(41)	85.6%	653	719	(66)	90.8%	**934**	**1,044**	**(110)**	**89.5%**
652	Speech & Language Therapy	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	1	(1)	37.7%	36	27	9	133.3%	131	94	37	139.0%	**167**	**122**	**45**	**136.9%**
654	Dietetics	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	212	227	(15)	93.5%	257	313	(56)	82.2%	**470**	**540**	**(70)**	**87.0%**
656	Clinical Psychology	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	**0**	**0**	**0**	**0.0%**
711	Child and Adolescent Psychiatry	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	17	16	1	106.3%	67	50	17	134.0%	**84**	**66**	**18**	**127.3%**
713	Medical Psychotherapy	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	**0**	**0**	**0**	**0.0%**
811	Interventional Radiology	6	4	2	150.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	16	27	(11)	59.3%	46	60	(14)	76.7%	**68**	**91**	**(23)**	**74.7%**
812	Diagnostic Imaging	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	0	0	0	0.0%	**0**	**0**	**0**	**0.0%**
822	Chemical Pathology	0	0	0	0.0%	0	0	0	0.0%	0	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 - Clinical Support (NNUH)		**6**	**4**	**2**	**150.0%**	**0**	**0**	**0**	**0.0%**	**0**	**0**	**0**	**0.0%**	**50**	**75**	**(25)**	**67.1%**	**1,099**	**1,164**	**(65)**	**94.4%**	**2,615**	**3,271**	**(656)**	**79.9%**	**3,770**	**4,514**	**(744)**	**83.5%**

Best Practice Guidance on Discharge – Self Assessment

The best practice guidance on discharge covers 8 high impact changes across the system:

1) **Early discharge planning –** in elective care, planning should begin before admission. In emergency / unscheduled care robust systems need to be in place to develop plans for management and discharge, and to allow an unexpected dates of discharge to be set within 48 hours.
2) **Systems to monitor patient flow –** robust patient flow models for health and social care, including electronic patient flow systems, enable teams to identify and manage problems (for example if capacity is not available to meet demand) and, to plan services around the individual.
3) **Multidisciplinary / multi agency discharge teams including the voluntary and community sector –** coordinated discharge planning based on joint assessments processes and protocols, and on shared and agreed responsibilities, promotes effective discharge and good outcomes for patients.
4) **Home first / Discharge to assess –** providing short term care and reablement in peoples homes or using "step down" beds to bridge the gap between hospital and home means that people no longer need wait unnecessarily for assessments in hospital. In turn this reduces delayed discharges and improves patient flow.
5) **Seven-Day Service –** successful, joint 24/7 working improves the flow of people through the system and across the interface between health and social care, and means that services are more responsive to people's needs.
6) **Trusted assessors –** using trusted assessors to carry out a holistic assessment of needs avoids duplication and speed up response times so that people can be discharged in a safe and timely way.
7) **Focus on choice –** early engagement with patients, families and carers is vital. A robust protocol, underpinned by fair and transparent escalation process, is essential so that people can consider their options, the voluntary sector can be a real help to patients in considering their choices and reaching decisions about their future care.
8) **Enhancing health in care homes –** offering people joined-up, coordinated health and care services, for example aligning community nurse teams and GP practises with care homes, can help reduce unnecessary admissions to hospital as well as improve hospital discharge.

NNUH has carried out a self-assessment against the system's Key Lines of Enquiry (KLOE) relating to the 8 high impact changes specific to the Acute Hospital Discharge 100-day challenge (across).

KLOE	RAG Rating
Identify patients needing complex discharge support early	Amber
Set expected date of discharge (EDD) and discharge within 48 hours of admission	Amber
Ensure multi-disciplinary (MDT) engagement in early discharge plan	Amber
Ensuring consistency of process, personnel and documentation in ward rounds	Amber
Apply 7-day working to enable discharge of patients during weekends	Amber
Treat delayed discharge as a potential harm event	Amber
Streamline operations of Transfer of Care Hubs	Amber
Develop demand/capacity modelling for local and community systems	Green
Manage workforce capacity in community and social care settings to better match predicted patterns in demand for care and any surges	Red
Revise intermediate care strategies to optimise recovery and rehabilitation	Amber

REPORT TO TRUST BOARD

Date	**7 June 2023**
Title	**Month 1 IPR – Finance**
Author & Exec Lead	**Roy Clarke (Chief Finance Officer)**
Purpose	**For Information/Discussion/Agreement** *[delete as appropriate]*
Relevant Strategic Commitment	**1 Together, we will develop services so that everyone has the best experience of care and treatment** **5 Together, we will use public money to maximum effect.**

Are there any quality, operational, workforce and financial implications of the decision requested by this report? **If so explain where these are/will be addressed.**	**Quality**	**Yes✓ No☐**	**Delivery of the financial plan supports the delivery of operational, quality and workforce plans**
	Operational	**Yes✓ No☐**	**Delivery of the financial plan supports the delivery of operational, quality and workforce plans**
	Workforce	**Yes✓ No☐**	**Delivery of the financial plan supports the delivery of operational, quality and workforce plans**
	Financial	**Yes✓ No☐**	**Delivery of the financial plan supports the delivery of operational, quality and workforce plans**
Identify which Committee/Board/Group has reviewed this document:	**Board/Committee: FIPC & HMB**		**Outcome: Report for information only, no decisions required.**

1 Background/Context

The Trust operational plan for FY23/24 as outlined in Cycle 4 of the 2023/24 planning process is breakeven.

2 Key issues, risks and actions

For the month of April 2023, the Trust delivered a £3.0m deficit, which on a control total basis is £1.2m adverse to plan. The adverse variance is due to £1.2m of net additional costs related industrial action in April, £1.2m underdelivery of CIP and an adjustment for the Aligned Performance Incentive (API) variable clawback which in April is estimated at a net £0.3m deduction. This is offset by non-recurrent savings of £1.5m.

Activity Plan: 2023/24 sees a return to the Trust being paid for Elective activity on an actual variable basis at national tariff rates. Elective activity is subject to a national target (which is 105% of 19/20 levels for N&W System). Chemotherapy Delivery and Diagnostic Imaging are also paid on a variable basis but are not subject to any target. All other activity is funded via the remaining fixed contract value.

Activity: April activity was behind plan, with estimated performance at 92% of plan for all elective activity. Value based activity performance for April was 96% of plan. Including other chargeable API (Chemotherapy Delivery and Diagnostic Imaging) activity value based activity performance was 98% of plan.

Forecast Outturn: Forecast outturn is breakeven, unchanged from the Cycle 4 FY23/24 plan. There is identified delivery risk to the breakeven plan of £60.7m which would result in a downside deficit of £60.7m. Risk of £2.7m and mitigation of £1.5m crystalised in April, a net impact of £1.2m adverse variance which will require mitigation through the remainder of the financial year.

Cash: Cash held at 28th April 2023 is £113m. The closing balance is £0.2m above the FY23/24 submitted forecast as result of the phasing to the capital programme, quarterly Learning and Development Agency (LDA) funding being received in April and a reduction in year end debtors. Cash balances have remained positive in April 2023 thus no revenue support has been required.

Income and Pay: The income and pay positions include the Agenda for Change (AfC) pay award of £1m for April. This is the difference between the amount included within plan, 2% and the agreed award in May of an average of 5.2%.

Capital Expenditure: In month the core programme was underspent by £0.02m. The current forecast outturn of £16.5m results in a significant overspend of £1.9m. This requires immediate management action to bring the programme back in line with plan. The total programme including the Central Programme, IFRS16 & the Donated Programme is overspent by £0.1m

3 Conclusions/Outcome/Next steps

In Month, the Trust delivered a £3.0m deficit against the planned £1.8m deficit, £1.2m adverse. Forecast Outturn remains Breakeven. The Trust underspent Capital Expenditure by £0.02 for the month. The latest Capital Forecast is an overspend of £1.9m.

Recommendations: The Board is recommended to: **Note** the contents of the report

Norfolk and Norwich University Hospitals NHS Foundation Trust

Finance Report
April 2023

23 May 2023

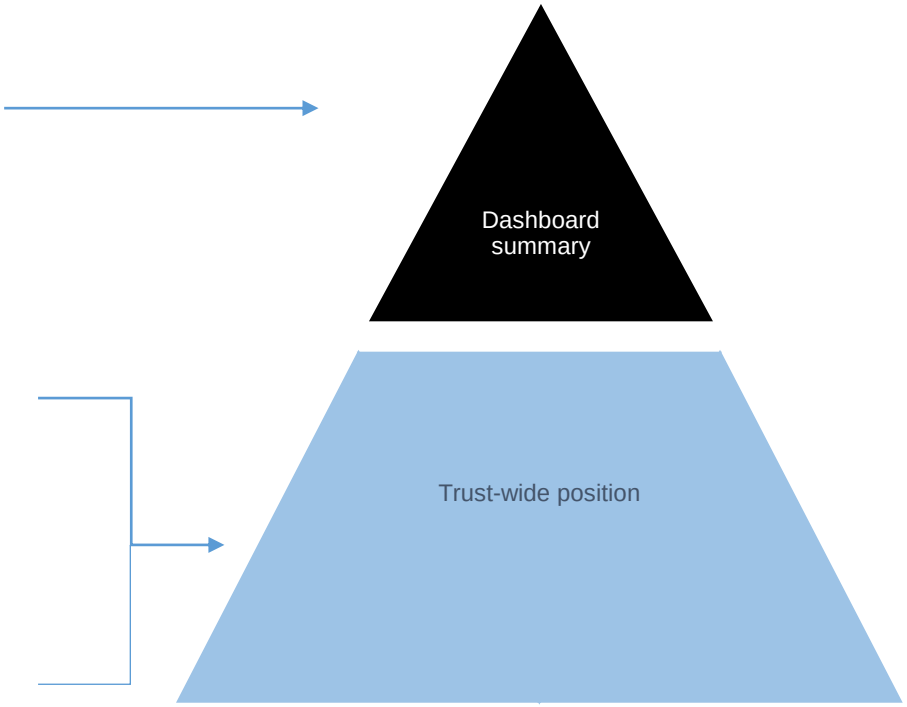
Roy Clarke, Chief Finance Officer

Norfolk and Norwich University Hospitals NHS Foundation Trust

Contents

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

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



Norfolk and Norwich University Hospitals NHS Foundation Trust

1.1 Executive Dashboard

The Trust operational plan for FY23/24 as outlined in Cycle 4 of the 2023/24 planning process is breakeven.

