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NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

MEETING OF THE TRUST BOARD IN PUBLIC
WEDNESDAY 05 JUNE 2024

A meeting of the Trust Board will take place at 9.30am on Wednesday 05 June 2024 in the Boardroom Norfolk & Norwich University Hospital and MS Teams

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

AGENDA

	Item	Timing	Lead	Purpose
0	Clinical/Departmental Visits – see separate schedule	08.45-09.15		
1	- Apologies & Declarations of Interest Apologies from Bernard (Tim Leary deputising) & Nikki - Reflections on Clinical/Departmental Visits	09.30-09.40	Chair	Information/ Discussion
2	Experience of Care: 'Valuing Volunteering – experiences pre and post- career' Sally Dyson, Sarah Higson, Will & Liz Volunteers attending	09.40-10.00	RC	Discussion
3	Minutes of the Board meeting held in public on 03.04.24	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	**Reports for Information and Assurance:**			
	(a) IPR – Workforce data	10.20-10.30	PJ	Information, assurance & approval as specified
	(b) Quality and Safety Committee (28.05.24) inc Quality Account (23/24) & Quality Priorities (24/25)* – for approval	10.30-10.50	PC	
	(c) IPR – Quality, Safety and Patient Experience data		TL/RC	
	(d) Finance, Investments and Performance Committee (29.05.24)	10.50-11.10	NG	
	(e) IPR – Performance and Productivity data		CC	
	(f) Finance – YTD report		LS	
	(g) Major Projects Assurance Committee (29.05.24)	11.10-11.20	NG	
7	Questions from members of the public	11.20-11.30	Chair	
8	Any other business			

*** 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 11 September 2024 in the Boardroom of the Norfolk and Norwich University Hospital

REPORT TO TRUST BOARD

Date	**5th June 2024**
Title	**Valuing Volunteering - experiences of volunteering pre and post-career**
Author & Exec Lead	**Sally Dyson, Voluntary Services Manager** **Sarah Higson, Associate Director of Patient Engagement and Experience** **Rachael Cocker Interim 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:**		**Outcome:**

1 Background/Context

1.1 Listening to people's experiences and stories gives us the opportunity to learn about the things that we do well and consider where we can make improvements. It helps put patients at the heart of service development and improvements. This is true for hearing from patients, Cares, staff – and Volunteers.

1.2 01-07 June is Volunteers' Week and the stories shared this month focus on the experiences of two of our, currently, over 400 valued volunteers. Their stories span 'pre career – post career' volunteering demonstrating there is 'something for everyone' and peoples lived and life experiences are a driving force behind their motivation to volunteer and give their time freely to the NNUH.

1.3 Will's Story highlights how his role volunteering in ED utilises his existing skills from being a care assistant and supports his career aspirations to become a clinical psychologist working within a clinical setting. Liz's story shows how she has taken up a Butterfly volunteer role to continue her contribution to patients and family care developed and honed during her long career as a GP.

2 Key issues, risks and actions

2.1 Key learning/actions:

- Volunteering brings with it brilliant personal and career development opportunities – utilising transferable skills to give our volunteers an opportunity to progress into future career paths within health and social care.

- Volunteering can be beneficial for people in both pre-career and post-career and it brings many benefits to the individuals, patients, Carers and our Trust.
  Pre-career volunteering (Will's story) illustrates the following benefits:
  - Opportunity to volunteer in a clinical environment
  - Develop new skills to support career aspirations
  - Demonstration of commitment on a CV/Resume
  - Build relationships with clinical staff/networking
  - Attracts young people to our organisation or other NHS careers
  - Enriches the diversity of our organisation

  Post Career volunteering (Liz's story) illustrates the following benefits:
  - Maintain a healthy lifestyle
  - Continue to utilise NHS and life acquired skills/experience
  - Bring specialist knowledge to the organisation which is invaluable to complex volunteer roles (for example, End of life)
  - Provides sense of purpose and value to the retiree
  - Aids social participation
  - Provides cognitive benefits

- Recruitment for Trust volunteers rightly focuses on both pre-career volunteering benefits through to post-career volunteering benefits to ensure our voluntary services can continue to provide roles that meet the requirements of all prospective volunteer recruits and enhance patient, Carer, staff and volunteer experiences by best and most productive match of lived experience and transferable skills

3 Conclusions/Outcome/Next steps

3.1 The experiences shared in this story have provided valuable learning.
3.2 Demonstrates the need to continue to invest and support our voluntary services who provide vital support to our Trust.
3.3 Demonstrates the need to develop innovate voluntary roles to support the services our Trust provides and the needs of our patients and carers.

Recommendations:
The Board is asked to listen to and reflect on the stories presented, using that information to inform future strategies and improvement plans suggested.

Brief outline of the "story"

Will's story (pre career volunteer experience)

Will Oyeleye is a psychology student at the UEA who is volunteering in ED supporting our mental health patients to support his career aspirations... During his first year at UNI Will worked as a care assistant... He felt this experience taught him how to show empathy to family members of end-of-life residents. By showing compassion to them, he felt that they felt acknowledged and understood and he wanted to use these transferable skills to support our patients who feel alone and anxious in ED.

He was particularly interested in voluntary work that involves communication with patients and especially with the elderly. In care, he saw loneliness and anxiety weigh down on the mental well-being of patients... These patients also increased the stress of colleagues who often had more pressing matters to attend to... However, he found that a friendly and compassionate attitude can uplift the mood of people going through stressful times and by offering his time to listen and communicate well, he was able to alleviate their loneliness.

Although his encounter with our patients in ED is a short one, he tries to build a repour with a friendly and caring attitude and provides patients with a stimulating conversation to help improve their mood. He feels the that the experience of volunteering in ED has really highlighted the power of kindness and whether providing a hot drink or a warm smile... his interactions help people have a better hospital experience.

Will says "Volunteering is an opportunity for me to serve and give back to the community of Norwich. This role is important because I find helping those in need very fulfilling. I enjoy working within a team and am honoured to assist the NNUH staff. Ultimately, volunteering allows me to use my time to make a difference in the lives of others. In my other roles, as a carer and LSA, I strove to respect each person as a whole. This respect allowed me to give support tailored towards each person. I bring this same attitude to my volunteer role. By volunteering, I can gain invaluable experience as an aspiring clinical psychologist working within a clinical setting and developing my interpersonal skills. I believe kindness costs nothing but makes all the difference. I aim to provide a service with a friendly and passionate attitude to help ease the stress of patients and staff."

Liz's story (post career volunteer experience)

Liz is a retired GP, who has worked as a Butterfly Volunteer for nearly 6 months supporting the clinical staff on the wards to care for patients approaching the end of life.

The daughter of a GP and a ward sister, she has had contact with the NHS all her life. Liz took history at A level – an odd choice for an aspiring medical student but she has always been interested in people and their stories and the newly created Nottingham Medical School was happy to accept her.
Her training had an emphasis on both good communication skills and community care and this, (alongside growing up with a GP father) greatly influenced her choice of career. General Practice provided continuity of care and the opportunity to get to know patients and their families and she continued in the same Practice in Staffordshire for over 30 years until her retirement.

It was in Primary Care that Liz developed an interest in End-of-Life care, working in a local hospice for one day a week and continuing this beyond retirement. She quickly became aware of the benefits of having more time to converse with patients and their families and feels she has regained this in her role as a Butterfly Volunteer.

To improve her skills and knowledge base she undertook the Diploma in Palliative Care, became a Macmillan Facilitator and helped to introduce the Gold Standard Framework to local practices. Following this she was nominated to become a Fellow of the Royal College of General Practitioners
Working with East Staffordshire Clinical Commissioning Group (the catchment area in which she then lived), became the End-of-Life Clinical Lead and was involved in several education events for GP colleagues. She moved to Norfolk 9 years ago to be closer to family and continued to work for the local CCG, now Integrated Care Board, as a GP advisor with an interest in dementia. Knowledge gained in this role has been invaluable when visiting people living with dementia on the wards and in A&E.

She found her work in Primary Care very fulfilling but acknowledged the difficulty of not spending as much time with patients and families as she would like, particularly those at the end of life. When the opportunity to become a Butterfly Volunteer arose, she saw this as a chance to undertake a role where there was more time to listen, and she has not been disappointed. She has appreciated the opportunity to learn new skills (doctors aren't trained to do mouth care!) and feels well supported. Like Will she enjoys having the ability to "give something back" and use some of the skills accrued over a long career in the NHS.

What "point" it is trying to convey

The benefits to patients, Carers, volunteers and the wider Trust from volunteering.

Will's story - Pre-career student volunteering illustrates the following benefits:

- Opportunity to volunteer in a clinical environment
- Develop new skills to support career aspirations
- Demonstration of commitment on a CV/Resume
- Build relationships with clinical staff/networking
- Attracts young people to our organisation or other NHS careers
- Enriches the diversity of our organisation

Liz story - Post Career volunteering illustrates the following benefits:

- Maintain a healthy lifestyle
- Continue to utilise NHS acquired skills/experience
- Bring specialist knowledge to the organisation which is invaluable to complex volunteer roles (for example, End of life)
- Provides sense of purpose and value to the retiree
- Aids social participation
- Provides cognitive benefits

Who will be "speaking"	
Patient	Will and Liz (Trust Volunteers)
Staff	Sally Dyson, Voluntary Services Manager
Time allocation for each element	
Sally Dyson's intro to volunteers week	1 minute
Will's slides x3	7 minutes
Liz's slides x3	7 minutes
Questions	5 mins

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National Volunteers Week 2024

National Volunteers' Week takes place every year from 1-7 June…. A UK wide campaign now in its 40th year... Its primary objectives are:

- To recognise, celebrate and thank volunteers
- To raise the profile of volunteering
- To demonstrate the benefits of volunteering
- To increase participation in volunteering

Our volunteer stories today are a demonstration and celebration of volunteering for NNUH pre-career & post-career.

"Will's Story"

Why Do I Volunteer As A Mental Health Volunteer?

- First-hand experience of the impact of the role.
- Opportunity to serve the community of Norwich & Norfolk.
- Involvement in a patient's journey to improved well-being.
- Passionate about people.

"Will's Story"

What Have I Gained From Volunteering?

- A new appreciation for Psychology.
- Invaluable experience for my career aspirations.
- A range of interpersonal skills e.g., Active listening and Adaptability.
- An insight into working within a clinical environment.
- Support from the Volunteer team and NNUH community.

"Will's Story"

What Has Been The Impact Of My Volunteering Experience?

- Appreciation from patients and staff
- Opportunity to restore a sense of normality to patients.
- Gives me a sense of commitment.
- Provides relief for staff within my capacity.
- Inspires others to volunteer.

Liz's Story

What do I feel makes a good Butterfly Volunteer?

- Good listener with a friendly open manner
- No time constraints
- Ability to empathise
- Good communication skills
- Caring and respectful
- Resilience
- Staying within the boundaries of the role

Liz's Story

What can I bring to the role?

- Enthusiastic about improving the experience of people at the end of life
- Familiar with hospital environment
- Extensive experience of supporting patients and their families at the end of life
- Knowledge of the dying process
- Awareness of the importance of creating good memories for families after the death of a loved one

Liz's Story

What have I gained from the role?

- Time to listen and talk
- Ability to utilise my career skills post-retirement
- New skills
- Appreciation from patients, families and staff
- Better understanding of the current hospital environment
- Learning from more experienced Butterflies
- MOST IMPORTANTLY – feeling that I have made a difference

Any Questions?

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MINUTES OF TRUST BOARD MEETING IN PUBLIC

HELD ON 03 APRIL 2024

Present:	Mr T Spink	- Chair
	Prof L Dwyer	- Chief Executive Officer
	Dr B Brett	- Interim Medical Director
	Dr P Chrispin	- Non-Executive Director
	Ms R Cocker	- Interim Chief Nurse
	Ms S Dinneen	- Non-Executive Director
	Prof C ffrench-Constant	- Non-Executive Director
	Mrs N Gray	- Non-Executive Director
	Mrs J Hannam	- Non-Executive Director
	Mr P Jones	- Chief People Officer
	Ms L Sanford	- Interim Chief Finance Officer
	Dr U Sarkar	- Non-Executive Director
In attendance:	Mrs E Batchelor	- Assistant to Board Secretary
	Mrs J Bradfield	- Head of Communications
	Ms T Badshah	- Deputy Director of Transformation (Deputising for Mrs Berry)
	Mr J P Garside	- Board Secretary
	Mr S Hackwell	- Director of Strategy and Major Projects
	Ms R Hook	- Deputy Chief Operating Officer (deputising for Mr Cobb)
	Members of the public and press	

24/034 **APOLOGIES, DECLARATIONS OF INTEREST, CHAIRMAN'S INTRODUCTION AND REFLECTIONS ON VISITS**

Apologies were noted from Mr Foster, Mr Cobb, Ms Berry and Mr Prosser-Snelling. No conflicts of Interest were declared in relation to matters for consideration by the Board.

Mr Spink welcomed Professor Dwyer to the Trust and her first meeting of the Board in public.

It was noted that 3 April 2024 was the 170th anniversary of the opening of the Jenny Lind Children's Hospital in Norwich. The clinical visits which preceded the Board meeting had accordingly focussed on areas of the JLCH:

- Buxton ward: Mr Jones, Mrs Dinneen, Mrs Hannam and Professor Dwyer
- NICU: Dr Brett, Mr Garside, Ms Sanford
- CHED: Mrs Gray, Mrs Cocker, Ms Badshah and Mr Hackwell
- Childrens Assessment Unit: Professor Ffrench-Constant, Mr Spink and Ms Hook.

24/035 **EXPERIENCE OF CARE - PATIENT/FAMILY REFLECTIONS**

The Board received a presentation from Lisa Mastrullo (Quality Improvement Lead Midwife), Jenny Whatling (Service User Lead for Maternity and Neonatal Voices Partnership - MNVP) and Rosie Bloomfield (Patient Engagement & Experience Facilitator). The presentation focussed on partnership working to embed service user 'voice' and perspectives in our maternity services.

Non-Executives thanked the presenters and asked for examples where this approach has made a difference to the service received by families. Examples were given around improved communication on tongue-tie, breast feeding and consent.

The Board was advised that the renewed approach to ensure service user voice is at the centre of decision making and improvements within maternity services has been recognised in the recent CQC inspection and 'Good' rating of the maternity department. The CQC had praised our relationship and partnership working with our MNVP.

24/036 **MINUTES OF PREVIOUS MEETING HELD ON 07 FEBRUARY 2024**

The minutes of the meeting held on 07 February 2024 were **agreed** as a true record for signing by the Chair.

24/037 **MATTERS ARISING AND UPDATE ON ACTIONS**

There were no actions arising.

24/038 **CHIEF EXECUTIVE REPORT**

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

Planning Guidance for 2024/25 has now been issued and is focussed around i) recovery of services; ii) supporting our workforce and iii) improving productivity. The Executive Team have a session planned to review our priorities and to ensure that these are aligned with the guidance. Our new Associate Medical Director is due to join the Trust shortly, with a specific role to support closer working with partners in primary and community care.

Professor Dwyer highlighted the progress that has been made in moving out of escalation beds and this was welcomed by members of the Board. The next CEO Forum with staff is to focus on use of escalation beds, to acknowledge and thank staff – recognising how difficult this has been and to reinforce communication about the commitment to de-escalate.

The Board was updated on the position relating to enhanced monitoring with regard to arrangements for and experience of doctors in training and neurology trainees in particular. The Trust has received formal notification from NHS England that, whilst they can see more recent progress, there is a requirement for a formal action plan to ensure meaningful and sustained improvement for these trainees. The plan is being finalised and we have been advised that our progress will be carefully monitored over the next 6 months with additional formal reviews specific to neurology training at 3 and 5 months.

The Board discussed the prospect of further national industrial action to be taken by junior doctors and doctors in primary care. Early engagement and planning will be important when details are issued in order to safeguard the improvements that have been made in the operational position for staff and patients.

24/039 **STAFF EXPERIENCE REPORT**

The Board received a report from Mr Jones with regard to the results of the national Staff Survey.

Whilst scores across all 7 key themes have improved on the previous year, our scores are still below the national average for acute trusts, indicating that there is considerable work still to do. Participation rates are significantly above national average for acute trusts. The commitment of staff in providing such extensive feedback is notable and it provides important information on how best we can focus our efforts to best effect. Staff highlight the feelings of tiredness and burn-out attributable to pressure of work. Other

staff report experience of physical violence at work and Dr Brett emphasised the experience of doctors in training as revealed by the national trainee survey and feedback around bullying, racial and sexual harassment.

The Board was updated on actions taken in association with the People Promise, some of which have been delivered whilst others are multi-year initiatives and will be ongoing.

Non-Executives enquired about what it would take for staff to feel that they and their work are valued. Mr Jones outlined the challenge for staff who feel unable to deliver the care to which they aspire due to operational pressure and use of escalation spaces and corridor care. The Board discussed the concern expressed by staff that the system will expect the hospital to use escalation beds on a routine basis and it is important to be clear that the Board has a firm commitment to de-escalation as a matter of priority.

Non-Executives reflected on comments in the survey and there is a sense that staff do not feel that action is happening at pace. It is recognised that resources for investment in facilities and services are limited and it has been necessary to prioritise. A message from staff feedback is that we need to optimise two-way communication so that there are clear messages around the rationale for decisions.

The Board was advised that the themes from the Staff Survey will be reviewed further with staff networks and unions, divisions and departments, and working groups in order to establish further actions and the next iteration of the People Promise programme.

24/040 **REPORTS FOR INFORMATION AND ASSURANCE**

(a) People and Culture Committee (25.03.24)

The Board received an update from Mrs Dinneen with regard to the work of its People and Safety Committee which had focussed on the Staff Survey, Workforce Strategy and Maternity Strategy.

The Committee considered the results of the Survey and discussed 3 particular areas in syndicate groups: i) behaviour and respect; ii) practical factors; iii) communication and engagement. The discussions generated a range of ideas, which will be considered as part of the planned wider engagement with staff and staff groups to develop a revised action plan. Strong emphasis was placed on the need for increased pace in delivering changes and improved two-way internal engagement and communication.

The Committee reviewed the draft Maternity Strategy as requested by the Board and with particular regard to workforce and cultural issues. The Committee asked the team particularly to review with the Management Board the sections on longer term strategic ambition and on research & education/training, so that an updated draft can be brought to the Board. Committee members offered to review an updated tracked-changes version between meetings if helpful.

The Committee also discussed an update on the draft Workforce Strategy, with further work to be undertaken on changing workforce models, within the context of significant financial and productivity challenges and evolving treatment options.

(b) IPR – Workforce

The Board received and reviewed the Workforce IPR. They Board was informed that the mandatory training target has been maintained for the 15th consecutive month. There is an improved position regarding reduction in vacancies and a revision to the KPI may be appropriate. The rate of appraisals is also improved but the challenge is to ensure that these are meaningful and have an impact in improving staff experience and retention.

(c) Quality and Safety Committee (26.03.24)

The Board received an update from Dr Chrispin with regard to the work of its Quality & Safety Committee. The Committee had received an update report regarding our Cardiology service and regarding the use of Drug Coated Balloons (DCBs) for cardiology procedures following a review of the position in 2021. The Committee heard that all the relevant recommendations have been implemented, with action monitored for compliance through audit where appropriate. Practice in the department has recently been 'showcased' by the British Cardiovascular Intervention Society (BCIS) with live-streaming of DCB angioplasty procedures at the Advanced Cardiovascular Intervention meeting and an audience of 1500 specialists and experts. The Committee had thanked the Department for its work in this area and for the audit information which provided good assurance.

The Committee had received an update report regarding implementation of the existing Cancer Strategy. The Strategy is ready for a refresh and is scheduled to come back to the Committee later in the year and will benefit from a strengthened corporate approach to strategy development. The Committee also discussed the need to enhance capacity in our Acute Oncology Service and the executive are considering options.

The Board was advised that the Committee has undertaken its annual review of performance and satisfaction of its Terms of Reference. The Committee recommended updates to its ToRs to reflect implementation of PSIRF and creation of the Research & Education Committee. The Board **approved** Terms of Reference for its Quality and Safety Committee as updated.

(d) IPR – Quality, Safety and Patient Experience

The Board received and reviewed the Quality & Safety IPR. Mrs Cocker explained that some difficulties had been experienced with data quality in the system for generating the IPR. The IPR is being reviewed to ensure that the metrics and associated commentaries focus on the right issues and meet our requirements, not least with regard to palliative care and mortality.

(e) Research & Education Assurance Committee (27.03.24)

The Board received an update from Dr Sarkar with regard to the work of its Research and Education Committee.

Dr Sarkar explained that this had been the inaugural meeting of the Committee and it had focussed on reviewing the current position. There had been discussion of the role of the Committee in seeking assurance on plans, responsibilities and ambitions with regard to research and education. The Committee had discussed the governance framework, and the subject areas to be included in future meetings.

The Board was advised that the Committee had discussed the draft education strategy and requested updates to include clear strategic ambitions and measurable objectives. The Committee has also requested development of a suite of IPR metrics for regular reporting to the Board regarding to both research and education.

The Committee had received a briefing with regard to the reported experience of junior doctors in training. It was noted that one of the drivers to create this Committee was to ensure that the Board is adequately sighted on matters affecting trainees and learners in the Trust. This is a real priority for the Trust and the Committee will receive updates regarding updates on implementation of relevant actions.

The Committee discussed potential changes to terminology in its Terms of Reference and will return to the Board with regard to proposed updates. In the meantime, with the

addition of the CEO and CDIO to the Committee's Membership, the Board **reapproved** the updated Terms of Reference for the Research & Education Assurance Committee.

(f) Finance, Investments and Performance Committee (27.03.24)

The Board received an update from Mrs Gray with regard to the work of its Finance, Investments and Performance Committee.

The Committee received the regular suite of reports relating to financial and operational performance. There is ongoing work to address waiting times for elective care and the Committee expressed thanks to all the staff concerned in achieving:

- Financial breakeven for 2023/24
- Sustained delivery of improved A&E waiting times - 'green'
- Real improvement in waiting times for cancer care – 'green'

Very good work has been undertaken in preparing operational plans for 2024/25 but the position remains very challenging. The Committee was particularly concerned to note the risk that £7.7m of lease renewals may not be fundable within the CDEL ceiling and this creates risks to safety and service resilience. There is ongoing discussion with system partners regarding the draft system plan for next year.

The Committee had been updated with regard to the project for digitisation of histopathology and Board members welcomed the news that was advised that the repatriation of QEHKL activity into the programme has been formally agreed, resolving that outstanding risk from the financial modelling.

The Committee received a report it had requested on plans to reduce and restrict the cost of nursing agency use to within the national cap. Board members asked if the Committee had discussed any specific actions with regard to spend on agency staff. The YTD agency spend on Registered Nursing staff across the Trust in 2023/24 was reported to be 6.36%. Compliance with the national cap will therefore require considerable change in practice and the Committee received improvement trajectories. In addition to the regular financial reports, the Committee scheduled an update on progress in controlling Agency usage. Mrs Gray confirmed that Committee had been assured on this subject and that there would be traction in applying the proposed actions.

(g) IPR – Finance, Performance and Productivity

The Board received the Performance & Productivity IPR and Ms Hook outlined the operational position, as reported to the Finance, Investments & Performance Committee. On behalf of the Board, Mr Spink offered thanks to everyone involved in achieving the operational targets, despite the pressure of escalation, industrial action and multiple competing priorities.

Non-Executives reflected on recent experience in ED, and the significant proportion of patients in the 'Minors' area who were there because they had been unable to get an appointment in primary care. Ms Hook confirmed that a system working-group has been established with a focus particularly on services for patients in care homes. The aim is to avoid unnecessary conveyance to hospital for patients who do not require this. There are further workstreams based around virtual care services in the Community Trust and triage of patients from primary care and EEAST.

(h) Finance YTD Report

The Board received an update from Ms Sanford with regard to the Finance Year to Date position at Month 11. Mrs Sanford informed the Board that expect to report a breakeven Outturn for 2023/24.

(i) Major Projects Assurance Committee (27.03.24)

The Board received an update from Mrs Gray with regard to the work of its Major Projects Committee. The Committee was informed that the DAC construction project is on track for operational readiness in February 2025. There have been some delays in delivery times for equipment for the N&N Orthopaedic Centre, but it is still planned for operational use in July 2024.

The Committee has undertaken a review of its performance and confirmed compliance with its Terms of Reference. As recommended by the Committee, the Board **reapproved** the Terms of Reference for its Major Projects Assurance Committee.

24/041 **COMMITTEES IN COMMON**

The Board received a report from Mr Spink with regard to the Committees in Common. The Committee had received updates regarding joint projects, in particular the EPR business case, the Macro Model of Care work and the DAC.

24/042 **QUESTIONS FROM MEMBERS OF THE PUBLIC**

Mrs Betts (Public Governor) reflected on personal experience regarding the provision of palliative care services in the community. It was recognised that the Palliative Care service at NNUH has been rated as Outstanding by the CQC and there is ongoing work with partners in the ICS to support provision of a comprehensive service across all settings to enable patients to receive care in the circumstances most suitable to their circumstances and wishes.

24/043 **ANY OTHER BUSINESS**

Mr Spink asked that the minutes of the public meeting should record the Board's thanks to Professor Fontaine and Mr Hulme for their work whilst at the Trust.

24/044 **BOARD IN ITS CAPACITY AS CORPORATE TRUSTEE**

(a) Report of Charitable Funds Committee

The Board received a report from Ms Hannam as Chair of the Charitable Funds Committee concerning its meeting held on 13 March 2024. The Charity continues to grow into its position as the primary Charity associated with the Trust and has raised over £3m in the last year. It has been actively using funds to make a real difference for patients and staff and the Board was updated that over £2.5m has been spent in 2023/24 on charitable activities in the Trust.

At its latest meeting, in accordance with its Terms of Reference, the Committee received and approved grant applications totalling **£541k**, including:

- funding a Cancer Information and Support Centre Officer for Cromer Hospital
- purchase of an additional 'point of care' ultrasound for use in the Acute Oncology and Haematology Service
- funding 2 x research PhDs to implement North Norfolk based research projects
- funding a new nurse-led Advanced Care Planning Clinic at Cromer Hospital for Trust patients with chronic illness.

The Committee had reviewed and approved the Charity's Annual Plan on a Page for 2024/25. A number of headlines were highlighted to the Board:

- our expenditure target is **£4.9m** – our highest ever
- the income target for this year is **£4.5m** – our highest ever.

The Committee had recognised that these are very challenging targets and approved a budget to support delivery of the Charity's Annual Plan. This will include some additional growth in the Charity infrastructure – with fundraising capacity and a new donor stewardship database. The safeguard to ensuring value-for money is the

strategic objective that at least 90p of each £1 of expenditure is spent on charitable activities, which compares very favourably relative to the VFM offered by other charities both locally and nationally. It was recognised that the approved Budget varies from the 5-year Financial Strategy agreed in 2021 and the Committee agreed to review updates to the Financial Strategy at its next meeting.

Major expenditure by the Charity is aligned with strategic developments in the Trust and will depend on progress in Trust strategic & business planning. The Committee reviewed a lengthy list of future projects that the Charity may be able to support in due course. These range across all specialities and parts of the Trust – and total over £20m. Some are unlikely to proceed but there is no shortage of potential opportunities to continue implementation of the Charity Strategy for *Supporting Better Care.*

In its capacity as Corporate Trustee, the Board **ratified** approvals made by the Committee for the Charity Plan on a Page and draft budget 2024/25, with associated variation to the Charity Financial Strategy.

(b) Approval of Charity Grants >£100k

In its capacity as Corporate Trustee, the Board received two requests for grants in excess of £100k, in accordance with the Scheme of Delegation. These were for:

- £185k – to fund a specialist nurse for children with complex care needs in the Jenny Lind Children's Hospital for 3 years;
- £107k – to support establishing a specialist nurse-led clinic at Cromer Hospital for patients with chronic heart failure.

The proposed expenditure has been reviewed by the Charitable Funds Committee and was recommended for approval. In its capacity as Corporate Trustee, the Board **approved** expenditure of charitable funds as requested.

Mr Spink noted that it has been a very successful year for the Charity and offered thanks to the Charity team and all supporters of the Charity.

24/045 **DATE AND TIME OF NEXT MEETING**

The next meeting of the Trust Board in public will be at 9.30am on 05 June 2024 in the Boardroom of the Norfolk and Norwich University Hospital and by MS Teams.

Signed by the Chair: …… Date: ……
Confirmed as a true record by the Board on 05 June 2024 [TBC]

Decisions Taken:

24/036 – Minutes of previous meeting	The minutes of the meeting held on 07 February 2024 were **agreed** as a true record for signing by the Chair.
24/040(c) - Quality & Safety Committee ToRs	The Board **reapproved** Terms of Reference for its Quality and Safety Committee as updated.
24/040(e) Research & Education Assurance Committee ToRs	With the addition of the CEO and CDIO to the Committee's Membership, the Board **reapproved** the updated Terms of Reference for the Research & Education Assurance Committee.
24/040(i) Major Projects Assurance Committee ToRs	The Committee has undertaken a review of its performance and confirmed compliance with its Terms of Reference. As

	recommended by the Committee, the Board **reapproved** the Terms of Reference for its Major Projects Assurance Committee.
24/044 - (a) N&N Charity Annual Plan 2024/25	In its capacity as Corporate Trustee, the Board **ratified** approvals made by the Committee for the Charity Plan on a Page and draft budget 2024/25, with associated variation to the Charity Financial Strategy.
24/044 - (b) N&N Hospitals Charity grant awards	In its capacity as Corporate Trustee, the Board **approved** expenditure of charitable funds as requested: • £185k – to fund a specialist nurse for children with complex care needs in the Jenny Lind Children's Hospital for 3 years; • £107k – to support establishing a specialist nurse-led clinic at Cromer Hospital for patients with chronic heart failure.

Action Points Arising:
There were no formal actions arising.

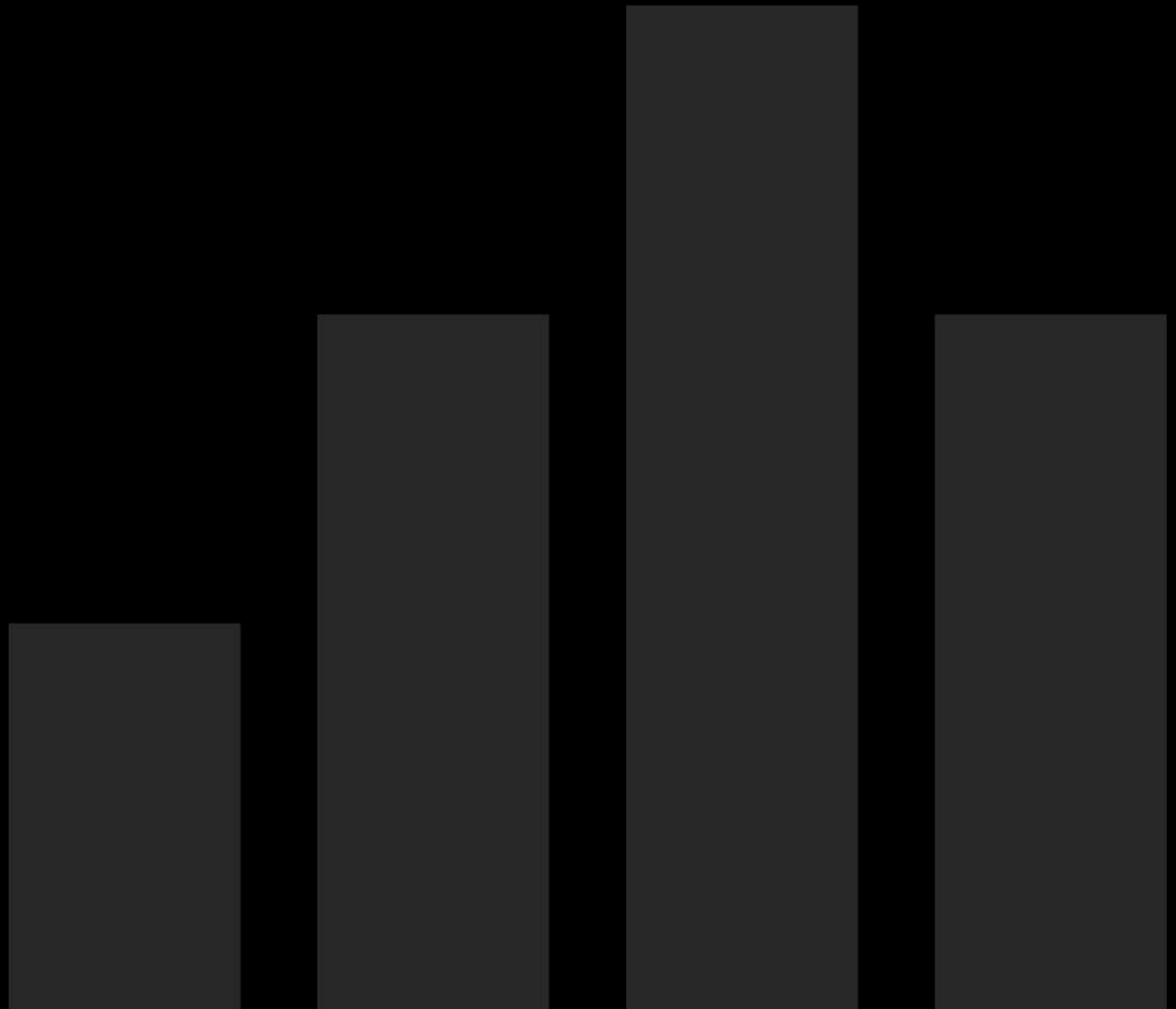
Microsoft | Power BI

Workforce

View in Power BI

Last data refresh:
15/05/2024 07:30:22 UTC

Downloaded at:
15/05/2024 08:18:55 UTC



Workforce Summary

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

NNUH Digital Health
business intelligence

Topic	Metric Name	Date	Result	Variation	Assurance
Staff Turnover	Monthly Turnover	Apr 2024	0.8%	Improvement (Low)	Inconsistent
Staff in Post	Actual Substantive Headcount (WTE)	Apr 2024	8,586	Improvement (High)	No Target
Mandatory Training	Mandatory Training	Apr 2024	92.7%	Improvement (High)	Inconsistent

SPC Variation Icons

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

SPC Assurance Icons

Capable | Inconsistent | Not capable

Mandatory Training

NNUH Digital Health
business intelligence

Mandatory Training

Apr 2024

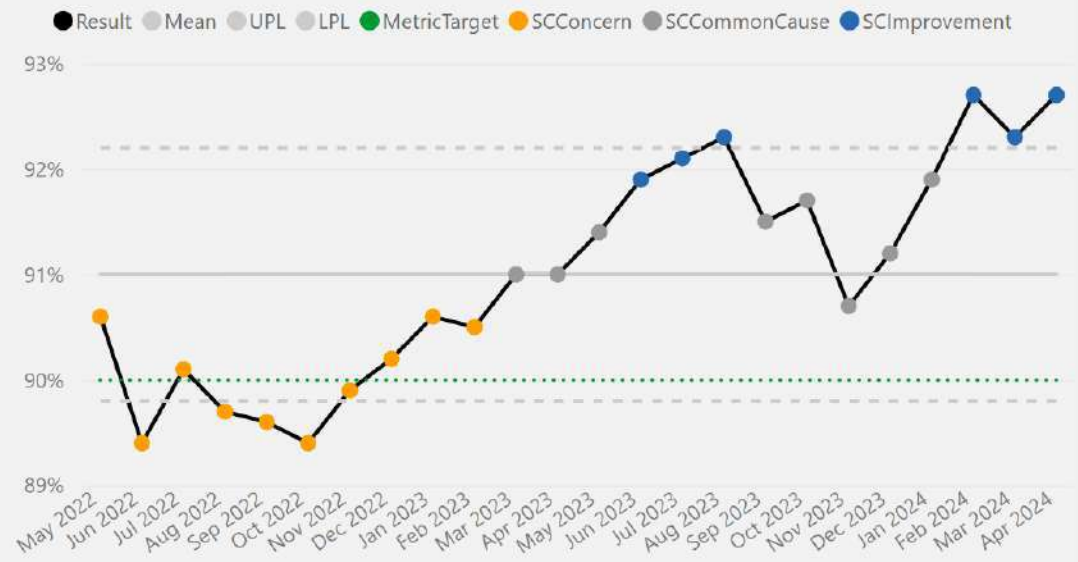
Variation	Assurance
H	?

92.7% Result
90.0% Target
92.2% UPL
91.0% Mean
89.8% LPL

Analytical Commentary

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

Mandatory Training



Assurance Commentary

The Trust continues to meet the 90% target, as at the end of April the overall compliance rate was 92.7% which is reflected in the special cause variation of high improvement. This has been maintained since December 2022. For Medical staff, the compliance rate for permanent staff was 92.0% - this figure reduces to 85.6% including the fixed term rotational junior doctors.

Classroom based training are two areas of lower compliance with manual handling at 86.25 and Resus at 89.35% (87.24% eLearning). A number of actions are being worked on as part of the CQC Evidence Group to reach compliance of 90%, including the development of a forecast trajectory based on the number of out of date colleagues along with colleagues who are a due date of the proceeding time scale. These trajectories will be shared with the Divisions as this does require colleagues to be released to attend the training. Once, the trajectories are agreed by Divisions, the compliance achievement date will be reported and then monitored against these trajectories.