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	In Month		
	Actual	Plan	Variance
SOCI	£m	£m	£m
Clinical Income	58.9	59.2	(0.3)
Other Income	7.8	7.5	0.3
Notional Income - Additional Consolidated Pay Award	1.0	0.0	1.0
TOTAL INCOME	**67.7**	**66.7**	**1.0**
Pay	(42.3)	(40.8)	(1.5)
Pay - Additional Consolidated Pay Award	(1.0)	0.0	(1.0)
Non Pay	(18.1)	(18.4)	0.3
Drugs (Net Expenditure)	(3.0)	(2.7)	(0.3)
TOTAL EXPENDITURE	**(64.4)**	**(61.9)**	**(2.5)**
Non Opex	(6.3)	(6.6)	0.3
Reported Surplus / (Deficit)	**(3.0)**	**(1.8)**	**(1.2)**

Other Financial Metrics	£m	£m	£m
Cash at Bank (before support funding)	113.0	112.8	0.2
Capital Programme Expenditure	0.7	0.6	0.1
CIP Delivery	0.5	1.7	(1.2)

Activity Metrics*	%	%	%
Day Case*	106%		6%
Elective Inpatient*	97%		(3%)
Outpatients - New & Procedures*	88%		(12%)
Activity performance v baseline*	92%		(8%)
Value based Activity performance v baseline	98%		(2%)

** Activity count as a % of 23/24 Planned Delivery*

Norfolk and Norwich University Hospitals NHS Foundation Trust

1.2 Executive Dashboard

Risk

The strategic financial risks remain the same as Cycle 4 Business planning Process in nature. Risk C has been reassessed following the industrial action in April and the financial value has deteriorated by £1.2m. They will remain beyond tolerable levels should the underlying issues not be resolved.

As part of FY23/24 annual planning there were 13 key strategic and operational risks identified with an initial score of ≥ 9. 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 seven risks rated as 'High' or 'Extreme' on the risk register which have a potential risk assessed financial impact of £45.7m, of which £2.7m has crystalised YTD. A further £0.9m is forecast to crystallise as a result of the increased WLI rates.

The YTD crystalised risks are:

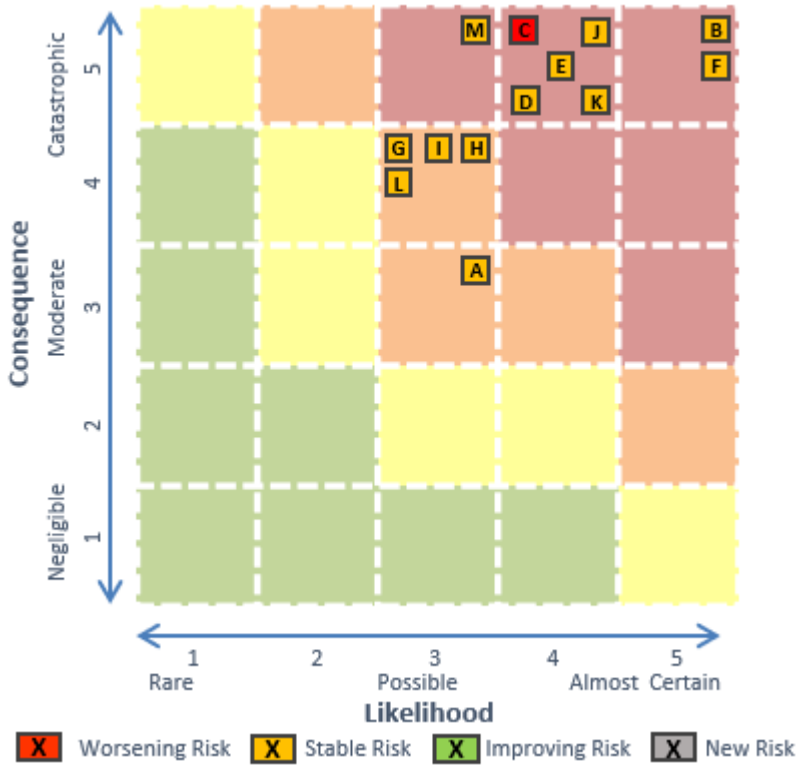
CIP Delivery (Risk B) is £0.5m year to date - £1.2m adverse to the budgeted plan of £1.7m, comprising of a planning variance of £1.2m and a performance variance of £0.0m, the equates to an underperformance of over 60%. The required CIP delivery run rate increases to £2.2m by Month 7, unless further schemes are identified promptly the shortfall will increase to £1.7m, an underperformance of 75%. Gateway 2 approved CIP value is £14.4m, £13.6m adverse to the Trust efficiency target of £28.0m.

Income claw-back as a result of failure to deliver the elective activity in line with plan (Risk F) has a crystalised impact of £0.3m YTD as a result of value based activity being c. 96% (£0.3m). This shortfall is required to be caught up in the remainder of the year. The Paediatric Theatres backfill capital works has been delayed by a further five weeks which will impact Surgery's ability to deliver the agreed activity plan. The value based calculation of the lost activity from the delay is c. £0.6m.

Continuing Management Actions Outstanding:

- **Identify remaining CIPs to meet Trust's efficiency target**
- **Deliver on existing CQIA approved CIP, including YTD shortfall**
- **Deliver Trust activity plan including YTD shortfall**
- **Mitigate pay expenditure overspends and enact required controls**
- **A variation to the latest capital programme for 23/24 is required to bring the programme back into financial balance**

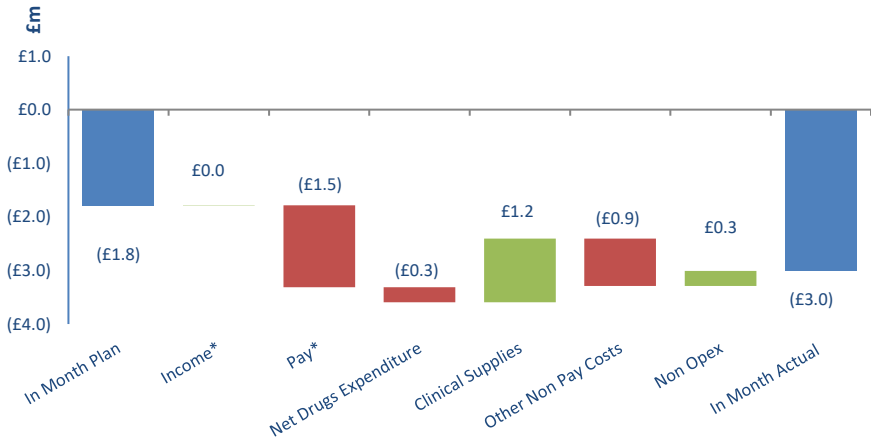
Risk Rating		Risks	Financial Impact FY23/24 (Cycle 4) £m	Financial Impact FY23/24 (Revised) £m	YTD Crystallised Impact £m
Extreme	15+	B, C, D, E, F, J, K, M	44.5	45.7	2.7
High	9-14	A, G, H, I, L	16.2	16.2	0.0
Moderate	5-8	-	0.0	0.0	0.0
Low	1-4	-	0.0	0.0	0.0
Total			60.7	61.9	2.7
Risk mitigated through Non Recurrent YTD underspends & Release of Expenditure Reserves					(1.5)
Total			60.7	61.9	1.2



Norfolk and Norwich University Hospitals NHS Foundation Trust

2.1 Financial Performance – April 2023

For the month of April 2023, the Trust delivered a £3.0m deficit, which on a control total basis is £1.2m adverse to plan. The adverse variance is due to £1.2m of net additional costs related industrial action in April, £1.2m underdelivery of CIP and an adjustment for the Aligned Performance Incentive (API) variable clawback which in Month 1 is estimated at a net £0.3m deduction. This is offset by non recurrent savings of £1.5m.



M1 adjustment - removing income and pay expense for the additional 23/24 consolidated pay award

Income*: Income is on plan in April. The income position includes API variable clawback which in M01 is estimated at a net £0.3m deduction, which is offset by additional research and development income of £0.3m.

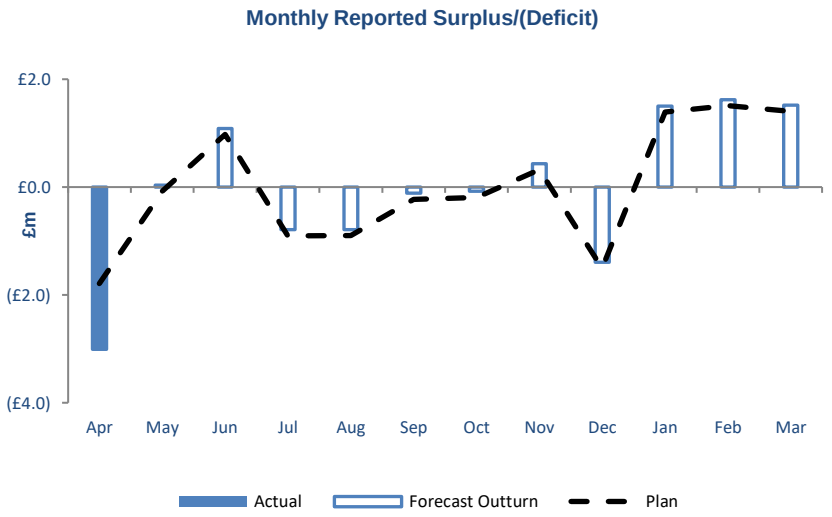
Pay*: Pay is overspent in Month 1 by £1.5m. £1.2m relates to additional pay costs due to the industrial action during April and £0.6 is as a result of underdelivery against the CIP plan. This is offset by savings across the Admin & Clerical staff groups.

Net Drugs Cost: The net drugs position for April is £0.2m adverse to plan. £0.1m is a result of underdelivery against the CIP plan and a further £0.1m is as a result of the mix of tariff and non tariff drugs which varies month on month.

Non Pay: There is a £0.3m favourable variance across Non Pay In April. This is made up of £0.6m as a result of underdelivery against the CIP plan offset by £0.8m of non-recurrent savings of £0.8m

Non Operating Expenditure: There is a (£0.3m) favourable variance in April. This is due to additional interest income received.

**In line with NHSE guidance a notional adjustment has been made for incremental pay expenditure of £1.0m offset by £1.0m of additional income relating to the agreed 23/24 AfC consolidated pay offer.*



Norfolk and Norwich University Hospitals NHS Foundation Trust

2.2 22/23 Forecast Outturn (FOT)

Forecast outturn is breakeven, unchanged from the Cycle 4 FY23/24 plan. There is identified delivery risk to the breakeven plan of £60.7m which would result in a downside deficit of £60.7m. Risk of £2.7m and mitigation of £1.5m crystalised in April, a net impact of £1.2m adverse variance which will require mitigation through the remainder of the financial year.

1 Delivery risk / downside (-£60.7m)

There are a number of significant risks to delivery of the breakeven plan:

- CIP under-delivery risk – the risk assessed delivery gap is currently £18.8m
- Cost pressure combined risk including identified residual pressures, further price pressure, and impairment risk – £24.2m
- Investment requests not progressing - £4.1m
- Elective variable income risk – estimated at £13.6m based on the gap between current activity run rate c97% of 19/20 and planned activity requirement at 105%.

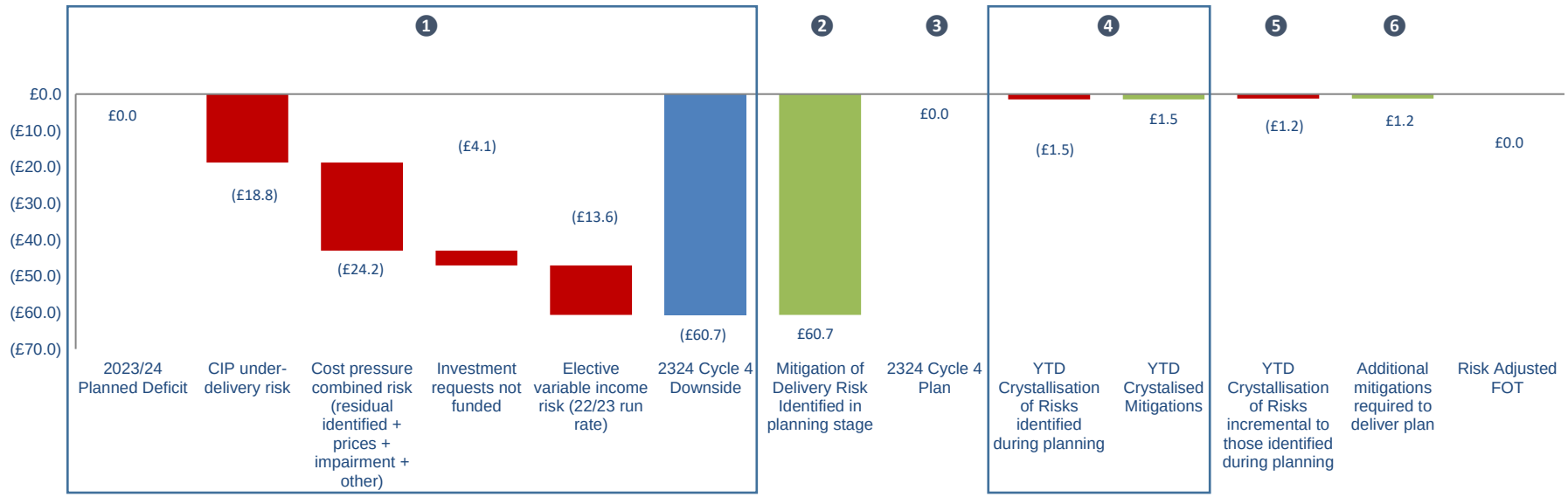
2 Cycle 4 planning assumes the £60.7m will be fully mitigated

3 Planned 23/24 position at Cycle 4 of the planning process was Breakeven

4 Crystallisation of risks identified at planning stage £1.5m offset by £1.5 of crystalised mitigations. Net movement £0.0m.

5 Crystallisation of risks incremental to those identified at the planning stage of £1.2m

6 Additional mitigations of £1.2m are required to deliver the breakeven plan



Microsoft | Power BI

Workforce

View in Power BI

Last data refresh:
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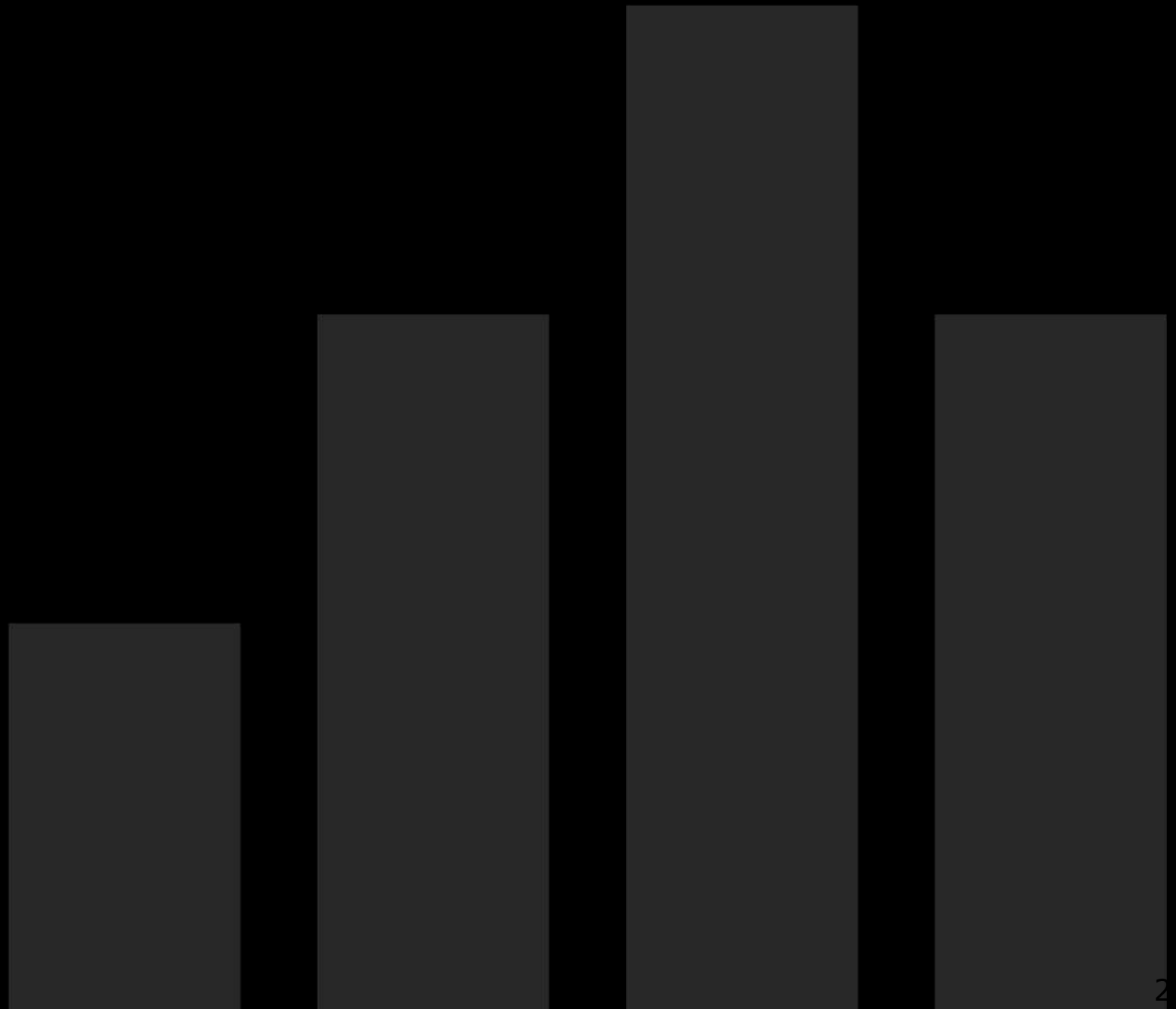


Workforce Summary

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 2023	88.9%	Improvement (High)	Not capable
Job Planning	Job Plans Signed Off % (Within 12months)	Apr 2023	55.7%	Concern (Low)	Not capable