The recruitment of a new Manual Handling trainer has increased the availability for this training while the move to a blended approach for Resus is also having a positive impact.

A review will also be undertaken of the colleagues who are not compliant across any areas.

Improvement Actions

April 2024 – Reminder emails have been sent to encourage staff attendance at Manual Handling, Resus, Safeguarding and Information Governance.

April 2024 – revised trajectories will be created to inform the projected date to achieve 90% compliance for classroom based mandatory training.

Non-Medical Appraisals

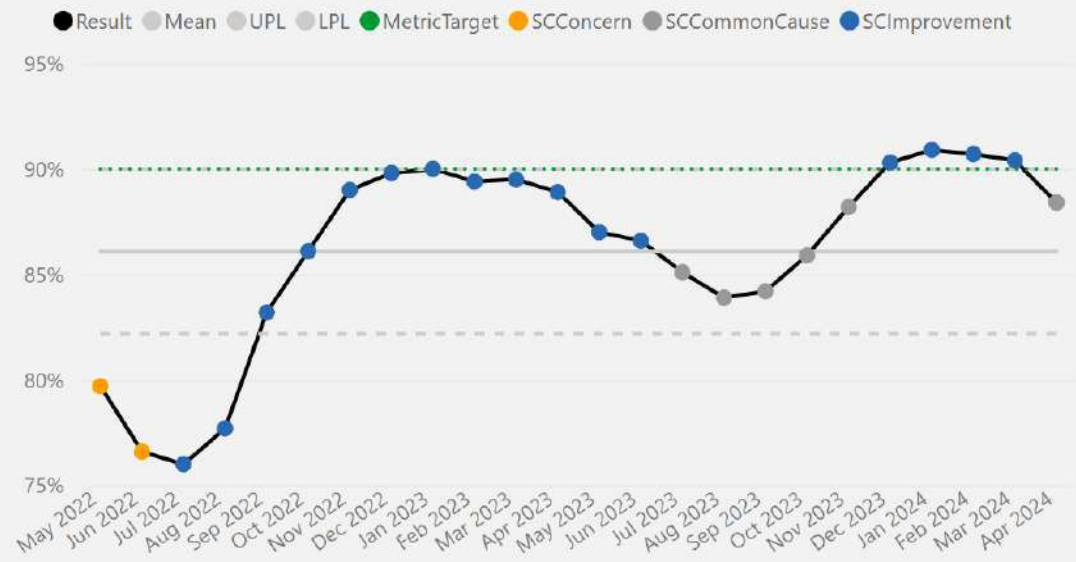
NNUH Digital Health
business intelligence

Non-Medical Appraisal

Apr 2024

Variation	Assurance		
	F	88.4% Result	90.0% UPL
		90.0% Target	86.1% Mean
			82.2% LPL

Non-Medical Appraisal



Improvement Actions

April 2024 – Divisional trajectories for the 24/25 cascade reviewed as part of Divisional Performance Framework and specific actions agreed to ensure the cascade model is further embedded into established practice within the Trust.

Analytical Commentary

Variation is Common Cause

Assurance Commentary

In the 12 months to April 2024, 88.4% of eligible staff (non-medical appraisals) had an appraisal. This represents a 2.0% decrease in performance compared to the previous month. This decline is comparable to last year and therefore does not currently require an escalation of risk.

All divisions, with the exception of Clinical Support Services are below the target of 90%. The new appraisal cascade commenced in April, and all divisions have set a new performance trajectory for this cascade. The monitoring of the cascade performance trajectory will be held at the Performance Assurance Framework Committee (PAF) and mitigations agreed to ensure that the 90% compliance is met within the trajectory timeframe.

Appraisal training remains available to line managers to assist with the quality of the appraisal.

Sickness Absence

NNUH Digital Health
business intelligence

Monthly Sickness Absence %

Apr 2024

Variation

Assurance

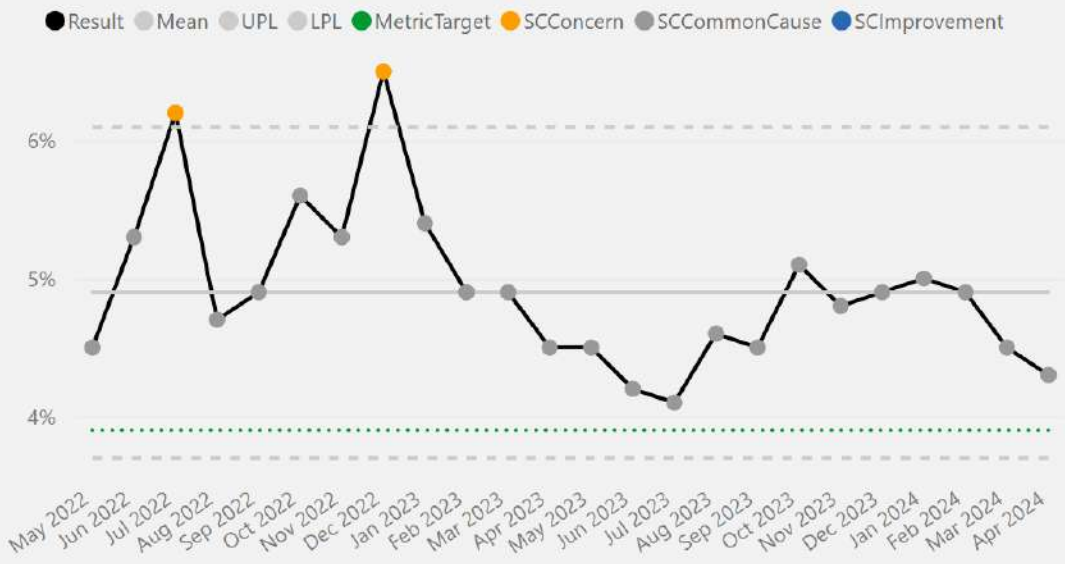
4.3% Result
3.9% Target

6.1% UPL
4.9% Mean
3.7% 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 2024, the rate is 4.6%. This compares to 5.2% in April 2023 and this is fourth month of a decrease. This is comparable to the decline trend of last year.

The monthly absence rate is 4.3% in April. Compared to the same month last year, long term absence is lower, whilst short and medium term absence is stable.

Latest national NHS sickness data (December 2023) reports the NHS England monthly average as 5.5%. The East of England reports a monthly average of 5.3% and Norfolk and Waveney reports at 5.5%. The Trust continues reports the lowest monthly sickness absence rate for Trusts in Norfolk and Waveney, 4.9% for the same period.

Last month, 37% of referrals to Workplace & Heath Wellbeing relating to psychological ill health were attributed to workplace stress. The main issues cited in this month link to Demands and Relationships within the workplace. The relationship issues appear to be linked to general communication and morale within teams. The demands concerns cite interestingly are within surgery and clinical support divisions. Increased surgical interventions and additional patients in bays are cited along with covering for staff.

From a muscular skeletal perspective, 13% were considered as caused by work this month. A wide spread of reasons were cited – Workplace posture – repetitive activities, use of trolleys (patient and equipment) resulting in injuries, as well as a result of a patient assault.

Improvement Actions

April 2024 – Ongoing engagement of Staff Support hub, particularly in the context of the current operational pressures and escalations.

Staff Turnover

NNUH Digital Health
business intelligence

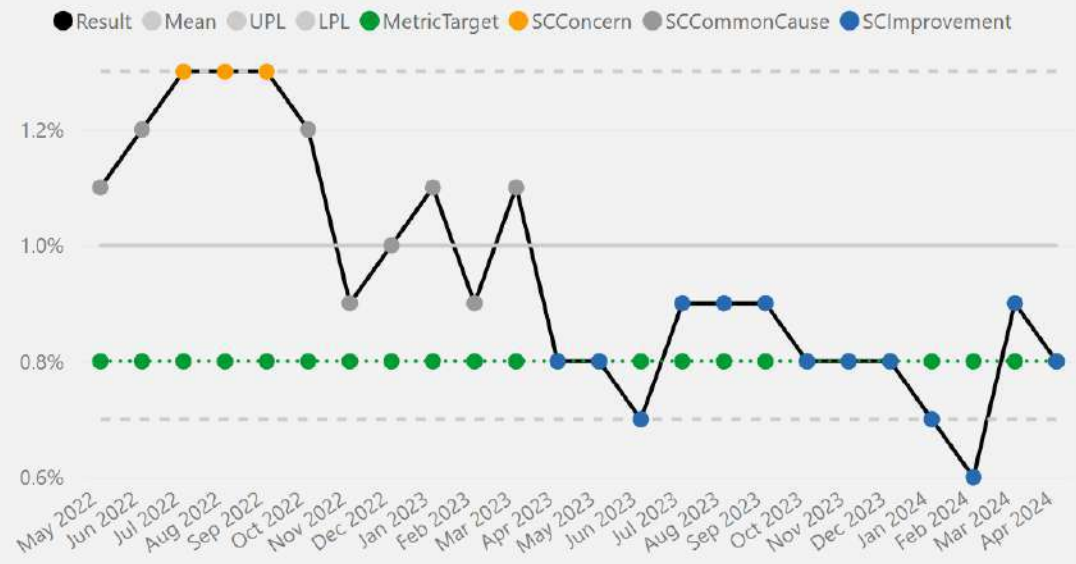
Monthly Turnover

Apr 2024

Variation	Assurance
L	?

0.8% Result	1.3% UPL
0.8% Target	1.0% Mean
	0.7% LPL

Monthly Turnover



Improvement Actions

April 2024 – Stay conversations will be reviewed as part of the updates to the People Promise plan

Analytical Commentary

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

Assurance Commentary

The monthly turnover rate for April 2024 is 0.8% which is a decrease from March 2024 (0.9%) and stable compared to April 2023. The data is consistently below mean and is therefore an special cause improvement.

The 12-month average turnover rate has stabilised at 9.5%. This maintains the lowest 12-month average turnover rate since August 2020.

Of the 60.5 (FTE) leavers that left in the month of April, which compares to 69.8 in March 2024; 52.4 were from three main staffing groups. These are: registered nursing and midwifery, additional clinical services (e.g Healthcare Assistants and other support workers) and administration and clerical.

The number of Stay Conversations is currently averaging 22% for the last 12 months (190 surveys from 860 leavers) against the target of 40%. Completion in April was 31%. This is reported and monitored through the divisional performance committees.

Retention is highlighted as a key focus for the NHS Operational Plan 2024/25 and therefore initiatives for the next year are being reviewed, in line with the staff survey results, reasons for leaving and the stay conversations data.

Staff in Post

NNUH Digital Health
business intelligence

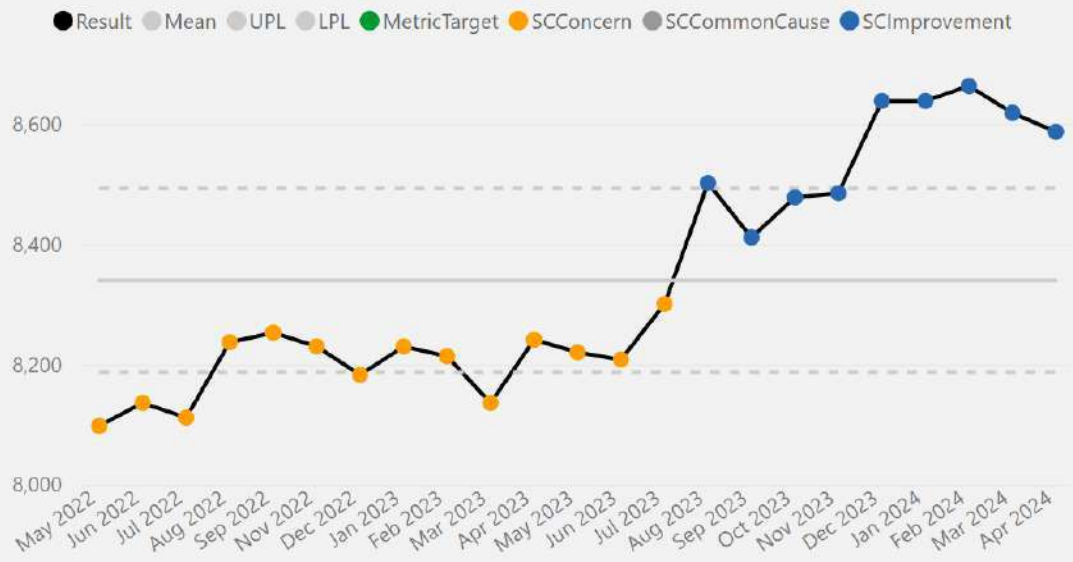
Actual Substantive Headcount (WTE)

Apr 2024

Variation	Assurance
H	

8,586 Result	8,492 UPL
N/A Target	8,339 Mean
	8,186 LPL

Actual Substantive Headcount (WTE)



Improvement Actions

April 2024 – Analysis of the staff survey comments to inform the People Promise plan

April 2024 - Prevention of Harassment Working Group established

April 2024 – Development of the staff occupancy rate

Analytical Commentary

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

Assurance Commentary

Substantive staff in post is 8,586 for April 2024, a decrease of 31.4 WTE on March 2024 (8,617.6). This compares to substantive staff in post of 8,240.6 for April 2023. Increasing headcount requires vacancy reduction and turnover reduction to be achieved. Vacancy rate is at 10.2% for April 2024, which is an increase from March 2024 (10.5%).

Despite a number of improvements, the ability to recruit, particularly HCAs, remains a risk for the Trust. This will be a priority area in the drafting of the Trust Annual Recruitment Plan.

Analysis of the staff survey results continue with the analysis of the staff survey comments is being undertaken with a view to updating the People Promise action plan. A Prevention of Harassment Working Group has been set up to review the relevant staff survey results and form actions. Via this work the People Promise Commitments 2024/25 are being drafted.

Work with the Digital Health Team has commenced to establish a staff in post occupancy metric with key milestone measures to be built into the reporting framework. Workforce Education Sub Board agreed with the proposal presented in March to review this KPI. The new proposed targets will be devised and be approved via the Committee process.

The Trust is leading on Norfolk and Waveney ICS Group to align the workforce key performance indicators across the ICS to enable effective benchmarking. The first meeting is due to commence in May 2024.

Vacancies

NNUH Digital Health
business intelligence

Variance: Headcount (WTE)

Apr 2024

Variation	Assurance
	

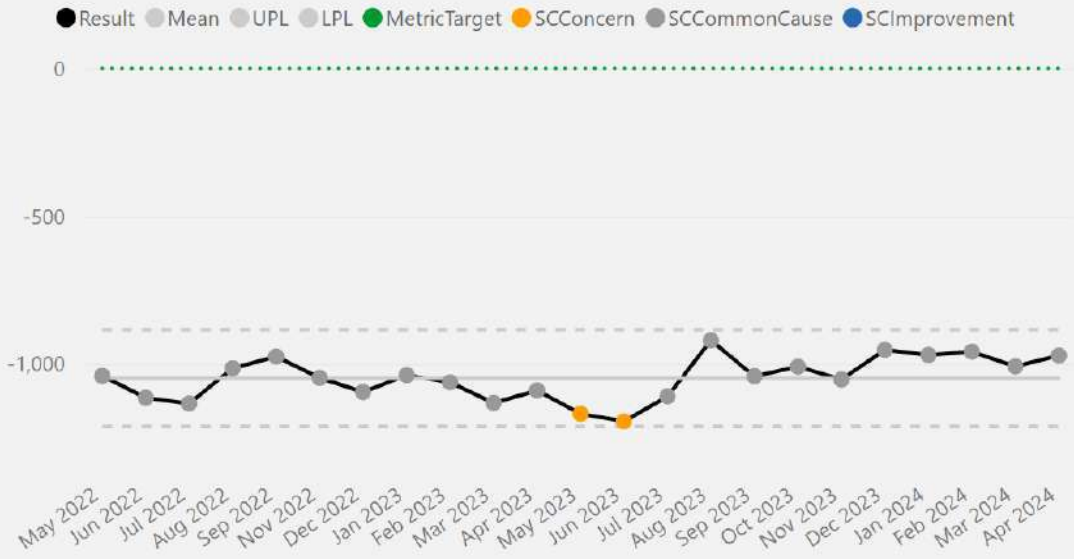
-973 Result
0 Target

-885 UPL
-1,049 Mean
-1,214 LPL

Analytical Commentary

Variation is Common Cause

Variance: Headcount (WTE)



Assurance Commentary

The Trust vacancy rate for April 2024 is 10.2% which is a decrease from 10.5% in March. There has been a decrease in the establishment in this month which has contributed to the vacancy reduction. This is variation of a common cause.

As part of the business planning cycle, divisional workforce plans have approved with new services, hard to fill posts and workforce risks identified. These are now being formulated into annual recruitment plan for 2024/25.

Due to the successful recruitment of international nurses in 2023, Nursing, Workforce, Finance and PD&E are working together to manage the newly qualified process for September 2024.

Career conversations with third year students who are due to graduate in September 2024 are ongoing.

The Trust is participating in Norfolk and Waveney ICS system wide events to attract 'New to Care' applications to Health Care Assistant roles.

The recruitment trajectory for Health Care Assistant roles continues as a risk due to skill mix changes in Divisions and recruited to the vacancy roles.

Improvement Actions

April 2024 – formulation of divisional recruitment plans, in line with the divisional workforce plans.

Recruitment (Non-Medical)

NNUH Digital Health
business intelligence

Time to Hire - Total

Apr 2024

Variation | Assurance

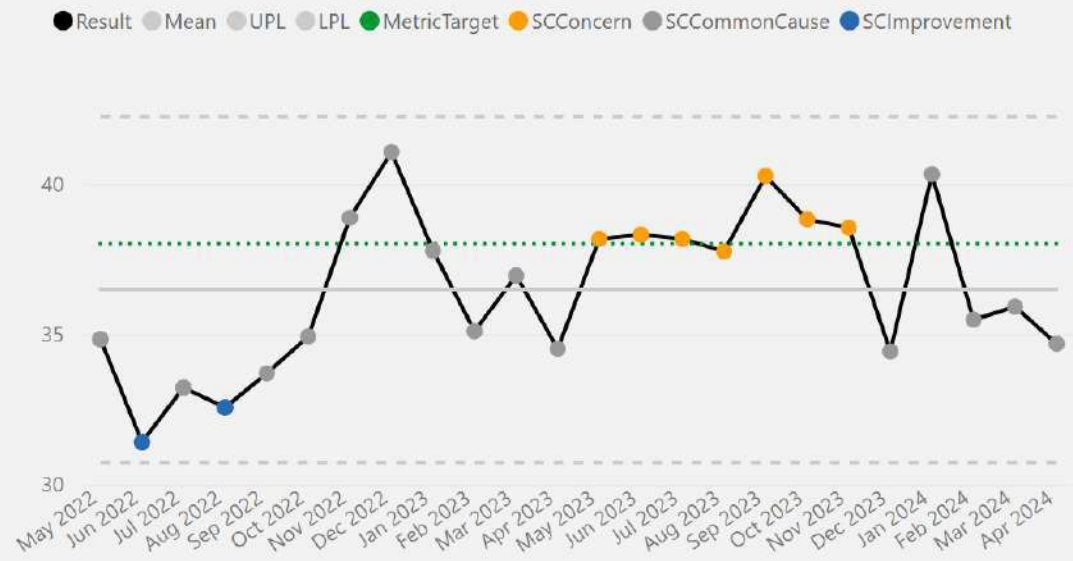
34.7 Result
38.0 Target

42.2 UPL
36.5 Mean
30.7 LPL

Analytical Commentary

Variation is Common Cause

Time to Hire - Total



Assurance Commentary

April Time to Hire was 34.7 working days, which is below the Trust KPI of 38 days. This compares to 34.5 working days in March 2023 and is the third month of being under the target. Time to Offer is 2.4 working days, slightly above the 2 day target. Time to Select is 11.2 working days, just over the target of 10 working days. Time to check is 23.1 working days, just under the internal target of 26 days.
In April, 154 candidates have been recruited to roles within the Trust, 65 of which were external to the Trust (which equates to 42.2%, below the current average of 50%). Due to the level of internal recruitment, a new internal recruitment SOP is being drafted and will be consulted with Divisions which will include a new process for generic job descriptions and essential roles.

A new waiver process for medical workforce has been developed to ensure an agile approval process can be put in place to optimise consultant recruitment.

Divisional annual recruitment plans are being drafted to align the business planning cycle with service improvements and the current hot spots.

Improvement Actions

April 2024 – A recruitment campaign is under way for Anaesthetic Consultants, which is a hard to fill post

April 2024 – First Post/ Newly Qualified Nurse recruitment is underway, with conditional offers made by Medicine (22) and Surgery (17) in addition to student radiographers (12).

April 2024 - Career conversations have commenced with third year students due

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Time to Hire - Time To Select	Apr 2024	11.2		Common Cause		No Target

Job Planning

NNUH Digital Health
business intelligence

Job Plans Signed Off % (Within 12months)

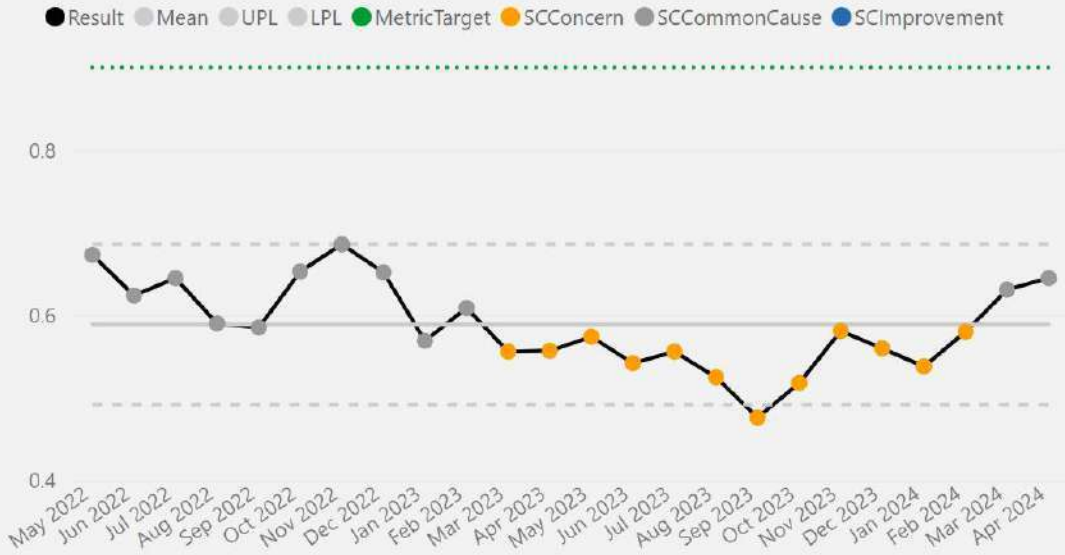
Apr 2024

Variation	Assurance
	

64.5% Result
90.0% Target

68.6% UPL
58.9% Mean
49.2% LPL

Job Plans Signed Off % (Within 12months)



Improvement Actions

To review the Job Plan Assurance TORs to consider closer alignment with medics rostering

To continue with updating the Beat with appropriate information

To review 'Team' job planning functionality and to consider whether this should be used in the organisation.

Analytical Commentary

Variation is Common Cause

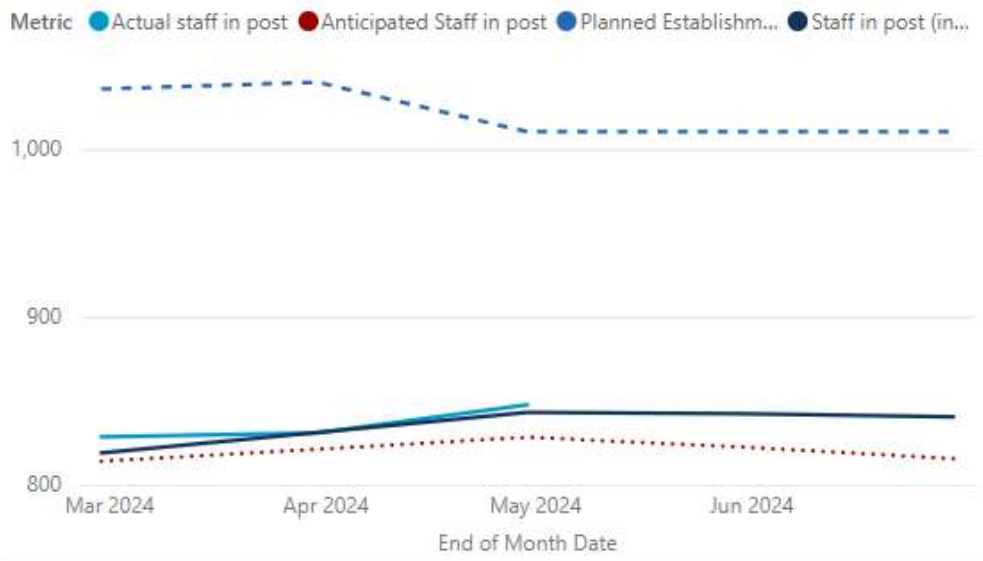
Assurance Commentary

Job Planning % continues to recover following the drop due to Industrial Action

Recruitment Trajectories

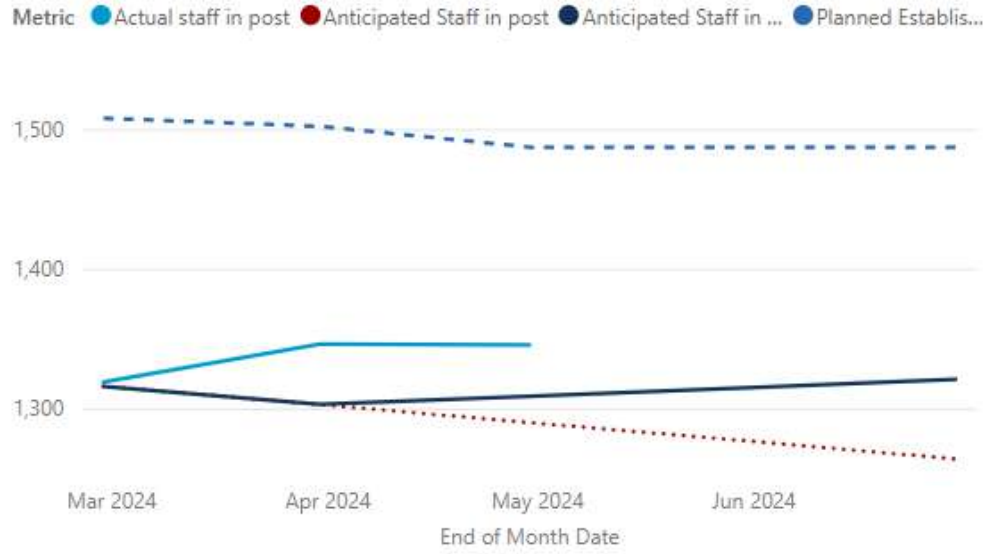
NNUH Digital Health
business intelligence

Recruitment Trajectory - Trust Band 2 Healthcare Assistant



Metric	Mar-24	Apr-24	May-24	Jun-
Actual staff in post	830.70	847.34		
Anticipated Staff in post	820.85	827.98	822.11	81
Anticipated Vacancy %	21.0%	18.0%	18.6%	19
Anticipated Vacancy % (increased capacity)	20.1%	16.5%	16.6%	16
Increased Capacity	5.00	5.00	5.00	
Internal Promotions	0.87	0.87	0.87	
Other Leavers	16.00	16.00	29.00	3
Planned Establishment	1,039.69	1,010.09	1,010.09	1,01
Recruitment Activity	24.00	24.00	24.00	2
Staff in post (increased capacity)	830.85	842.98	842.11	84

Recruitment Trajectory - Trust Band 5 Nurse



Metric	Mar-24	Apr-24	May-24	Jun-24
Vacancy % (INR)	13.3%	12.0%	11.6%	11.2%
Recruitment Activity	6.00	6.00	6.00	6.00
Promotions	7.00	7.00	7.00	7.00
Planned Establishment	1,501.83	1,486.91	1,486.91	1,486.91
Leavers	12.00	12.00	12.00	12.00
Increased Capacity		19.00	19.00	19.00
Anticipated Vacancy FTE (INR)	199.07	178.15	172.15	166.15
Anticipated Vacancy FTE	199.07	197.15	210.15	223.15
Anticipated Vacancy %	13.3%	13.3%	14.1%	15.0%
Anticipated Staff in post (INR)	1,302.76	1,308.76	1,314.76	1,320.76
Anticipated Staff in post	1,302.76	1,289.76	1,276.76	1,263.76
Actual staff in post	1,346.07	1,345.39		

REPORT TO THE TRUST BOARD

Date	**05 June 2024**
Title	**Chair's Key Actions Report from Quality and Safety Committee**
Lead	**Dr Pam Chrispin (Committee Chair)**
Purpose	**For Information and agreement as specified**

1 Background/Context

The Quality and Safety Committee met on 28 May 2024 and discussed matters in accordance with its Terms of Reference. Papers for the meeting have been made available to all Board members for information in the usual way via Admin Control. The meeting was quorate and was attended by Erica Betts (public Governor) as Governor Observer.

2 Key Issues/Risks/Actions

In addition to reviewing standard reports in accordance with its Terms of Reference, the Committee identified the following matters to highlight to the Board:

	Issues considered	Outcomes/decisions/actions
1	Capital programme review	The Committee had requested additional information regarding the Capital Programme with particular regard to items/schemes that are not included within the funds available for the Programme. The Committee noted that funding for the £2.5m of works required for introduction of Stroke Thrombectomy is not included. Given that establishing a thrombectomy service in Norwich has the support of regional/national specialist commissioners, it is hoped that some central funding may become available.
2	Radiology waiting times	The Committee had requested an update with regard to radiology waiting times and was advised that progress is being made in reducing waits. An interim outsourced solution is being sought until a longer-term solution is realised in September, at which point 5 new consultants take-up post, with another to follow next year.
3	Mortality	The Committee reviewed mortality in accordance with its Work Programme, noting that HSMR (as reported in the IPR) is within expected range. The SHMI remains higher than expected (reflecting the difference in methodology) and an overarching action plan is in development to address the recommendations of the clinical documentation review and those that are anticipated from the RCP. The Committee had requested that lessons from our Learning from Deaths reviews should be incorporated in the new Quality Priorities and this is very evident in the work overseen by the Interim Chief Nurse and Interim Medical Director in focussing our new Quality Priorities on improving the safety, effectiveness and outcomes of clinical services for patients.
4	Quality Account 2023/24 and Quality Priorities	The Committee reviewed and **recommends for approval** the Quality Account 2023/24 and Quality Priorities 2024/25 (as per attached paper). These documents are more than just a requirement of statute and best practice guidance. They provide an opportunity to reflect and highlight some really excellent work underway in the Trust but also to assess and frame our areas of future focus. The Committee

	2024/25	offered thanks to the team involved in their production and the particular work of the Interim Chief Nurse and Interim Medical Director in ensuring that the priorities are clinically relevant and informed by feedback and quality metrics to have maximum impact for patients.
5	Maternity	The Committee received the regular reports from the Maternity Team regarding safety and incident reporting in Maternity and Neonatal Services. The Committee receives monthly data reports on a bi-monthly cycle to ensure close oversight and compliance with CNST best practice standards. Board members are reminded that full details are available in the Committee papers on Admin Control. The Committee has asked the team to review the metrics that are reported, to ensure that the right indicators are being used and reported in a consistent and easily accessible format with targets/benchmarks as appropriate.
6	IPR- cardiology & SSNAP data	The Committee considered the Q&S IPR and requested reintroduction of an overall summary page to highlight key issues/progress against key metrics. • Regarding cardiology performance, it had been thought that when we improved ambulance turnaround performance this would be reflected in improved Call to Balloon times but that hasn't happened. The in-hospital component (Door to Balloon) is better than target and there needs to be further liaison with the ambulance service regarding the pre-hospital component. • Regarding stroke performance, if we are not yet able to introduce thrombectomy for stroke patients due to capital constraints it is incumbent on us to optimise the stroke services that are available. The Committee has asked for further information on what it will take to improve the SSNAP score at pace and on a sustainable basis.
7	Paediatric Audiology Services	The Committee was advised that in April 2024, the CQC wrote to providers nationally requesting confirmation whether Paediatric Audiology Services have achieved accreditation with UKAS IQIPS (Improving Quality In Physiological Services). This follows expert review of a number of Trusts in England and Scotland which found failings in some audiology services for children. The Committee received a report advising that 23% of Trusts hold this accreditation. NNUH is UKAS IQIPS accredited. This was temporarily suspended during 2023, while the Audiology Head of Service post was vacant, but has now been reinstated. An accreditation assessment undertaken in April 2024 identified 5 mandatory actions and these have been completed as required. The Committee was advised that continued achievement of the UKAS target for access to services may require creation of an additional paediatric soundproof booth. The next routine accreditation assessment is scheduled for November 2024 and the risk associated with growing demand for paediatric audiology services and need for paediatric-friendly soundproof facilities has been added to the Risk Register. To satisfy the CQC request for information and confirmation of assurance about the safety, quality, and accessibility of children's hearing services, Board members are reminded that full details are available in the Quality & Safety papers on Admin Control. The Committee will receive an update in July with regard to the Risk Register – which will enable review and assurance against maintenance of UKAS accreditation in advance of the November reassessment. The Committee accordingly **recommends** that the Board agree submission of the required information return to CQC.
8	Accreditations framework	The Committee has identified that the compliance framework around maintenance of accreditations needs to be strengthened. The Governance Compliance Manager reported that a formal SOP for processes and arrangements around external assessments is in

		development for review by the Management Board/Quality Programme Board. The Committee has also established in its Work Programme for 2024/25 that it wishes to receive two overview reports of the Framework, supported by a cycle of quarterly divisional reports – with each division reporting annually that they have implemented recommendations from clinical audits and that all appropriate accreditation standards have been met.

3 Conclusions/Outcome/Next steps

The Committee is scheduled to meet again on 25 June 2024 in Cromer

Recommendation: The Board is recommended to:

- **note** the work of its Quality and Safety Committee;
- **receive** the recommendation of the Committee with regard to approval of the Quality Accounts and Quality Priorities;
- **approve** submission of the information return to CQC regarding paediatric audiology services as recommended by the Committee.

REPORT TO TRUST BOARD				
Date	**29/05/2024**			
Title	**2023/2024 Quality Account**			
Author & Exec Lead	**Gemma Lynch, Governance Compliance Manager & Rachael Cocker, Chief Nurse**			
Purpose	**For Agreement**			
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.** **3. Together, we will join up services to improve the health and wellbeing of our diverse communities** **4. Together, we will provide nationally recognised, clinically led services that are high quality, safe and based on evidence and research** **5. Together, we will use public money to maximum effect.**			
Are there any quality, operational, workforce and financial implications of the decision requested by this report?	**Quality**	**Yes☐ No✓**		
	Operational	**Yes☐ No✓**		
	Workforce	**Yes☐ No✓**		
	Financial	**Yes☐ No✓**		
Identify governance review of this document	**Quality & Safety Committee -** April & May meetings		**Outcome/decision/changes made:** April - feedback provided with request to review Quality Priorities May - approved with feedback as referenced to below.	

1 <u>Background/Context</u>

NHS England explains:

Organisations are required……. to produce Quality Accounts if they deliver services under an NHS Standard Contract, have staff numbers over 50 and NHS income greater than £130k per annum. If you are a provider above this threshold, you will be required to publish your Quality Account for the 2022-23 financial year by 30 June 2024

The processes for producing Quality Accounts remain the same as previous years, with the following exceptions to NHS providers:

a. ***NHS foundation trusts are no longer required to produce a Quality Report*** *as part of their Annual Report. NHS foundation trusts will continue to produce a separate Quality Account for 2023-24.*
b. ***There is no national requirement for NHS trusts or NHS foundation trusts to obtain external auditor assurance*** *on the quality account or quality report, with the latter no longer prepared. Any NHS trust or NHS foundation trust may choose to locally commission assurance over the quality account; this is a matter for local discussion between the Trust (or governors for an NHS foundation trust) and its auditor. For quality accounts approval from within the Trust's own governance procedures is sufficient.*

c. ***The publication process has been amended for this year,*** *as noted below.*

d. ***Integrated Care Boards (ICBs)*** *have assumed responsibilities for the review and scrutiny of Quality Accounts. ICBs must clarify with providers where they are expected to send their Quality Account.*

Publishing requirements for 2023/24

The NHS.uk website no longer allows NHS organisations to upload reports. Therefore, we ask all providers producing Quality Accounts (NHS and non-NHS) to:

a. *Upload your Quality Account to an appropriate page on your organisation's website. Please ensure this is clearly visible and easily accessed by members of the public.*

b. *Forward the link of the webpage to the following email addresses: NHS providers – quality-accounts@nhs.net*

As the feedback from previous years has been positive, the look and layout of the Quality Account have been retained but focused on the 75 years of the NHS. As per previous years, a summary and Easy Read version have been created.

2 Key issues, risks and actions

The Quality Priorities were revised and updated following initial feedback from the Quality and Safety Committee and review by the Interim Chief Nurse & Interim Medical Director. The updated report was then reviewed again by the Committee and was approved for recommendation to Board with the following feedback:

- (Full Account) Amend the presentation regarding the North Norfolk Cancer Centre to make clear that this is a Trust facility run by NNUHFT staff.
- (Easy Read) revision of some terminology.
- (Easy Read) Query over amending some/all the achievements of this year within the document. However, this is not yet completed due to the tight turnaround for submitting papers for Trust Board after the Committee.
- Possible addition of post year-end information/events to the Summary and Easy Read versions, as there is local discretion over contents of these 'supplemental' documents and this may help to provide relevant updating context.

3 Conclusions/Outcome/Next steps

- The Quality Account has been sent to the ICB and Healthwatch for review and scrutiny. The deadline for their responses has not yet passed but these will need to be reflected in the final version.
- Once finalised the Account will be uploaded to the Trust website by 30 June in accordance with national requirements.
- The Summary Report will be particularly useful to use in public engagement and at the AGM in October and the Quality Priorities will be subject to monitoring and ongoing reporting.

Recommendations: The Board is recommended to:

- **review and approve** the Quality Account 2023/24, Summary and Easy Read versions;
- **confirm delegated authority** for CEO and Interim Chief Nurse to incorporate appropriate changes to the documents to reflect feedback from the Quality & Safety Committee and from ICB and Healthwatch;
- **agree delegated authority** for CEO and Interim Chief Nurse to update the introductions to the Summary version to incorporate post-year-end information where relevant to provide context eg if the final CQC report is received prior to publication.

NHS 75

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

NNUH Annual Quality Account 2023/2024

Quality Account 2023/24 – Contents

Foreword

What is a Quality Account?

All providers of NHS services in England have a statutory duty to produce an annual Quality Account (QA) to the public about the quality of services they deliver. This includes the requirements of the NHS (QAs) Regulations 2010 as amended by the NHS (QAs) Amendments Regulations 2011 and the NHS (QAs) Amendments Regulations 2012. The QA aims to increase public accountability and drive quality improvement within NHS organisations. They do this by getting organisations to review their performance over the previous year, identify areas for improvement, and publish that information, along with a commitment to you about how those improvements will be made and monitored over the next year.

Quality consists of three areas that are essential to the delivery of high quality services:

- How safe the care is (patient safety)
- How well the care provided works (clinical effectiveness)
- How patients experience the care they receive (patient experience)

Scope and Structure of the QA

This report summarises how well the Norfolk & Norwich University Hospitals NHS Foundation Trust ('NNUH' or 'the Trust') did against the quality priorities and goals we set ourselves in 2023/2024. It also sets out the quality priorities we have agreed for 2024/25 and how we intend to achieve them.

The report is divided into three parts:

Part One: includes statements from our Chief Executive, Chairman and Chief Nurse.

Part Two: Looks at our performance in 2023/2024 against our quality priorities we set for the year and also sets out the quality priorities for 2024/2025. Part two also includes statements of assurance relating to the quality of services and describes how we review them.

Part Three: Looks at how we identify our own priorities for improvement and gives examples of how we have improved services to patients.

The annexes towards the end of the report include comments from Healthwatch, the Integrated Care Board (ICB) and our Governors. There is also a glossary of terms used. This document is available in an Easy Read version. If you would like this document in another language, large print or braille, please email: q-s.team@nnuh.nhs.uk.

*** Please note - Text written in blue is to highlight mandatory wording as per the requirements set by NHS England.**

Celebrating 75 years of our amazing National Health Service (NHS)

On 5th July 2023 the Country celebrated the amazing 75 year anniversary of the NHS.

Treating over a million people a day in England, the NHS really does touch all of our lives. When the NHS was founded back in 1948, it was the first universal health system to be available to all, free at the point of delivery. This is because, over the past 75 years, the NHS has always evolved and adapted to meet the needs of each successive generation.

We are sure that many would agree that the NHS is something we can all be proud of.

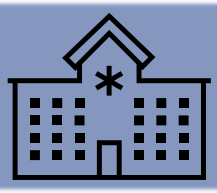
Some of the NNUH 75-year celebrations included a baking competition 'The Great NNUH Bake Off'

Tom Spink, NNUH Chairman, said:
"*We are proud of the achievements of the NHS over the last 75 years and the NNUH's vital role within Norfolk and Waveney.*
We were humbled by the public support for our hospital's 250th anniversary last year, and I'd like to thank all of our patients, carers and local community for their support and pay tribute to our more than 10,000 staff and volunteers for their dedication and hard work.
Our services are constantly evolving to meet the needs of our patients, and we are proud to be offering state-of-the-art healthcare including our award-winning Virtual Ward, robotic-assisted surgery, which is improving outcomes and recovery times for patients, and we are playing a key role in tailored genomic treatments. "

Various members of the NNUH staff were asked what they enjoy about their role. You can read some of these responses throughout this Quality Account.

Celebrating 75 years of our amazing National Health Service (NHS) continued….

Here are some Milestones of the NHS over the years.



1948 – the NHS is born, providing healthcare services that are free for all at the point of delivery

1960 - First implantable heart pacemaker is used

1978 - The world's first test-tube baby, Louise Brown, is born as a result of in-vitro fertilisation (IVF), developed by Dr Patrick Steptoe

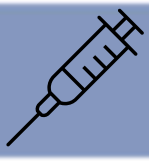
1987 - The world's first heart, lung and liver transplant is carried out by Professor Sir Roy Calne and Professor John Wallwork at Papworth Hospital in Cambridge

1992 - World's first laser surgery on babies in the womb to treat potentially fatal twin to twin transfusion syndrome takes place at King's College Hospital, London

2006 - NHS Bowel Cancer Screening Programme launched for those aged 60-69, the first ever screening programme to target both men and women

2012 - First UK hand transplant – a surgical team at Leeds General Infirmary carried out the operation

2020 - The NHS becomes the first health system in the world to commit to become carbon net zero



2021 - Dexamethasone, discovered as an effective treatment for COVID-19 in a clinical trial in the NHS, saves one million lives worldwide

You can find the full timeline at:
https://www.england.nhs.uk/nhsbirthday/about-the-nhs-birthday/nhs-history/

Part 1 - Chief Executive's Statement on Quality

Lesley Dwyer

A very warm welcome to our Quality Account for 2023/24. This document provides an overview of activity that has been taking place within our Trust on the quality agenda over the past year. As this is my first Quality Account, I need to acknowledge and thank the clinical staff and leaders within our Trust who have provided an overview of activity that has been taking place within our Trust on the quality agenda over the past year.

We ended the year with many of our access indicators showing marked improvement and green across planned care, cancer services and urgent and emergency care. This followed a concerted effort from teams across the hospital who deserve thanks for all their hard work and willingness to think and work differently.

Urgent and emergency care
Our position on ambulance handovers was significantly challenged in the early part of 2023/24. In October our performance started to improve as we focussed on reducing ambulance handover waits of over 30 minutes. This approach has placed us in the top performing Trusts across the country and saved lives by enabling the Ambulance Service to respond more quickly to sick patients in the community. When demand for our services has been high, this has meant having escalation beds on wards. Whilst theses are being phased out during May 2024, we recognise how difficult it is for our patients, visitors and our staff when we have beds in areas outside our usual practice. We have taken care to ensure those treated outside of main ward areas are treated safely and respectfully. We need to continue a clear focus on further improvements to reduce the challenges that we would otherwise face next winter.

Cancer performance
Our cancer performance has improved through 2023/24. In August 2023, we had 650 patients waiting longer than 62 days for their treatment against a national expectation of no more than 225. The hard work of our teams has brought the number of patients waiting over 62 days down to 179, fulfilling our nationally agreed improvement trajectory. For 2024/25, we will need to eliminate the backlog and focus on delivering the 62 day standard.

We have also seen an improvement in our performance on the faster diagnosis standard and in March 2024 we achieved the national standard of 75%. This performance compares well to other cancer centres nationally and provides vital treatment to the Norfolk and Waveney community we serve.

Planned care
After treating 78,000 patients for planned care, we have narrowly missed the 78 week standard with 268 patients still waiting longer for treatment. Industrial action has hampered our efforts, and some patients can be reluctant to travel where we have sourced alternative capacity outside Norfolk.

We are continuing to look at all available options to treat patients in this cohort of patients and have some of our theatres working seven days a week alongside the use of the independent sector capacity wherever possible to help reduce these excessively long waits for treatment. We have also started our planning to ensure that we are doing all we can to get ready for the new national standard of no patients waiting longer than 65 weeks for treatment by September 2024.

Discharge and patient flow
Our 'Home for Lunch' Taskforce initiative was established in autumn 2023 to establish a new way of working, where everyone's focus is on achieving as many discharges as possible before lunch**.** Enabling more discharges earlier in the day creates capacity for incoming patients, reduces time spent waiting in ED for an inpatient bed, reduces hospital length of stay and supports the Trust step out of escalation beds and areas. The project work is focused on three key areas: embedding daily flow, the weekend and evening operating model and urgent care flow pathways to reduce pressure on the hospital by increasing the number of discharges before midday. The number of discharges overall have increased, and the number of patients discharged before lunch has risen since the taskforce first started from an average of 11% to 21%. We have also started to roll out Optica, a real-time reporting tool that provides information about a patient's healthcare journey, including with our partners and providers. It is an important way to help ward teams to streamline discharge processes.

CQC rated maternity as good
Moving onto our Midwifery colleagues, I would like to say a huge congratulations to everyone in the maternity team, whose CQC inspection report was published in February 2024 and rated our maternity services as 'Good'. This is an incredible achievement at a time when maternity services nationally are under so much scrutiny and is credit to the leadership team and whole team. NNUH is only one of three units in the East of England rated 'Good' and the CQC only identified three 'should dos' and no 'must dos' during their inspection in November. It is important that the best practice adopted and being practiced in our maternity services is shared across the organisation and with other Trusts.

Demonstrating our commitment to children's care, we celebrated the 170th anniversary of the Jenny Lind Children's Hospital in April 2024. Norwich became the second city in the UK to establish a dedicated Children's Hospital. As an example of the excellent care for all young patients, our Neonatal Intensive Care Unit has also achieved stage one accreditation of the UNICEF UK Baby Friendly Initiative (BFI). The initiative supports breastfeeding and developing close and loving parent infant relationships so that all babies get the best possible start in life. Trusts which implement the Baby Friendly standards receive the prestigious Baby Friendly award, a nationally recognised mark of quality care. I am delighted to have been asked to be the Trust UNICEF Baby Friendly Initiative (BFI) Guardian.

Staff survey
More generally I am pleased to report some improvements in our Staff Survey results although there is much more to be done. The results of the 2023 Staff Survey show a small upward trend in all seven People Promise themes, as well as those relating to staff engagement and morale. However, the scores remain below the average for all 122 acute trusts nationally in each of these areas. In total, we scored above the acute trust average for five Staff Survey questions.

Giving staff a greater say in how we operate, listening carefully to their views and embedding a positive and connected leadership style are very important to me. We believe that we can do things differently, improve services for patients and make NNUH a better place to work. There are many challenges ahead, however we will continue the conversation about how we can improve staff experience and shape the work environment and more importantly make those changes.

Looking forward to the year ahead I can see tremendous potential across the organisation and the amazing work that is carried out by our staff, each and every day. I know how challenging things are, however all our efforts mean the Trust is making good headway and I have every confidence that together we will see the NNUH continue to move from strength to strength and be the place where we deliver high quality care consistently to every patient every day.

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.

Lesley Dwyer
Chief Executive

Our Chair

Tom Spink

To begin with I would like to offer my sincere thanks again this year to all members of staff and volunteers who have continued to work so hard to ensure the safe and effective care of our patients, whilst embracing changes for improvements to our services. Our hospital is at the centre of the community, affecting the lives of hundreds of thousands of families every year. It has been pleasing to see our continued and increased positive collaboration across the Norfolk and Waveney System involving the Queen Elizabeth Hospital Kings Lynn, James Paget Hospital, Norfolk Community Health & Care, Norfolk and Suffolk Foundation Trust, University of East Anglia and many others. This is always with the aim of improving our shared community's health journey.

At each Trust Board meeting, we hear from a patient from our community who describes their experience of care. We recently heard from a patient who explained how we could make reasonable adjustments for patients who had hearing loss. The challenge for our services is having all staff trained to respond to reasonable adjustments and recognising that people have different ways of communicating. Patients should always be given a choice, selecting the method that is most accessible for them, whether that be telephone, email or text. Better communication with our patients will improve our level of care, reduce DNAs (Do Not Attends) and save more time in the long term. Some teams are better at accommodating patient requests than others and it is apparent that we need a more consistent approach to recording and actioning a patient's preferred communication method. Everyone should be able to understand their appointment information, diagnosis and medication. Technology can often make this easer and we expect that the introduction of an Electronic Patient Record will make it easier to record a patient's preferences. In the meantime, we continue to take simple steps such as asking, 'how can we support you with communication today'.

We have had a lot to celebrate over the year and I am immensely proud of the progress made regarding our staff recruitment and particularly that of our nursing profession. This was one of the priorities from last year's staff survey. I also offer congratulations to our Midwifery colleagues following their CQC rating of Good. Again, this year we are so proud that we have 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. I also want to acknowledge the fantastic efforts of everyone that contributed to the tremendous improvements in ambulance handovers, reducing elective waiting lists and improving cancer treatment times during the year.

I would like to take this opportunity to thank Nick Hulme, who was our Interim Chief Executive Officer (CEO) for much of the year. I would also like to welcome our new CEO Professor Lesley Dwyer. I look forward with great optimism to all our future achievements in this coming year.

Tom Spink
Chair

Our Chief Nurse

Nancy Fontaine

Since becoming Chief Nurse in August 2018, I have been immensely proud to lead our nurses, midwives, AHPs, Pharmacists and Bio-Scientists across the Trust and be your Director for Infection Prevention and Control and executive lead for Quality, Safety, Patient Experience and Engagement. I am particularly proud of our progress with Quality Improvement, developing our staff and our Trust achieving an Outstanding rating for our End of Life Service, getting 'Good' ratings from the CQC with our latest 'Good' for Maternity services. These results are a testament to staff commitment to our patients and our local communities.

I would like to thank our Emergency Department (ED) colleagues and the teams that support ED for opening their doors to the cameras and giving the public a valuable insight into their work and clinical expertise. Our emergency nursing teams made their national television debut in September, featuring in the new series of "Emergency Nurses: A&E Stories", shown on ITVBe over 10 weeks and streamed on ITV X. Film crews from Crackit Productions were in the department between March and June 2023 shadowing selected nursing staff working in Resus, Majors, Minors and Children's Emergency Department. The series is the first TV documentary hosted here at the NNUH in almost 15 years and gives viewers a unique behind-the-scenes view of what it's like to work in one of the busiest Emergency Departments in the country and the lives of our emergency nurses and healthcare assistants. These insights included some of the major trauma, serious injuries and illnesses the ED team deal with every day.

An update on our Virtual Ward, the respiratory department has continually evolved the service over the past year. Oxygen and bronchiectasis nurses provide specialist input virtually. Patients who need oxygen, nebulisers or intravenous antibiotics can now manage this at home because they are monitored daily. Technology alerts the team to any potential concerns, and patients are contacted by video call or telephone to discuss how they are. For respiratory patients with long term health conditions, the longer they stay in hospital the risk of deconditioning is greater, as is the risk of further infections. The sooner we can get them home, the better. It is a real positive in trying to ensure patients remain active and mobile. The entire Virtual Ward team need credit for the success, they are such an engaged group, the hospital couldn't run the Virtual Ward without the team we have, they are so proactive and enthusiastic. The virtual ward continues to be a key element in managing pressures for the hospital. Future collaborations are focusing on working closely with our community partners.

Finally, I should let you know that I am leaving NNUH to take up a new leadership role with the Nursing and Midwifery Council (NMC). I will be taking up a new post supporting the transformation and improvement programme after five and a half years at the Trust, I am extremely proud of the work we have achieved together and the challenges we have overcome, in particular the significant improvement in registered nursing and midwifery staffing. It has been an honour to serve our patients, carers and staff and I have worked with brilliant people throughout my time here. There are so many staff who have and will continue to make significant contributions to the ongoing improvement journey for the Trust. I leave the organisation knowing that the focus on improvement is truly embedded.

Nancy Fontaine
Chief Nurse

Our Medical Director

Bernard Brett

I have been the Deputy Medical Director since January 2019 and am very proud to be appointed the Interim Medical Director since September 2023, whilst Professor Erika Denton is seconded as Interim National Medical Director for Transformation, with NHS England.

It has been challenging time across the NHS since the pandemic due to the number of patients on waiting lists, with many having to wait much longer and an increase in the number of patients attending the hospital as emergencies, a lot of whom have been so unwell they needed to be admitted. This has been compounded further by Industrial Action.

It is important to me to say thank you to all our staff and our volunteers for providing safe and effective care to our patients and their families when their working environment is not always supportive to deliver that care in the way we would like. All their hard work and dedication is appreciated.

One of the key priorities for me in this role is to ensure that our staff and our patients have a say in how we deliver our services and listen to their ideas on how we improve their care. Our Home for Lunch transformation project focused on key areas through workgroups with our staff from November 2023, pre-Noon discharges reminded us as clinical staff, that basic information such as an expected discharge date helps our pharmacy team prioritise their workload for getting medication ready for our patients for the morning of the day they are due to go home. This also helps other ward teams ensure that other key elements of discharge such as transport, home care packages and equipment if required are in place in time.

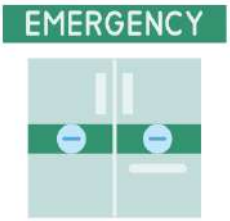
Assessment to Wards, have been reviewing how our patients are managed as they are admitted from an assessment area to become an inpatient on a ward. A similar workstream is looking at patients admitted to the Emergency Department.

The Emergency Department supported by our site teams and the ward teams have undertaken a massive amount of work to reduce the length of time patients are waiting on Ambulances. This has meant that we have had to have additional patients in bays or corridors at times, which I acknowledge is less than ideal, but by doing this, it has meant that we have been able to release ambulances back into the community to see patients with urgent conditions such as those with Chest Pain or elderly patients who have fallen outside and have broken their hips.

Equally, I want to improve the training, education, and research opportunities for all our staff. We need to improve the experience of all our staff, as it is important that we ensure that our hospital is a really good place to work.

Bernard Brett
Medical Director (Interim)

There were 148,832 Emergency Department attendances at the NNUH and Cromer Hospitals



We have 1,398 Hospital Beds

We have 11,446 Employees across all sites.

Across the sites, we had 3,200 hours of voluntary support

4,833 babies born

Of which **65** were sets of twins and **1** set of triplets

185 were born at home

2216 born in Theatre

540 born in Midwifery Led Birthing Unit and **1887** in the Delivery Suite

Spotlight on our Paediatric Theatres Complex

On Thursday 9th January 2024, our hospital opened the Jenny Lind Paediatrics Theatres.

The complex, which cost a total of £8.6million, consists of a twin paediatric theatre suite, a recovery unit and associated staff and patient supporting facilities.

The new team will carry out theatre procedures initially over five days a week, including orthopaedics. The opening of this new complex will also provide additional capacity to theatres more generally as paediatric patients will now move out of general theatres to be treated in these new facilities.

Clinical Lead Caroline Banson, who has been leading this project, said: *"I would like to thank everyone involved who has helped us reach this point. I am really proud of the unit, which has been created very much with our younger patients at the heart of our decision-making. It also provides a much better working space for our teams."*

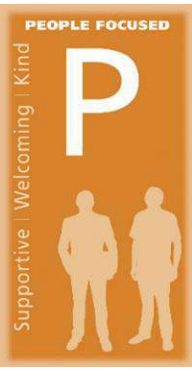
A £160,000 grant from N&N Hospitals Charity has provided audio-visual equipment in both theatres, ensuring that the new operating facilities can be used for training and education, recording, conferencing, improved digital documentation and improved visual clarity for the whole team. Part of the grant has also paid for engaging artwork by Norfolk artist Toby Rampton and Norfolk storyteller Amanda Smith, who has provided a narrative to run alongside the artwork.

Julie Cooper, Norfolk & Norwich Hospitals Charity Head of Grants, said: *"We are extremely pleased to see how donations to our charity have made it possible for enhancements to be made to the new surgical theatres for the Jenny Lind Children's Hospital. We hope that the installation of the wonderful artwork by Toby Rampton and words by Amanda Smith have made the hospital environment a friendlier place for children and families at what can be a very stressful time. We also look forward to seeing how the audio-visual equipment that we have funded for each of the new theatres will enhance the ability to train and develop NHS staff for many years to come."*

Sustainability is also high on the agenda with Consultant Paediatric Anaesthetist Dr Amy Greengrass leading the way. The team will be continuing with waste segregation to reduce emissions from waste and aim to use cylinders of nitrous oxide (gas and air) to avoid leakages and waste of a potent greenhouse gas known to be associated with piped nitrous oxide.

To find out more about the N&N Hospitals Charity or to make a donation please visit: **www.nnhospitalscharity.org.uk**

Our Trust PRIDE Values



People Focused: We look after the needs of our patients, carers and colleagues to provide a safe and caring experience for all

Respect: We act with care, compassion and kindness and value others' diverse needs

Integrity: We take an honest, open and ethical approach to everything we do

Dedication: We work as one team and support each other to maintain the highest professional standards

Excellence: We continuously learn and improve to achieve the best outcomes for our patients and our hospital

Part 2 – Priorities for improvement and Board Assurance Statements…

75 year spotlights…

Name and role: Will Davison – Consultant in Older Peoples Medicine

Length of NHS/ NNUH service: I qualified in 2011 and have worked for the NHS since then, doing my postgraduate training in the East of England deanery. I was appointed as a Consultant at NNUH in September 2022.

What do you love most about your role?
I get satisfaction from my job because I know that, as part of a team who care for and try to make things better for frail and vulnerable patients, I am spending my energy and working hours doing something that makes a difference for people. I also love that older patients invariably have an interesting story or two to tell!

Name and role: Victoria Cole – Biomedical Scientist (Biochemistry)

Length of NHS/ NNUH service: 14 years

What do you love most about your role?
I am proud to be part of a very hard-working team. We face massive challenges with the huge daily workload to serve the hospital and the GPs in Norfolk. I am proud to be part of a team that plays an integral role in the care of the majority of patients. The role of a Biomedical Scientist is always interesting. Advances in medicine, science and technology mean that the role is always changing.

Name and role: David Hewson - MRI Deputy Lead Radiographer and MR Safety Officer

Length of NHS/ NNUH service: NHS: 24 years, NNUH 19 years

What do you love most about your role?
Really enjoy the daily scanning of a wide variety of clinical exams. As the MR safety officer, I support complex cases involving the clearance of various implants to ensure MRI can be safely offered to as many of our patients as possible. The role also requires the provision of MR safety education to various staff groups across the Trust. NNUH is very fortunate to have a very talented MRI team working here.

Name and role: Fiona Springall – Children and Young People's Learning Disability and Autism Specialist Nurse

Length of NHS/ NNUH service: 5 and a half years

What do you love most about your role?
I love knowing that I am making a difference to the care and experiences of children and young people with learning disabilities and/or Autistic children and young people that access the hospital. Supporting patients to gain positive hospital experiences and equitable access to healthcare supports them to achieve best possible health outcomes, which is the most rewarding part of my role.

Part 2.1 - Priorities for improvement

Introduction to Quality Priorities

Photo of inside the Norfolk Kidney Centre

2024/2025 Quality Priorities

The 10 Quality Priorities for 2024/2025 contained in this account, were proposed by Hospital Management Board (HMB). These priorities have been aligned with new Chief Executive Officer's strategic commitments to support continuous improvement and to reduce some of our highest risks:

Patient Safety

- Care of patients who are frail: Develop Comprehensive Acute Frailty Services.
- Reducing our standardised mortality scores through specific pathway improvement and clinical data quality improvement: Early recognition of Deterioration and Sepsis, and implementation of Martha's rule.
- Reducing our standardised mortality scores through specific pathway improvement and clinical data quality improvement: Heart Failure Pathways.
- Hospital@Night transformation programme optimising out of hours care to deliver high quality safe care at night and supporting the wellbeing of those working at night.

Clinical Effectiveness

- Reducing our standardised mortality scores through specific pathway improvement and clinical data quality improvement: Frailty and Fragility Fractures, Management of Older Major Trauma Patients.
- Improving Patient Flow to improve patient and staff experience and reduce number of patients cared for in escalation areas.
- Elective care recovery and Theatre Transformation / Cancer services
- Pharmacy Transformation: to provide the Trust with more robust, safe pharmaceutical services, create an improved working environment for our team and in the process increase efficiency.

- Health Inequalities.

Patient and Staff Experience:

- Transition Pathways for young people.
- Improving Communication around End-of-Life Care.
- Improving learner experience.

In addition to linking our quality priorities with our strategy commitment, we have also linked them to the Norfolk and Waveney Integrated Care System (ICS) quality priorities 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.

2023/2024 Quality Priorities

The progress of these priorities is contained within our ‘Quality Priorities Update’ (pages 28 – 50).

The 2023/2024 Quality Priorities will be absorbed as ‘business as usual’ in 2024/2025.

New Quality Priorities for 2024/2025

Patient Safety

QP1 – New priority - Care of patients who are frail: Develop Comprehensive Acute Frailty Services	
Rationale	Patients who are frail make up a substantial proportion of patients presenting to urgent and emergency care settings. Early, comprehensive assessment of these patients can improve outcomes by ensuring the acute care, management pathway, and future care plans are all tailored appropriately to the patient's needs. An Acute Frailty service routinely and systematically identifies and grades frailty in people who present acutely to Urgent and Emergency Care services. These services then consider the personalised needs of individuals living with frailty, considering their grade of frailty and degree of illness, supported by clear reliable pathways into and out of hospitals, aligned to the grade of frailty identified. The aim is to provide care in the right place, first time. This may be in the patient's home for a group of patients or through SDEC aiming to get the patient home with onward care as soon as initial diagnostics and treatment have been initiated. SDEC aims to reduce admissions and thus deconditioning of patients who would otherwise be admitted to hospital.
How these will be monitored and measured	• Standardised mortality rates • Patient experience • Quality Indicator 'Identification and response to frailty in emergency departments'
How these will be reported	Quarterly Evidence Group and Quality Programme Board
Executive Lead and Delivery Leads	Medical Director

QP2 – New Priority - Reducing our standardised mortality scores through specific pathway improvement and clinical data quality improvement: Early recognition of Deterioration and Sepsis, and implementation of Martha's rule	
Rationale	Acute physical deterioration can occur in any health and care setting and is a dynamic process in which a patient becomes suddenly more ill, potentially leading to death. It can be identified by changes in standard physiological indicators. Early identification of clinical deterioration is important in preventing subsequent cardiopulmonary arrest and to reduce mortality. Sepsis is a life-threatening emergency in which timely diagnosis and emergency therapy has been shown to reduce mortality. Evidence indicates that access to a rapid review from a critical care outreach team (CCOT) or paediatric critical care outreach team is an additional and beneficial safety net in the identification, escalation and response to deterioration.
How these will be monitored and measured	• Reducing standardised mortality scores from current baseline • Patient experience 'being listened to' and achievement of key milestones for implementation of Martha's Rule. • Increase in the percentage of patients with timely repeat observations • Monitor Trust compliance of NEWS2 eLearning Package • Timely medical response to NEWS2 score trigger
How these will be reported	Recognise and Respond Steering Group Quarterly Evidence Group and Quality Programme Board
Executive Lead and Delivery Leads	Medical Director Rapid Response Team Matron Consultant Lead for AMU

QP3 – New Priority - Reducing our standardised mortality scores through specific pathway improvement and clinical data quality improvement: Heart Failure Pathways	
Rationale	Across Norfolk there are 8,600 patients who have been diagnosed with heart failure by their GP, but there are probably another 6,000 to 10,000 who haven't been diagnosed yet. Heart failure patients can rapidly deteriorate, leading to long hospital admissions, and this condition is the most frequent cause of hospitalisation for over 65-year-olds. Currently there are gaps in provision and many undiagnosed patients are seen in our Emergency Department. By establishing a dedicated service, we can achieve better continuity of care and a better experience for patients, their families and the clinicians. Last year there were 1,600 admissions, accounting for 17,000 hospital bed days for patients with heart failure.

	Hospitals admissions are expensive, they can also be harmful for patients, reducing their mobility and independence, and by intervening earlier we hope to avoid them.
How these will be monitored and measured	• Reducing our standardised mortality scores for heart failure pathways • Improve patient experience: by removing delays, provide appropriate assessment to support shared decision making about priorities of care and treatments. • Evidence of a standardised approach to the treatment of heart failure patients across all the healthcare providers in Norfolk and Waveney.
How these will be reported	Quarterly Evidence Group and Quality Programme Board
Executive Lead and Delivery Leads	Medical Director Cardiology Consultant (Heart Failure)

QP4 – New Priority - Hospital@Night transformation programme optimising out of hours care to deliver high quality safe care at night and supporting the wellbeing of those working at night.	
Rationale	Hospital at Night is a clinically driven and patient focused approach to managing care out of hours, which has the capacity to call in specialist expertise when necessary. It advocates supervised multi-speciality handovers; other staff taking on some of the work traditionally done by junior doctors and moving a significant proportion of non-urgent work for the night to the evening or daytime. There is an emphasis on team working and flexibility across Specialities. The existing Hospital at Night model has been in place since January 2012 when the Trust made a commitment to working towards a 24/7 approach to the deteriorating ward patient and Hospital at Night was renamed Hospital 24/7. This Quality Priority will review the current hospital 24/7 model to ensure that it encompasses all hospital wide escalation processes including but not limited to, Recognise and Respond Team, and use of Alertive to provide safe care at night.
How these will be monitored and measured	• Response times to H@N requests • Staff experience of H@N • Evidence of updated 24/7 handbook
How these will be reported	Quarterly Evidence Group and Quality Programme Board
Executive Lead and Delivery Leads	Medical Director H@N Site Matron Medicine Division Chief of Division

Clinical Effectiveness

QP5 – New priority - Reducing our standardised mortality scores through specific pathway improvement and clinical data quality improvement: Frailty and Fragility Fractures, Management of Older Major Trauma Patients	
Rationale	The care of patients with fragility fractures of the femur has long demonstrated the importance of the coordinated input of multiple specialties in improving patient outcome. Concerted and effective pathways involve nurses, doctors, therapist and allied healthcare professionals both in hospital and in the community setting. Ageing, comorbid disease, medications and frailty may all affect the expected physiological presentation of major trauma in older people. Many patients with orthopaedic trauma injuries have to be admitted to hospital, most frequently due to associated frailty, immobility or co-morbidities. Older patients have been consistently shown to have poorer outcomes following rib fractures, which may be related to: • Multiple comorbidities; • Reduced physiological reserve; • Greater difficulty in assessing and managing hemodynamics.
How these will be monitored and measured	• Reducing our standardised mortality scores for specific pathways • Improve patient experience: by removing delays, provide appropriate assessment to support shared decision making about priorities of care and treatments
How these will be reported	Quarterly Evidence Group and Quality Programme Board
Executive Lead and Delivery Leads	Medical Director Deputy Medical Director

QP6 – New priority - Improving Patient Flow to improve patient and staff experience and reduce number of patients cared for in escalation areas	
Rationale	Improving patient flow is not just about resourcing and expanding urgent and emergency care capacity to keep pace with rising demand – it is also about delivering transformation in how services are delivered, expanding out-of-hospital capacity, embedding preventative approaches and realising the benefits of emerging technologies.
How these will be monitored and measured	Improvement measures to include: • Patient experience • Reduction in the number of escalation beds • Virtual ward dashboard metrics • Door to needle time (AOS)
How these will be reported	Hospital Status Overview - Power BI alongside the Trust flow meetings. Quarterly Evidence Group and Quality Programme Board

Executive Lead and Delivery Leads	Director of Operations Medicine Division Triumvirate

QP7 – New Priority - Elective care recovery and Theatre Transformation / Cancer services	
Rationale	In line with 2024-2025 operational planning guidance to support elective care, a Theatre Transformation Programme has been implemented. The aim of this programme is to first drive the increased utilisation of theatre utilisation towards 85% and second, increase the level of day case procedures to 85%. This increase in both theatre utilisation and increased levels of day case procedures will help to reduce current waiting lists, whilst ensuring patients are getting the right care in the right location.
How these will be monitored and measured	• Reduction in on-the-day cancellations • Improved theatre utilisation tracked through Data Matrix System • Theatre utilisation rates target 85% • Rate of Day case target 85% • Reduction in agency spend
How these will be reported	Theatre Transformation Steering Group Quarterly Evidence Group and Quality Programme Board
Executive Lead and Delivery Leads	Director of Operations Transformation lead(s)

QP8 – New Priority - Pharmacy Transformation Programme: delivering high quality efficient, productive care.	
Rationale	Recruitment and retention challenges (national shortages, plus competition with primary care roles and band inflation at neighbouring acute trusts) Inadequate job cover and succession planning for key roles (single point of failure). Inadequate levels of pharmacy staff to be able to provide reliable services to ward / departments and train new starters / students. Low staff morale and full potential of Pharmacist and Pharmacy Technician roles not understood or utilised by wider Trust. Lack of capacity to participate in clinical and practice research, and to deliver value added pharmaceutical clinical support for in patients and outpatient clinics.
How these will be monitored and measured	• % automation, patient & staff satisfaction, error rate, IMR rate • Patient satisfaction, Dispensing Turnaround time, Reduction in Missed doses • Error rates and critical incidents • % growth of clinical trials and practice research • CIP Savings

How these will be reported	Quarterly Evidence Group and Quality Programme Board
Executive Lead and Delivery Leads	Medical Director Chief Pharmacist Clinical Support Services Division Director of Operations

QP9 – New Priority - Equality, Diversity and Inclusion (EDI) and Diversity, Inclusion and Belonging (DIB) including developing and delivering a Core20PLUS5 plan	
Rationale	For some people there are still unfair and avoidable inequalities in their health as well as their access to and experiences of NHS services. Health inequalities are the preventable, unfair and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental, and economic conditions within societies. They can determine the risk of people getting ill, their ability to prevent sickness, or their opportunities to take action and access treatment when ill health occurs. The approach defines a target population cohort – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.
How these will be monitored and measured	• Completed self-assessment. • Approved improvement plan based on self- assessment . • Evidence of ongoing progress against improvement plans for each workstream.
How these will be reported	Quarterly Evidence Group and Quality Programme Board
Executive Lead and Delivery Leads	Medical Director Associate Medical Director Primary Care and Integration Named workstream leads

Patient and Staff Experience

QP10 – New Priority - Transition Pathways for young people	
Rationale	The transfer of health care for children and young people into adult services can often be difficult. In many cases, the health needs of young people will have been met by the same people who have looked after them for as long as the child or young person can remember. As they reach adulthood, they 'transition' to an adult healthcare environment they may be faced with having to consult with several different health teams, therapy teams and adult social care services. This Quality Priority will ensure that no child or young person will become lost in the gaps between children's and adult services, and their experience of moving between services will be safe, well planned and prepared for. They will feel supported and empowered to make decisions about their health and social care needs.
How these will be monitored and measured	• Evidence that Quality Standards (QS140) have been met • Patient experience
How these will be reported	Quarterly Evidence Group and Quality Programme Board
Executive Lead and Delivery Leads	Interim Chief Nurse Lead Transition Nurse

QP11 – New priority - Improving Communication around End-of-Life Care	
Rationale	Poor communication with patients as they approach the end of their life is a recurring theme in complaints, feedback from the Medical Examiner reviews, Structured Judgement Reviews and in the results of the National Audit of Care at the End of Life (NACEL). Norfolk and Norwich University Hospitals NHS Foundation Trust has around 3000 deaths per year during admission or in the 30 days after discharge, and it is estimated that 30% of inpatients in acute hospitals are likely to be in their final year of life. As stated in the "Ambitions for Palliative and End of Life Care National Framework", end of life care "has to be considered as everybody's business". This is because the majority of end-of-life care will be carried out by generalists working in all specialties across the hospital. Good communication, advance care planning and individualisation of care are recognised to be essential components of good end-of-life care in the National End of Life Care Strategy (2008), Ambitions for Palliative and End of Life Care National Framework 2021-2026, and NICE Quality Standard QS144 (2017). The Integrated Care Board has recently carried out a review which identified the actions that are urgently required to ensure that it delivers its statutory duty in the provision of palliative and end-of-life Care for Norfolk and Waveney, in accordance with the National Delivery Plan. The delivery of personalised care and to support planning was one of those urgent priorities.