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 2023

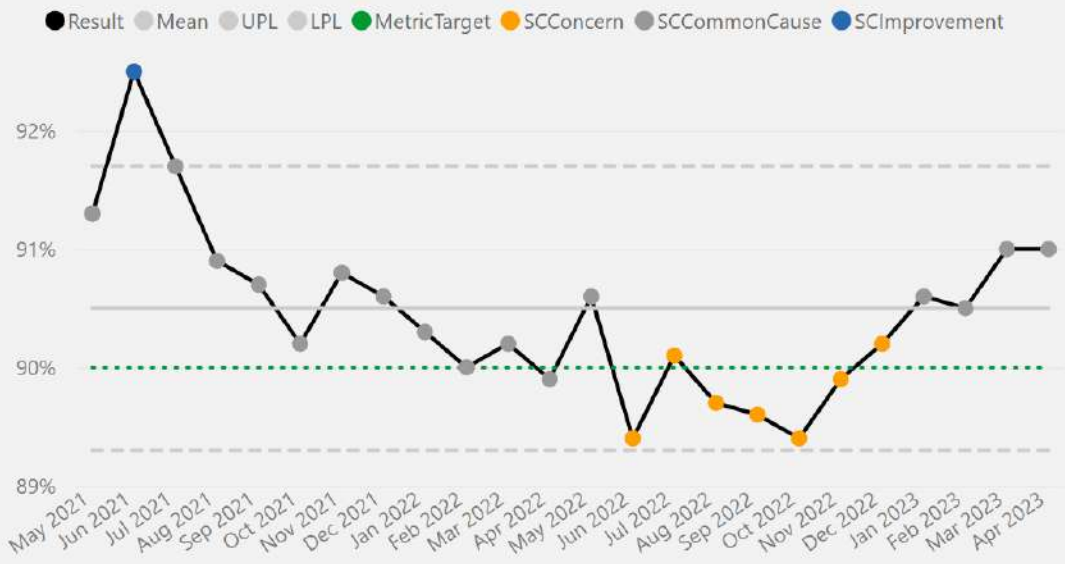
Variation | Assurance

91.0% Result
90.0% Target
91.7% UPL
90.5% Mean
89.3% LPL

Analytical Commentary

Variation is Common Cause

Mandatory Training



Assurance Commentary

As at the end of April, the overall compliance rate was 91.0%. For Medical staff, the compliance rate for permanent staff was 92.0% - this figure reduces to 83.8% including the fixed term rotational junior doctors.

This is the fifth consecutive month achieving the trust compliance target of 90%.

Following the change of level 2 Safeguarding Adults to Safeguarding level 3, the compliance continues to increase, as planned. Safeguarding children level 3 has maintained compliance above 90% for the last 4 months and safeguarding adults level 3 has increased again this month to 89.78%, in line with the trajectory is anticipated to reach 90% by May.

Classroom based training remains the primary area of lower compliance and being affected by the extreme pressures that the hospital has been under.

The new Resuscitation eLearning training launched in February. The teams have worked hard to achieve a smooth transition from the current annual classroom requirement to the new model of annual eLearning with 2-yearly classroom-based training. Compliance has seen a month on month improvement with Adult basic life support now pulling out of the red risk rating into amber achieving 79% compliance.

Improvement Actions

April 2023 - Targeted messages were sent to staff who have fallen below on their compliance for Information Governance, Safeguarding and Resuscitation.
April 2023 – Safeguarding children level 3 is at 90.6% and remains above the Trust target.

Non-Medical Appraisals

NNUH Digital Health
business intelligence

Non-Medical Appraisal

Apr 2023

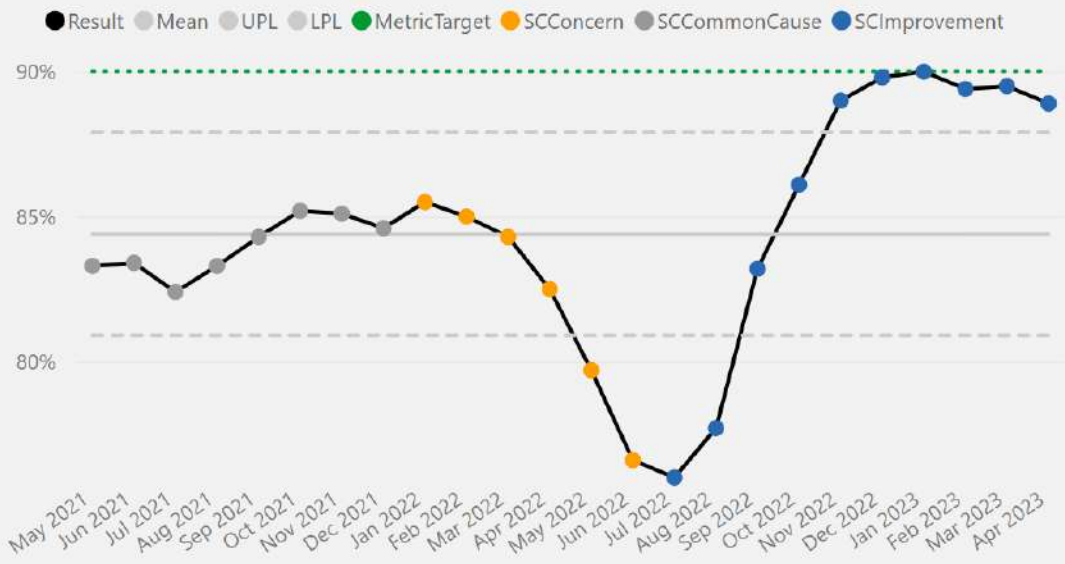
Variation	Assurance
H	F

88.9% Result	87.9% UPL
90.0% Target	84.4% Mean
	80.9% LPL

Analytical Commentary

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

Non-Medical Appraisal



Assurance Commentary

In the 12 months to April 2023, 88.9% of eligible staff (non-medical appraisals) had an appraisal (inclusive of the new PDR or the previous appraisal process). This represents a 0.6% decrease in performance compared to the previous month. This is slightly under the target of 90%.
Each Division has achieved the 80% consistently since October 2022. As of April 2023, Women and Children's Division, Surgery Division and Clinical Support Services remain above the target of 90%.
Appraisal was the most improved NNUH staff survey 2022 sub-score (which comprises of four appraisal related questions) which is encouraging given the actions taken to launch a new PDR process April 2022, supported by line management training. However, the quality of appraisal question scores remain below the national acute average (124 trusts) and further improvement is required to enhance staff appraisal experience for our staff.

HMB agreed principles and improvements to the PDR process and form;
- The PDR year 23/24 for cascade with 90% completion by 30.9.23.
- Agreement for Staff Experience improvement objective to be added into all leaders and managers PDR objectives.
- HRBPs to promote the PDR materials, with minor tweaks to the PDR form and addition of Health and Wellbeing guidance.
- Departments that scored low staff satisfaction for their appraisal experience will be targeted for improvement interventions

Improvement Actions

April 2023 - HRBPs have worked with divisions to commence the PDR planning for the 23/24 cascade with trajectories to meet the 90% completion requirements

April 2023 – Promotion of PDR training for managers will take place as we prepare the launch of PDR 23/24 as we continue to seek improvement to the staff PDR experience.

Sickness Absence

NNUH Digital Health
business intelligence

Monthly Sickness Absence %

Apr 2023

Variation

Assurance

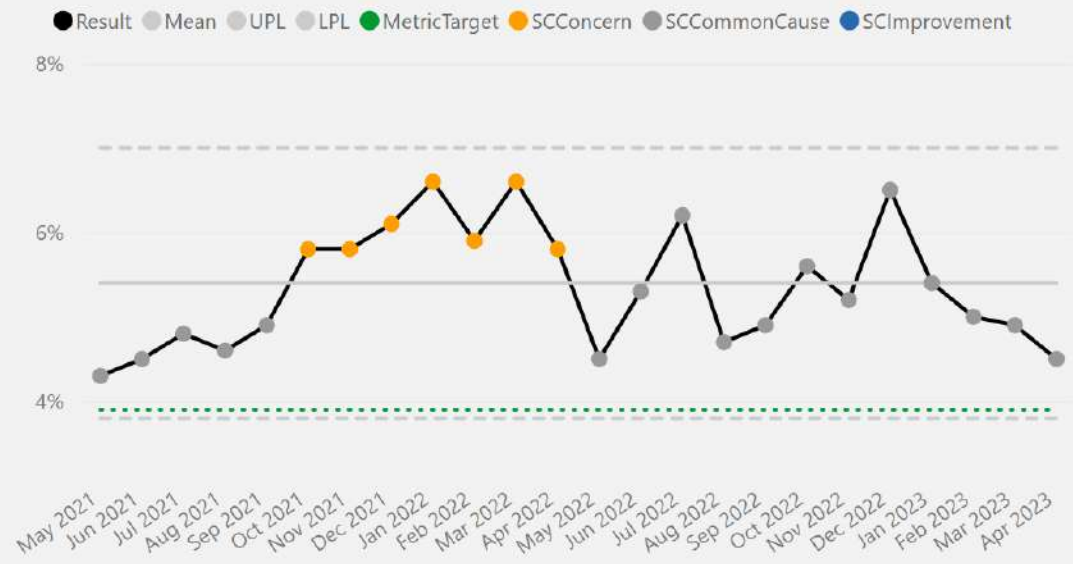
4.5% Result
3.9% Target

7.0% UPL
5.4% Mean
3.8% LPL

Analytical Commentary

Variation is Common Cause

Monthly Sickness Absence %



Assurance Commentary

The Trust's 12 month rolling average target for sickness absence is 3.9%. As at 30 April 2023, that rate is 5.2%. The monthly absence figure for April 2023 is 4.5%. Had Covid sickness been excluded the 12-month rolling average rate would be 4%. Covid related sickness in April 2023 was 0.5%; a slight decrease from March 2023.

The latest national NHS sickness data (December 2022) reports the NHS Acute trust 12 month average sickness rate as 5.6%, NHS England average as 5.63% and East of England average as 5.5%. The NNUH 12 month average at 31st December 22 was 5.66% and was lower than QEH at 7.01%, JPUH at 6.07% and NCH&C at 5.97%.

This is encouraging, however the December 2022 sickness data identifies Acute Trusts with sickness rates below the 5.6% average e.g. Guys and St Thomas rolling 12 month average at 4.79% and Cambridge University Hospitals at 4.9%.

Attendance Improvement Group continue to identify and progress Key Enablers for Maximising Attendance and actions for improvement. It is acknowledged that there is significant variance in absence levels at divisional/ departmental level and within the different staff groups.

The main issues cited was the impact of work experiences – eg shift allocation and inflexibilities as well as concerns when caring of particular patient groups. A wealth of support offerings are available to support staff however organisational actions to address the root cause.