	Improving the timing, quality and effectiveness of communication with patients and their loved ones offers an opportunity to greatly enhance the quality of the care experienced by our patients. By identifying and clarifying patient's wishes and preferences as they approach the end of their life, good communication has the potential to not only enhance patient autonomy but can also reduce unwanted attendances at the Emergency Department, reduce admission to hospital, and shorten length of stay in hospital.
How these will be monitored and measured	• ReSPECT audit • IPOC audit • Reduction in complaints related to communication at EOL • Improvement in communication identified through SJR • Increase in numbers of patients with a documented ACP • EOLC lead appointed • Increase in patients achieving preferred place of death (via IDT data)
How these will be reported	End of Life Steering Group Quarterly Evidence Group and Quality Programme Board
Executive Lead and Delivery Leads	Interim Chief Nurse Palliative Care Consultant and Specialty leads

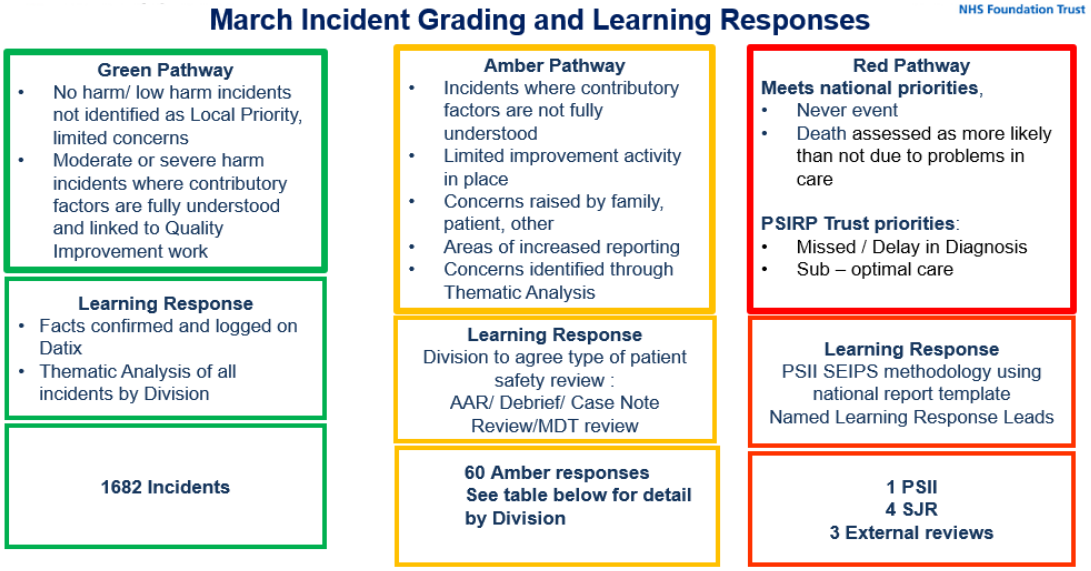
QP12 – New Priority – Improving learner experience	
Rationale	To meet requirement of education contract, and obligation as a University Teaching Hospital, ensure we are supporting our future workforce and meet our responsibility to be an exporter of excellence. To satisfy the General Medical Council standards and exit enhanced monitoring for Curriculum coverage, Staff behaviour; Supportive environment and Time for training
How these will be monitored and measured	• Data from the various surveys of learner and trainee experience: • National Education and Training Survey (NETS) • GMC and Staff Survey questions • Health Education England (HEE) Quality Assurance Framework
How these will be reported	Quarterly Evidence Group and Quality Programme Board
Executive Lead and Delivery Leads	Medical Director Director of Medical and Dental Education Associate Director for Education

Quality Priorities Update

Patient Safety

QP1 – New priority for 2023/24 - 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 (AAR) • 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
Executive Lead and Delivery Leads	Chief Nurse Associate Director of Quality & Safety (Patient Safety Specialist)
Progress during 2023/2024	**Key achievements for 2023/24** **QP1a**: All Serious Incidents (SI) Root Cause Analysis (RCA) under the SI Framework reports have been closed by Last SI closed on STEIS 24/04/24 by ICB **QP1b:** In March, the first PSII went through the governance process to final approval and sign off by the PSII Review and Sign Off Group. Daily Triage by the Divisional Governance teams continues to triage incidents to the proportionate learning response. The Complex Case Review Group heard 51 incidents and escalated 9 for a full PSII. **QP1c:** Proportionate learning responses are being used but low numbers of AAR and MDT reviews, see improvement actions below.



	Medical Division	Surgery, Critical and Emergency Care	Women and Children's Division	Clinical Support Services Division	Total
AAR (After Action Review)	0	2	0	1	3
MDT Review	2	3	0	0	5
Case-Note Review	1	1	50	0	52
Total	3	6	50	1	60

QP1d: 113 staff have attended AAR training up to 12/12/23. This training has been paused and is being refreshed to include systems-based investigations using SEIPS methodology.

Four Patient Safety Investigators have completed the systems based investigation training. The Patient Safety Specialist is undertaking the level 3-5 PSS training.

	QP1e: 1457 staff have completed essentials of patient safety Level 1. 113 staff have completed essentials of patient safety Level 2 **QP1f:** Staff in post: 0.8WTE Head of Patient Safety 3.8 WTE Patient Safety Investigators, 1.0 WTE Patient Safety Learning Coordinator, 1.0 WTE Patient Safety Administrator; Patient Safety Partner. **QP1g**: Processes are in place to QA assure PSII reports against the national standards. This includes peer review of PSII reports against the Learning Report template content. Patents, families and carers contribute to the Terms of Reference and review process. Formal sign off by the PSII Review and Sign Off Group. **QP1h:** Norfolk and Norwich University Hospitals NHS Foundation Trust » Patient Safety Incident Response Framework (nnuh.nhs.uk)
	What are the improvement actions and next steps to take forward for sustainability?
	• Continue working with Patient Experience and Complaints team to share learning and resources and experience across Patient Safety and Patient Experience • Work with PSS network and ICB on developing meaningful engagement training. Workshop to start designing content Tues 30th April. • AAR training restarting with a refreshed focus on applying systems-based approaches to learning from incidents Training restarts 18th June. • Work in progress to create local learning response guidance and tools to enable Governance teams to facilitate learning responses. Pilot Virtual SEIPS training scheduled for 23rd May: SWARM Huddle tool animation and MDT tool available by end of May. • To agree the governance process for agreeing and monitoring improvement actions to address the areas of improvement identified in PSII reports. Ensuring the actions are sufficient and robust to deliver the required improvements. • Continue to develop resources the sharing learning from incidents, using a variety of media and forums. For example, Safety conversations, attendance at grand round, Joint Patient Experience and Patient Safety department visits and awareness sessions, resources and news articles posted on The BEAT.

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
Progress during 2023/2024	**Key achievements for 2023/24**
	PCSP • The PCSP has been launched in collaboration with the Local Maternity Neonatal System and Maternity Voices Partnership. • PCSP and guideline approved. • All women from booking have been given a booklet at booking since launch. • Training for staff has been rolled out and has had positive engagement. **Score survey** • There have been four culture conversations with the quad and the team regarding the SCORE survey results

	• April 2024 KornFerry (External culture coach) met with quad to discuss feedback from the survey, culture conversations and facilitated creation of an action plan. • Action plan in process of being confirmed e.g. – shift buddy's and lanyards.
	What are the improvement actions and next steps to take forward for sustainability?
	PCSP • 'Easy read' version is currently being processed through each trust governance systems, and feedback provided to the LMNS team by end of May 2024. NNUH Maternity Guidelines agenda item in May 2024. • LMNS team to action any changes required from feedback with medical illustration and send to print when confirmation received from each trust's governance of approval with the aim of launch by end of June 2024. • We understand this is not usable by those where English is not the first language and does not address equality issues. Costs are being calculated for this via an external company as plans in place for a fully translated PCSP documents. However, this would need to be funded. • Plan to add as digital document when new EPR in place. This is in scope of the system. • Audit planned to review usage and satisfaction as this project will be at a cost to the Trust next year and needs to be fit for purpose. **Score Survey** • Implement action plan • Action plan split into Now Next and Then • Long term plan to address culture

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 2024 QP3b: Paediatrics should wait no longer than 18 weeks for first attendance
Executive Lead and Delivery Leads	Chief Operations Officer Divisional Operational Directors
Progress during 2023/2024	**Key achievements for 2023/24**
	Ophthalmology • With new management structure there is ongoing improvement across all areas. Working with the Governance team to ensure staff and patient safety at all times. **Respiratory** • Good uptake for WLI lists –with good clinical engagement. • Ability to use WLI from Consultant vacant post until recruited. **Spinal Surgery** • Despite the N2S contract has now ended, this has helped to clear some of the backlog of patients waiting to be seen. There has been around a 50% conversion rate to needing surgery, after first OPA, so this has meant that many patients are discharged after their first OPA at N2S so do not need to come via NNUH. • DNA rate has reduced – appointment reminders sent to patients to prevent them forgetting appointments.

	• Increased use of PIFU **Trauma and Orthopaedics** • PIFU still continuing to work well. **ENT** <u>Teledermatology</u> • Widened use of Teledermatology services initially for Basal Cell Carcinomas and now expanded to Squamous Cell Carcinomas • Ederma is now an established part of the service with the potential to expand its use • Working with Open Medical to create an online questionnaire which patients can complete prior to their images being taken to streamline and reduce time taken for images and questionnaire. We will then be able to fit in 16 patients instead of 12 patients in a day. NB: these patients all continue to require a consultant review where there is currently no additional capacity identified. <u>Waiting list reduction</u> • Admitted waiting list reduction of 398 since its highest in December 2023. • Non-Admitted waiting list reduction of 2825 since highest Sept 2022. **Dermatology** Within 1 year we have moved from 104 weeks to booking new appointments at 35 weeks (currently). This is in line with National targets driven through resource solutions. Increased our 'core' capacity through template changes has made a sustainable difference and ease reliance on high-cost drivers such as outsourcing and locums. Plans to develop the ENT workforce are in place and we will be bringing in extra consultant resource in later 2024. We have developed a 5 year workforce plan. Targets are reviewed daily, addressing bottle necks across the service. **Gynaecology** • Reduction of outpatient waiting list across all subspecialties within Gynaecology • Weekend 'super clinics', from April 23- December 23, 1738 additional slots undertaken. • Healthshare commenced October 23. Increased numbers being sent from January 24 to 70 patients per month.

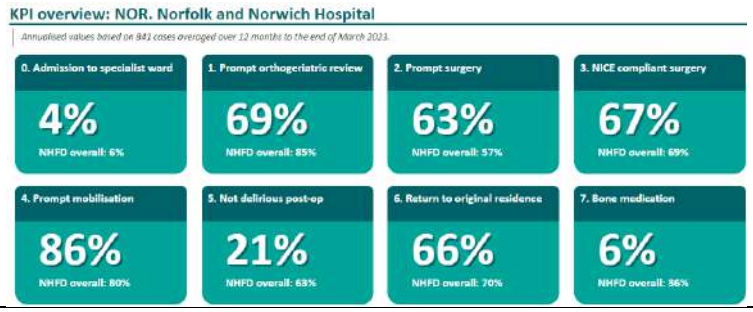
	• Engagement with PIFU. • Clinic template changes to reduce number of follow ups.
	What are the improvement actions and next steps to take forward for sustainability?
	Ophthalmology • Deep dive of all subspecialties to ensure resources are sufficient to cover demand. • Utilise Central Norwich eye clinic with more Outpatient (OP) clinics being undertaken away from main site. • Consider "1 stop type" oculoplastic clinics to reduce day case waiting lists, identify cases that can be treated as an OP. • Work with the Patient Engagement team to review OP pathway and aim to reduce the time patients are within the department. • Recruit "technician" type roles to assist with the diagnostic testing required when patients attend the OP clinics, and support patients when attending. • Reduce delays in the waits for imaging by training other staff within the OP area to undertake simple OCT's. • Recruit into vacant Optometry roles, with the aim to cover, extended roles, within the service covering OP activity for glaucoma, corneal and medical retinal. • Working with the ICB for low-risk glaucoma patients to be monitored within the community. • Ongoing work with the independent sector to assist with the new patients waits. **Respiratory** • Respiratory Physiology: o reviewing sleep PIFU pathway. Sleep team meeting on 17.04.2024. o Engagement with Business Support Team. o Good progress made to initiative PIFU/XPIFU pathways with clinical/admin team engaged. • Respiratory Medicine: o To be discussed at Senior Staff as to the best way forward as PIFU numbers have decreased recently. **Spinal Surgery** • Continue to run additional clinics, where able to. • Create an effective triage system. **Trauma and Orthopaedics** • Continue to put all suitable patients onto PIFU; difficulty arises with patients who are now more complex due to long wait for surgery. Also, as patients are being moved between Consultants, to meet

	long wait targets for electives, this creates more follow-ups with the new Consultant. • Convert large room in Outpatients to smaller rooms to create more capacity. • Look to book super clinics at weekends. **ENT** The team are undertaking the following steps to continue to reduce the number of follow-ups undertaken: • Increased use of PIFU and use of questionnaire if a patient on a PIFU indicates they want a follow-up to assess if a face-to-face follow-up required. • Use of text messaging and proactive cleansing of the follow-up caseload to ensure unnecessary follow-ups are not added. • Ongoing close working with Primary Care to encourage local management of patients to avoid referrals to Tertiary care. **Dermatology** • Continual focus as described above. Action to enact PIFU to review waiting lists and contact patients by telephone to review. • Focus will remain on utilising GIRFT guidance on ENT pathways to achieve FU reduction. **Gynaecology** • Continue with actions to ensure we stay on track. • Weekly monitoring of wait times across all sub-specialties

QP4 – 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 first 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
Progress during 2023/2024	**Key achievements for 2023/24**
	Paediatric Surgical pathways • Re-establishing the Paediatric surgical forum with all the consultants across specialties invited. • Opening of the new theatres and collaborative working of all teams • Initiation of the Paediatric sub board to include elective recovery reporting. • Paediatric Surgery team achieving all patients receiving their surgery under 78 weeks by the end of March 24.

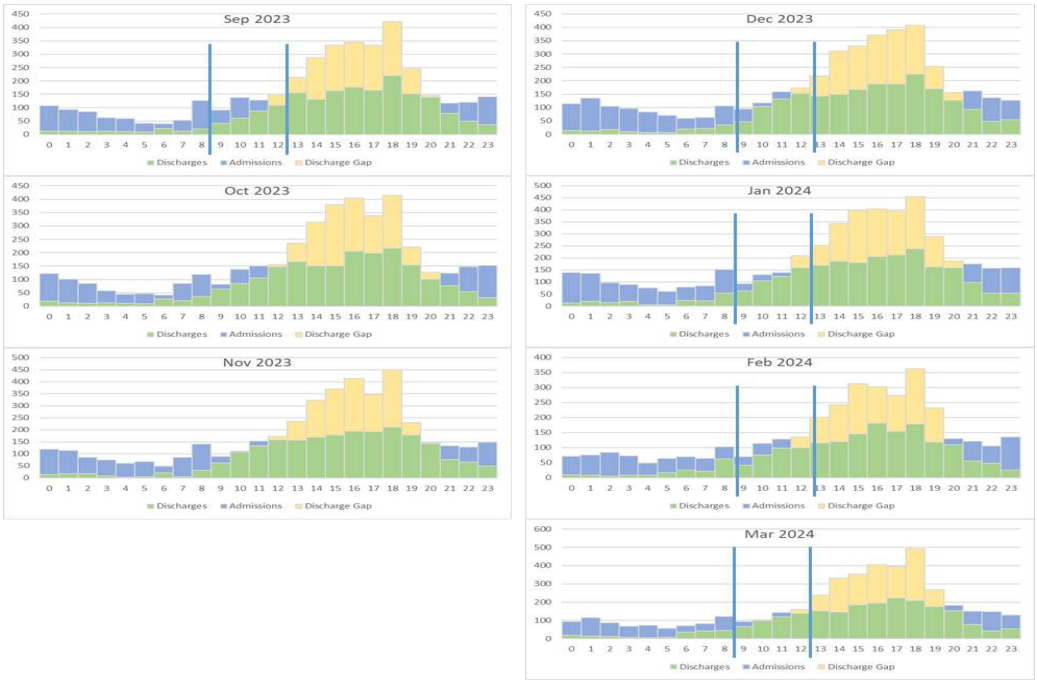
	Head and Neck Cancer The Head and Neck service has started to show improvements to 62 day performance in Q4 2023/24. Due to staff absences across the year in clinical and administrative roles and industrial action having a large impact on plastics surgery provision to head and neck surgery it has been difficult to maintain the rate of recovery across the year. Diagnosed patients requiring surgery are discussed weekly to ensure timely mitigation to delays.
	What are the improvement actions and next steps to take forward for sustainability?
	Paediatric Surgical pathways • Cross division resolution on staffing back fill for theatre. • Preoperative sustainable solution. • CHART roll out. • Surgical forums to look at reoccurring themes of issues. • Consideration of a collective Paediatric approach to recovery rather than individual team approach on allocation of theatre lists. To support working more together for the whole. **Head and Neck Cancer** Review of timed pathway milestones to be completed in 2024/25 GIRFT action plan to be created post formal feedback.

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 **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
Progress during 2023/2024	**Key achievements for 2023/24** • Establishing an executive-led NOF working group • Establishing a multi-disciplinary and Trust wide action plan to improve the NOF pathway and ultimately outcomes • Establishment of Direct to Earsham Standard Operating Procedure with close adherence (>90% since launch) • Improvements made to documentation and data capture for the pathway • New FIB Packs in ED • New PowerBi dashboard to improve oversight and monitoring of KPIs • Discussion at Quality & Safety Committee in February 2024
	What are the improvement actions and next steps to take forward for sustainability? • The NOF Task & Finish group will continue to progress all ongoing actions ensuring process improvements are embedded and actions completed, primarily:

	○ Conduct bed modelling to understand the impact of step-downs of NOF patients into Gateley Ward (Orthopaedics) and OPM Wards ○ Development of a sustainable operating procedure to prioritise NOF time to Theatre <36 hours. ○ Monthly data reviews utilising the new PowerBi NOF Dashboard to understand Best Practice attainment and patient outcomes. ○ Focus on patient experience improvements with direct to Earsham SOP – as per actions from Q&S Committee (To be presented in September 2024)

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 remains a high risk on the risk register. • 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 to 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
Progress during 2023/2024	**What are your key achievements for 2023 -24?** • Increased morning discharges and moved discharge profile to earlier in day. • Approximately 100 extra discharges per week, peak profile of discharges moved from 17:00-20:00 to 14:00-17:00.  • Implemented Communication & Clinical Engagement Programme; Criteria Led Stickers; Patient Information and Leaflets; The Beat Page; Comms email; Trust-wide and role specific events; posters and live screens across trust. • Alternatives to Emergency Department processes created for paramedics, via QR codes. Initiating Directory of Services work. • Ringfenced Medical Same Day Emergency Care (mSDEC) Unit to protect flow through the unit. • Daily cadence (9am today's discharges, 11am all patients seen and 2pm tomorrow's discharges). • Weekend planning improved with Think Thursday, Finalise Friday, Work Weekend and Monitor Monday. • Developed Clinical Standards, corresponding dashboard and a Directory of Services. • Hotline to reduce GP calls to find the correct specialty. • Single Clerking Form for all junior doctors. • Process changes in Imaging have reduced inpatient waits from over a week to under 28 hours.

	• WardView now follows the user on any desktop. • OPTICA discharge application between trust, community and local authority
	What are the improvement actions and next steps to take forward for sustainability? Collation of all UEC flow programmes of work underway to reduce duplication of work. Focus to cover: 1. **Daily flow** – working at ward level, addressing evening flow, supporting transport and prescription blockages. 2. **Urgent pathways** – expanding the Directory of Services, aligning with the community pathways, developing Hot Pathways 3. **Discharges** – expanding & embedding OPTICA, aligning SOPs to support changes in processes. 4. **Working with providers** across the ICS. e.g. aligning virtual wards in trust and in community to maximise efficiency.

Patient Experience

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 Musculoskeletal (MSK) Gap analysis and actions to meet NICE guidance for SDM.
Improvement Measures	QP7a: Evidence of Decision Support Tools uploaded to the intranet. 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
Progress during 2023/2024	**Key achievements for 2023/24**
	Resources available for specialty teams via the Beat which includes links to NHS England's Decision support tools https://www.england.nhs.uk/personalisedcare/shared-decision-making/decision-support-tools/ As part of the Shared Decision Making CQUIN, Cancer teams have been supporting a system wide approach to Shared Decision-Making through the development of digital tools for Decision Making for patients diagnosed with Prostate Cancer The Cambridge Prognostic Tool has been developed by a Consultant Urologist at Cambridge and offers patients the ability to plug in metrics to an algorithm which then identifies recommended treatment plans. NNUH

	have then worked with the Cancer Alliance to build on the Cambridge Prognostic Tool with a range of patient information videos. These have been co-produced with our cancer patient representative group. Patient are directed to the tool at the initial consultation and then supported by the Clinical Nurse Specialist to make a treatment plan. The use of the CPT and videos is being evaluated by the Cancer Alliance. https://www.canceralliance.co.uk/prostate
	What are the improvement actions and next steps to take forward for sustainability?
	Promote the NHSE SDM tools via the Beat and specialty teams for information. Discuss and agree plan to take forward SDM . Explore the role of Acute Services Collaborative to ensure consistency across ICS To link NHSE resources on the Trust's Website

QP8 - Improving equity of access to services	
Rationale	Equality Delivery System 2 (EDS2) Core20PLUS5 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
Progress during 2023/2024	**Key achievements for 2023/24**
	• Completion and publication (soft launch) of the Diversity Inclusion and Belonging (DIB) Strategy in Nov 2023 - Diversity, Inclusion and Belonging Strategy launches - The Beat (nnuh.nhs.uk) • Preparation and planning for a 'showcase' of progress and engagement in Spring 2024 – date confirmed for 24/05/24 • EDS – completed review for 2023-24 in line with NHSE requirements and aligned with ICB agreed focus areas – Children & Young People, Mental Health and Learning Disabilities/Autism • Patient Experience Facilitator – EDI - recruitment completed and person in post from January 2024. • EDS prep provided scope for targeted engagement and to support new Youth Forum and establishment of onward programme to engage with the key groups from the EDS and as the Cotre20+5 HI plans. • AMD (primary care and HI) – recruitment completed Q4 – to support HI going forward. • Governance – managed via EDGE – developed a strategy tracker to enable co-ordinated monitoring of progress.
	What are the improvement actions and next steps to take forward for sustainability?
	• The recently published Reducing health inequalities: A guide for NHS trust board members (nhsproviders.org) provides a self-assessment and guidance for ensuring HI is prioritised – this is being completed for NNUH and will inform next steps for this work. • EDGE – use of tracker for DIB monitoring.

QP9 – 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 – Year 1 objectives: • Implement the Accessible Information Standard (AIS) 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
Progress during 2023/2024	**Key achievements for 2023/24** • QP9a - Thorough review of the AIS Policy to be completed end May 2024 coproduced with colleagues and people with lived experience. Development of robust resource for staff to access via the Beat where Reasonable Adjustments are identified as required. • Comms and training offer developed and will roll out following final publication of the updated AIS Policy. • PAS alerts are available to ID patients with communication and support needs - they can be flagged. Waiting the development of an AIS icon for PAS to switch this on. • Work with DoctorDr is enabling greater opportunity for email contact/letters via portal and requests for different formats but it is not automated yet – may require implementation of EPR to complete this. • QP9b – The Maternity work has resulted in a robust, co-production and Health Inequalities focus for Maternity. Board Experience of Care item at April ’24 Board meeting shared the progress and the work will be presented nationally as an example of good practice as part of NHSE Experience of Care Week events (30.04.24).

	• The learning from the work will inform the development of engagement and involvement linked to the DIB/Health Inequalities work in Q1 and 2 in 2024/25. • QP9c - Develop information for communities to explain importance of collecting demographic information and for staff to ask – updated information leaflet drafted during Q4 with colleagues and community / lived experience contacts. • QP9d - Ongoing discussions to review and update HR training to include patient experience and health inequalities to be developed as part of DIB strategy plans for 24/25
	What are the improvement actions and next steps to take forward for sustainability?
	The recently published Reducing health inequalities: A guide for NHS trust board members (nhsproviders.org) provides a self-assessment and guidance for ensuring HI is prioritised – this is being completed for NNUH and will inform next steps for this work.

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
Progress during 2023/2024	**Key achievements for 2023/24** Recruitment has continued across all areas, current trajectories are in place and the vacancy rate for Registered Nurses is 10%, from a highpoint of 18.3% in April 2023. Healthcare Assistant recruitment continues, and current vacancy rate is 20%, from a highpoint of 25% in March 2023. The target of 100 newly qualified nurses joining NNUH was met and our new “settle in” process launched in September 2023. The Trust currently has the highest staff in post figure, of 8,617 (March 24). The Trust also has the lowest sickness absence rate amongst neighbouring Trusts in the Norfolk and Waveney System. The time to hire figure of 38 days also benchmarks as best in region. Turnover also continues to improve, reducing to 9.5% overall, from the high point of 15.1% in July 2022. The number of staff leaving in their first 12 months service has improved by 15% in the period January to December 2023 compared to January to December 2022.

	Of the 191 staff leaving for retirement reasons between January to December 2023, 55% returned and continued working for the Trust, and an additional 28 staff opting to use the more flexible retirement "drawdown" option since its launch in October 2023. This is anticipated to increase further, with the number of staff retiring and returning potentially decreasing over time. The work to develop the flexible working dashboards is behind schedule, predominantly due to operational pressures meaning divisional staff have not been able to provide the information needed but work continues with an aim to complete by end February 2024 for divisions and the Trust to utilise. The National Staff Survey closed on 24th November 2023. A Summary of the Achievements at the Trust: • Improvement in 96 of 106 questions in the staff survey • Improvement in all of the People Promise Themes on previous year, which are noted as being statistically significant • Ranked in the 5 x most improved acute Trusts for staff survey by the HSJ The NNUH question results which score above the Acute Trust national average are; ✓ Q6d I can approach my immediate manager to talk openly about flexible working. ✓ Q4d How satisfied are you with each of the following aspects of your job? The opportunities for flexible working patterns. ✓ Q10b On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours? ✓ Q19d We are given feedback about changes made in response to reported errors, near misses and incidents. ✓ Q31b Has your employer made reasonable adjustment(s) to enable you to carry out your work? Significant progress has been made with the actions in the People Promise programme which has contributed to the improvements experienced by the NNUH in the last year. In summary, 26 actions have been achieved, 8 have been implemented and are ongoing and 7 are still to be achieved. The National Quarterly Pulse Survey received its highest ever responses in July 2023, with 685 colleagues taking part. And again, in January 2024, 431 colleagues completed the survey. The April NQPS opened on 2nd April, with a campaign of works to encourage participation currently underway. Due to the additional optional pressures in January the NQPS scores showed a decline in all areas except two.

Question	2022 National Staff Survey Score	July 2022 Quarterly Pulse Survey Score	2023 National Staff Survey Score	January 2024 Pulse Survey Score
Engagement - Motivation	6.5	6.56	6.62	6.20
Engagement - Involvement	6.3	6.06	6.41	5.73
Engagement - Advocacy	5.6	5.82	6.04	5.41

Question	July 2023 Quarterly Pulse Survey Score	January 2024 Quarterly Pulse Survey Score	Variation
Motivation - Time passes quickly when I am at work	68.5	65.8	-2.7
Motivation - I am enthusiastic about my job	60.6	53.4	-7.2
Motivation - I look forward to going to work	43.3	36.7	-6.6
Involvement - I am able to make suggestions to improve the work or my team / department	64.8	63.7	-1.1
Involvement -There are frequent opportunities for me to show initiative in my role	60.9	57.7	-3.2
Involvement - I am able to make improvements happen in my area of work	47.9	46.6	-1.3
Advocacy - Care of Patients / service users is my organisations top priority	57.0	57.0	0
Advocacy - If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	52.6	53.6	1.0
Advocacy - I would recommend my organisation as a place to work	43.5	41.2	-2.3

What are the improvement actions and next steps to take forward for sustainability?

- Staff Survey results were communicated on 7th March.
- Supported with a 'line manager briefing guide' managers have been provided with guidance to understand their survey results and how they should celebrate their successes and agree a department specific plan.
- Department plans are to be cascaded to the Divisional leads, with departmental and corporate actions.
- The thematic analysis of the free text comments will be finalised by mid-April. These will build our understanding of staff experience more fully.
- An engagement event is planned for April, with invites to all staff groups and union representatives to seek feedback on future meaningful actions to inform the next iteration of the People Promise programme.
- These actions will be used to inform an updated People Promise improvement plan.
- The people promise plan will include actions to the results from the new Q 17) on of unwanted behaviour of a sexual nature in the workplace
- Following the success and building on the learning from last year, the OD Team will provide themed workshops and coaching for up to 30 teams identified as benefitting from additional focussed development.

Spotlight on the Rainbow Maternity Team

What is a rainbow baby?

A rainbow baby is a baby born after miscarriage, ectopic pregnancy, molar pregnancy, termination for medical reasons, stillbirth or neonatal death. The rainbow symbol has been used by members of the baby loss community for many years. For some parents, the symbol of a rainbow over-simplifies their experience because the arrival of a rainbow baby doesn't take away the grief they feel about their loss. But for many parents, rainbows symbolise hope and light after a dark time.

What is the NNUH Rainbow Clinic?

An individualised Rainbow pathway of antenatal care is offered to all women and birthing people who have experienced a previous late miscarriage (>20 weeks gestation), stillbirth or neonatal death. The Rainbow Clinic consists of a small multidisciplinary team of Consultant Obstetricians, Specialist Midwives and administrative staff who liaise closely with other health professionals such a perinatal mental health services.

It was set up in 2018 by Beth Gibson (Chief of Service for Obstetrics) having witnessed first-hand the pioneering work of the 'Hub' National Rainbow Clinic at St Mary's Hospital, Manchester. The clinic has since grown from a single clinician to a team of health professionals enabling care to be continuous throughout the antenatal period. The work was recognised in 2020 when the Rainbow Team won a Patient Choice Award. Beth said: '"*Creating a space for families to feel safer in future pregnancies after loss over the last 5 years has been hugely rewarding. We understand how hard it may be for families to trust when they may have been let down by care previously and are constantly humbled in the trust we are given to be able to provide expert care to improve their pregnancy outcomes*"

L – R: Photo of Beth Gibson, patient: Gemma and baby and Tori Maxey (Consultant Obstetrician)

Why is the Rainbow Clinic needed?

Following a stillbirth a birthing person has a five times increased risk of having a subsequent stillbirth (2.5%), which is higher than other long established risk factors such as obesity, smoking or diabetes. Adverse pregnancy outcomes such as preterm birth, placental abruption and low birth weight are also increased in this group of patients.

Research suggests that routine antenatal care is unable to meet the additional needs of this group of patients, with historically most birthing people needing to seek additional care through their GP, maternity services, and other health professionals. Additional support and continuity of care provider are highly valued, with local internationally presented data showing that the NNUH Rainbow clinic both increases continuity with healthcare professionals but also decreases the number of planned and emergency antenatal contacts for patients under their care.

Through reviewing the clinical history, placental histology, and blood results from the previous loss recurrent pathology can be identified. This together with advanced ultrasound techniques guide an individualised need for care, with the ability to change with the physical and mental health needs of the patient. This includes shared decision making around the timing and mode of delivery.

The Rainbow Midwives, Davina Bowen and Suzy Hankinson said:

L – R: Photo of Suzy Hankinson and Davina Bowen

'*In a subsequent pregnancy following loss in the perinatal period, the continuity provided by a Rainbow Clinic midwife helps create a safe and reassuring environment for families during a time where anxiety and fear are known to be heightened. '*

'From the midwife's perspective, the care we provide these families brings professional fulfilment, continuity, and the opportunity to work within a small and dedicated Obstetric team. Giving the families one of our precious rainbow hats, visiting them postnatally and the follow up calls we provide, allows us to ensure a fully holistic and personalised experience and can help with the new and exciting journey ahead for the family.'

Part 2.2 - Board Assurance Statements

Photo of inside the Norfolk Centre for Interventional Radiology (NCIR)

Review of services

During 2023/2024 the Norfolk and Norwich University Hospitals NHS Foundation Trust provided and/or sub-contracted 83 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 83 of these relevant health services.

The Trust remains mostly funded in 2023/24 by block/fixed funding, with a variable element for elective activity. The elective activity is paid on a unit price basis, with the Trust's performance included within the clinical income total. The clinical income total represents 88.4% of the Trust's overall income for the 2023/24 financial year.

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

During 2023/2024, 53 of the Quality Account national clinical audits and 5 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. There was 1 national audit that the national provider did not commence; this was the British Hernia Society audit, they confirmed

that the registry was in trial phase during 2023/2024, and the Trust was not eligible to participate.

We also 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 2023/2024 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 Audits in Alphabetical Order

National Clinical Audit (Alphabetical order)		Eligible Y/N	Took part Y/N	Participation Rate Cases Submitted	Completed/ In-progress/ Ongoing
Adult Respiratory Support Audit		Y	Y	18/18 (100%)	Completed
British Association of Urological Surgeons Nephrostomy Audit		Y	Y	8/8 (100%)	In-progress
Breast and Cosmetic Implant Registry		Y	Y	10 (January to June 2023) No percentage available	Ongoing
British Hernia Society Registry		Y	N	National audit in trial phase, and Trust was not a selected trial site	Expected to rollout to all Trusts late 2024
Case Mix Programme (CMP)		Y	Y	1513/1513 (100%)	Ongoing
Child Health Clinical Outcome Review Programme[1]		Y	Y	Juvenile Idiopathic Arthritis Study: 9/9 (100%)	Ongoing
Cleft Registry and Audit NEtwork (CRANE) Database		N	N/A	N/A	N/A
Elective Surgery (National PROMs Programme)		Y	Y	Hips 514 / 538 (95.54%) Knees 439 / 458 (95.85%)	Ongoing
Emergency Medicine QIPs:	a) Care of Older People	Y	Y	108 / 108 (100%)	In progress until October 2024
	b) Mental Health (Self-Harm)	Y	Y	188 / 188 (100%)	In progress until October 2024
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People[1]		Y	Y	10 percentage not known	Ongoing

National Clinical Audit (Alphabetical order)		Eligible Y/N	Took part Y/N	Participation Rate Cases Submitted	Completed/ In-progress/ Ongoing
Falls and Fragility Fracture Audit Programme (FFFAP)	a) Fracture Liaison Service Database (FLS- DB)[1]	N	N/A	No Fracture Liaison Service at NNUH	N/A
	b) National Audit of Inpatient Falls (NAIF)[1]	Y	Y	19/19 (100%)	Ongoing
	c) National Hip Fracture Database (NHFD)[1]	Y	Y	797 / 797 (100%)	Ongoing
Improving Quality in Crohn's and Colitis (IQICC) [Note: previously named Inflammatory Bowel Disease (IBD) Audit]		Y	Y	Paediatric: 77/77 (100%)	Completed
Learning from lives and deaths of people with a learning disability and autistic people (LeDeR)		Y	Y	14/14 (100%)	Ongoing
Maternal, Newborn and Infant Clinical Outcome Review Programme[1]		Y	Y	38/38 (100%) Breakdown: Maternal deaths: 4/4 Late Fetal Loss: 1/1 Terminations: 4/4 Stillbirths: 8/8 Early Neonatal Deaths: 10/10 Late Neonatal Deaths 11/11	Ongoing
Medical and Surgical Clinical Outcome Review Programme[1]		Y	Y	Endometriosis Study: 3/5 (60%)	Ongoing
Mental Health Clinical Outcome Review Programme[1]		N	N/A	N/A	N/A
National Adult Diabetes Audit (NDA):	a) National Diabetes Footcare Audit (NDFA)[1]	Y	Y	323/323 (100%)	Ongoing

National Clinical Audit (Alphabetical order)		Eligible Y/N	Took part Y/N	Participation Rate Cases Submitted	Completed/ In-progress/ Ongoing
	b) National Diabetes Inpatient Safety Audit (NDISA)[1]	Y	Y	23/23 (100%)	Ongoing
	c) National Pregnancy in Diabetes Audit (NPID)[1]	Y	Y	37/37 (100%)	Ongoing
	d) National Diabetes Core Audit[1]	Y	Y	Submission not undertaken until April 2024	Ongoing
National Asthma and COPD Audit Programme (NACAP):	a) COPD Secondary Care[1]	Y	Y	533/533 (100%)	Ongoing
	b) Pulmonary Rehabilitation[1]	N	N	Service not commissioned	No
	c) Adult Asthma Secondary Care[1]	Y	Y	229/229 (100%)	Ongoing
	d) Children and Young People's Asthma Secondary Care[1]	Y	Y	31/31 (100%)	Ongoing
National Audit of Cardiac Rehabilitation		Y	Y	2230/2865 (77.8%) (will be 100% patients entered once course completed)	Ongoing
National Audit of Cardiovascular Disease Prevention in Primary Care (CVDPrevent)[1]		N	N/A	N/A	N/A
National Audit of Care at the End of Life (NACEL)[1]		Y	NA	Audit did not run due to national redesign	Ongoing
National Audit of Dementia (NAD)[1]		Y	Y	39/39 (100%)	Completed
National Audit of Pulmonary Hypertension		N	N/A	N/A	N/A
National Cancer Audit Collaborating Centre - National Breast Cancer Audit[1]		Y	Y	The audit body uses existing sources of patient data, including the National Cancer Registration and Analysis Service	Ongoing

National Clinical Audit (Alphabetical order)		Eligible Y/N	Took part Y/N	Participation Rate Cases Submitted	Completed/ In-progress/ Ongoing
				(NCRAS)	
National Cardiac Arrest Audit (NCAA)		Y	Y	27/27 (100%) (01/04/2023 – 30/06/2023: Data for July 2023 – February 2024 are still to be recorded)	Ongoing
National Cardiac Audit Programme (NCAP):	a) National Adult Cardiac Surgery Audit (NACSA)	N	N/A	N/A	N/A
	b) National Congenital Heart Disease Audit (NCHDA)	N	N/A	N/A	N/A
	c) National Heart Failure Audit (NHFA)	Y	Y	602/604 (99.7%)	Ongoing
	d) National Audit of Cardiac Rhythm Management (CRM)	Y	Y	Electrophysiology 584/607 (96.2%) Pacemakers 1506/1506 (100%)	Ongoing
	e) Myocardial Ischaemia National Audit Project (MINAP)	Y	Y	887/913 (97.2%)	Ongoing
	f) National Audit of Percutaneous Coronary Intervention (NAPCI)	Y	Y	1364/1388 (98.3%)	Ongoing
National Child Mortality Database (NCMD)[1]		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 (Alphabetical order)		Eligible Y/N	Took part Y/N	Participation Rate Cases Submitted	Completed/ In-progress/ Ongoing
National Clinical Audit of Psychosis (NCAP)[1]		N	N/A	N/A	N/A
National Comparative Audit of Blood Transfusion:	a) 2023 Audit of Blood Transfusion against NICE Quality Standard 138	Y	Y	10/10 (100%)	Ongoing
	b) 2023 Bedside Transfusion Audit	Y	Y	Data collection in progress, expected 100%	Ongoing
National Early Inflammatory Arthritis Audit (NEIAA)[1]		Y	Y	318/318 (100%)	Ongoing
National Emergency Laparotomy Audit (NELA)[1]		Y	Y	292 / 292 (100%)	Ongoing
National Gastro-Intestinal Cancer Audit Programme (GICAP):	a) National Bowel Cancer Audit (NBOCA)[1]	Y	Y	599 / 599 (100%)	Ongoing
	b) National Oesophago-Gastric Cancer Audit (NOGCA)[1]	Y	Y	150 / 150 (100%)	Ongoing
National Joint Registry		Y	Y	547/547 (continuous data entry)	Ongoing
National Lung Cancer Audit (NLCA)[1]		Y	Y	959/959 (100%)	Ongoing
National Maternity and Perinatal Audit (NMPA)[1]		Y	Y	100% All births are registered as required and data is taken directly by NHS Digital	Ongoing
National Neonatal Audit Programme (NNAP)[1]		Y	Y	868/868 (100%)	Ongoing
National Obesity Audit (NOA)[1]		Y	N/A	Audit relies on the use of the Community Services Data Set, which the Trust does not use and is not mandated to use, which was confirmed to Commissioning by NHS England. NHS England was asked for alternative ways to	Ongoing

National Clinical Audit (Alphabetical order)		Eligible Y/N	Took part Y/N	Participation Rate Cases Submitted	Completed/ In-progress/ Ongoing
				participate, but no reply was received. Data from complications for excess weight (CEW) clinics is exempt from the NOA audit.	
National Ophthalmology Database (NOD) Audit	National Cataract Audit	Y	Y	2021/2021 (100%)	Ongoing
National Paediatric Diabetes Audit (NPDA)[1]		Y	Y	355/355 (100%)	Ongoing
National Prostate Cancer Audit (NPCA)[1]		Y	Y	467/467 (100%)	Ongoing
National Vascular Registry (NVR)[1]		Y	Y	565 / 565 (100%)	Ongoing
Out-of-Hospital Cardiac Arrest Outcomes (OHCAO)		N	N/A	N/A	N/A
Paediatric Intensive Care Audit Network (PICANet)[1]		N	N/A	N/A	N/A
Perinatal Mortality Review Tool (PMRT)		Y	Y	29/29 (100%)	Ongoing
Perioperative Quality Improvement Programme		Y	Y	49 (percentage not known) Although on Quality Accounts, this is a research project. The NNUH recruits patients undergoing a thoracic operation on certain days of the week. The study sponsor has agreed this methodology.	Ongoing
Prescribing Observatory for Mental Health (POMH):	a) Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services	N	N/A	N/A	N/A
	b) Monitoring of patients prescribed	N	N/A	N/A	N/A

National Clinical Audit (Alphabetical order)	Eligible Y/N	Took part Y/N	Participation Rate Cases Submitted	Completed/ In-progress/ Ongoing
lithium				
Sentinel Stroke National Audit Programme (SSNAP)[1]	Y	Y	1025/1025 (100%)	Ongoing
Serious Hazards of Transfusion UK National Haemovigilance Scheme	Y	Y	30/30 (100%)	Ongoing
Society for Acute Medicine Benchmarking Audit	Y	Y	101/101 (100%)	Completed
The Trauma Audit & Research Network (TARN)	Y	Y	150/1115 (13%) NB: the TARN database was taken offline in June 2023 following a cyber incident.	Replaced by National Major Trauma Registry
The UK Transcatheter Aortic Valve Implantation (TAVI) Registry	N	N/A	N/A	Ongoing
UK Cystic Fibrosis Registry	Y	Y	Total 154/154 (100%) Paeds 61/61 (100%) Adults 93/93 (100%)	Ongoing
UK Renal Registry Chronic Kidney Disease Audit	Y	Y	832/832 (100%)	Ongoing
UK Renal Registry National Acute Kidney Injury Audit	Y	Y	6717/6717 (100%)	Ongoing

[1]National Clinical Audit and Patient Outcomes Programme (NCAPOP)

The reports of published national clinical audits or confidential enquiries were reviewed by the Norfolk and Norwich University Hospitals NHS Foundation Trust in 2023/2024. 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: Examples of actions from National Clinical Audits

National Audit Title	Keys Successes	Key Concerns	Key Actions
Child Health Clinical Outcome Review Programme – Transition Study	The NNUH was one of 8 out of 50 Trusts surveyed to have a dedicated Lead Nurse for transition. We have 10 specialities working on a transition pathway for their patients including use of a transition tool and introduction of joint clinics between Paediatric and Adult teams. We have employed a Youth Worker to set up and establish a Youth Forum at the NNUH. Overarching Transition Policy for the Trust.	Transition is not currently written into the job plan of most professionals caring for this age group. Education Health Care Plans (EHCP) are not currently well communicated opportunity to share that information in the transition plans sometimes missed. Clinic appointments are not always offered at convenient times for young people to attend. Lack of involvement of Primary Care in transition plan.	Alert set up on Patient Administration System (PAS) to identify patients who are on a transition pathway. Transition pathway set up for all specialties. Training offered for all staff who care for young people between 13-25 years. All correspondence copied to young people from the age of 13 years, where appropriate. Youth Forum established to co-produce resources and work on service improvement projects with the voice of young people.
LeDeR - Learning from Lives and Deaths of People with a Learning Disability and Autistic People	Nationally, improvements identified in resuscitation decision making, and continuous improvement noted in average age of death. Locally, improvement identified in the collaboration with familiar carers and forward care planning.	Nationally significantly increased inequality for those with additional protected characteristics or experiencing health inequalities. Risk of death by suicide highlighted as key risk for autistic people.	Thematic review of local deaths of patients with learning difficulties, using key indicators from LeDeR as a benchmark. Collaboration with Mental Health colleagues to establish if specific pathway needs to be introduced for autistic people at risk of suicide.
National Audit of Cardiac Rehabilitation	The Cardiac Rehabilitation programme at NNUH has been given green fully certified status from the National	Potential non-replacement of staffing hours following retirement or reductions in hours. This may	The National Audit of Cardiac Rehabilitation was published on 13th December 2023. It was discussed at the Cardiology

National Audit Title	Keys Successes	Key Concerns	Key Actions
	Certification Programme for Cardiac Rehabilitation again. All patients who have revascularisation or Myocardial Infarction are invited to the rehabilitation programme at discharge, and offered home-based, group-exercise based and a hybrid of the two.	impact on service delivery and ability to maintain certification status.	Governance meeting on 22nd February 2024 and the Clinical Effectiveness Operational Group on 24th July 2023. Actions included: present the case for replacement staffing at all levels; Business case to support ongoing service to be completed and submitted; promotion of the Digital Heart Manual on the wards.
National Audit of Inpatient Falls (NAIF) (Part of the Falls and Fragility Fracture Audit Programme)	Appointment of Falls Lead. Falls Steering Group, multi-disciplinary group, now undertaking monthly meetings.	Increased patient numbers (7 patients in 6-bedded bays). Reduced staffing levels. Falls documentation not National Institute for Health and Care Excellence (NICE) compliant. Only one clinical auditor.	The Falls and Fragility Fracture Audit Programme - Inpatient falls and fractures 2023 NAIF report on 2022 clinical data was published on the 9th November 2023. Dr S. Lee presented the findings to the Clinical Effectiveness Operational Group on 21/03/2024. Multifactorial Falls and Fracture Risk Assessment (MFFRA) introduced. Online falls training now available.
Adult Asthma Secondary Care (Part of the National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme)	Positive feedback from patients about the asthma service and the care they have received	Improvement required with the first hour of care for patients admitted to hospital with an asthma exacerbation. Data collection is low and support is needed	The National Respiratory Audit Programme (NRAP): COPD / adult asthma / children and young people asthma regional report (1 October 2022 – 31 March 2023) was published on the12th July 2023. It was presented to Clinical Effectiveness Operational Group on

National Audit Title	Keys Successes	Key Concerns	Key Actions
			26th June 2023. Actions identified included, training and education for Emergency Department staff undertaken. Staff support for data collection added to risk register
National Lung Cancer Audit (NLCA)	Higher than average resection rate. Rapid histopathology turnaround time. Daily triaging of referrals being undertaken	Delays on the patient pathway resulting in breaches of the 22 Week Wait/62 day breaches.	The National Lung Cancer Audit (NLCA) has published a State of the Nation Report 2023 was published on 13th April 2023. Presented to the Clinical Effectiveness Operational Group on 21st August 2023. Actions included employment of more Endobronchial Ultrasound (EBUS) trained Bronchoscopists. Appointment of new Clinical Nurse Specialists as per National Guidance
National Hip Fracture Database (NHFD) (part of the Falls and Fragility Fracture Audit Programme)	Performance noted to be better than national average for Consultant presence in theatre, mobilisation day one post operatively, completion of nutrition risk assessment, and overall length of stay. Good progress has been made compared to previous results.	Below national average on key performance indicators for direct admission to specialty ward and post operative delirium assessment. Prompt Orthogeriatric assessment remains an area of concern	Multidisciplinary working group re-established to review and improve fractured neck of femur pathway.
National Bowel Cancer Audit (NBOCA)	Percentage of patients having major resection for stage three colon cancer who received adjuvant chemotherapy, and patients with rectal cancer receiving	The national data suggests that the Trust is lower than national average rate for patients being seen by a Clinical Nurse Specialist	The issue of data entry for national audits has previously been escalated to Divisional and Trust leads and is under review. Recognition required,

National Audit Title	Keys Successes	Key Concerns	Key Actions
	neoadjuvant treatment, were on a par with national average. Better than national average rate for lymph node yield and patients experiencing severe acute toxicity after adjuvant chemotherapy. Adjusted 2-year mortality rate of 12.5%, lower than national average of 15%.	(CNS). However, local data confirms that all elective cancer patients are seen by a CNS, so this represents a reporting issue. The figures for laparoscopic surgery attempted does not include robotic surgery which is also minimally invasive, and local data for a 2-year period confirms that 91.4% of patients had minimally invasive access attempted.	in nationally reported figures, that all robotic cases are minimally invasive (laparoscopic).
National Vascular Registry (NVR)	The Trust has one of the busiest Vascular units in the United Kingdom. Achieved excellence in time to surgery for Abdominal Aortic Aneurysm (AAA) and Carotid Endarterectomy (CEA), time to revascularisation for Chronic Limb Threatening Ischemia (CLTI), submission of angioplasty data, ratio of above knee amputations to below knee amputations, and length of stay for all vascular procedures. In all other Key Performance Indictors, the department met the national average.	Perioperative data submission for AAA and bypass cases remains a concern. Mortality rate for CEA remains higher that the national average but has reduced from 4.5% in 2021 to 3.8% in 2022. This is within the Vascular Society recommendation of less than 6% for continued practice.	No key actions identified, as support requirements for data entry previously escalated to Divisional and Trust leads and is under review.
National Pregnancy in Diabetes (NPID) Audit (Part of the National Diabetes	Lower than national average of women with large for gestational age babies in both type 1 and type 2 diabetes.	Higher than national average of babies admitted to Neonatal Intensive Care Unit	Local audit planned to identify themes around babies admitted to NICU in people with type 1 diabetes.

National Audit Title	Keys Successes	Key Concerns	Key Actions
Audit (NDA) Programme)	Lower than national average of women experiencing preterm birth in both type 1 and type 2 diabetes.	(NICU) in people with type 1 diabetes.	
National Improving Quality in Crohn's and Colitis (IQICC) Audit	The Trust did well with registering all newly diagnosed paediatric patients with irritable bowel disease (IBD) on the registry. The Trust was good at using the registry for side projects like the PINPOINT study (Paediatric Inflammatory Bowel Disease Epidemiology), through consistent recording of the relevant information. This has allowed Norwich to be an active recruiting centre for the PINPOINT study. The results of this study are about to be presented on national (British Society of Paediatric Gastroenterology, Hepatology and Nutrition) and international (European Crohn´s and Colitis Organisation/European Society for Paediatric Gastroenterology Hepatology and Nutrition) meetings this year.	The Trust was not calculating IBD disease activity scores (Paediatric Crohn's Disease Activity Index and Paediatric Ulcerative Colitis Activity Index) during assessments in the Outpatient Clinic / Children's Day Ward. This information could not be formally recorded in the IBD registry.	Since February 2023, when the issue with activity scores was identified, the Trust started to calculate disease activity scores on each patient assessment in Clinic or on the Children's Day Ward. This was then systematically recorded in the registry, and it has now become a regular habit / action. The team are very positive about how the registry drove this quality improvement action.
National Paediatric Asthma Audit (Part Of The National Asthma And Chronic Obstructive Pulmonary Disease Audit Programme (NACAP))	Patients discharged with personalised asthma action plans close to national number	Documentation of parental and patient (age appropriate) smoking. Documentation of checking of inhaler technique. Steroids administered within 1 hour.	The National Respiratory Audit Programme (NRAP): children and young people asthma regional report was published on 12th July 2023. Following review actions identified included: adding

National Audit Title	Keys Successes	Key Concerns	Key Actions
			'wheezy/asthma' questions into Symphony clerking in order to capture data; Education for Children's Assessment Unit/Ward nursing staff undertaken; Education for Junior Doctors/Advanced Paediatric Nurse Practitioners in relation to 'wheezy/asthma' questions on Symphony in progress.
Surgical Site Infection Surveillance Service	Improved electronic recording of Caesarean section wound surveillance information provided by electronic system. This provides improved oversight of infection rates.	Due to staffing pressures demands on services and acuity of admissions some surveillance information may not have been collated. The increased prevalence of winter viruses and Whole-Time Equivalent staff vacancy has impacted upon the workload of the Infection Prevention and Control team. This has delayed analysing and reporting of Surgical Site Surveillance.	Surgical Site Infection (SSI) Surveillance results are reviewed at Clinical Governance meetings for discussion and learning. Results are discussed at the Hospital Infection Control Committee (HICC) meeting quarterly with Divisional and Governance leads.
Mandatory Surveillance Of Healthcare Associated Infection (HCAI)	Methicillin-Resistant Staphylococcus aureus Bloodstream Infection (MRSA BSI) - bacteraemia was classified as Healthcare Associated Infection (HAI) due collection of blood culture over 48 hrs after admission. It was acknowledged on case review with the ICB that the	Objectives set to include Community onset healthcare associated and Hospital onset hospital acquired figures. Definitions provided makes these objectives difficult to achieve. Some patients who are defined as HAI cases, are admitted	Reported as a mandatory requirement, monthly to United Kingdom Health Security Agency. Reported via NNUH Monthly Infection Prevention and Control report and Clinical Safety Effectiveness Sub Board meetings. Governance Boards

National Audit Title	Keys Successes	Key Concerns	Key Actions
	bacteraemia was due to a medical condition present prior to admission and therefore truly a Community Attributable Infection (CAI). Fulfilled commitment to mandatory reporting	with chronic conditions which attribute to the bacteraemia, therefore not truly hospital acquired. Exceeded Klebsiella species & Pseudomonas targets. Klebsiella threshold reduced by 50% from 48 to 24 for 2023/24. Increased volume of patients admitted to the Trust during 2023/24.	have been made aware when thresholds have been exceeded. All cases are discussed at weekly surveillance meetings with Consultant Microbiologist/Infection Control Doctor. Any learning is shared with the appropriate teams.

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 2023/2024 that were recruited during that period to participate in research approved by a research ethics committee was 4180.

Commissioning for Quality and Innovation (CQUIN)

A proportion of NNUH income in 2023/2024 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 NHS England » 2023/24 CQUIN.

Name and role: Jürgen Long – Emergency Department Deputy Operations Manager

Length of NHS/ NNUH service: 3 and a half years

What do you love most about your role?
I love seeing positive changes being made which benefits our teams and supports patient care. I am fortunate to be in a position to support these changes being made that continues to improve our service, and I am proud when the feedback and performance reflects these progresses in our Trust.

Name and role: Dr Jo Derisley – Consultant and Head of Clinical Psychology

Length of NHS/ NNUH service: I have worked in the NHS since 1st September 1993, however, I have been at the NNUH since 1st June 2011.

What do you love most about your role?
Clinical Psychology is a varied profession that I have had the privilege to be part of for over thirty years. I have loved providing psychological therapy to a range of clients, with my clinical focus at the NNUH over the last 13 years supporting the wellbeing of children, young people and their parents with a range of long-term conditions and overseeing the Clinical Psychology service. Psychological therapy is ever evolving, which has led to exciting developments in learning new and evolving therapeutic models and approaches, which I have embraced to ensure that my practice is always high quality, evidence based and adapted to our unique client group. Research and Publications in peer reviewed journals has been an integrated part of my early career, now focusing on ensuring our team deliver clinical research to ensure that the profession develops and grows. I have published a self-help guide for overcoming obsessive-compulsive disorder in children, that became part of the GP prescribable series, ensuring sound mental health advice is accessible for all. As I have progressed through my NHS career, I have taken on more leadership responsibilities, bringing a focus on ensuring that the Psychology Department is well led, as I have moved from Child Psychology Lead in Paediatrics in 2011, to Head of the Clinical Psychology Department in 2018, and an integrated member of the Therapy Services Senior leadership team. I have loved the freedom to provide psychological advice, support or input to a range of NNUH projects, policies and initiatives, including leading the hospitals response to psychological support for Staff with the 'Caring for You' strategy in 2020. Providing psychological consultation, supervision and training has enabled our service to upskill other colleagues' psychological knowledge, again making mental health support more accessible to a larger cohort of patients. The diverse range of experiences and skills has ensured that Clinical Psychology, as a profession, has been a career that I continue to feel passionate about.

Name and role: Bhaskar Kumar - Consultant Oesophago-gastric and Laparoscopic Surgeon

Length of NHS/ NNUH service: 10 years

What do you love most about your role?
It is an absolute pleasure to be in a position to be able to perform major complex cancer surgery for patients with oesophago-gastric cancer. I also love the interaction with patients, relatives and my colleagues as we work together as a team to save patients from cancer. My role also has a large amount of teaching as well as research and it is a privilege to work towards developing the next generation of surgeons.

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 2023/2024.
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 2023/2024:

- An announced focused inspection of Maternity at the Norfolk and Norwich University Hospital
- Unannounced focused inspection of Diagnostic imaging, Outpatients and Surgery at the Norfolk and Norwich University Hospital.
- An announced Well Led inspection the Norfolk and Norwich University Hospitals NHS Foundation Trust

Table 3: CQC Ratings of the inspection of Maternity Services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Maternity	**Good**	**Good**	**Good**	**Good**	**Good**	**Good**

The CQC are yet to report their finding and any requirements on the inspections conducted on Diagnostic imaging, Outpatients, Surgery and Well Led; therefore, the Trust's overall rating has not been updated.

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 Maternity reported February 2024

Area	Level	Ref	Recommendation
CORE SERVICES			
Maternity	**Should Do**	**Mat001**	The service should consider developing itemised checklists to support staff with daily checks of emergency and specialist equipment.
		Mat002	The service should monitor the required duties of the manager-of-the day to ensure there is effective monitoring of equipment and medicine checks.
		Mat003	The service should consider the suitability of storing the obstetric emergency trolley in a locked clinical room.

The full CQC report can be viewed at: https://www.cqc.org.uk/location/RM102

Norfolk and Norwich University Hospitals NHS Foundation Trust has made the following progress by 31st March 2024 in taking such action:

Table 5: Progress on CQC 'Must Do' and 'Should Do' Recommendations for Maternity reported February 2024

Area	Level	Ref	Action
CORE SERVICES			
Maternity	**Should Do**	**Mat001**	An approved revised checklist is being introduced for the obstetric emergency trolley. Compliance with use will be monitored.
		Mat002	Monitoring of the equipment and medicines checks has been added to coordinators daily checklist. This will then be verified through Manager of the Day checks. Escalation is required they are unable to complete. There is also to be a review teaching methods and guides for checking
		Mat003	A risk assessment is going to be performed considering risks and benefits of changing location of trolley.

As of the 1st February 2024, there are 18 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.	**4**
Amber – At risk of not meeting outcome date.	**5**
Red - Will not meet the outcome date or has already passed outcome date.	**6**
Blue – Recommendation is complete but requires further monitoring from Quality Programme Board (QPB).	**3**

Once a recommendation has been agreed as complete it is turned **Black** and is archived. Since April 2023, 17 recommendations have been turned black.

Data Quality

The Norfolk and Norwich University Hospitals NHS Foundation Trust submitted records during 2023/2024 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 10 – January 2024

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%	99.8%
Outpatient care	100%	99.8%	100%	99.5%
Accident & emergency care	99.5%	98.9%	100%	99.5%

- Completed Referral to Treatment (RTT) Audit Programme for 2023/24.
- Implemented a Commissioning Assurance Programme for 2023/24 to determine whether effective arrangements, consistent with National Tariff, National Guidance, Data Standards and Information Governance are being applied in practice to ensure high quality data assurance.
- Implemented a Trust Induction / Refresher for all Staff with RTT in job description.
- Referral to Treatment and Data Quality web pages reviewed and updated, providing guidance documents and Standard Operating Procedures 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
- Provide a monthly RTT back to basics refresher session for all other staff.
- Reviewed existing and introduced additional Data Quality Metrics to support robust management of patient pathways. Produced comprehensive user guide to support staff.
- Use benchmarking tools such as the Secondary Uses Services 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.
- Worked with the development team to introduce Robotic Process Assurance (RPA) to undertake repetitive duties to keep data clean i.e., in progress is Elective Planned Waiting Lists past target date to flip to Elective Wait and start RTT clock and diagnostic target if appropriate.
- 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)

Information Governance Data Security & Protection Toolkit Attainment Levels

Norfolk and Norwich University Hospital Foundation Trust's Data Security & Protection Toolkit overall score for 2023/2024 was of a "standards met" assurance status.

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 2023/2024 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.
- Monthly Data Quality Referral to Treatment Operational Meetings (RTTOMG) to discuss RTT performance by Specialty, discussing RTT issues / concerns, this is a forum to share best practice. Minutes are provided and can be used as a reference tool.
- Roll out rebranded Data Quality Metrics which highlight under performance in key areas and implement monthly training sessions on the Data Quality Metrics.
- Continue to review data recording issues raised via DQ SUS dashboards, Commissioning issues and ad-hoc audits.
- Continue to provide RTT training and coaching to Operational Managers, Admin Managers and RTT Validators to support as part of their induction programme.
- Implement more robotic processes to assist with workflow improvement and reduction of costs.
- Continue to work on the workstreams for implementation of the EPR.
- Support Information Governance Team with initial roll out of duties for System Information Asset Owners (AIO'S) and Information Asset Administrators (IAA'S)
- Upon review of PAS policies, ensure they are fit for purpose for all Systems i.e., the NHS number policy will cover all systems where appropriate.
- Manage the Information Standard Notice Data Base to ensure the trust works towards compliance by the implementation date, escalate when necessary and ensure risks are highlighted and recorded if the Trust is non-compliant.
- Complete ad-hoc commissioning audits to support business need.
- Complete ad-hoc audits to support EPR and System working.

Learning from Deaths

Learning from deaths of patients in the care of NNUH is a key priority for the organisation to ensure that it learns from the care and treatment provided to patients who have died, in order to identify where it can develop and implement improvements to the quality of care.

During the financial year 2023/2024 2666 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:

678 in the first quarter, of which 6 were patients with Learning Difficulties, 8 had a Severe Mental Illness, 0 were Still Births and 0 were Neonatal Deaths.

583 in the second quarter, 13 were patients with Learning Difficulties, 11 had a Severe Mental Illness, 5 were Still Births and 4 were Neonatal Deaths.

688 in the third quarter, 5 were patients with Learning Difficulties, 8 had a Severe Mental Illness, 3 were Still Births and 2 were Neonatal Deaths.

717 in the fourth quarter, 6 were patients with Learning Difficulties, 10 had a Severe Mental Illness, 4 were Still Birth and 1 were Neonatal Deaths.

Table 7: Summary of In-Hospital deaths and deaths within 30 days of discharge for the financial year 2023/2024

Financial Year 2023/2024	Total Discharges	Deaths within 30 days of Discharge	In-hospital deaths	Total Deaths	In-hospital Deaths with Learning Difficulties	In-hospital Deaths with Severe Mental Illness	In-hospital Still births	In-hospital Neonatal Deaths
Q1	18760	252	678	930	6	8	0	0
Q2	18528	269	583	852	13	11	5	4
Q3	19067	262	688	950	5	8	3	2
Q4	19553	259*	717	976*	6	10	4	1
Total	75908	1042	2666	3708	30	37	12	7

* These figures are provisional as at 08/04/2024 as the full 30 day period has not passed since the end of Q4

Medical Examiner Reviews

Table 8: Medical Examiner reviews and escalations

Financial Year 2023/2024	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	733	1	65
Q2	623	4	34
Q3	736	4	59
Q4	770	18	35
Total	2862	27	193

The totals are only deaths occurring within NNUH sites.

The Medical Examiner Service has scrutinised 100% of all acute inpatient deaths during 2023/2024. The statutory phase of the service is awaiting government approval; however, this is expected mid-2024.

There were no escalations to SJR/ Morbidity and Mortality (M&M) of deaths within 30 days of discharge by the Medical Examiner Service.

Learning Disabilities

The Trust takes seriously the learning gained from LeDeR (Learning from Lives and Deaths - people with a learning disability and autistic people (external reviewers)) 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 Norfolk and Waveney Integrated Care Board, with whom the learning disability team works closely, approached the Trust to share positive feedback about its 'learning from deaths' programme, 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 (CDOP) Reviews

By the end of quarter 4 of those reported during 2023/2024, there were 13 deaths where a child had some degree of hospital involvement. 6 of the 13 cases have been discussed in CDOP, alongside some cases from previous years.

Case Record Reviews: Structured Judgement Review (SJR) Method

An SJR is a review conducted by an independent, senior health professional/s using an evidence based methodology for reviewing case notes. It is based on the principle that health professionals trained in SJR use explicit statements to comment on the quality of healthcare in a way that allows a judgement to be made that is reproducible.

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

Whilst every inpatient death is independently reviewed by the Medical Examiner Service, they may not require an SJR. The criteria for an 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, Summary Hospital-level Mortality Indicator (SHMI)/ Hospital Standardised Mortality Ratio (HSMR)/ Structured Medication Reviews (SMR) alerts, concerns raised by CQC/ other external regulators
- Coroners Regulation 28 Report (actions which NNUH should take to prevent further deaths)
- Aligned to Trust QI priorities

From the 1st September 2023, the Trust implemented the Patient Incident Response Framework (PSIRF) which replaced the NHS Serious Incident (SI) Framework. As set out in the Trust's Patient Safety Incident Response Plan (PSIRP) and Patient Safety Incident Response Policy any incident resulting in death will have an SJR conducted.

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. They will assess the SJR findings to identify key learning and areas of focus for improvement which may ultimately help all patients. The panel will also agree any appropriate governance response. The scrutiny panel chair will 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: SJR's completed during the 2023/2024 reporting period, including a breakdown by vulnerable group.

Financial Year 2023/2024	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	36	8	14	1
Q2	43	6	14	0
Q3	25	10	8	1
Q4	50	5	11	0
Total	154	29	47	2

Note: these are total SJR's completed in the 2023/24 period regardless of the date of death.

Table 10: SJR's reviews completed in relation to the deaths which occurred during the 2023/2024 reporting period, including a breakdown by vulnerable group.

Financial Year 2023/2024	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	2	1	0	0
Q2	15	3	8	0
Q3	23	10	8	0
Q4	39	4	8	1
Total	79	18	24	1

A collaboration led by MBRRACE-UK developed and established a national standardised Perinatal Mortality Review Tool (PMRT) building on the work of the Department of Health/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 PMRT tool is used on all Stillbirths delivered from 24 weeks, and Neonatal deaths from 22 weeks.
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 care to 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 engage patients with the local review process and improvements in care.

Table 11: Case Record Review - Perinatal Mortality Review Tool (PMRT) –

Financial Year 2023/2024	Total Number of PMRTs completed during the reporting period on Neonatal/Post Neonatal deaths	Total Number of PMRTs completed during the reporting period on Still Births
Q1	6	2
Q2	3	1
Q3	7	5
Q4	6	1
Total	22	9

Note: these are total PMRT's completed in the 2023/24 period regardless of the date of death.

Investigations: Serious Incidents and Patient Safety Incident Investigation
Up until the 1st September 2023, the National Serious Incident Framework required any death deemed a Serious Incident to be investigated using Root Cause Analysis (RCA), rather than by a Structured Judgment Review.

Table 12: Serious Incidents reported, and investigations completed in relation to the deaths which occurred during the 2023/2024 reporting period:

Financial Year 2023/2024	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	0
Q2	1	3
Q3	Transition to PSIRF	0
Q4		2
Total	8	5

From the 1st September 2023, the Trust implemented PSIRF and conducts Patient Safety Incident Investigations (PSII) where patient safety incidents meets one of the following criteria:

- Patient safety incident is a Never Event
- Deaths more likely than not due to problems in care. This can be identified through an incident and/or the learning from deaths process.
- Missed/ Delay in Diagnosis (Patients under the care of the Emergency Department or Medical Specialties where a missed or delay in diagnosis leads to a significant delay in the initiation of essential treatment.)
- Sub Optimal Care (Incidents affecting patients where care is being managed between more than 1 clinical specialty, where management resulted in the patient being transferred to multiple wards and there was a failure or delay in acting on an escalation of a deteriorating clinical situation.)

All patient safety incidents which result in a death under PSIRF will have a SJR conducted to help determine if the incident meets one of the above criteria.

Table 13: Patient Safety Incident Investigations reported, and completed in relation to the deaths which occurred during the 2023/2024 reporting period:

Financial Year 2023/24	Total Number of PSII's reported in relation to the deaths which occurred during the report period	Total Number of PSII completed
Q1	0	0
Q2	0	0
Q3	3	0
Q4	0	1
Total	3	1

Total number of case record reviews and investigations in 2023/2024

By the end of Quarter 4, 101 case record reviews and 6 investigations have been carried out in relation to the 2,666 in-patient deaths reported during the 2023/2024 financial year, however, all in-patient deaths are scrutinised by the Medical Examiners Service.

In 1 case a death was subject to both a case record review and investigation.

The number of deaths in each quarter for which a case record review or investigation was carried out was: 3 in the first quarter; 21 in the second quarter; 35 in the third quarter; 48 in the fourth quarter.

Of the 107 deaths reviewed, 12 representing 0.5% of patient deaths during 2023/2024 (2,666) 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: 0 representing 0% of patient deaths during 2023/2024 (678)
Quarter 2: 6 representing 1.1% of patient deaths during 2023/2024 (583)
Quarter 3: 2 representing 0.3% of patient deaths during 2023/2024 (688)
Quarter 4: 4 representing 0.6% of patient deaths during 2023/2024 (717)

This number has been estimated using the following:

1. Case record reviews:

Table 14: SJR Case record reviews completed in relation to deaths which occurred during the 2023/2024 reporting period, where the death was judged to be more likely than not due to problems in care

Financial Year 2023/2024	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.	% of Total Number
Q1	2	0	0%
Q2	15	2	13%
Q3	23	1	4%
Q4	39	4	10%
Total	79	7	9%

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 and PSIRF.

Note: Of the 7 deaths judged at SJR to be more likely than not due to problems in care, 2 have been validated through PSIRF and are undergoing a PSII, 5 are awaiting validation at an SJR scrutiny panel.

Table 15: PMRT Case record reviews completed in relation to Neonatal/Post Neonatal deaths which occurred during the 2023/2024 reporting period, where the death was judged to be more likely than not due to problems in care

Financial Year 2023/2024	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	1		
Q2	3	1	33%
Q3	7		
Q4	6		
Total	17	1	6%

Note**:** One of the cases graded was for the antenatal care provided at a different hospital, however, as the baby died at NNUH it falls in our figures. The care received at NNUH was excellently graded.

Table 16: PMRT Case record reviews completed in relation to Still Births which occurred during the 2023/2024 reporting period, where the death was judged to be more likely than not due to problems in care

Financial Year 2023/2024	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		
Q2	0		
Q3	5	1	20%
Q4	1		
Total	6	1	17%

2. Investigations:

Table 17: Serious Investigations completed in relation to patients who have died during the 2023/2024 reporting period where the death was judged to be more likely than not due to problems in care

Financial Year2023/2024	Total Number of Serious Incident investigations completed	Number of deaths judged to be more likely than not due to problems in care following investigation	% of Total Number
Q1	0	0	
Q2	3	3	100%
Q3	0	0	
Q4	2	0	0%
Total	5	3	60%

(Total above for Q2 includes 3 covid related deaths where Covid was hospital acquired)

Thematic analysis of the 6 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.

Table 18: Patient Safety Incident Investigations completed in relation to patients who have died during the 2023/2024 reporting period where the death was judged to be more likely than not due to problems in care

Financial Year2023/2024	Total Number of PSII's completed	Number of deaths judged to be more likely than not due to problems in care following investigation	% of Total Number
Q1	0	0	
Q2	0	0	
Q3	0	0	
Q4	1	1	100%
Total	1	1	100%

Note: the figures for problem in care are already counted within the SJR figures in table 8.

Thematic analysis of the death was conducted using Systems Engineering Initiative for Patient Safety (SEIPS) model. SEIPS is a framework for understanding outcomes with complex socio-technical systems.

Learning from Case Record Reviews and Investigations

Methods and tools to share the learning include:

- Dedicated pages on the Trust Intranet the Beat,
- Grand Rounds,
- SJR panel meetings,
- Speciality Mortality and Morbidity meetings,
- Speciality/Divisional Governance Meetings,
- Trust wide OWLS (Organisation Wide Learning)
- Patient Safety Bulletin
- Speciality/Divisional safety newsletters

Below are areas where improvement work is required.

Table 19: Learning from Case Record Reviews – SJRs

	Themes identified through case record review	Update/ Action
1	Diagnosis	This is the top theme from the SJR process this year. Main sub-themes include: • Delays in performing an indicated test • Delayed action to a clinically significant result The Trust transitioned to the new Patient Safety Incident Response Framework (PSIRF) on 1st September 2023. The insights gained from Structured Judgement Reviews have been used with other sources of patient safety data and feedback to inform the Trust's local priorities for Patient Safety Incident Investigation (PSII) in the development of our Patient Safety Incident Response Plan. Delayed or missed diagnosis is one of these. Particularly for patients under the care of the Emergency Department or Medical Specialties where a missed or delay in diagnosis leads to a significant delay in the initiation of essential treatment. This was the 2nd highest reported Serious Incident and the top incident resulting in lower level of harm. It was also identified as a theme in complaints, SJR and claims.
2	Monitoring	The main sub-theme is failure to recognise and respond to deterioration. The Trust has a 24/7 Rapid Response (critical care outreach) team who staff can contact should they have concerns about a patient. The Trust has also implemented a 'call for concern' service to enable those patients who have been stepped down to a ward from critical care as well as their families, carers, and advocates to contact the Rapid Response team if they are worried about their/the patient's condition. They plan to roll this out to all adult in-patients within the next few months. More recently, the Trust has been accepted as an NHS England pilot site for the implementation of 'Martha's rule'. This will enable all patients, their families, carers, and advocates to have access to 24/7 rapid review from a critical care outreach team if they are worried about the patient's condition. There is additional work being undertaken for Sepsis as this is a recurrent mortality outlier alert for both HSMR and SHMI. The Trust Rapid Response team and the Patient Safety Team are also working on an

		improvement programme across the Trust in how SEPSIS data is recorded, monitoring SEPSIS 6 compliance and improved documentation to support improved patient care. Sepsis is a Trust Quality Priority for 2024-2025
3	Communication and coordination	The main sub-themes are: 1) sub-optimal communication between teams 2) inadequate handover communication within or between teams 3) sub-optimal communication with patients/families. These sub-themes are inter-related and, also areas of good practice for the Trust SJRs, discussions at second stage SJR scrutiny panels and the Trust Learning from Deaths committee highlight that patients who are subject to ward moves, patients who are outliers and complex patients with multiple co-morbidities requiring input from multiple specialist teams during their stay are at higher risk of communication failures and fragmentation of care. Multiple systems for recording care provided to a patient – both paper and multiple electronic – compound these issues Work continues to improve patient flow, ensure timely discharge, and reduce ward moves through projects such as the 'Home for lunch' initiative and an initiative to identify patients suitable for 'step down' to an escalation ward. A thorough risk assessment supports the multi-disciplinary team making decisions to move patients but also can identify those patients who must not be stepped down from the wards. The Trust internal professional standards have been updated to emphasise the requirement for the responsible Consultant to be always clear to all staff, patients, families, carers, and their advocates. The implementation of an EPR to provide accurate, up to date and complete information about patients at the point of care, enable quick access to patient records for more coordinated, efficient care and securely share electronic information with patients and other clinicians will also help improve communication. The Trust continues work to improve communication with patients and families via measures such as relative liaison staff.