Musculoskeletal injuries occurring from increased demands and repetitive activities and postures having to be adopted in overcrowded wards and patient environments.

Improvement Actions

April 2023 – The HWB team are now offering weekly drop in sessions for staff in the East Atrium (travel Kiosk) instead of monthly to help and support individuals on a more frequent basis. This allows for signposting to interventions where identified. New series of Rest and Restore days are being planned to support staff

April 2023 – Attendance Management Workshops continue to be held to upskill managers in managing sickness absence. All monthly workshop dates are available to be booked via ESR until March 2024.

April 2023 – Attendance Improvement Group are reviewing Key Enablers for Maximis

Staff Turnover

NNUH Digital Health
business intelligence

Monthly Turnover

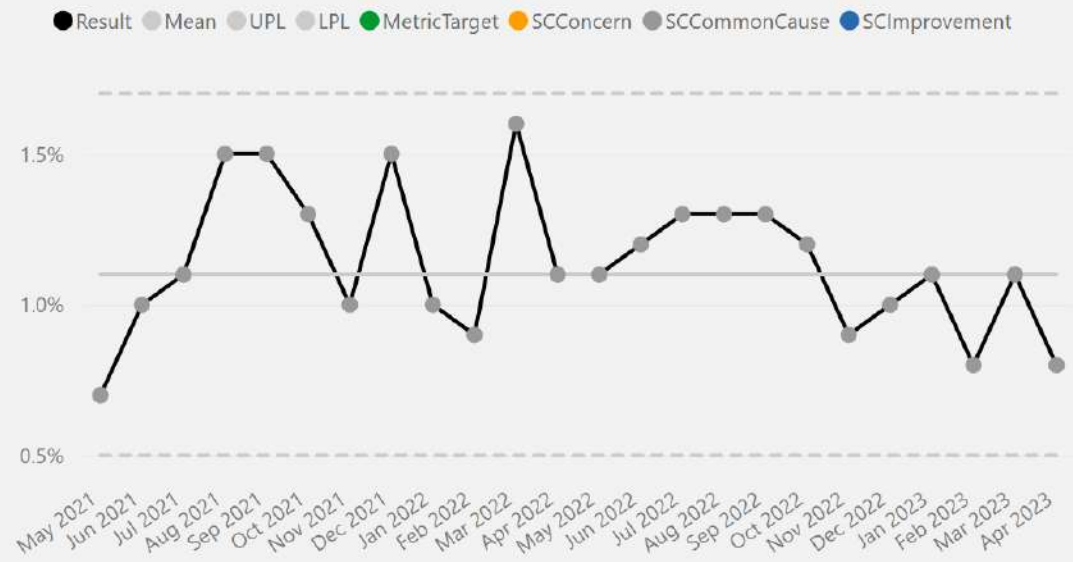
Apr 2023

Variation		Assurance	
0.8% Result		1.7% UPL	
N/A Target		1.1% Mean	
		0.5% LPL	

Analytical Commentary

Variation is Common Cause

Monthly Turnover



Assurance Commentary

The monthly turnover rate for April 2023 is 0.8% which is lower than March 2023 (1.1%) and lower than April 2022 (1.1%). The 12-month average turnover rate is 13.0%, a reduction of 0.3% from March 2023.

To reduce turnover to 10% per annum, a monthly turnover rate of 0.83% needs to be achieved and maintained. This equates to 58 WTE leaving per month.

In April 2023, 57 WTE left the Trust which is a decrease from March 2023 where 75 WTE left. February seeing 60 leave and January 76.

As part of the ICS retention steering group, a review has been undertaken of the high impact actions to ensure these are in line with the ICS priorities and plan.

A Nursing retention group has been set up to focus on the elements of staff retention which relate specifically to nursing. The group meets monthly with representatives from all the divisions, and the key actions include:

- Implement Legacy Nurses into the organisation
- Embed the internal transfer policy
- Give staff flexible working opportunities which do not involved 12 hour shifts
- Reduce the number of in-shift redeployments
- Define career pathway to enable progression from HCA to RN.

In order to encourage a culture of support and increase the awareness of the reasons staff leave, an increase in the stay conversations taking place is required. A divisional KPI of 40% of all leavers to have had a stay conversation was agreed at the Workforce and Education Sub-Board.

Improvement Actions

April 2023 – Completion of review of our high impact actions to ensure they are in line with the ICS retention review and priorities.

April 2023 – Nursing Retention Group formalised and actions agreed, with reporting accountability to the Retention Board.

April 2023 – Stay Conversations re-launched.

Staff in Post

NNUH Digital Health
business intelligence

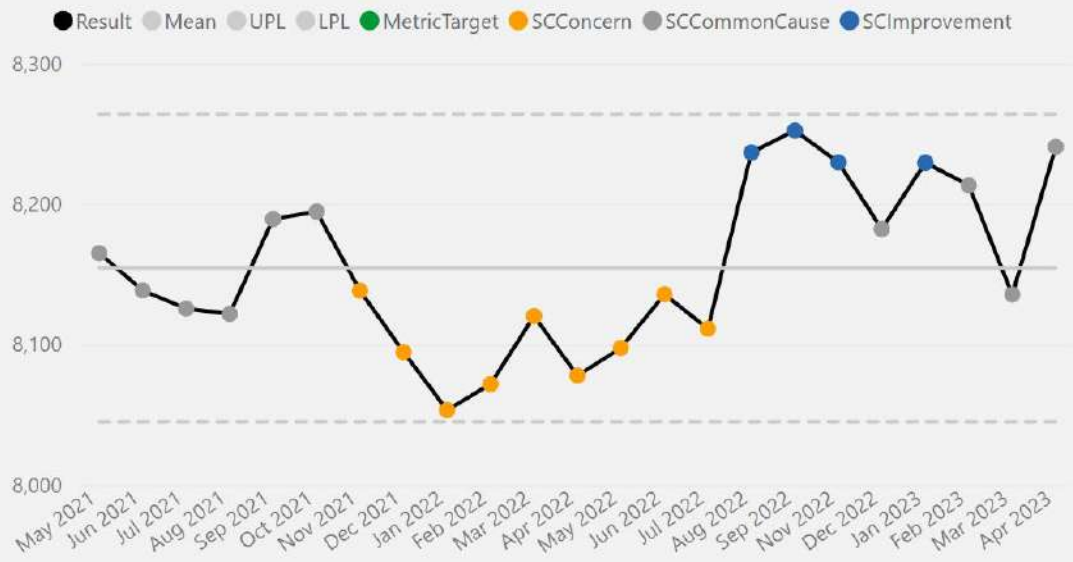
Actual Substantive Headcount (WTE)

Apr 2023

Variation | Assurance

8,241 Result	8,264 UPL
N/A Target	8,154 Mean
	8,045 LPL

Actual Substantive Headcount (WTE)



Improvement Actions

Analytical Commentary

Variation is Common Cause

Assurance Commentary

Vacancies

NNUH Digital Health
business intelligence

Variance: Headcount (WTE)

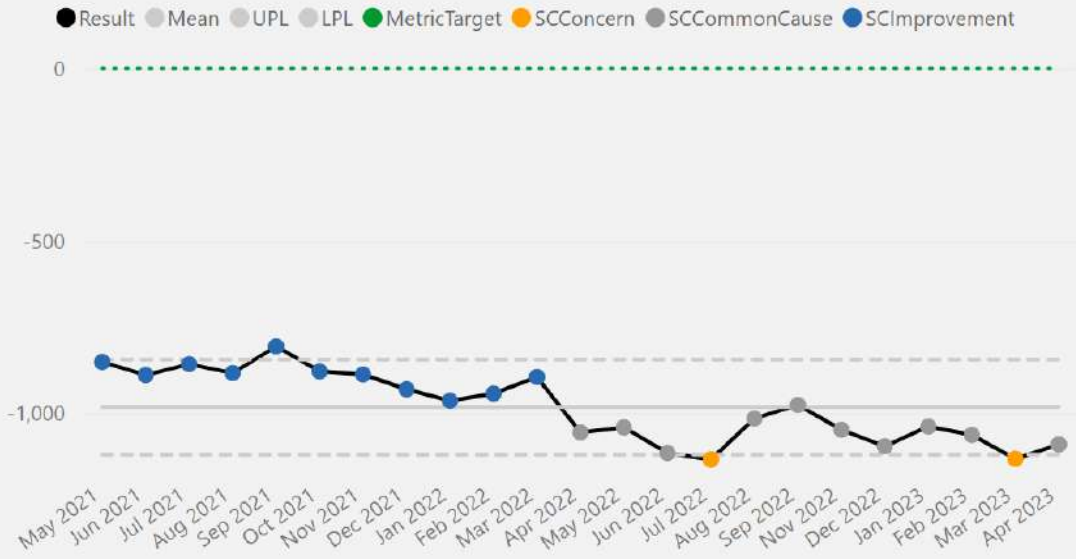
Apr 2023

Variation	Assurance
	

-1,091 Result
0 Target

-845 UPL
-983 Mean
-1,121 LPL

Variance: Headcount (WTE)



Improvement Actions

April 2023 – Divisional recruitment trajectories updated based on the finalised 2023/24 workforce plans and the Trust recruitment plan for 23/24.

April 2023 –People Promise Priority Improvement Actions for 2023/24 is drafted and continues to be consulted upon

Analytical Commentary

Variation is Common Cause

Assurance Commentary

Substantive staff in post is 8,241 for April 2023, a decrease from March 2023 (8,135).
Improving headcount performance requires vacancy reduction and turnover reduction to be achieved. Vacancy rate is at 11.7% for April 2023, which is a reduction from March 2023 (12.2%).
Through the Performance Assurance Framework, performance against trajectories for nursing vacancies in Medicine, Surgery, Midwifery and Paediatrics are reviewed on a monthly basis.
Trust wide trajectories for key clinical posts that span the next 2 years, inclusive of data relating to internal promotions, so that we can monitor the progress of our recruitment planning to achieve a reduction in the vacancy gap. For the priority areas of band 5 nursing and healthcare assistants, the actual staff in post is ahead of the planned trajectory.
Staff engagement is critical to assist with retention of staff. The People Promise Priority Improvement Actions for 2023/24 have been developed, following the staff survey results and feedback from line managers which have been discussing the results with their teams to agree actions. This drafted plan has been consult with JSCC and Staff Council, Trust Board, HMB, People and Culture Committee for feedback and comments (which included feedback from divisions which was required by 30.4.23). The final version will be to presented to People & Culture Committee during May 2023 to progress agreement for the plan.