4	Documentation	The main sub-themes are gaps in medical and gaps in nursing documentation. The Trust continues to use paper case records so there is a higher risk of poor legibility, misfiling, mishandling, loss, or damage. Sub-optimal clinical information data quality is also a theme from work undertaken as part of mortality surveillance and clinical coding It is recognised that poor record keeping can impact on the quality and safety of patient care particularly as this can impact on the comprehensiveness and quality of communication within and between teams as well as the quality of communication with patients and families A Clinical Information Data Quality workstream is being created in response to this concern. This encompasses work to develop a single admission clerking document by junior doctors and the launch of revised nursing clinical assessment documentation. A shared EPR is being implemented across the 3 acute trusts in Norfolk and Waveney. This should help reduce the risk of poor documentation and record keeping.

Table 20: Learning from Case Record Reviews – PMRT

	Themes identified through investigations	Update/ Action
1	Extreme prematurity	Updated guideline to identify risk factors for extremely premature delivery. Recognising the lack of a pre-term specialist midwife. Added to the risk register.
2	Multiple pregnancy	To monitor national guidance related to multiple pregnancy as amendments are expected and our guidelines will be addressed to consider accepting these changes and amend our local guidelines if appropriate. Recognising the lack of a multiple pregnancy specialist midwife. Added to the risk register.
3	E3 downtime	The system had an unexpected downtime of 10 days this year and in this time, maternity services had to revert to paper documentation with a varied effect and was recognised to have had a significant potential effect on patient care planning. In response we have reverted to printing paper copies of all antenatal contacts for every patient and added to their handheld notes. This will continue until the planned EPR is in place which we anticipate being 2-3 years in the future.

Table 21: Learning from investigations

	Themes identified through investigations	Comments
1	Clinical decision making (investigations and tests)	
2	Communication issues within team and between clinicians and families	Please see Theme 3 from the SJRs on the work to improve communication.
3	Delayed discharge of patients leading to increased LOS and exposure to infection risks	Work is continuing to increase the number of beds in the community with an expansion of Virtual Wards and a modular 48 bed unit on Norwich Community Hospital is due to be opened by Norfolk Community Health and Care NHS Trust (NCH&C) this summer. Since October the Trust has been running Home for Lunch (page 114) to increase the number of discharges before midday.

Reporting

A comprehensive report on mortality and learning from death data and information including themes, areas for improvement, risks and key actions is compiled and presented to our Clinical Safety and Effectiveness Sub-Board, Quality and Safety Committee (committee of the Board) and through to the Trust Board.

Update on Case Record Reviews and Investigations for 2022/2023

71 case record reviews and 3 investigations were completed after 1st April 2023 which related to in-patient deaths which took place before the start of the reporting period.

Of the 74 deaths reviewed, 16 representing 0.6% of in-patient deaths before the reporting period (2,842) 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) as well as the SEPIS model, and the Perinatal Mortality Review Tool.

57 representing 2% of the in-patient deaths (2,842) during 2022/2023 are judged to be more likely than not to have been due to problems in the care provided to the patient. 28 of the 57 have had a serious investigation completed; 4 of the 57 have had a comprehensive PMRT review, and the remaining 25 are to be validated through the SJR scrutiny panel process.

Celebrating the importance of Black History Month

How Neuroscience celebrated

Neuroscience celebrated Black History Month on 12 October by holding a special event on Ingham ward.

"*The idea came from the fact that the African community in Neuroscience had grown from about four staff members in 2019 to about 25 staff members in 2023 and we have a large representation of African countries (Nigeria, Ghana, Kenya, Zimbabwe, Cape Verde and Kingdom of Eswatini)*," said Staff Nurse Temitayo Adeleke.

"*We called the event 'We are black we are Africans' as we showcased the beauty of Africa in our history, language, outfits, food, music and culture, to mention a few*."

The event began with a speech from Godwin Mamutse, Consultant Neurologist, followed by a presentation about Africa, including the history, mineral resources, notable events such as wars, colonisation and independence, tourism, notable people from Africa within the NHS England and NNUH, as well as slogans such as "hakuna matata", which means "no worries", in Swahili.

A time for reflection

Christine Cherop, Senior Information Analyst in the Business Intelligence team, reflects on the importance of Black History Month as a time of celebration and reflection.

"*Black History Month is a time of celebration and reflection. We get a chance to celebrate the rich Black culture in Britain, and recognise its contributions to our world, from science, healthcare, politics, to sports and music. This matters deeply to me because Black History is often omitted from history taught in schools, which is a missed opportunity to truly learn and understand British history in its entirety.*

Black History Month gives us as an opportunity to pause and reflect on historical injustices against Black people in Britain and across the world and on the reality that there are still social, economic and health issues that disproportionately affect the Black community. Being part of the NNUH Together (BAME) Staff Network has also provided a safe space to share experiences and actively contribute to driving change on equality, inclusivity and belonging within the trust. As we take essential steps to make all staff feel welcomed and creating a sense of belonging in the trust, it is also important to extend this to patients from minority groups using our services. A diverse workforce and a diverse patient population should challenge all off us to work towards being open minded, welcoming, and making space to listen and understand the different experiences and needs of those around us."

Part 2.3 - Reporting against core indicators

Photo of inside the Quadram Institute

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 Sep 22 – Aug 23 Published by NHS Digital	National Average	Best performer	Worst performer	NNUH Oct 21 – Sep 22	NNUH Nov 20-Oct 21
SHMI value and banding	1.1979 Band 1	1.0019	0.7126	1.2220	1.2340 Band 1	1.1860 Band 1

Location: Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation, England, September 2022 - August 2023 - NHS Digital **> SHMI data at trust level**

Latest version available covers: 1st September 2022 to 31st August 2023, published 11th January 2024

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this rate is as described for the following reasons:
The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level across the NHS in England using a standard and transparent methodology. It is produced and published monthly as a National Statistic. The Trust has an opportunity to review and carry out additional quality assurance on some of the indicators produced by NHS England prior to publication.

The 'higher than expected' SHMI is considered to reflect a number of factors including:

- Clinical Data Quality
- Community healthcare provision including social care

- Functionality of specific pathways of care – SHMI Fractured neck of femur and septicaemia are particular areas of concern
- Hospital capacity and utilisation

The Norfolk and Norwich University Hospitals NHS Foundation Trust has taken and will take the following actions to improve this rate, and the quality of its services:
The Trust commissioned an external review by Grant Thornton of clinical coding processes; the full report has been published, as well as an external review by the Royal College of Physicians (RCP); the full report is yet to be published.

Work underway includes:

1. Home for Lunch initiative to improve patient flow through the hospital, patient safety and patient experience
2. Task and Finish group led by the Deputy Medical Director with key stakeholders to improve the fractured neck of femur pathway
3. Work by the Trust Rapid Response (24/7 Critical Care outreach team) together with the Patient Safety team to improve the recognition, documentation of and response to Sepsis and the recognition and response to deterioration
4. Clinical Data Quality improvement workstream

Planned work includes:

1. Implementation of Martha's rule - the Trust has been accepted as an NHS England pilot site for the implementation of 'Martha's rule'. This will enable all patients, their families, carers, and advocates to have access to 24/7 rapid review from a critical care outreach team if they are worried about the patient's condition.
2. Work with the ICB to pull together system-wide improvement of patient flows and pathways, particularly palliative, community and social care provision.
3. Work to improve the recognition of Frailty and implementation of an Acute Frailty Service

% of patient deaths with palliative care						
Indicator	NNUH Sep 22 – Aug 23 Published by NHS Digital	National Average	Best performer – Lowest %	Worst performer – highest %	NNUH Nov 21 – Oct 22	NNUH Nov 20 – Oct 21
% of patient deaths with palliative care coded at either diagnosis or specialty level for the reporting period	55%	41%	15%	66%	55%	54%

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 September 2022 – August 2023, published January 2024.

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this rate is as described for the following reasons:
The SHMI methodology does not make any adjustment for patients who are recorded as receiving palliative care.

SHMI contextual metrics show that more deaths occur in the NNUH than the national average and fewer outside hospital within 30 days of discharge. In addition, more deaths have specialist palliative care recorded at either treatment or speciality level than the national average.

The high percentage of patient deaths with palliative care coding is considered to reflect:

- Insufficient community social care provision resulting in more patients dying in hospital. Norfolk has an older population than average. While the proportion (count per 1000 resident population) of people in both North and South Norfolk living in all care homes is close to the national average, the total supply of nursing home beds (as opposed to care) in Norfolk is very low at 2.5 per 100 residents aged 75 years and above. There are also proportionately less deaths in a hospice than for other parts of the country.
- Work by the Trust palliative care team to ensure that patients recognised as end of life have access to specialist palliative care provision in a timely manner and robust systems for capturing this activity.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has taken and will take the following actions to improve this rate, and the quality of its services: Please see the SHMI value and banding above.

PROMS					
Indicator	2021/2022				NNUH 20/21
	NNUHFT	National Average	Best performer	Worst performer	
Patient reported outcome scores for groin hernia surgery	No longer measured	No data available	No data available	No data available	No data available
Patient reported outcome scores for varicose vein surgery	No longer measured	No data available	No data available	No data available	No data available
Patient reported outcome scores for hip replacement surgery	0.442 2021/22	No data available	No data available	No data available	0.444 2020/21
Patient reported outcome scores for knee replacement surgery	0.28 2021/22	No data available	No data available	No data available	0.271 2020/21

Location: Provisional Patient Reported Outcome Measures (PROMs) in England - for Hip and Knee Replacement Procedures (April 2021 to March 2022) - NHS England Digital

Latest version available: April 2021 – March 2022, published June 2023
At the time of publication, the score comparison tool for 2022/2023 has not been published to gain the result required.

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this rate is as described for the following reasons: The number of patients eligible to participate in PROMs survey is monitored each month.

The Norfolk and Norwich University Hospitals NHS Foundation Trust will take the following actions to improve this rate, and the quality of its services: Results are monitored and reviewed within the orthopaedic directorate prior to an action plan being agreed.

28-day readmission rates						
Indicator	2023/2024 (NNUH reported based on the NHS Outcomes Framework Specification)				NNUH 22/23	NNUH 21/22
	NNUHFT (Apr 23 – Mar 24)	National Average	Best performer	Worst performer		
28-day readmission rates for patients aged 0-15	Average Rate 5.6%	No data published	Average rate 10.9%	No data published	Average rate 7.09%	Average rate 10.9%
28-day readmission rates for patients aged 16 or over	Average Rate 10.8%	No data published	Average rate 11.2%	No data published	Average rate 9.27%	Average rate 11.2%

There is no data published since 2012/13. Data above has been based upon clinical coding within Norfolk & Norwich University Hospitals NHS Foundation Trust.

The Norfolk and Norwich University Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and the quality of its services: Please see our initiatives on virtual ward (page 106) and Home for Lunch (page 114)

Trust responsiveness						
Indicator	CQC Adult Inpatient Survey 2022				NNUH 21/22	NNUH 20/21
	NNUHFT	National Average				
Trust's responsiveness to the personal needs of its patients during the reporting period.	7.8	'About the same as others'			No data available	No data

Location: This data has been obtained from the CQC Adult Inpatient Survey – overall view of Inpatient Services. https://www.cqc.org.uk/provider/RM1/surveys/34

Latest version available: 2022, published September 2023

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this rate is as described for the following reasons: This is nationally published results. The NNUH performance reflected a period of particular strain on inpatient services at NNUH with additional beds in bays and other service and system pressures. The results reflected this situation.

The Norfolk and Norwich University Hospitals NHS Foundation Trust have taken and will take the following actions to improve this rate, and the quality of its services: The Trust has continued to implement its patient engagement and experience strategy successfully engaging with a number of communities which are the less well heard. The NNUH strategy contains experience of care as a key component with continued emphasis on equality, diversity and inclusion. The Patient Engagement & Experience Group (PEEG) continues to oversee divisional reporting against actions arising from all forms of feedback, including the Friends and Family Test (FFT), complaints and PALS and engagement with community groups including Healthwatch Norfolk.

% Staff employed who would recommend the trust						
Indicator	2023 NHS Staff Survey Results				NNUH 2022	NNUH 2021
	NNUHFT	National Average	Best performer	Worst performer		
NHS Staff Survey *Q25d If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.*	54.07%	63.32%	88.82%	44.31%	47.28%	60%

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

The Norfolk and Norwich University Hospitals NHS Foundation Trust will take the following actions to improve this rate, and the quality of its services:

In comparison to 2022, all seven People Promise themes and the two additional themes of staff engagement and morale have improved and the rate of improvement for the NNUH is above the Acute Trust average. However, the NNUH results score below the Acute Trusts average on all of these themes.

When comparing the NNUH 2023 question to 2022 results, out of 106 questions 96 questions improved, 3 were new, (so no comparison to previous year) and 7 declined. Significant progress has been made with the actions in the People Promise programme which has contributed to the improvements experienced by the NNUH in the last year. In summary, 26 actions have been achieved, 8 have been implemented and are ongoing and 7 are still to be achieved.

The national NHSE People Promise team have shared some of the metrics about the improved performance of the 1st cohort sites in comparison with non-People Promise sites. This included reduced turnover, lower vacancies and improvements in staff engagement.

In summary, we have achieved;

- Reduction in turnover
- Lower vacancies
- Highest level of staff in post in our history
- Improvement in 96 of 106 questions in the staff survey
- Improvement in all of the People Promise Themes on previous year, which are noted as being statistically significant
- Ranked in the 5 x most improved acute Trusts for staff survey by the HSJ

The national team also commented positively on our approach to having named Executive leads for each of our work programme themes.

NNUH compared with the National Acute Trust Average

When comparing the 106 NNUH question scores to the national Acute Trust average, 5 score above average, 14 are aligned to the average and 87 are below average, with 7 questions being equal to the lowest scoring Trust.

We need to make transformational, sustained improvement into how our staff feels about working at NNUH. A 3-year Improvement Plan, aligned to the 7 elements of the NHS People Promise, will be updated to reflect the 2023 results, and identify priority actions which will have the greatest impact. Significant improvement over multiple years is required to continue the improvement.

% of patients assessed for Venous Thromboembolism (VTE)						
Indicator	2023/2024 (Trust data)				NNUH 22/23	NNUH 21/22
	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.	99.52%	No data available	No data available	No data available	99.35%	No data available

Location: 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.

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this rate is as described for the following reasons: The data has been provided by our Digital Health – Business Intelligence Team at NNUH

The Norfolk and Norwich University Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and the quality of its services:
The target level previously was above 95% and our current level of 99.52%, which is above the standard, this is comparable to the previous year. There will be continued communication and education of staff of risk assessing patients for VTE.

Clostridium difficile						
Indicator	2022/2023 NHS Digital				NNUH 21/22	NNUH 20/21
	NNUH FT	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	15.4	18.47	0	48.5	13.68	14

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

Latest data available for 2022/2023

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

Current version uploaded: Friday 6th October 2023

The Norfolk and Norwich University Hospitals NHS Foundation Trust considers that this rate is as described for the following reasons: The data has been sourced from the UK Health Security Agency's Data Capture System and compared to internal Trust data.

Norfolk and Norwich University Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and 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 (IP&C) 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. National Standards of Healthcare Cleanliness 2021 are in place.
The IP&C team at the NNUHFT work closely together with the Integrated Care Board (ICB) and IP&C colleagues throughout the healthcare system to contribute to the C.difficile infection workstream.

Patient Safety Incidents
NHS England have confirmed that the annual publishing of this data has been paused due to the introduction of Learning from Patient Safety Events (LFPSE) to replace NRLS, therefore at the time of this publication, this data was not available.

Review of Implementation of 7 Day Services

The ten national standards are used to underpin our internal clinical standards of care for our patients and are aligned with our Caring with Pride strategy which reflects our continual commitment to improve the care and experience our patients receive no matter what day of the week they require our care and support.
Seven Day standards performance is evidenced through a number of data sources across the organisation, work is in progress to provide a report to the Quality Programme Board which meets the reporting standards as required by NHS Improvements.

Review of Speak Up Policy

NHS England are responsible for producing the National Freedom to Speak up policy (June 2022). Trusts are required to adopt the policy as the minimum standard. At the NNUH we have taken this opportunity to engage with colleagues and teams across the organisation, to ensure that this policy is practical for the user, gives clear guidance and support and underpins safety, transparency, and learning, the key factors for healthy speak up culture.

During the review, NHS speak up culture became visible again, in the national press, as findings from the Countess of Chester investigations became known. This briefly delayed our timeline for launching the policy but crucially we needed to look with fresh eyes and consider, was it robust enough?

It now includes more avenues for direct reporting into safety teams and governance channels in divisions. The policy ensures correct channels for escalation are clear, and that emphasis is on the “normality” of speaking up.

Should someone feel they have suffered detriment, guidance to raise this with their manager or a FTSU Guardian is now given. Previously any clarity around this was missing and vague. Statistics around this are reported externally to the National Guardians Office, by FTSU Guardians.

How matters are reported is included, making staff aware of what happens and the Trust more accountable to that process. This policy can now help educate its users on what best practice is and therefore what to expect.

Speak up training is now categorised as essential for staff.

Freedom to Speak Up (FTSU) Guardian Service

The Freedom to Speak Up Guardian Service consists of a network that is now well-established. We have increased the number of trained Guardians and Champions, ensuring each division has representation. We are soon to be recruiting a Freedom To Speak Up Coordinator, reducing business continuity risks and to assist in the delivery of improving speak up culture in line with our people and culture strategy.

- Designated Non-Executive Director – Sandra Dineen
- Executive Lead – Paul Jones, Chief People Officer
- Lead of Service – Frances Dawson
- Guardians – Aligned to each division (8)
- Champions – Aligned to departments (17)

We introduced a caseload management tool that is assisting in exception reporting response times and matters that don't resolve in a timely manner with associated KPI's.

We are currently developing a FTSU communication strategy. Sharing feedback received, outcomes and lived experiences from our staff, to assist us in reducing more barriers for staff. This will demonstrate the breadth and diversity of colleagues using the service, from roles, protected characteristics, and themes. We are triangulating information e.g. from the NNUH NHS staff survey to guide us in our approach.

We are assessing the benefits of a detriment risk assessment tool, that may enable staff to feel and be more protected from fears or actual detriment occurring.

We continue to be 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

Each year circa 450 junior doctors and dentists rotate throughout our Trust in support of the foundation and specialist medical education training programmes, under arrangements with Health Education East of England (The "Deanery").

The enablement of a positive education and employment experience for each of our junior doctors is of paramount concern. Whilst there is still work to be done to, we continue to work with our partners, stakeholders, and junior doctors to maximise potential in this important area.

Specifically, our focus aimed at achieving positive outcomes include:

- Pro-active liaison with HEEofE to ensure timely receipt of junior doctor allocations and supporting information via the Training Information System (TIS)
- Developing compliant Work Schedules and Rotas to meet with national terms and conditions of service

- Recruiting locally employed Doctors, Advanced Nurse Practitioners, and Physician Associates to support vacancies in training rotas
- Responding to improvement outputs highlighted in the General Medical Council (GMC) National Training Survey and National Education and Training Survey (NETS)
- Establishment of a pro-active Junior Doctors Forum, to take account of junior doctor suggestions and concerns
- Appointment of a Guardian of Safe Working Hours, who acts as a champion for safe working hours for Doctors and Dentists in training, with a primary focus of recording and responding to escalated concerns submitted by our junior doctor cadre
- Adoption of Optima as an electronic solution to junior doctor e-rostering
- Execution of a bespoke Medical & Dental Workforce Improvement Programme. This intense programme has resulted in improved performance across a number of workstreams and subjects related to our medical and dental workforce
- Investment in the Medical Workforce and Health Rostering Teams to support the recruitment, deployment and experience of our junior doctors

Hospital Charity funds anaesthetic simulator

An epidural training simulator has been purchased by the N&N Hospitals Charity to benefit staff and patients in the Anaesthetic department.

The simulator models the lower back in silicone which is cast around plastic anatomy to form an exact copy of the human body. It can be used for training of a range of procedures, including a spinal block (injections of medicines that block pain from specific nerves which can be used for pain relief) and a spinal catheter which is placed into the epidural space of the spine and left in place for a period of time.

The simulator is not only a useful way to teach Anaesthetists, but also allows for more experienced staff to maintain their skills with practice and be able to perform procedures in many different conditions.

Dr Siddharth Adyanthaya, Lead Consultant for Obstetric Anaesthesia, said of the £3,650 grant: "*We are grateful to the N&N Hospitals Charity in helping us procure the Genesis Epidural-Spinal Injection Simulator. It is a valuable teaching and training tool that will help many anaesthetists to practise and hone their skills in a safe environment and, in the process, make the management of our patients safer and efficient*."

To find out more about the N&N Hospitals Charity or to make a donation please visit: **www.nnhospitalscharity.org.uk**

75 year spotlights continued…

Name and role: James Artherton-Howlett (Jamie) - Senior Dementia Support Worker

Length of NHS/ NNUH service: 16 years

What do you love most about your role?
Living with dementia whilst in hospital can be a challenging time, I enjoy finding out about people and use this to help the person remain engaged and calm throughout their time here, this could be providing meaningful activity. I also enjoy helping staff understand dementia from the persons perspective and supporting their families/carers.

Name and role: Sarah Aldis – Healthcare Support Worker

Length of NHS/ NNUH service: 7 and a half years

What do you love most about your role?
What I love about my role as a HCA is being part of a dedicated team, getting to know my patients and assisting them with their care and recovery.
I also enjoy mentoring new staff members when they start on Edgefield Ward, as well as the ability to learn something new regarding my role almost every day, I find being a HCA a very rewarding job and I am proud to be part of the NHS.

Name and role: Toby Lewis – Major Trauma Project Manager

Length of NHS/ NNUH service: 4 years

What do you love most about your role?
The people that I work with. Everyone has a unique background, set of skills and attributes that benefit our services and I enjoy being able to work with these colleagues everyday across the NHS.

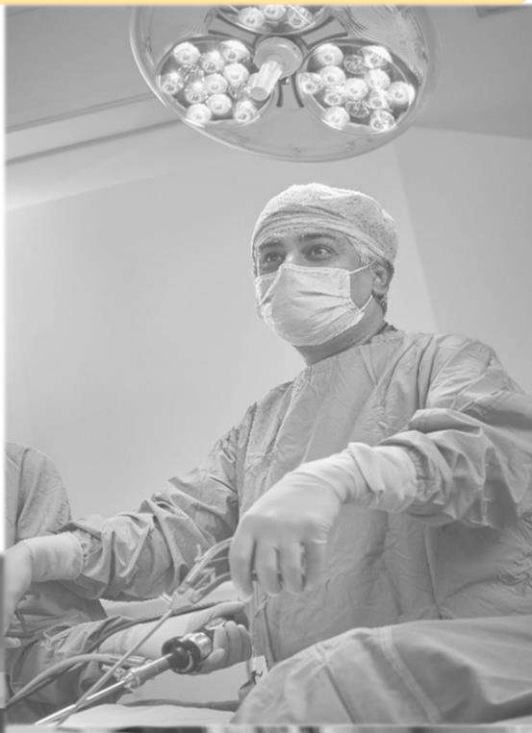
Name and role: Jenny Nobes – Consultant Clinical Oncologist

Length of NHS/ NNUH service: I started at NNUH on 1st June 2010. I have worked in NHS for over 24 years.

What do you love most about your role?
This role allows me the opportunity to change the course of the disease for patients with cancer, either by providing curative treatments, or by extending and improving quality of life when cure is not possible. It is a very clinically focussed speciality, with much of my week being spent in outpatient clinics, in the radiotherapy department or on the wards. The technical aspects of radiotherapy planning and involvement in clinical trial recruitment provide additional interest to my role. I love working as part of a team of hard-working nurses, doctors, radiographers, managers and administrative staff - all of whom are committed to achieving the best quality of care for our patients, as we would hope to receive ourselves.

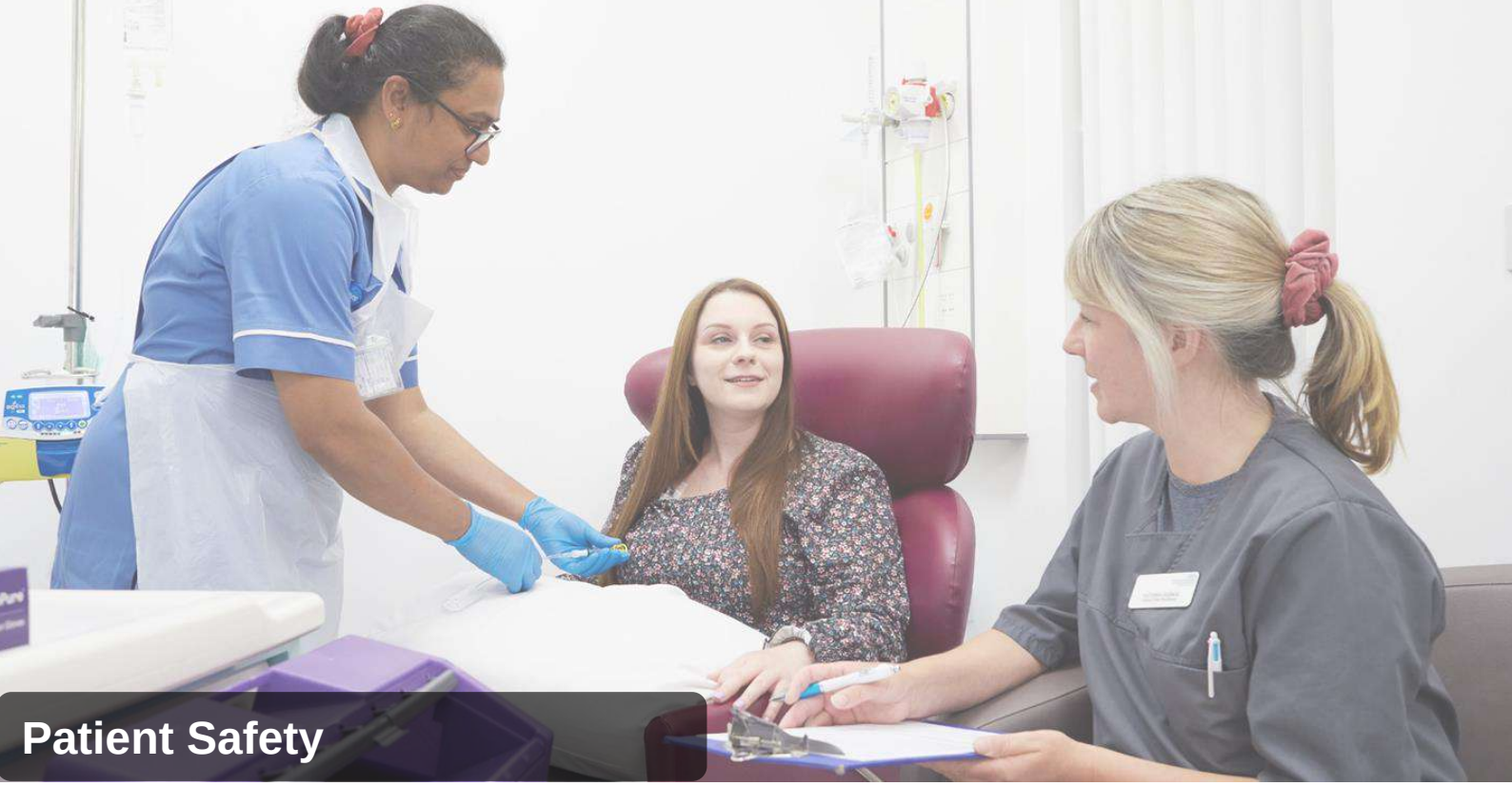
Together we are…

empathetic excellence resilient
forward-thinking positive people-focused
teamwork professional trust
protect dedication
honest friendly supportive
effective pride caring
collaborative helpful listening safe
innovative
respect together open dignity aspiring
quality kind welcoming communicate
inclusive appreciative learning
resourceful integrity hard-working
accountable creative interesting





Patient Safety

Patient Safety Incident Response Framework (PSIRF)

The Patient Safety Incident Response Framework (PSIRF) replaces the NHS Serious Incident (SI) Framework. The SI Framework mandated when and how to investigate a serious incident whereas PSIRF focusses on learning and improvement. With PSIRF, there are a set of principles which we need work to but outside of that, we are responsible for the entire process, including what to investigate and how. There are no set timescales or external organisations to approve what we do.

The PSIRF supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

COMPASSIONATE ENGAGEMENT & INVOLVEMENT OF THOSE AFFECTED BY PATIENT SAFETY INCIDENTS

APPLICATION OF A RANGE OF SYSTEM BASED APPROACHES TO LEARNING FROM PATIENT SAFETY INCIDENTS

CONSIDERED AND PROPORTIONATE RESPONSES TO PATIENT SAFETY INCIDENTS

SUPPORTIVE OVERSIGHT FOCUSED ON STRENGTHENING RESPONSE SYSTEM FUNCTIONING AND IMPROVEMENT

Our Patient Safety Incident Response Plan (PSIRP) was published in September 2023 and sets out how we intend to respond to safety incidents under the PSIRF.

One of the underpinning principles of PSIRF is to do fewer "investigations" but to do them better in a small number of areas of highest patient safety risk.

Better means taking the time to conduct a systems-based investigations by people that have been trained to do them.

There are only 2 mandated patient safety incidents that must be investigated under PSIRF

- Patient safety incident is a Never Event
- Deaths more likely than not due to problems in care. This can be identified through an incident and/or the learning from deaths process.

Through analysis of our patient safety insights, we have identified 2 local patient safety priorities that will undergo an in depth Patient Safety Incident Investigation (PSII), these were agreed at the Quality & Safety Committee in April 2023.

Table 22. Local Priorities that will be investigated under PSIRP

Key Theme	Key Risks from Activity
Missed/ Delay in Diagnosis	Patients under the care of the Emergency Department or Medical Specialties where a missed or delay in diagnosis leads to a significant delay in the initiation of essential treatment.
Sub Optimal Care	Incidents affecting patients where care is being managed between >1 clinical specialty, where management resulted in the patient being transferred to multiple wards and there was a failure or delay in acting on an escalation of a deteriorating clinical situation.

Patient Safety Learning Responses

There are a range of system-based approaches and a toolkit which we will be using to ensure we have a considered and proportionate response to patient safety incidents which are focussed on learning and improvement following a patient safety incident. Incidents not meeting the criteria for an in depth PSII, but where there is potential for significant learning to be identified, will have a Patient Safety Review using a proportionate learning response to review what has not gone as expected.

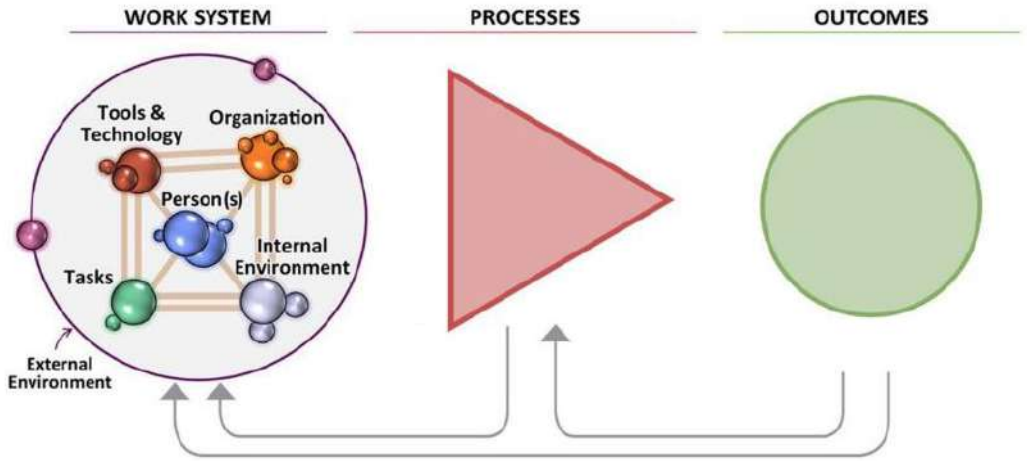
Figure 1. Learning Response Approaches

Progress to date

3.8 WTE Patient Safety Incident Investigators have been appointed to carry out Patient Safety Investigations. They have completed investigation training using the Systems Engineering Initiative for Patient Safety (SEIPS) model with the Healthcare Services Safety Investigation Body (HSSIB) and are equipped with knowledge and tools to support high quality, system-based investigations to identify learning from patient safety incidents.

SEIPS is a framework for understanding outcomes with complex socio-technical systems.

Figure 2 below describes how a **work system** (or socio-technical system, left) can influence **processes** (the work done middle) which in turn shapes **outcomes** (right).



The SEIPS framework acknowledges that work systems and processes constantly adapt and that multiple interactions between the work system factors help us to look at complex system issues rather than simple linear cause and effect relationships.

Table 23. Sept 23 – March 24 PSIIs

Incidents meeting Never Event Criteria to undergo PSII	1
Incidents resulting in death, assessed as more likely than not due to problems in care following Structured Judgement Review to undergo PSII	3
Missed / Delay in Diagnosis to undergo PSII	3
Sub – optimal care to undergo PSII	2

Alongside our PSIRF Plan we also published our PSIRF Policy outlining our approach and describing the supporting governance processes for successful implementation. Divisional Governance leads have adapted to new ways of working to review all incidents and triage them to the most appropriate learning response. They are supporting teams to carry out Patient Safety Reviews using a range of learning responses, such as Swarm Huddles, After Action Reviews and MDT reviews.

Table 24. Sept 23 – March 24 Incidents selected for a PSIRF Learning Response

Learning Response	Total
AAR (After Action Review)	15
SWARM	4
MDT Review	144
Total	163

Next Steps

We recognise that PSIRF is a complex change programme that seeks to change mindsets and beliefs in the way we respond to patient safety incidents. The success of PSIRF will be measured by staff reporting that they feel safe to speak up without fear of blame, and that patients and families feel listened to and concerns acted upon.

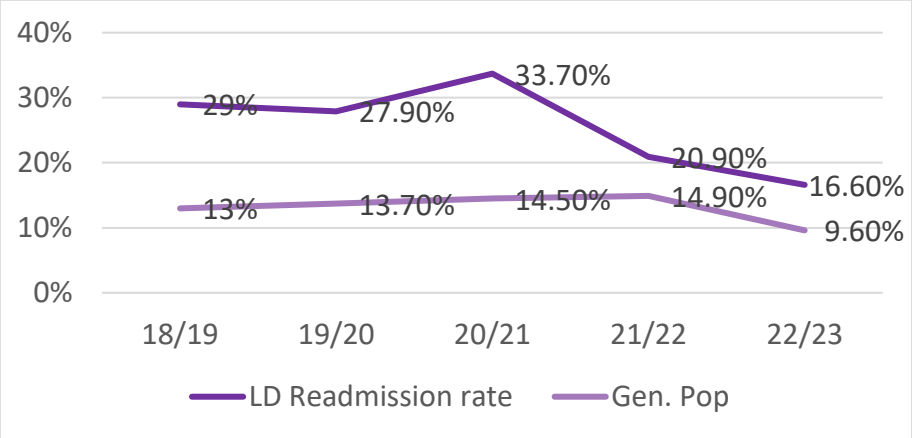
We know that we may not get it all right at the beginning and over the next 12 months we will monitor the impact and effectiveness of embedding PSIRF by listening and responding to feedback from patients, families and staff, and adapting our processes as we learn from experience.

We will be developing more resources to help learning response leads feel confident to use the different learning response tools and to engage compassionately with patients, families and staff affected by patient safety incidents.

Learning Disability Readmission Rate reduction

The journey so far this year (April 2023 – March 2024)

Recent reports to NHS Benchmarking demonstrate significant and sustained improvement in the readmission rate for learning disabilities and autism. In 2020, the NNUH had the 3rd highest readmission rate for this patient group nationally.