Recruitment (Non-Medical)

NNUH Digital Health
business intelligence

Time to Hire - Total

Apr 2023

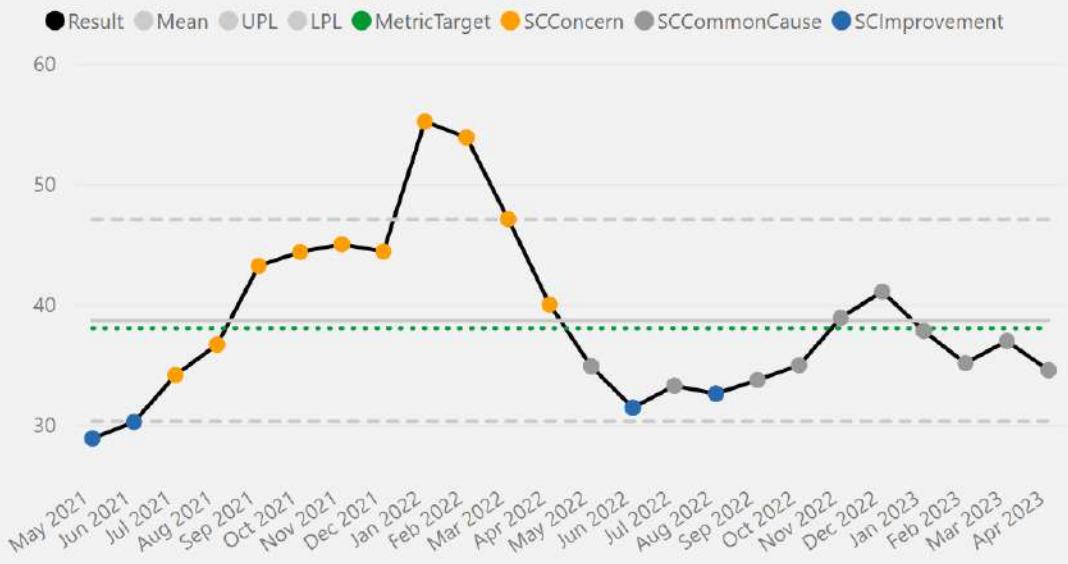
Variation | Assurance

34.5 Result
38.0 Target
47.0 UPL
38.7 Mean
30.3 LPL

Analytical Commentary

Variation is Common Cause

Time to Hire - Total



Assurance Commentary

The April Time to Hire was 34.5 working days. This is within the new Trust KPI of 38 days. This has seen 98 candidates be recruited to roles within the Trust, 45 of which were external to the Trust.
Time to Offer is at 2.4 working days, this is a reduction of 0.2 working day but is above the target of 2 days. Work allocation will be reviewed to ensure this meets the target.
The average Time to Select was 10.4 working days. This is slightly over the target time of 10 days. Three Divisions have achieved the time to select this month during significant operational pressures and industrial action.
Time to check was 23.9 which is under the internal target of 26 days.

Model Hospital has been reviewed for time to hire for peers across the England and also in the East of England. High performing Trust's have been contacted to gain understanding of any improvements that may be of benefit to the recruitment processes. A Recruitment Summit was held with Recruitment to develop further improvements to processes and candidate experience. A report to highlight improvements that will be

Improvement Actions

April 2023 - 31 Health Care Assistants commenced their induction training (23 Medicine, 7 Surgery, 1 W&C).
May 2023 - 26 Health Care Assistants are due to start (16 Medicine, 9 Surgery, 1 W&C)
April 2023 - 9 International Nurses commenced their induction training (9 Medicine).
March 2023 - 113 FPQs (First post qualified) Registered Nurses and Midwives are in offer/starting stages (1 CSS, 18 Medicine, 42 Surgery, 52 W&C).

Supplementary Metrics

Metric Name	Date	Result	Variation	Assurance
Time to Hire - Time To Select	Apr 2023	10.4	Common Cause	No Target

Job Planning

NNUH Digital Health
business intelligence

Job Plans Signed Off % (Within 12months)

Apr 2023

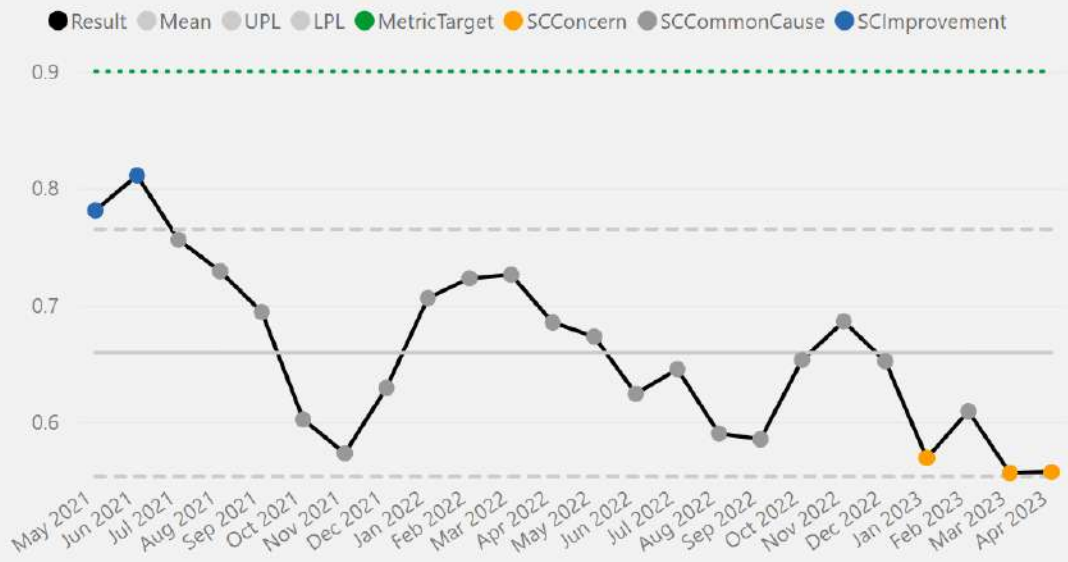
Variation	Assurance
L	F

55.7% Result	76.5% UPL
90.0% Target	65.9% Mean
	55.3% LPL

Analytical Commentary

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

Job Plans Signed Off % (Within 12months)



Assurance Commentary

Overall performance has remained the same as the previous month.

Improvement Actions

To continue to the project work to review and update information for end users on the intranet relevant to job planning.
To continue to work with the BI team to implement new IPR report which allows for job plans that have been signed off within 12 months but are in discussion phase to be updated due to a change in service or the individual's needs to be included in the performance figures.

Recruitment Trajectories

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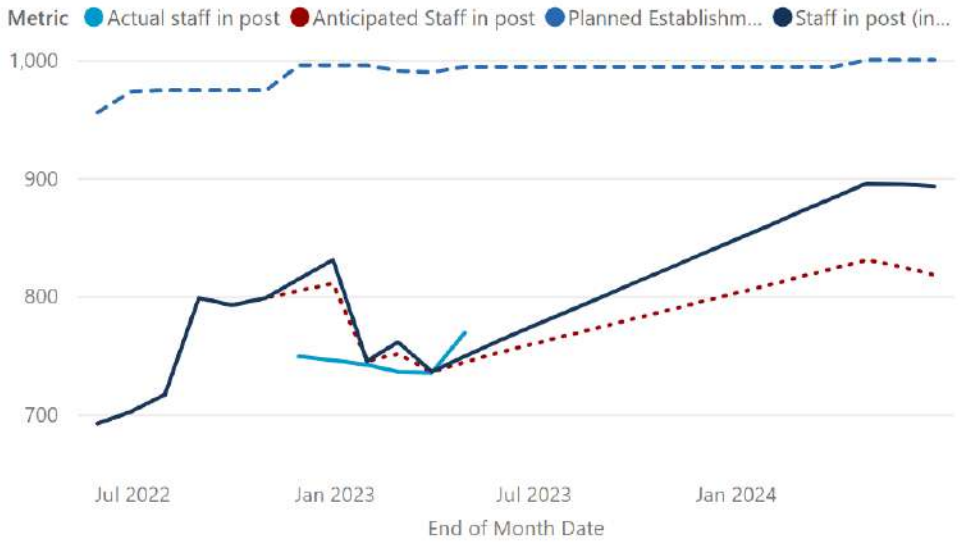
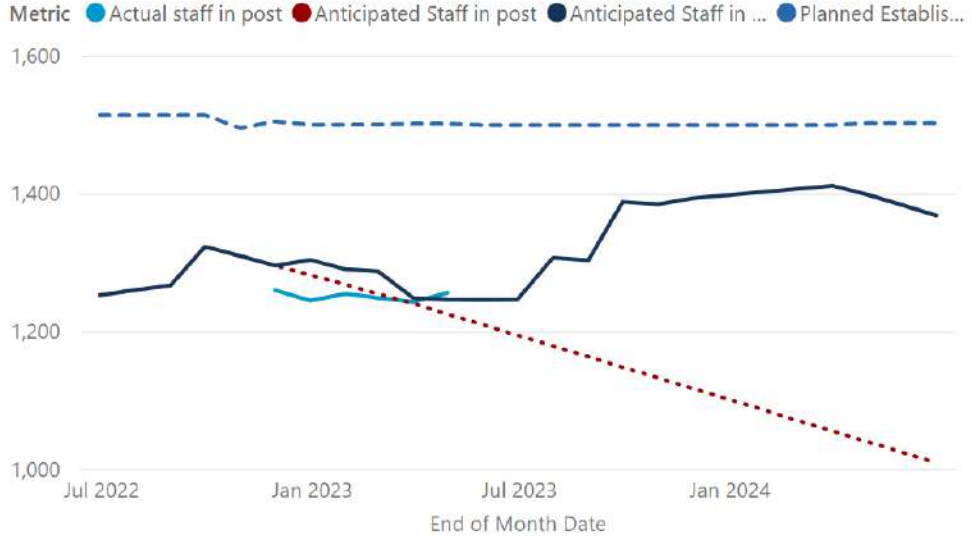
business intelligence