Readmission rate for people with learning disabilities, which evidence suggests is often potentially preventable, is a key focus of the learning disability and autism team and several improvement steps have been taken in the past 3 years, including:

- Thematic review of 'failed' discharges.
- Close engagement with the Integrated Discharge team.
- A proactive strategy for identifying potentially complex discharges alongside Complex Discharge team, including pre-discharge monitoring, preparation and liaison.
- Establishment of cross-agency forums with community services.
- Identify where readmissions are concentrated by division/ward/specialty, enabling targeted support for those areas.

Following the success of the previous year reduction in readmission rate, the learning disability and autism team aimed to focus on remaining areas of preventable readmission and sustain the improvement.

The chart above shows that the readmission rate has continued to decrease, with the most recent data showing reduction to a rate more comparable to those without learning disabilities or autism, concordant with a generalised reduction in readmission rate in the Trust. This, however, remains an encouraging development as it suggests that improvement measures are applied equitably across patient groups.

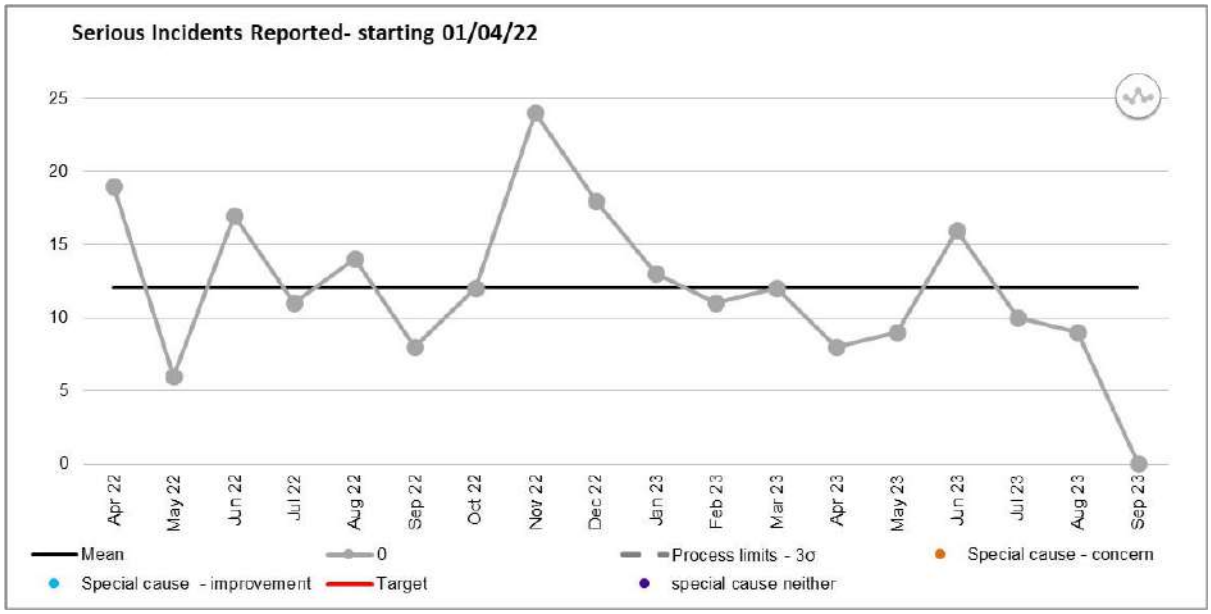
The team will henceforth monitor this in a more contemporaneous manner to enable dynamic responses. The team is also working with ICB colleagues to improve the communication of symptom management plans to care providers, with a view to avoiding preventable readmission following discharge.

Serious Incidents

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).

Between April 2023 and August 2023, 52 Serious Incidents were externally reported to the national StEIS (Strategic Executive Information System). Serious Incidents that were reported onto StEIS. 4 cases were declared void and removed from the system but continued to be investigated by the relevant teams.

The Trust transitioned to the Patient Safety Incident Response Framework (PSIRF) on the 1st September.



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, with staff signposted to various offers of support such as Professional Nurse and Midwife Advocates and Staff Health and wellbeing services.

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) supported patients and families according to individual needs and wishes.

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 four never events during the period covered by this Quality Account

May 2023	Retained foreign object post procedure
May 2023	Retained foreign object post procedure
July 2023	Wrong site surgery
October 2023	Wrong site surgery

Never Events remain a national priority that requires a full Patient Safety Incident Investigation under the PSIRF.

Macmillan Centre receives ‘five star’ report

Healthwatch Norfolk officers have praised the North Norfolk Macmillan Centre at Cromer Hospital for the excellent service it offers to patients and their families.

The North Norfolk Macmillan Centre, located at Cromer Hospital, has been built in partnership between Macmillan Cancer Support, the Norfolk and Norwich University Hospitals NHS Foundation Trust, and the Norfolk & Norwich Hospitals Charity. The Centre is open to anyone affected by cancer.

Healthwatch has visited the Macmillan Centre, who provide treatment as well as practical, emotional, physical and financial support to anyone who has been affected by cancer, to gather feedback from patients, families and visitors.

“*All the people we spoke with rated their experience as five star*,” said Sophie Slater, Community Development Officer for Healthwatch Norfolk.

“*They were complimentary of the staff for how they treat both patients and their families or carers. They also told us they liked the convenience of the hospital which meant they did not have to travel as far for treatment*.”

This is some of the feedback from patients and their relatives:

“It's a fantastic local service. The staff are wonderful and very caring. I am very impressed with how comfortable the seats are in the waiting room. I can't say enough positive things about this place.”

“I've never had any issues coming here. It is a very convenient location. The service always feels nice and personal.”

“All the staff are wonderful. I joined a breast cancer support group here through Macmillan and it's been a huge help to me and others.”

“*We’re so proud of such positive feedback*,” said Anita Martins, Cromer Matron. “*We do always get feedback from patients and relatives but to see it all highlighted in one report makes it seem even more special and truly reflects the hard work and dedication of the team involved*.”

“*It is very important that we hear what people have to say about the centre and what it offers*,” said Wendy Marchant, Macmillan Information Manager. “*Everyone works very hard to make sure that patients and their families have a good experience at a time when things can be tough for them*.”

Clinical Effectiveness

Virtual Ward

Baseline: what increased the focus on the virtual ward
On the 13th of 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.

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'.

In the last year we have seen great strides forward in the expansion of the NNUH VW and continuing collaboration with our wider Norfolk and Waveney organisations. We have now expanded to 60 acute beds with the capacity for an additional 33 'soft beds. We have also transitioned to Feebris remote monitoring to ensure all organisations within the ICS are using the same technology.

What you are measuring success on

- 98% patient satisfaction of service
- 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 in comparison to physical acute bed
- Sets a platform for integrated Virtual Care across the ICS, to improve patient flow through the whole system
- 3380 patients now seen through Virtual Ward since Feb 2021

The journey so far this year (April 2023 – March 2024) successes

- Moved to Feebris in line with N&W system
- Expansion to 60 acute + 33 soft beds and recruitment to support
- NNUH model still being requested and followed nationally/internationally
- Moved to our VW hub on Hoveton
- Professor Ramani Moonesinghe, NHS England's National Clinical Director for Critical and Perioperative Care, chose the NNUH case study for inclusion in the 2023 NHS Digital Playbook for Perioperative Care.
- Emily Wells, CNIO, was asked to contribute to a book commissioned by Elsevier, 'Harnessing digital technologies and data for nursing and midwifery practice' and has authored a chapter titled 'Remote Care and Virtual Wards: Transforming Nursing Practice' and the 'Virtual Wards: Tech matters, but so do people' article published by the Journal of mHealth.
- Increasing our Clinical Consultant Champions who support engagement and pathway expansion for the VW.
- Successful bid to provide training on Virtual Wards for across the ICS.

The journey so far this year (April 2023 – March 2024) challenges

- Recruiting at pace to support expansion
- Moving to different technology with initially less capabilities
- Training and supporting staff in use of new technology
- Continuing to increase engagement among clinical colleagues
- Moving to national standardised method of reporting created issues within our model

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

- 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 particularly across the 3 acutes.
- Communications Strategy to continue to drive expansion
- Increase in active referrals from teams across Trust

Maternity Reviews

The journey so far this year (April 2023 – March 2024)

Baseline: what increased the focus on the whole of the maternity reviews
NHS Maternity services across the whole of England continue to be under the spotlight. We are working closely with our Local Maternity and Neonatal System (LMNS) and our Maternity Neonatal Voices Partnership (MNVP) to achieve continued compliance. Working this way has allowed whole system change, with combined projects and shared learning with the focus on including and coproducing with inclusion of our service users.

We continue to work on compliance to the independent review reports requirements, regional NHS England visits and the Maternity Incentive Scheme via our Maternity Action Plan. We are supported by our Quality Improvement Team to ensure we are meeting the requirements and recording this effectively with appropriate scrutiny from our colleagues from the wider Trust.

What you are measuring success on

- Our Good CQC Overall Rating and working on the 'Should Do's'
- Meeting the requirements to obtain the Maternity Incentive Scheme
- Our 'Maternity Vision' A 5-year strategy for maternity services
- Compliance with the Saving Babies Lives Bundle version 3
- Listening to our service user feedback and coproduced quality improvements

The journey so far this year (April 2023 – March 2024) including successes and challenges

Inspected and rated Good CareQuality Commission

Following a CQC visit in November we have received a 'Good' rating for our maternity services. There were no 'Must Do's but three 'Should Do's which have been added to our Maternity Action Plan.

We have also been successful in our compliance to the ten Safety Actions for the Maternity Incentive Scheme.

Work continues with collating evidence for compliance to our Maternity Action Plan and presentation of evidence at the Maternity Evidence Group.

The challenge has been the amount of similar repetition of recommendations/themes. This has been reduced with the help of our Quality Improvement colleagues in producing a document which aligns the similar themes and evidence can be cross matched to avoid repetition of work.

Further challenges to compliance with national reports is funding for specific roles, or services which carry a cost to the Trust and are not financially viable within the current climate. These are RAG rated within the maternity evidence group and raised as an issue for transparency. If necessary and pose a risk can be added to the risk register.

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

The maternity team will be releasing the 'Maternity Vision' in May and will be monitored by the wider Trust on our progress towards the objectives via the Nursing Midwifery and Care Professionals Board. This has been written with input from our MNVP and maternity team.

Maternity Incentive Scheme compliance remains high on the agenda for 2024-2025 to evidence our service safety.

Continuation of coproduction with our MNVP for improvements to maternity services. This work reviews our feedback from service users and working groups aim to coproduce solutions to improve services and experience.

Working with our LMNS to demonstrate continues quality improvements for compliance with the Saving Babies Lives Bundle version 3.

Maternal Diabetes Research

The NNUH Maternal Diabetes Team are leading clinical researchers in the field of diabetes in pregnancy.

NNUH was the sponsor site and lead recruiter for AIDAPT (Automated Insulin Delivery in Women with Pregnancy Complicated by Type 1 Diabetes). This study demonstrated the huge benefits to women, birthing people and their babies from using hybrid closed loop technologies, sometimes known as 'artificial pancreas technology'.

The results have been published internationally and have been used by NICE (National Institute for Health and Care Excellence), who have mandated the use of this technology in a recent Health Technology Appraisal.

Building on this success, the team have become the first site to recruit to a study looking to address health inequity in women and birthing people with early onset type 2 diabetes in pregnancy (PROTECT). The work done by the team has implications for women and birthing people with diabetes in pregnancy worldwide.

Electronic Patient Record (EPR)

The three acute Trusts in the Norfolk and Waveney Acute Hospital Collaborative (James Paget University Hospital, Norfolk and Norwich University Hospitals and Queen Elizabeth Hospital) are investing in a single, shared, integrated Electronic Patient Record (EPR) system – Meditech Expanse.

The vision is that an EPR will act as an enabler for a greatly improved health care system in which care givers and patients have electronic access to more complete health records and are empowered to make better health decisions with this information. An EPR system contains patient-centric, electronically maintained information about an individual's health status and care and focuses on tasks and events directly related to patient care. The EPR provides support for all activities and processes involved in the delivery of clinical care.

Benefits will include:

- Improved clinical quality
- Operational productivity
- Staff efficiencies
- Better patient and staff experiences
- Displaced IT costs and non-staff savings
- Research opportunities
- Environmental sustainability
- Population wellness and reduced inequalities

What you are measuring success on

The EPR will support improved patient outcomes, staff well-being, and cross-Trust collaboration and measures of success will include:

- Improved patient experiences and outcomes due to more time spent with care team
- Reduced waiting time
- Improved patient outcomes and reduced deconditioning
- Easier identification of patients with infections, contributing to less moves between wards
- Improved visibility of accurate, up to date safeguarding alerts
- More efficient and safer ward rounds
- Reductions in clinical risk
- More efficient and improved serious case and mortality reviews
- Improved capacity management
- Improved discharge efficiency

- Improved staff working experience and satisfaction
- Enhanced organisational reputation, thereby improving retention and recruitment
- Single digital function enabled and efficient scale of service
- Increased data quality and confidence, improving national reporting reputation
- Reduced IG risk due to improved traceability and auditing of information access

The journey so far this year (April 2023 – March 2024) successes

- Procurement to choose our EPR supplier was carried out over approximately 3 months.
    - 484 stakeholders across the 3 Acutes were asked to take part in the review of the functional requirements of the systems. 168 responses were received.
    - 274 colleagues were involved in the evaluation process
    - 2 in person site visits
    - 4 virtual site visits
    - Our chosen suppler was Meditech Expanse
- We are in the final stages of regional and national approval for the Full Business Case (FBC), this is has already gone through individual Trust Boards and the subject matter expert queries from NHS Frontline Digitisation have been received and responded too. This is the furthest any of the Acute Trusts in Norfolk & Waveney have progressed in this process.

<u>Even though we have not received final approval on our FBC, we have ensured we have maximised the time in EPR readiness:</u>

- Clinically led programme
    - CCIO/CMIO/CNIO in post at each acute and part of the core programme team
- Key stakeholders and subject matter experts being identified across all Trusts
    - Change network launched
    - Utilising Tractivity to be able to identify and target comms for stakeholders
- As is process mapping close to completion for first 5 priority areas and next priority areas have been agreed – Positive engagement across 3 Acutes with process
- Clinical safety by design
    - Robust collaboration across the 3 acutes
    - Documents standardised
    - Strategy in development

    - Clinical safety training had been completed by all core clinical colleagues and wider clinical safety training planned
- Support from 3 Acute HR directors and funding for recruitment team
- Data workstream is progressing:
    - the development of a clinical data repository strategy (for legacy data not being migrated) supported by an external advisor.
    - The development of a data science strategy to support the use of clinical data to drive benefits planning and realisation.
- The technical workstream have completed initial system landscape looking at what systems will be in/out of scope across the 3 acutes.
    - Strong understanding of integration requirements
- 2 EPR events have been held, with an audience of more than 80 people from the programme and the three trusts, in February. Meditech also attended (Meditech UK GM and staff, Meditech International Sales) and provided a demonstration of the EPR system. Feedback on the event was very positive. The next event is planned for after FBC approval and contract signature with Meditech.
- Set up CXIO Development Network that meet monthly to ensure continuing development of our team
- Site visits have been organised with focus on pertinent areas

The journey so far this year (April 2023 – March 2024) challenges

- Changes in staffing, contracts and recruitment
- Delays in Full Business Case approval
- Lack of standardisation across 3 Acutes in relation to policies, procedures and documentation.
- Engagement due to industrial actions, annual leave and Trust wide pressures

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

- FBC going through approval process within 3 Acutes, which is due to be finalised 26th April 2024
- National approvals scheduled for 24th May 2024
- Contract negotiations underway with Meditech (EPR Supplier) and contracts due to be signed end of May 2024
- Software shared for initial design workshops to begin September 2024
- Completion of ‘as is’ and future state process mapping
- Benefits baselining
- Recruitment of staff to support EPR programme and associated facilities planning to support expansion of teams
- Continuing communications and engagement to teams throughout

Home for Lunch

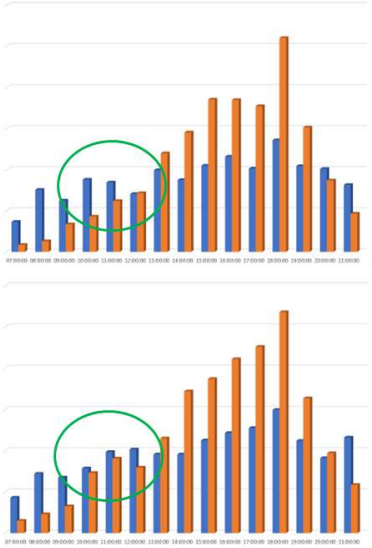
The Home for Lunch Taskforce was created in recognition that the greatest risk to a patient is those waiting for health care. Therefore, the Trust committed to bringing in patients from ambulances in a timely manner and release the paramedic team to answer the next call in the community.

The taskforce is focused on the core outcome metrics:

- To increase the number of patients brought in from ambulance within 30 minutes.
- To increase the number of discharges before lunch to 30%
- To reduce the average length of stay for non-elective admissions by 3 hours.

Phase 1 ran from October to December 2023 and looked at the patient flow in three stages: (a) ED to assessment areas, (b) assessment areas to wards and (c) more efficient discharges from wards. Each working group focused on the standardisation of documentation, improve efficiencies and reduction of unnecessary processes & steps. In Phase 1 there were a number of significant changes that enabled an increase in morning discharges and moved the discharge profile to earlier in day. The Trust increased morning discharges from below 10% in September to over 20% since January 2024 and moved the core time of discharges from 17:00-20:00 to 14:00-17:00.[1]

Graphic showing increase discharges (orange) in the mornings against admissions (blue) and an earlier peak in the day between September and December:



NNUH Data: Sept V Dec

- Discharges can be seen to have increased in the morning, trending closer to need.
- More even flow across the afternoon.
- Remains a mismatch.

During Phase 1, the clinical teams worked hard on revising the patient leaflets and staff communication regarding discharges. This included a lime green Criteria Led

Discharge Sticker that is easy to see in patient notes. The Same Day Emergency Care Units worked with the Emergency Department and the EEAST Paramedics to create alternative pathways for patients who required urgent access to the Trust but did not need Emergency Care. This was undertaken in line with the decision to ringfence Medical Same Day Emergency Care (mSDEC) Unit to protect flow through the unit. The assurance of knowing that the unit will be available every day has meant that the team can agree not to bring a patient in if they are stable at home. i.e. if there is a referral at 5pm and the patient is stable then the team can book the patient to come in the next morning.

The radiology department has redesigned their inpatient processes and were able to reduce their inpatient waits from around a week to a maximum of 28 hours from referral to reported scan. This was undertaken by focusing on inpatient referrals, holding daily huddles to review and discuss today's patients and priorities, and focus on specific wards to improve referrals and to prioritise patients when capacity exceeds demand.

Other simple changes that made a significant impact on patient care include the Principles of Clinical Standards that were developed by the Medical Director's Office and are based on the Trust's PRIDE values about respect, integrity and a single focus on our people (patients and colleagues). This has enabled the creation of the Directory of Services and the Internal Professional Standards.

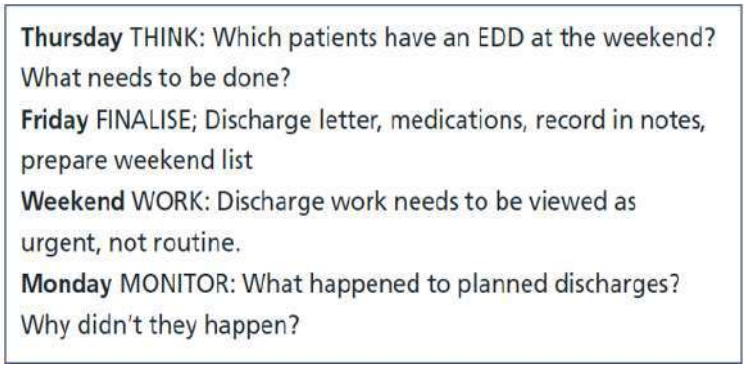
An important delivery for the Trust's clinical teams is that the WardView application now follows the user on any desktop. This is a digital tool that shows the whiteboards for all wards and shows the current position and details of all inpatients. This change means that the clinicians no longer have to remember the first computer they logged into when coming on shift and then wait for it to become free before being able to check on their patients.

The Taskforce has now moved into Phase 2 and this is focused on reducing variance and to create an urgent care pathway that is simple to use and runs in conjunction with the emergency pathway but doesn't interfere with the emergency department.

The Trust has agreed a daily cadence that requires today's discharges to be confirmed by 09:00, all patients to have been seen in the order sickest first, home then all other patients by 11:00 and finally, tomorrow's discharges to be identified by 14:00. The taskforce is focusing on five wards to understand how they deliver this currently and what the challenges are for consistency.

There is also a focus on specific periods of weekends and evenings, which there are less staff around and other distractions that will make discharging less of a priority.

The Trust has introduced:



The final group are looking at the urgent care flow, expanding beyond the Same Day Emergency Care Units to redirect all urgent patients away from the Emergency Department into the correct flow – either in the Trust or in the community. This group have developed a single Clerking Form and a Directory of Services. They are also looking at increasing their senior decision making in the Acute Medicine Unit and creating greater access to the 'Hot Pathways' for patients who need time dependent access to care.

The taskforce is ongoing into 24/25 and will continue to minimise the variance observed in the discharge process and to work beyond the first five wards to ensure patients are discharged more efficiently once they are ready to leave the trust.

Spotlight on our urology surgical team

Our first Urethral Stricture Disease Operation….

A new procedure to help hundreds of men affected by a common urinary condition has been carried out by our Urology consultants.

Ruth Doherty, Consultant Urologist, and the Surgical team marked the successful completion of the first operation of its kind in the hospital, with three more carried out the same day.

The urethra is the tube carrying urine away from the body and in men Urethral (u-REE-thrul) Stricture Disease, or scarring of the urethral tract, causes narrowing of the tube, making it difficult to urinate, meaning less urine comes out of the bladder. Previously men with this condition could widen the tube themselves with a procedure called self-dilatation, which required them to insert a single-use catheter. Many find this difficult to do themselves and usually opt for corrective surgery that involves reconstruction work to create a new urethra using a tissue graft from another part of their body. Performing a urethral dilatation alone comes with 90% risk of recurrence after the scar tissue has returned. Now patients who qualify can have an operation called Optilume drug-coated balloon procedure during which the balloon dilates the scarred urethra while pushing a disease-modifying drug into the affected area.

The procedure has been around for about three years and Ruth Doherty, Consultant Urologist, has spent that time building a case to bring it to our patients: “It has been a long road, but it was worth it,” she said. “This is a very common condition in men and treating it can be difficult because it is painful and uncomfortable for them. The Optilume has a lower risk of failure, between 25-27%. This means that fewer patients will need reconstructive surgery or need to perform self-dilatation. Patients are still offered all options upfront, so this is greatly improving patient choice. It is great to have a minimally invasive day-case procedure available.

“Quite often the men who need treatment have other co-morbidities which would prevent them from even being considered for surgery as the risks would be thought to be too high. Now we’ll be able to see so many more people as the risks are greatly reduced for them. It is a much quicker procedure too, taking only about 15 minutes, and this will free up capacity in theatre for those who need more complex surgery.” This new development has further benefits, including reduction in the number of costly consumables. “And there is a sustainability benefit because the catheters are single-use, so we are reducing our waste as well,” Ruth added.

We have enrolled in a worldwide study which will investigate the longer-term effects of the procedure over five years. Asheesh Kaul, Consultant Urology Surgeon, is the study co-investigator said: “We are interested to see the longer-term impacts of this procedure in terms of gathering data around reoccurrence and recovery rates compared to more established procedures.

Patient Experience

Patient Experience

We reviewed the Patient Engagement & Experience Strategy, and it was agreed to extend it to 2025. Objectives were refreshed under the main headings of Partnership Working, Co-Production, Using Feedback, Supporting Staff and Volunteering. Below we have charted progress and actions during this year against each objective.

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

Partnership Working - Working in partnership with patients is normal - there is a strong Patient Voice including those who are seldom heard

Co-production - Services and Pathways are co-designed with patients, staff and other stakeholders

The Patient Engagement Team attended a total of **30 engagement events** in 2023 to strengthen the voices of those less well heard or under-served. These ranged from baby groups and library visits with the Maternity and Neonatal Voices Partnership (MNVP), Norwich PRIDE to hear from lesbian, gay, bisexual, transgender communities, NANSA Neurodiversity Festival, Armed Forces Event, HMP Wayland, Deaf Connexions, Ear to Hear Support Group and more!

An Experience of Care event was held highlighting some of the good practice happening across the Trust to support our patient experience and engagement. The team also attended awareness raising and networking sessions including a Palliative Care Conference, CYP transition evening, Carers Conference, Healthwatch Norfolk Live and a SSAFA Training Day. The team also improved how we are able to interact and support our diverse communities e.g. Deaf Awareness and Sign Language Workshop, Embedding Psychological Safety Leadership training, Beyond the data – creative poetry workshops and NHSE Making Data Count sessions.

The Patient Panel has continued to work closely with Trust staff on a growing range of projects and are now a well-established and respected core group of patients, Carers and community members with individual portfolios of involvement activities harnessing their lived experiences, professional knowledge and diverse backgrounds. They have been central to the Patient Led Assessment of the Care Environment (PLACE) annual audits alongside regular Care Assurance Visits which sees members, alongside clinical colleagues, visits wards to observe and talk with patients and families about their experiences. Members sit on a number of committees, working ad project groups including the Mental Health and Complex Care Board working closely with the Complex Health team to co-produce a process for those patients wishing to self-discharge and also the Dementia Strategy Group, bringing their experiences and insights to influence decision making.

A **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 co-chaired by Veterans – a staff member and a Patient Panel member, the priority for the group this year has been to support the Veteran Aware (VA) reaccreditation award. In March the MCWG support SSAFA caseworker will commence work on site, supporting patients and families who are veterans to support discharge and community support.

The **Carers Forum** meet bi-monthly and have continued to work on improving identification of and recognition of Carers and support for when their cared for person is accessing care at the NNUH. We have been re-accredited 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 with almost 3,000 now issued via Carers Voice. This will support teams and staff with better identification of carers alongside continued carer awareness training offered. The Forum have supported ongoing review our Carers' Policy and supporting with co-production of projects providing valuable input to shape our service delivery.

The **Divisions** have been strengthening their local patient and carer engagement - Clinical Support Services Division patient panel has been strengthened, promoting co-production in quality improvement projects; Medicine Division have a Patient Panel 'partner' embedded and supporting their improvement initiatives whilst Maternity have continued to develop and strengthen their relationship with Maternity Voices Partnership (MVP). During the year the Women's and Children's Division recruited a Youth Worker and have commenced recruitment to a Youth Forum to work on a range of co-production improvement initiatives.

As part of the introduction of a new national patient safety strategy, we have introduced the **Patient Safety Partner** role. This is a new role, drawing in people with lived experience to focus specifically on patient safety strategy issues and initiatives. We have recruited the first PSP for NNUH during the year and they operate at a strategic level as a member of the Quality and Safety Committee and Clinical Safety and Effectiveness Sub-Board and support the review and sign off of

the new Patient Safety Incident Investigations. The Patient Experience and safety teams are working collaboratively to develop this role and embed it as part of our wider involvement and engagement approach.

Healthwatch Norfolk have continued to work closely with us - visits continued in several areas within the hospital and during the year they completed a mammoth task through a 3-hospitals in 3-weeks programme whereby they went to each of the acute trusts in Norfolk, covering almost every department, ward, area to collect and analyse feedback to inform a shared thematic approach for acute care across the county. Feedback collected from the visits and via the website is shared at the Patient Engagement and Experience Group sub-board quarterly and the 3 hospitals work is informing collaborative improvement work for experiences of care across the 3 acute trusts.

A major **co-production project with the Maternity and Neonatal Voices Partnership (MNVP)** focusing on health inequalities took place during the year. Within this project we held multiple listening events to hear the voices of services users who we may not always hear from. Service users influenced the conversations and themes that came out of the listening events were truly what mattered to them and these conversations have informed task and finish groups and plans for improvements led by Maternity and MNVP in partnership.

This project inspired and informed the next steps for embedding more co-production across the Trust. It also highlighted that we needed to do even more to address health inequalities which has enabled the post of Engagement Facilitator with our local MNVP to be created. They will develop and maintain links with community groups on behalf of the MNVP as a 'trusted contact' which has proved vital to gain trust with the local community. Our local MNVP have worked with NNUH Voluntary Services to develop the role of community engagement volunteer to support widening the reach of the MNVP and also develop trusted contacts in local communities.

The **Call for Concern** QI project had Patient Panel and Patient Safety Partner involvement to co-produce the information and design of the emerging service.

Using Feedback - Feedback, whether complimentary or critical is proactively sought, coordinated, analysed & used to make improvement - "you said, we did …. Together"

Supporting Staff - All staff feel engaged, confident and empowered to proactively listen, respond and act - from the top and embedded throughout the organisation

Every day we collect feedback via the **Friends and Family Test**. This is a nationally endorsed question asking about the quality and experience of care received. In the last year we had over 48,000 responses. Most of these were positive with the Trust highly rated for staff interactions and attitude.

Extending the ways people can respond to this question has continued, widening access via multiple routes including SMS txt messages, QR codes, Cards, links on our website and volunteers play a crucial role in collecting feedback on wards and via post-discharge phone calls.

Feedback collected from FFT is utilised within Divisions to inform improvements and has been used for example by our Emergency Team to change the process and deliver service improvement, resulting in better satisfaction and improved outcomes of patients and families.

The **PALS and Complaints** team have updated the information provided on their service and promoted it across the Trust; ongoing improvements to the service continue with the support of Patient Panel members and closer working with the Divisions to develop point of care resolution wherever possible. The team have delivered their bespoke **Let's Resolve It Together** training to support this with 13 sessions delivered – 100% of those attending reported feeling empowered to de-escalate concerns and resolve things in the moment.

Advanced communications skills training - palliative / end of life care - offered to all band 7's and 6s with over 40 places per year allocated. This training will be crucial in improving the skills of frontline staff – enabling improvements to communication overall, which is a key theme identified through surveys and complaints and compliments – demonstrating its importance to patients and carers.

This year's **Equality Delivery System** (EDS) submission focussing on Children and Young People, Learning Disability Including Autism and Mental Health utilised analysis of feedback from a range of sources including FFT, PALS and Complaints and compliments as well as engagement activity feedback on measures taken trust wide, to ensure equity of access and experience. Key actions will align with the Diversity Inclusion and Belonging strategic developments, especially as they relate to Health Inequalities.

Building on direct feedback from our communities, the Accessible Information Standards Policy has been reviewed and additional support for those requiring Reasonable Adjustments has been identified with support and training for staff to implement extended.

Similarly, building of direct feedback, we have been able to introduce virtual interpreters increasing accessibility for those requiring interpreters, especially at short notice or in emergency situations.

The Board have continued to embed **experience of care stories** at their meetings in public, supporting patient and carers having a voice 'at the top' and grounding the meetings in the reality and issues that matter to the people the Trust serves. Support

for recording and utilising experience of care stories has been updated and support to staff made more widely available.

Family Liaison Service

Originally developed as a response to Covid19 and reduced visiting, the Family Liaison Service has continued to provide a ward-based service which has been further extended until October 2024 to improve patient and family experience and wellbeing by maintaining a line of communication during their time in hospital. The Family Liaison Officers have supported patients and families directly and also staff on the wards to improve their communication with patients and families through role-modelling person-centred support and ensuring people's voices are heard at ward level.

From March 2023 up to present day the service has supported 11,254 patients, families and/or Carers. Providing 109 Carers passports and signposting to Carers Matters/Voice on 98 occasions. The service has identified and supported 38 veterans since June 2023.

Volunteering - Volunteers support this patient experience to be outstanding through innovative roles and opportunities

Following a major depletion in volunteer numbers due to the impact of Covid 19, the focus has been on rebuilding and consolidation whilst enabling continued innovation and so-design of new roles to support experience of care and freeing staff to care.

We now have over 600 volunteers (across seven sites) providing around 3,000 hours of help throughout the Trust every week and we also benefit from the support of volunteers from many external voluntary, community and social enterprise (VCSE) organisations who are able to provide more specialised help. Volunteers come from all walks of life with lived and life experiences, many having been patients or Carers at NNUH. Roles are generalist and specialist and support key milestone in patient journeys e.g. we now have over 50 end of life, Butterfly volunteers. Butterflies can just sit with a patient, offer gentle hand massage or provide a respite break for the families.

Other roles are key to supporting patient flow and ensuring a smoother and earlier discharge e.g.; volunteer drivers who have access to 2 wheelchair accessible vehicles provided by our charity. Our volunteer drivers cover the whole of Norfolk and Waveney and are available Monday to Friday to discharge our patients home in comfort.

During the year we strengthened key roles within Voluntary Services through a restructure of the service – this will enable us to embed discharge support (driving/settle in and post discharge welfare calls), ED support, ward based volunteer opportunities (especially OPM roles to support mobilisation and reduced length of stay etc), and end of life support with additional Butterfly volunteers and a role to strengthen the support for off-site volunteering e.g. at Cromer and the Macmillan Centre.

Whilst consolidating, the team continued to innovate in volunteer roles – the post discharge welfare check calls have seen over 20,000 calls made to check on recently discharged patients garnering mostly positive feedback for wards and colleagues as well as providing the opportunity to identify and fix quickly any issues.

The ED roles have extended to offer emotional mental health support and a new role, building on the success of the phone service, will support patients who are waiting for a Radiology appointment to prepare and reduce missed appointments, understanding what matters to them to support attendance and signpost for support.

Spotlight on our Butterfly Volunteers

Our 31 Butterfly Volunteers offer comfort to patients who are in the last days, weeks or hours of their lives

The service was set up in 2019 in partnership with the Anne Robson Trust, which was founded by Liz Pryor in memory of her mother, Anne Robson, in 2018 and currently works with 18 Trusts to establish a dedicated end of life volunteering service providing emotional and practical support, making a significant difference to patients and their visitors.

Volunteers can spend their time chatting to patients, reading to them, or playing music, or can simply sit with patients who may have no relatives and let them know they are not alone. The care is also there to support relatives.

"The main qualities a Butterfly Volunteer needs is simply to be compassionate and caring," said Caroline Stevens, Butterfly Volunteer Co-ordinator. "They don't need a clinical background. They just need to be a supportive person, but they do need a bit of resilience."

That resilience is necessary to help deal with the emotional impact the role can have. Some patients may be lucid, but others may be unresponsive or with relatives who are very upset. After every session, the volunteers meet Caroline or a member of the Chaplaincy team to de-brief so that they can talk about how they are feeling.

"Of course it can be highly emotional," she said. "Spending time with relatives is a joy because they share so much with us about their loved ones. It's a real privilege. We try to make sure the time we're there is a good experience for the patient and family."

The volunteers range in age from their 30s to their 70s and most commit to around two to three hours a week, although some come in fortnightly. They work closely with the Palliative Care team who give the volunteers training, and alongside the Chaplaincy who also give guidance. Some may have experience of being with a loved one at the end of their life, or they may have had a relative who's received good end of life care and want to give something back to the hospital.

Butterfly Volunteers Shortlisted for 'Who Cares Wins' award

The volunteers were shortlisted as one of the top three health charities in the awards, reflecting their commitment to providing compassionate care and support to individuals facing the end of life, and their families.

Pictured from left: Chris Adlam, Caroline Stevens and Carol Robinson

The charity was nominated by Peter Harrison, 79, when his wife Christine was cared for at the Trust and subsequently died following a stroke. The volunteers supported Peter and Christine here during the last days of her life in April 2022.

"Christine went into a coma which she never came out of," said Peter, who was married to Christine for 53 years. "If I stayed too long in the hospital it would have been too much for me. You can't be there 24/7. I could go for two or three hours a day. It was a relief to know there was more than me talking to her, to have other people able to say comforting things."

Staff Experience

NHS Staff Survey

The NHS Staff Survey 2023 launched at NNUH on 2nd October 2023 and closed on 24th November 2023. The response rate for the Trust was 47% with 4,348 staff sharing their views, which was lower than the 2022 response rate of 51%. The 2023 response rate was also above the national acute trust 45% median response rate (benchmarked with 122 acute trusts).

2023 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 – 122 acute trusts
When comparing the 106 NNUH question scores to the national Acute Trust average, 5 scores above average, 14 are aligned to the average and 87 are below average, with 7 questions being equal to the worst in the country.