Recruitment Trajectory - Trust Band 2 Healthcare Assistant



Metric	May-22	Jun-22	Jul-22	Aug-22
Actual staff in post				
Anticipated Staff in post	692.30	702.20	716.57	798.41
Anticipated Vacancy %	27.5%	27.8%	26.4%	18.0%
Anticipated Vacancy % (increased capacity)	27.5%	27.8%	26.4%	18.0%
Increased Capacity				
Internal Promotions			0.87	0.87
Other Leavers	18.84	15.92	19.76	15.29
Planned Establishment	955.40	973.10	974.10	974.10
Planned Establishment %	00.0%	00.0%	00.0%	00.0%
Recruitment Activity			35.00	98.00
Staff in post (increased capacity)	692.30	702.20	716.57	798.41

Recruitment Trajectory - Trust Band 5 Nurse



Metric	May-22	Jun-22	Jul-22	Aug-22
Vacancy % (INR)		17.3%	16.8%	16.3%
Recruitment Activity		15.44	29.30	28.44
Promotions		8.66	8.66	8.66
Planned Establishment %			00.0%	00.0%
Planned Establishment		1,513.20	1,513.20	1,513.20
Leavers		13.00	13.00	13.00
Increased Capacity				
Anticipated Vacancy FTE (INR)		261.30	253.66	246.88
Anticipated Vacancy FTE		261.30	253.66	246.88
Anticipated Vacancy %		17.3%	16.8%	16.3%
Anticipated Staff in post (INR)		1,251.90	1,259.54	1,266.32
Anticipated Staff in post		1,251.90	1,259.54	1,266.32
Actual staff in post				

Staff Survey

Current View: Trust 2022

Division: All | Promise / Theme: All | Question: All | Year: 2022

Norfolk and Norwich University Hospitals NHS Foundation Trust

Hold CTRL to select multiple selections. Please be aware Promise and Theme scores only show on individual divisions.

6.8 Promise 1: We are compassionate and inclusive

5.2 Promise 2: We are recognised and rewarded

6.1 Promise 3: We each have a voice that counts

5.4 Promise 4: We are safe and healthy

5.1 Promise 5: We are always learning

5.8 Promise 6: We work flexibly

6.3 Promise 7: We are a team

6.1 Theme: Staff Engagement

5.1 Theme: Morale

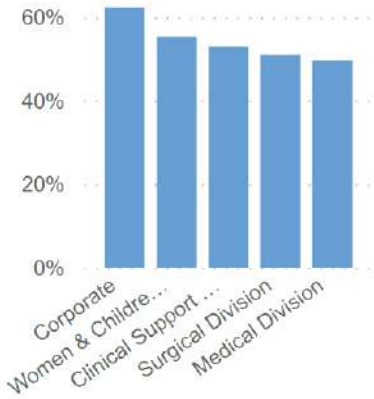
Hover to find out more:

People Promise and Theme Scores by Year and Comparators

Year on Year Difference

People Promise/Theme	21 & 22 Diff
We are always learning	0.24
We are a team	0.04
We work flexibly	-0.02
We are compassionate and inclusive	-0.09
We are safe and healthy	-0.10
We each have a voice that counts	-0.13
We are recognised and rewarded	-0.14
Morale	-0.15
Staff engagement	-0.21

% Scored Positively by Division



% Scored Positively by Question Breakdown

Division	% Scored Positively	Avg Acute %	21 & 22 Diff
Clinical Support Division			
We are compassionate and inclusive	63.8%	70.12%	-2.2%
We are recognised and rewarded	48.4%	50.61%	-2.9%
We each have a voice that counts	56.7%	64.37%	-1.2%
We are safe and healthy	47.7%	51.57%	-1.4%
We are always learning	42.2%	49.96%	2.1%
We work flexibly	47.3%	53.75%	0.0%
We are a team	58.8%	64.42%	-0.9%
Staff engagement	53.4%	64.31%	-3.4%
Morale	44.3%	51.02%	-1.0%
Corporate			
We are compassionate and inclusive	70.9%	70.12%	-0.3%
We are recognised and rewarded	58.1%	50.61%	0.4%
We each have a voice that counts	65.8%	64.37%	0.0%
We are safe and healthy	56.4%	51.57%	0.0%
We are always learning	52.8%	49.96%	5.2%
We work flexibly	67.4%	53.75%	6.7%
We are a team	68.6%	64.42%	2.6%
Staff engagement	63.2%	64.31%	-1.6%
Morale	54.5%	51.02%	-0.3%
Medical Division			
We are compassionate and inclusive	60.4%	70.12%	-2.9%
We are recognised and rewarded	39.9%	50.61%	-1.6%
We each have a voice that counts	53.6%	64.37%	-3.5%
We are safe and healthy	42.4%	51.57%	-1.9%
We are always learning	42.9%	49.96%	1.6%

REPORT TO TRUST BOARD

Date	**7 June 2023**
Title	**Chair's key Issues report from Major Projects Assurance Committee meeting on 31.05.23**
Lead	**Mr Tom Spink (Committee Chair)**
Purpose	**For Information**

The Major Projects Assurance Committee met on 31 May 2023. The focus of this meeting was receiving update reports with regard to specified major estates projects and an overview of progress in the Transformation Programme. The following issues were identified to highlight to the Board:

1	Update on Estates Major Projects	The Committee was updated with regard to progress in completing major projects in the Trust: i) **Jenny Lind Children's Hospital (JLCH) theatre complex:** The Committee was updated on the construction work to create the complex of paediatric theatres. Specialist finishes are being applied to the theatre walls to enable use of lasers and the facility is projected to be operational for clinical use in October 2023. This will be a significant step forward in enhancing the services of the Jenny Lind Children's Hospital. ii) **Diagnostic & Assessment Centre (DAC)**: The Trust still awaits final confirmation of national funding for the DAC. Arrangements are in place for rapid project initiation as soon as we have the final go-ahead. This is thought to be imminent, and the Board will be updated on the latest position.
2	Update on Transformation Programme	The Committee was updated on progress with the Trust's Transformation Programme, to deliver improved efficiency, quality and VFM. Including unmet challenge carried forward from 22/23, the Trust is facing a financial savings target of £28m for delivery in 23/24. The Transformation Programme is overseeing the delivery of key strategic initiatives with a specific focus on Length of Stay, Outpatients, diagnostics and theatres. Current plans across these Strategic Initiatives and Cost Improvement Plans (CIPS) total £17.9m, with a remaining gap of £10.8m for 23/24. It is evident that significant further progress is required to mitigate the risk to achievement of the savings target.
3	Draft Committee Annual Report	In accordance with its ToRs the Committee has produced an annual report regarding its work, albeit that this only covers the period Jan-Mar 2023. The Annual Report (uploaded to Resource Centre) confirms the Committee has been established with formal approved Terms of Reference, an agreed cycle of meetings and a Work Programme of scheduled reports. The Committee also considered and **agreed** the most significant risks relating to its remit, as detailed in the report.

The next meeting of the Major Projects Assurance Committee is scheduled to take place on 28 June 2023.

Recommendation: The Board is recommended to **note** the work of its Major Projects Assurance Committee and **receive** its Annual Report 2022/23

REPORT TO TRUST BOARD			
Date	**7th June 2023**		
Title	**The Norfolk and Waveney ICB Joint Forward Plan**		
Authors	**Jim Barker (Head of Strategy); Simon Hackwell (Director of Strategy and Major Projects)**		
Purpose	**Review and approve**		
Relevant Strategic Commitment & BAF Reference	**Our Patients**	Together, we will develop services so that everyone has the best experience of care and treatment.	
	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.	
	Our Partners	Together, we will join up services to improve the health and wellbeing of our diverse communities.	
	Our Services	Together, we will provide nationally recognised, clinically led services that are high quality, safe and based on evidence and research.	
	Our Resources	Together, we will use public money to maximum effect.	
Are there any quality, operational, workforce or financial implications of the decision requested by this report?	**Quality**	Yes☑ No☐	The Joint Forward Plan is a statutory requirement outlining how the ICB, working with Health and Care partner members, will deliver health and care services over the next five years. This has potential implications for all corporate functions of the Trust.
	Operational	Yes☑ No☐	
	Workforce	Yes☑ No☐	
	Financial	Yes☑ No☐	

1. Background/Context

The Joint Forward Plan (JFP) is a statutory national requirement set out in the Health and Care Act 2022, for Integrated Care Boards (ICB's) and partner trusts to describe how they will arrange or provide NHS services for their local populations.

The JFP should include the delivery of:

1. Universal NHS commitments defined in the annual NHS priorities and operational planning guidance and NHS Long Term Plan.
2. ICSs' four core purposes to:
    i. Improve outcomes in population health and healthcare
    ii. tackle inequalities in outcomes, experience and access
    iii. enhance productivity and value for money
    iv. help the NHS support broader social and economic development
3. Standing legal requirements, including the National Health Service Act 2006 and the requirements of the Public Sector Equality Duty, section 149 of the Equality Act 2010

1. Background/Context continued

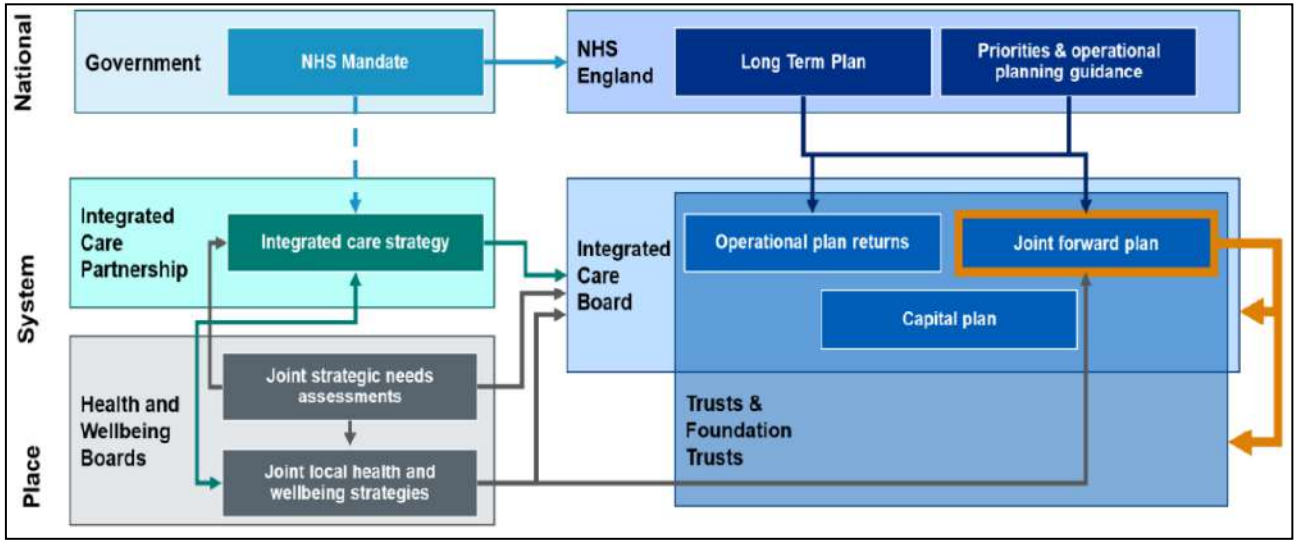
The JFP is a long document and has been uploaded separately to the Board Resource Centre on Admin Control. To help the Board review this there are two appendices attached to this report:

Appendix 1 Sets out the 8 ambitions and underpinning objectives;
Appendix 2 Contains the section relating to Provider Collaboratives.

There is a requirement for formal submission of the plan to NHSE by the 30th June 2023. Ahead of this each partner organisation is requested to agree and sign off the plan.

The diagram below sets out how the JFP fits into the overall ICB and NHS landscape.

Figure 1. Relationship of JFP to other strategies and plans



2. Key issues, risks, and actions

Trust Leads (NNUH Head of Strategy) have had an opportunity to feedback on sections of the JFP. In May HMB recommended approval of the plan to the Board. Discussion at HMB included:

- In the JFP there is no mention of the ICS's current strategic oversight framework (SOF) position or sense that plans are designed to improve the current Level 4 rating which sees N&W as one of only 4 ICS's at this level.
- The Plan is too long
- The plan lacks the detail to assure the Trust how the ambitions and objectives will be achieved. HMB also felt that given the current challenges and pressures both locally and nationally the trust needs to understand the proposed pace of change and transformation of services to support and deliver the plan.

These comments will be communicated to the ICB along with any other points raised by the trust Board.

4. Recommendations

The Board is asked to:

1. Formally receive and approve the ICB Joint Forward Plan as a statutory partner of the ICS
2. Consider whether the plan appropriately aligns with the Trust's risks and ambitions.

Joint Forward Plan eight Ambitions and underpinning objectives

	Ambition Objectives
1	**Transforming Mental Health Services**
1a	Build system resources for early intervention and prevention for people of all ages, including those who experience mental health inequalities. This work will include enhancing and expanding skills and knowledge of mental health across our populations; providing a framework of tools and capacity to support mental wellbeing; and delivering a refreshed suicide prevention strategy.
1b	Mobilise mental health system collaboratives to facilitate partnership working and deliver better health outcomes for our residents. The focus of the adult collaborative in year one is to improve support for older people living with dementia, delirium and depression which also has alignment with the Ambition Transforming Care in Later Life.
1c	Establish a Children and Young People's (0-25 years) Emotional Wellbeing and Mental Health 'integrated front door' so all requests for advice, guidance and help are accepted, and support provided to navigate the system and meet the presenting level of need. This will be developed in line with the Thrive principles, with children and young people at the centre of delivery with resources wrapped around them, enabling them to Flourish.
1d	See the whole person for who they are, beyond their complex behaviour. Develop pathways that support and promote recovery for people living with multiple and complex needs – with a focus on dual diagnosis and complex emotional needs (CEN)
2	**Improving UEC**
2a	Improve emergency ambulance response times
2b	Expand virtual ward services
2c	Delivery of the Improving Lives Together programme to reduce length of stay (LoS) in hospitals
3	**Elective Recovery & Improvement**
3a	Effectively utilise capacity across all Health System Partners
3b	Implement digital technology to enable elective recovery
4	**Primary Care Resilience & Transformation**
4a	Developing our vision to provide a wider range of services closer to home, improving patient outcomes and experience
4b	Stabilise dental services through increasing dental capacity short term and setting a strategic direction for the next five years.
5	**Improving Productivity & Efficiency**
5a	Improve the services we provide by enhancing productivity and value for money, embracing digital innovation and delivering services together where it makes sense to do so.
6	**PHM, Reducing Inequalities & Supporting Prevention**
6a	Development and delivery of two strategies to support prevention: A Population Health Management Strategy, and a Norfolk and Waveney Health Inequalities Strategy to deliver the "Core20plus5" approach
6b	Smoking during pregnancy – Develop and provide a maternity led stop smoking service for pregnant women and people
6c	Early Cancer Diagnosis - Targeted Lung Health check Programme
6d	Cardiovascular disease Prevention
7	**Improving Services for Babies, Children, Young People & Maternity**
7a	Successful implementation of Norfolk's Start for Life (SfL) and Family Hubs (FH) approach
7b	Continued development of our Local Maternity and Neonatal System (LMNS), including the Three Year Maternity Delivery Plan
7c	Reducing health inequalities including an initial focus on asthma, epilepsy and mental health
7d	Develop an improved and appropriate offer across Norfolk and Suffolk for Children's Occupational Therapy, to meet their needs
8	**Transforming Care in later life**
8a	To develop a shared vision and strategy with older people that will help us to transform our services to be easy to access and designed and wrapped around the needs of older people.

6.2 Provider collaboration

This is about partnership arrangements between Trusts who are working together and at scale across multiple places or locations, with a shared purpose. We are on a journey to develop the potential of provider collaboration, which is an important part of successful ICS working.

Acute hospital collaboration

The Norfolk and Waveney Acute Hospital Collaborative (N&WAHC) is a Provider Collaborative formed by the Queen Elizabeth Hospital Kings Lynn NHS Foundation Trust, the Norfolk and Norwich University Hospital NHS Foundation Trust and the James Paget University Hospitals NHS Trust. The aim of the N&WAHC is to improve health outcomes for all through:

- Enhancing clinical effectiveness and patient experience and,
- Reducing known inequities in health outcomes and access to services.

These aims are consistent with the JFP through the ambitions focused on prevention and reducing health inequalities.

The N&WAHC has identified a number of pivotal programmes of work it will be focusing on, which will make a real difference to our local population by doing them together:

The first is **implementation of a single acute Electronic Patient Record (EPR)**
This is a joint digital solution that enables clinical and operational processes to run seamlessly and efficiently on one platform across the three acute trusts bringing tangible benefits around reduced clinical risk, efficient use of clinician time, improved decision-making, patient care and experience. It will also provide a platform to transform integrated acute pathways and services. It is a critical component of the ICS Digital Strategy for good reason because it will make a difference on the ground to our population and our staff and is referenced in nearly all the ambitions as a key enabler.

The second is the **development of a joint Acute Clinical Strategy**
The joint clinical strategy will align directly to the clinical objectives set out in the ICS clinical strategy and it will also support the individual acute hospital trusts' clinical strategies by identifying the specific opportunities where clinical collaboration can improve the way we deliver services for our patients. The objective of the strategy is to ensure right sized and stable inpatient capacity that responds to long-term population health and demand. Underpinning this are design principles of onsite acute care only where true clinical value is added and vertical and horizontal integration of services, teams, and pathways. The development of this strategy is referenced in the place-based approach as we focus on care closer to home as an initial priority, and the ambition that is about primary care resilience and transformation where we talk about the development of neighbourhood teams.

The third programme is about **Unblocking delayed discharges; creating stronger, consistent support for frail elderly**
With an existing population demographic weighted towards people living longer into later life, which is projected to grow and age faster than most other places in England, the collaborative will prioritise resource and capacity to appropriately configure and integrate services, teams, and pathways to reduce the burden of unnecessarily long inpatient stays and the deconditioning of patients. This collaborative focus from the N&WAHC will be a critical enabler to the ambition that is about transforming care in later life and improving urgent and emergency care where we have a focus on length of stay in hospitals.

The fourth programme is about **Improving productivity across the acutes and the wider system**
N&WAHC will be working more closely together, identifying areas to align support and corporate functions with a focus on doing things once and at scale. This focus is consistent with the ambition to improve productivity and efficiency, and without this focus this ambition is unlikely to succeed as the three hospitals collectively account for the majority of the NHS Norfolk and Waveney budget.

The fifth programme is about **Major acute capital projects.** For example, N&WAHC is collectively working on plans for three Diagnostic Access Centres (DAC's), one at each hospital, which will significantly improve access to diagnostic services and reduce waiting times for treatment, especially for a cancer diagnosis. These are referenced within the elective recovery and improvement ambition as key enablers to the creation of more capacity so more patients can be treated and waiting lists reduced.