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

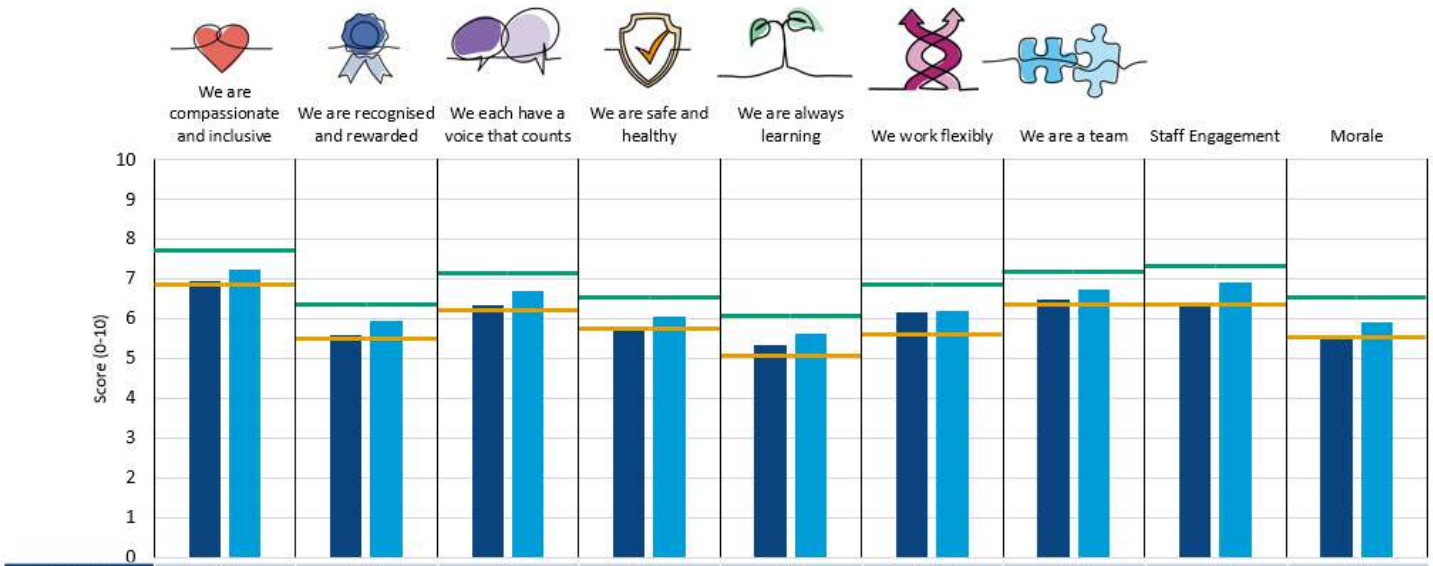
In comparison to 2022, all seven People Promise themes and the two additional themes, staff engagement and morale have improved for NNUH.

The nine themes have 21 sub-scores which make up the overall theme score. All sub-scores have improved from 2022 to 2023. **Work pressure** was the NNUH most improved sub-score, and **Diversity and Equality** was the NNUH least improved sub- score in the 2023 survey.

When compared with the national acute trust average:

- 1 is above the national acute average – flexible working
- 5 are aligned to the national acute average – diversity and equality, negative experiences, development, support for work-life balance and thinking about leaving.
- 15 are below the national acute average - compassionate culture, compassionate leadership, inclusion, autonomy and control, raising concerns, health and safety climate, burnout, appraisals, team working, line management, motivation, involvement, advocacy, work pressure and stressors.

NNUH 2023 theme scores compared to the benchmark of 122 acute trusts



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	6.95	5.57	6.32	5.75	5.33	6.17	6.47	6.38	5.56
Best result	7.71	6.37	7.16	6.55	6.07	6.87	7.19	7.32	6.52
Average result	7.24	5.94	6.70	6.06	5.61	6.20	6.75	6.91	5.91
Worst result	6.85	5.50	6.21	5.75	5.05	5.60	6.35	6.34	5.54
Responses	4369	4371	4346	4354	4232	4348	4366	4375	4374

Next Steps
We have built firm foundations in the commitments though our NNUH People Promise on which to develop and will continue to focus on delivering the key changes we have 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 having invested 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.

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.

Improving engagement during 'Tea with Sister'

Every Wednesday afternoon, Samantha Ritchie, Buxton ward Sister, hosts "Tea with Sister" to give her team the chance to chat, raise issues and suggest ideas in a relaxing environment.

Spotlight on the NNUH Organ Donation team

The NNUH has been placed in the top 20 in the Country for organ donation

The Organ Donation and Transplantation Activity Report published today by NHS Blood and Transplant places our hospital as one of the best in the country for organ donation. In the last year 20 patients went on to save the lives of 51 patients following their death at our hospital.

“I have the privilege of meeting some of the most incredible families who have made the selfless decision to support their loved ones to help save and improve the lives of others through the gift of organ donation. What better legacy can there be?,” said Natalie Ashley, Specialist Nurse for Organ Donation at NHS Blood and Transplant.

“In September 2023 we celebrated Organ Donation Week and held ‘The Great Organ Hunt’ in Norwich city centre, and hosted an ‘Organ Donation Bake Off’ where departments *were asked to bake some organ themed goodies.* All these events help us to get more people talking about organ donation, so that their loved ones know their wishes when they die.”

The report shows deceased organ donation in the UK increased by 2% last year thanks to the continuing recovery of organ donation and transplant activity following the Covid-19 pandemic.

Despite this, the number of people being listed for a transplant has increased, due to most being suspended during the height of the pandemic and, subsequently, others needing a transplant being added to the list. There are more than 7,000 people on the active waiting list and a further 3,822 suspended.

“Organ donation is such a wonderful gift and I’m extremely grateful to those patients, and their families, who save or improve the lives of others by donating their organs after their death,” said Prof Nancy Fontaine, Chief Nurse.

“I’d urge you to please register your organ donation decision on the NHS Organ Donor Register. If your family know what you want to happen when you die, they are much more likely to honour that decision and make organ donation is a possibility.”

Organ Donation

Find out more and register your decision by visiting NHS Organ Donor Register and share your decision with your family.

Statement from Healthwatch Norfolk

Healthwatch Norfolk Statement – NNUH Quality Account 2023/2024

Healthwatch Norfolk appreciates the opportunity to make comments on this NNUH Quality Report.

Chief Executive's Statement on Quality

Alex Stewart
Chief Executive
Healthwatch Norfolk **June 2024**

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: xx/xx/2024

<>
Norfolk and Norwich University Hospitals NHS Foundation Trust,
Colney Lane,
Norwich,
NR4 7UY

Dear <>,

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:

The challenges facing the NHS, including NNUH have continued throughout the year. It is therefore encouraging to read the comprehensive Quality Account, which highlights much of the excellent work that takes place at the Trust but also shows the in-depth scrutiny patient safety, clinical effectiveness and patient experience receive. Congratulations to the teams which contribute and to those who put this document together.

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

This year's comprehensive Quality Account provides an in-depth view of the challenges and pressures facing the NNUH. Set across three key priority areas; patient safety, clinical effectiveness and patient and staff experience, the Quality Account also celebrates the many achievements and outstanding contributions which continue to be made by all its dedicated and committed workforce. This is the NHS at its very best.

Name and role: Dr Pankaj Garg – Associate Professor in Cardiovascular Medicine and Honorary Consultant Cardiologist

Length of NHS/ NNUH service: 2 and a half years

What do you love most about your role?
I love being able to make a difference in people's lives. I see patients with a wide range of heart conditions, and I am always motivated to find the best way to help them. I also enjoy working with a team of dedicated professionals who are passionate about providing excellent care.
In addition, I love being able to use my skills and knowledge to improve the lives of my patients. I am passionate about translational research, which is the process of translating scientific discoveries into new clinical treatments and practices. I believe that innovative translational research has the potential to transform healthcare and improve clinical excellence. One example of this is the use of 4D flow MRI. 4D flow MRI is a new imaging technique that allows us to visualize and quantify blood flow in the heart more accurately. This information can be used to diagnose and treat a variety of heart conditions, including valvular heart disease and heart failure.

Name and role: Judy Butcher – Patient Safety Incident Investigator

Length of NHS/ NNUH service: I started my nurse training at The London Hospital, Whitechapel in Set 500, on 26/06/1986, qualifying in 1989. After different jobs at the (by then) 'Royal' London Hospital, in Acute Medicine and Renal, and also in the King's College Hospital Renal Team, in February 1999 I came back to Norfolk where I had grown up. I came to manage the Renal Dialysis Unit at QEHKL (a satellite unit of Addenbrooke's). I joined NNUH on 03/08/2003, initially as the Renal Senior Nurse, becoming Renal Matron and then in 2015 moving over to the Patient Safety Team. Therefore, my length of service at NNUH is over 20 years now.

What do you love most about your role?
Being able to make a difference to someone. As a nurse, it's always been the most important thing for me - to try and make patients and their families feel that they matter and that they are at the centre of everything I do. I meet people at some of the most vulnerable times in their lives, often when they have been through unimaginable trauma and loss. The safety investigations that I do can be complex, and it is so important to facilitate the patient/family being central to our investigation. For staff involved in these processes it can be a very scary time and I also provide support to staff throughout the investigation, if required. The NHS has changed enormously since 1986 and I have been so proud to be a nurse and be a tiny part of so many people's lives during that time. I would not change a thing, and NNUH has been a great place to nurse where I have made some lifelong friends and met so many different people.

Name and role: Kieron Steele – Recognise & Respond Team: Clinical Nurse Specialist

Length of NHS/ NNUH service: 7 years and 7 months

What do you love most about your role?
What I love most about my role is being given the opportunity to have a positive impact on people's lives and the hospital as a whole by responding to and treating acutely deteriorating patients and also providing education and training to support the development of other staff members.

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
Chair

Date: xx/xx/2024

Lesley Dwyer
Chief Executive

Date: xx/xx/2024

Patient Choice Award – Individual

Each year some our wonderful staff are nominated for awards, to reflect how hardworking and caring they are. One of these awards includes the 'Patient Choice Award' for an individual member of staff. Below showcases our incredible winner and two extremely worthy runners up of this category:

Winner: Anna Haestier, Obstetrics and Gynaecology Consultant

"During my pregnancy with my little girl in 2017, I remember so vividly the care and attention that Miss Haestier offered to me and my husband, and what an incredible doctor she was. During my following pregnancy Miss Haestier had to give us the devastating news that our baby had died. She supported us through the process of losing a child and was incredibly compassionate and gentle. In my current pregnancy she has consistently shown kindness, compassion and empathy and has been a huge part of our journey as parents. She is fully invested in the care of her women and their families and is an exceptional doctor, and a wonderful person."

Silver: Marie-Ronnie Arellano, Staff Nurse

"Ronnie is my oncology nurse - she is so, so kind. I have stage 4 terminal cancer. She always takes the time to chat to me and ensure that I am comfortable throughout treatment, getting me blankets and chatting. Her meticulous attention to detail never wanes which inspires a lot of confidence from colleagues and patients alike. Ronnie listens patiently to me when I am worrying aloud about how my little girl is going to cope with my death and gives me words of comfort and wisdom. When Ronnie has had to stay late to help me, she has always done this uncomplainingly and with the utmost kindness. She is an exceptional human being as well as being a wonderful nurse who truly and deeply cares about all of her patients."

Silver: Elodie Tardits, Healthcare Assistant

"Elodie is unique and wonderful and treats her patients with compassion and is always focused on listening to her patients. Elodie was very reassuring when I needed a life-saving embolisation twice, and helped to make me laugh and forget a little about what was happening. She always makes me feel safe and protected and that everything's going to be alright. She truly is a gem - one of a kind - and I appreciate everything she's done to try and help me during my admissions. Elodie goes above and beyond and that's what truly matters."

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.
Dementia	The loss of cognitive ability (memory, language, problem-solving) in a previously unimpaired person, beyond that expected of normal aging
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.
GPs	General Practitioners i.e., family doctors
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.
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
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
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.
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
No criteria to Reside	Term for patients who are medically fit to leave a hospital but are waiting for social care or primary care services to facilitate transfer
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)
PLACE – Patient Led Assessment of Clinical Environment	A national programme that replaced PEAT from April 2013.
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
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
Thrombus	A clot which forms in a vein or an artery
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

Patient Choice Award – Team Winners

This award is similar to the 'Patient Choice Award – Individual Winner', however this award is for teams within the hospital, as nominated by our patients. Below shows our incredible winner, and two runner ups:

Winner: Acute Oncology Service (AOS)

"The AOS team offers incredible treatment and support to cancer patients. A cancer diagnosis comes as a complete shock and leaves you needing the very best support. I have been truly lucky to have received exceptional care from my Oncology Consultant and team at the N&N's Colney Centre. I was provided with an AOS card, which is a lifeline to all cancer patients and their families. When I had a severe reaction and called the AOS - words cannot express how exceptional the entire service and team were. They go out of their way to take the very best care of you and your family. I was able to access treatment daily instead of being an inpatient, which was unbelievably important for wellbeing and recovery. It is an exceptional service given by an exceptional team."

Silver: Hethel Ward

"Our mother was admitted to hospital with significant breathing difficulties and received the most outstanding care on Hethel Ward from staff of all levels. The doctors were open and honest with Mum about her condition and treatment options and showed such careful consideration yet clarity over her treatment and her end-of-life options. Mum hugely valued their time and never felt rushed and appreciated the doctors' honesty and commitment to her and her care - they were respectful and so kind. She really valued their time and their humour. We cannot thank the staff enough and want them to know the significant difference they made to our family at such a tragic time."

Silver: Juniper Homebirth Team

"From the moment I was referred to this team I was made to feel confident and when the time came to give birth, they supported me so well I will never forget it. The aftercare continued to amaze me, with experienced and supportive midwives arriving at my home almost every day to help get through the early issues of having a new-born. The care I received was simply first class: personalised and professional and making us feel like we were the only family they had to care for. I could never thank them enough for the experience they gave us and the wonderful memories they left us with. They are all a credit to the profession and our hospital."

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
AIO	Asset Information Owner
AIS	Accessible Information Standard
APC	Admitted Patient Care
BAME	Black, Asian and minority ethnic
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
CAI	Community Attributable Infection
C.difficile (C. diff)	Clostridium difficile
CAPE	Carer and Patient Experience Committee
CCC	Critical Care Complex
CCG	Clinical Commissioning Groups
CDOP	Child Deaths Overview Panel
CEA	Carotid Endarterectomy
CEO	Chief of Operations
CG NICE	Clinical Guideline from NICE
CHD	Congenital Heart Disease
CNST	Clinical Negligence Schemes for Trusts
CMP	Case Mix Programme
CNS	Clinical Nurse Specialist
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
DNA’s	Do not attend’s
DQ	Data Quality
DQMI	Data Quality Maturity Index
EADU	Emergency Admission and Discharge Unit
EAUS	Early Assessment Unit – Surgical

ECG	Electrocardiogram
ED	Emergency Department (See A&E)
EDD	Estimated Discharge Date
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
EBUS	Endobronchial Ultrasound
ENT	Ear, nose and throat
EPR	Electronic Patient Record
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
GP	General Practitioner
HALO	Hospital Ambulance Liaison Officer
HANA	Head and Neck Cancer Audit
HAPU	Hospital Acquired Pressure Ulcers
HCA	Healthcare Assistant
HDU	High Dependency Unit
HEE	Health Education England
HES	Hospital Episode Statistics
HFACS	Human Factors Analysis and Classification System
HICC	Hospital Infection Control Committee
HMB	Hospital Management Board
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
IR	Interventional Radiology
IS	Information Services
IT	Information Technology
JPUH	James Paget University Hospitals NHS Foundation Trust
KPIs	Key Performance Indicators
KLOE	Key Lines of Enquiry
LD	Learning Disability
LeDeR	Learning Disability Death Review

LEDG	Local Divisional Equality and Diversity Group
LFPSE	Learning from Patient Safety Events
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
MCA	Mental Capacity Act
MDT	Multi-Disciplinary Team
MEOWS	Modified Early Obstetric Warning Score
MFFRA	Multifactorial Falls and Fractures Risk Assessment
M&M	Morbidity and Mortality
MR	Magnetic Resonance
MRI	Magnetic Resonance Imaging
MRSA	Methicillin-Resistant Staphylococcus aureus
MSK	Musculoskeletal
MUST	Malnutrition Universal Screening Tool
MVP	Maternity Voices Partnership
N/A	Not applicable
NAD	National Audit of Dementia
NAOGC	National Oesophago-Gastric 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
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
NICU	Neonatal Intensive Care Unit
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
NRAP	National Respiratory Audit Programme
NRLS	National Reporting and Learning Service
N&W	Norfolk & Waveney
OPM	Older People Medicine
OWLS	Organisational Wide Learning
PAF	Patient Assurance Framework
PALS	Patient Advice and Liaison Service
PAS	Patient Administration system
PAT	Pets as Therapy
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
PSII	Patient Safety Incident Investigation
PSP	Patient Safety Partner
PSS	Patient Safety Specialist
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plan
PTL	Patient Treatment List
PUCAI	Paediatric Ulcerative Colitis Activity Index
QA	Quality Account
QEHKL	Queen Elizabeth Hospital Kings Lynn
QI	Quality Improvement
QIR	Quality Incident Report
QoL	Quality of Life
QPB	Quality Program Board
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
SDM	Shared Decision Making
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
SSF	Surgical Site Infection
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
u-REE-thrul	Urethral
VA	Veteran Aware
VC	Virtual Clinic
VTE	Venous Thromboembolism
VW	Virtual Ward
WTE	Whole Time Equivalent

Our Haematology Department has won a top cancer award for the second time

Our haematology department has scooped a national award for its commitment to patients living with incurable blood cancer. Members of the team were presented with the Myeloma UK Clinical Service Excellence Programme (CSEP) Award in recognition of its outstanding care and dedication to patients with myeloma.

This is the second time the team have received the award, which is only handed to a select few hospitals every four years. Staff were praised for their efforts to improve patients' quality of life and eagerness to adapt and listen to their needs.

The accolade, awarded by blood cancer charity Myeloma UK, recognises hospitals' commitment to raising the bar for treatment and providing compassionate care.

"On behalf of the myeloma team, we are immensely proud and delighted to receive this award. It not only validates our dedication but also invigorates our commitment to providing the best possible care. This honour inspires us to keep improving our patient services, striving in all we do," said Dr Cesar Gomez, Consultant Haematologist.

Myeloma is especially hard to spot as the symptoms are often vague and dismissed as ageing or other minor conditions.

By the time many patients are diagnosed, their cancer has often advanced and they require urgent treatment. This can significantly impact their chances of survival and quality of life.

"Myeloma is a challenging cancer that can change on a dime, so we were hugely impressed with the team's efforts to adapt to patients' needs and make sure they are given every chance to keep their disease in check – no matter where they live," said Jess Turner, Clinical Practice Services Programme Manager at Myeloma UK. *"The focus on allowing patients to get on with their lives as much as possible, treating them closer to home and sparing them from exhausting back-and-forth trips to hospital really stood out. The hospital's Mobile Cancer Unit alone, supported by the N&N Hospitals Charity, has made a dramatic difference to patients over the last three years, some of whom would otherwise face 50-mile round trips for treatment."*

How to contact us

Write to us:

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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**

Microsoft | Power BI

Quality & Safety

View in Power BI

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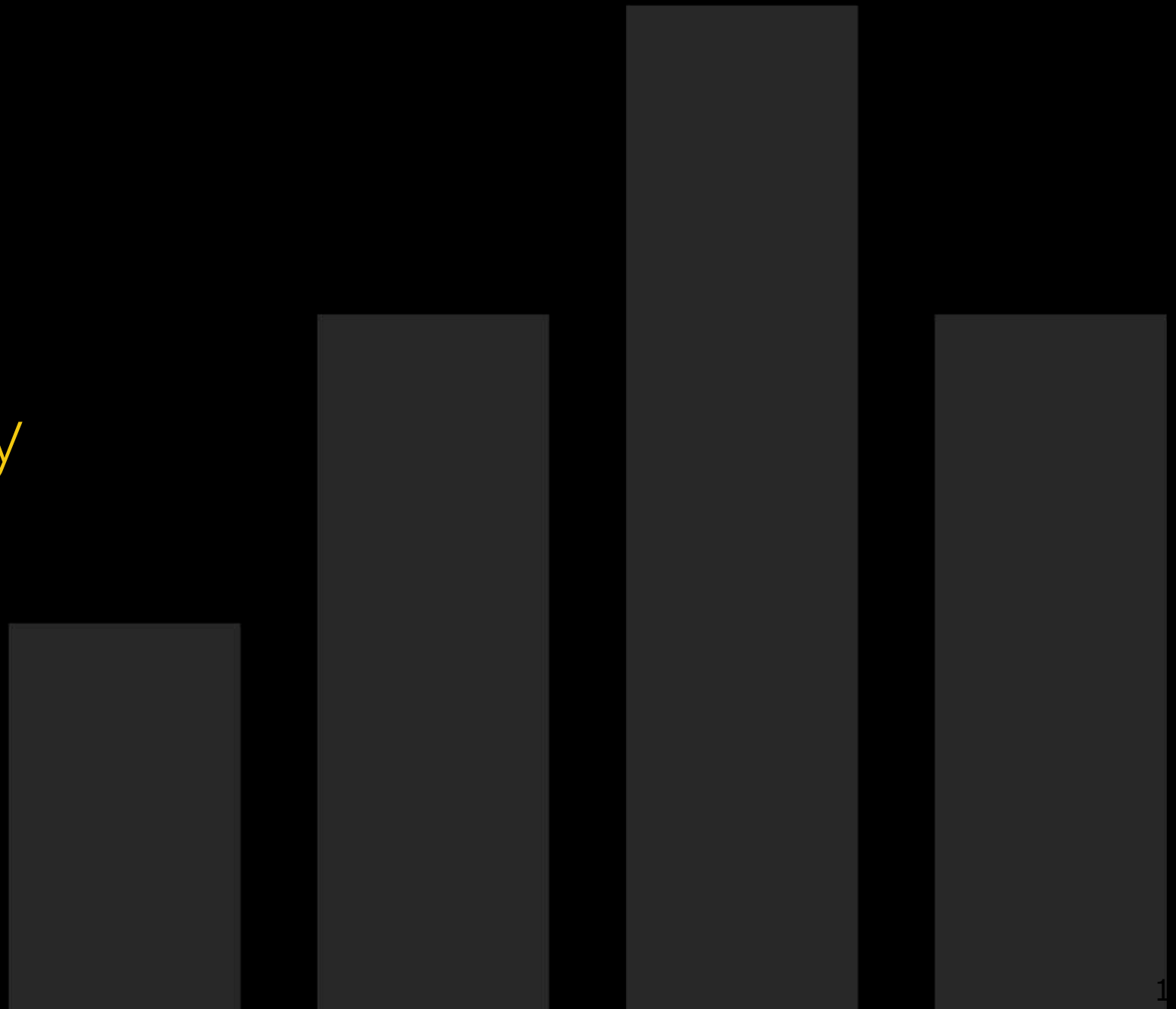


Patient Safety

NNUH Digital Health
business intelligence

	Incident Type	Last Month	YTD
National Priorities	Maternity & Neonatal incidents which meet the 'Each Baby Counts' criteria referred to MNSI	0	0
	Maternal deaths referred to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE)	0	0
	Neonatal Deaths Referred To PMRT	2	2
	Child Death referred to local Child Death Overview Panel (CDOP)	0	0
	Death involving patient with Learning Disability referred to local LeDeR reviewer	0	0
	Safeguarding Adults Referrals	56	56
	Information Governance incidents referred to Information Commissioner's Office (ICO)	0	0
	Incidents related to National Screening Programmes referred to local Screening Quality Assurance Team	0	0
	Deaths of patients in custody, in prison or on probation referred to Prison and Probation Ombudsman	0	0
	Incidents meeting Never Event Criteria to undergo PSII	0	0
	Incidents resulting in death, assessed as more likely than not due to problems in care following Structured Judgement Review to undergo PSII	0	0
Trust PSII Priorities	Missed / Delay in Diagnosis to undergo PSII	0	0
	Sub-optimal care to undergo PSII	0	0
Local Level PSR	Incidents to undergo another Patient Safety Review (PSR) to provide a proportionate learning response	71	71

	Supplementary Metrics	Last Month	YTD
Other	Duty of Candour Compliance	89%	89%
	Incidents	2,135	2,135

Assurance Commentary

There were no patient safety incidents escalated for a Patient Safety Incident Investigation. There are 5 completed PSII waiting for allocation of leads to develop safety actions following identification of areas for improvement. 69 incidents have been referred for a Patient Safety Review and proportionate learning response. 1930 incidents were triaged for facts to be confirmed on Datix. Duty of Candour compliance was 89% for April.

Improvement Actions

For Divisional Governance teams to continue reviewing all incidents to allocate them to the proportionate learning response.
For the Patient Safety Team and Business Intelligence Team to review and refresh the data and reporting requirements in the Integrated Performance Report and the Performance Assurance Framework to reflect the Patient Safety Incident Response Plan (PSIRP).
Oversight of safety action plans will be included in the Trust governance review.

Pressure Ulcers

NNUH Digital Health
business intelligence

Hospital Acquired Pressure Ulcers per 1,000 bed days

Apr 2024

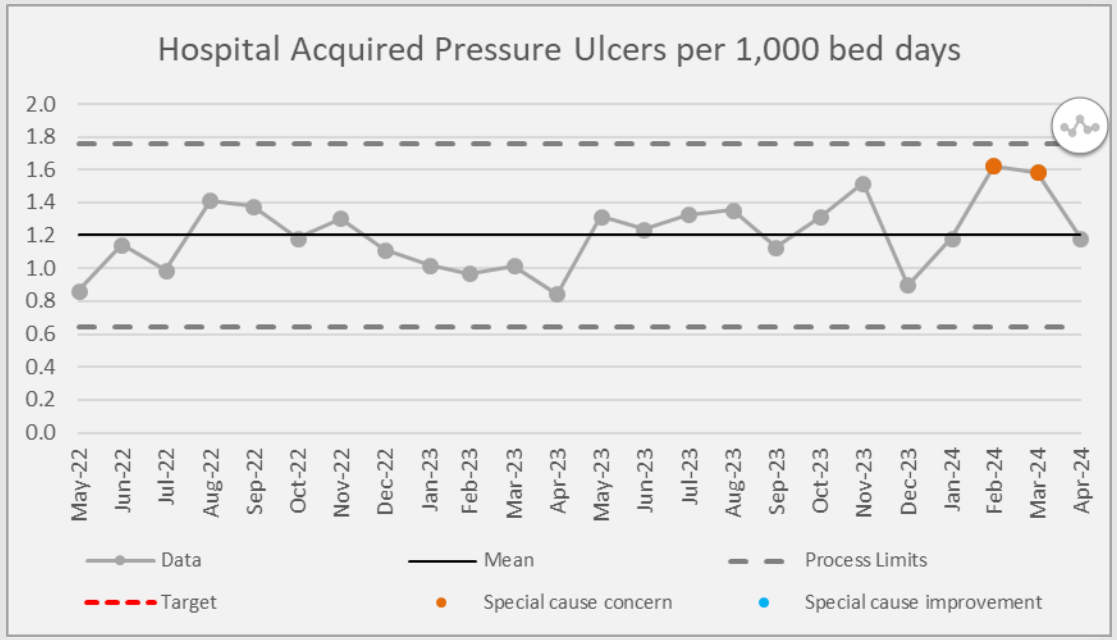
Variation | Assurance

0.6 Result
N/A Target

1.7 UPL
1.1 Mean
0.6 LPL

Analytical Commentary

Variation is Common Cause



Assurance Commentary

April saw a continued downward trend in incidence with 17 Category 2 and 13 Category 3 hospital acquired pressure ulcers.
This appears to be a reflection of the focused QI work for Medicine begining to see an impact as this division has seen the biggest reduction. 5 of the Hospital Acquired Pressure ulcers were device related damage, 4 from oxygen delivery systems and 1 from incorrectly sized TED stockings. Overall this is a positive reduction when bed numbers remain high.

Improvement Actions

Further targetted training for Medicine Division on Purpose T risk assessment completion and care plans and documentation to imporve accuracy planned following results from staff survery in April This will be linked with the new Admission booklet.
Health Care Support Worker (HCSW) inductions and newly qualified nurses have access to pressure care awareness sessions across the rest of the year to support knowledge and confidence. June and July will see training and roll out of clinical photography of pressure ulcers for patient records and verification purposes.

Patient Falls

NNUH Digital Health
business intelligence

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

Apr 2024

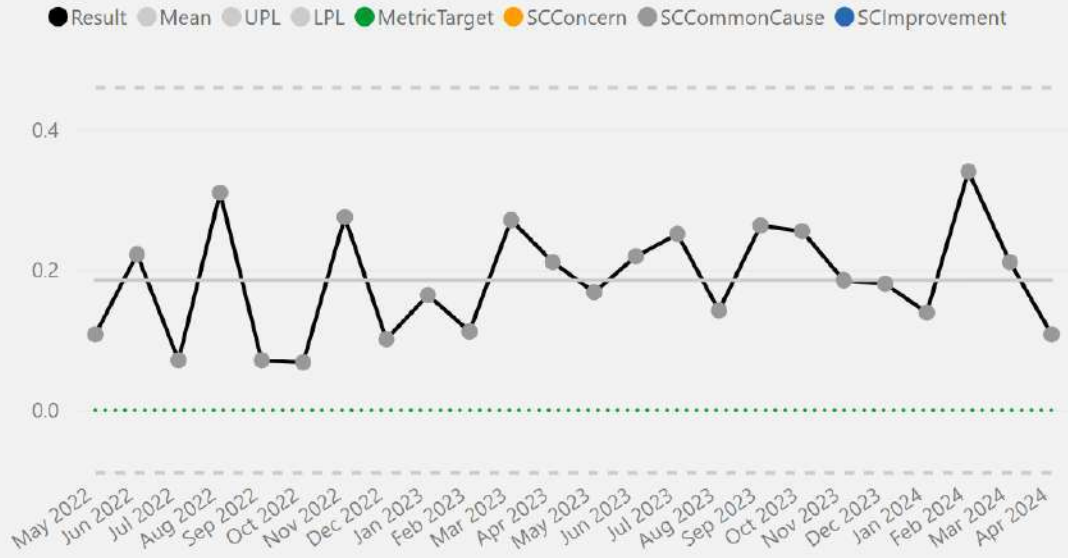
Variation | Assurance

0.1 Result	0.5 UPL
0.0 Target	0.2 Mean
	-0.1 LPL

Analytical Commentary

Variation is Common Cause

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



Assurance Commentary

Falls per 1000 bed days was 8.4 with common cause variation. Additional patients remain on multiple wards. There has however been a reduction in falls resulting in moderate harm and above to 4 with variation remaining at common cause. Falls per 1000 bed days moderate harm and above has reduced to 0.1 well within the upper process limit of 0.5. There continues to be a year on year reduction in falls per thousand bed days compared with 2023.

Improvement Actions

Assistive Technology implementation complete as planned,training ongoing and use of technology embedding. ED Falls project with ICS and North Norfolk DC starts late May.
New lying and standing blood pressure report available. Falls lead directly training new HCA's at induction. Ongoing support with compliance with investigation page on incident reporting through governance. Refreshed Falls Steering Group TOR distributed to DND's to relaunch group in May/June. Admissions booklet launch 29.4.24 to improve documentation with additional audio completion training description.

Patient Experience

NNUH Digital Health
business intelligence

Friends & Family Score

Apr 2024

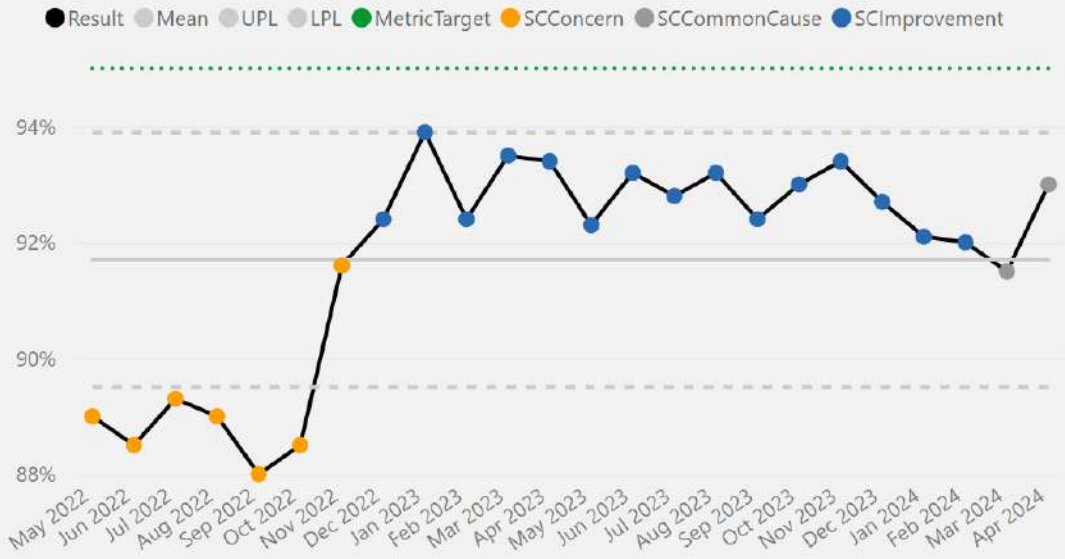
Variation	Assurance
	

93.00% Result	93.90% UPL
95.00% Target	91.70% Mean
	89.50% LPL

Analytical Commentary

Variation is Common Cause

Friends & Family Score



Assurance Commentary

3717 Friends and Family Test (FFT) responses received in April, both the score and responses remain within our usual limits.

Top feedback themes continue to be staff attitude, implementation of care, waiting times, communication, and environment for both positive and negative. 93% of feedback received is positive.

Improvement Actions

FFT (SOP) was approved at PEEG in April. Regular oversight meetings to support FFT are scheduled.
Issues with accessing our server were escalated to Digital Health Service Management Specialist who has detailed the new process for providers to request access via our service desk. Envoy have been able to contact Digital Health directly to action this. The service provider and Patient Experience Team are working together to take forward the SMS test with one inpatient.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Compliments	Apr 2024	128		Common Cause		No Target

Patient Concerns

NNUH Digital Health
business intelligence

PALS % Closed within 5 days - Trust

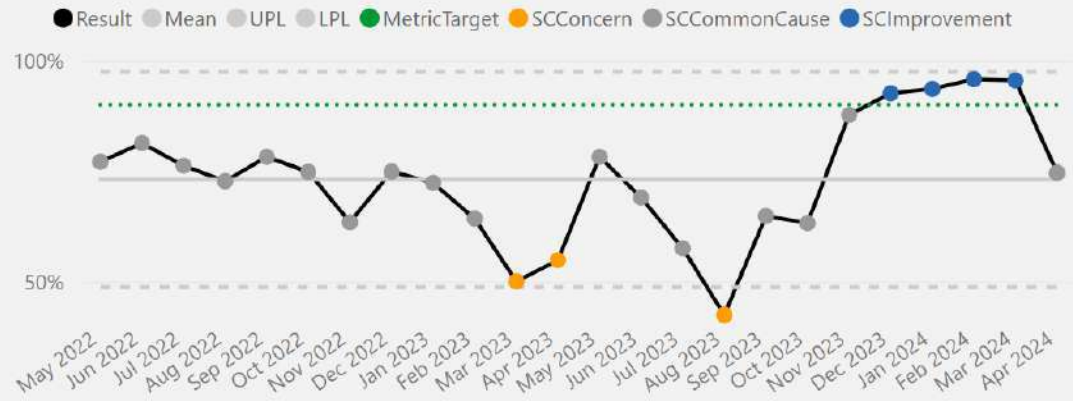
Apr 2024

Variation | Assurance

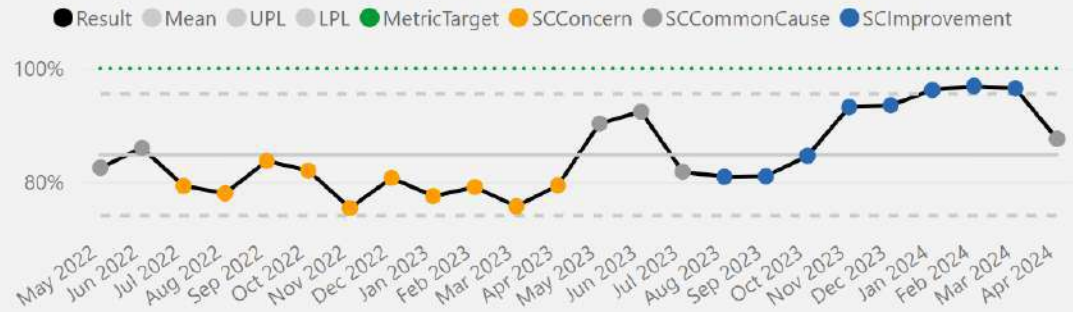
74.6% Result
90.0% Target

97.5% UPL
73.1% Mean
48.7% LPL

PALS % Closed within 5 days - Trust



PALS % Closed within 7 days - Trust



Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
PALS Contacts - Trust	Apr 2024	323		Common Cause		No Target

Analytical Commentary

Variation is Common Cause

Assurance Commentary

312 PALS matters raised this month. The KPIs have been impacted by the ending of Bank support to the team and another 1WTE staff sickness absence for 50% of the month.
PALS KPI 77.2% of contacts were closed within 5 days from first received, target being 90%
PALS KPI 90.7% of contacts were closed within 7 days from first received, target of 100%
Main subject for PALS matters remained to be appoints including delays and cancelations at 36.

Improvement Actions

Additional Bank support to be sourced to cover sickness until return to work.
We continue to work with Digital Health and facilities to install additional phone lines to enable better communication with families. Concerns and have been escalated accordingly.
Awaiting resolution from relevant teams.

Complaints

NNUH Digital Health
business intelligence

Complaints (Trust)

Apr 2024

Variation | Assurance

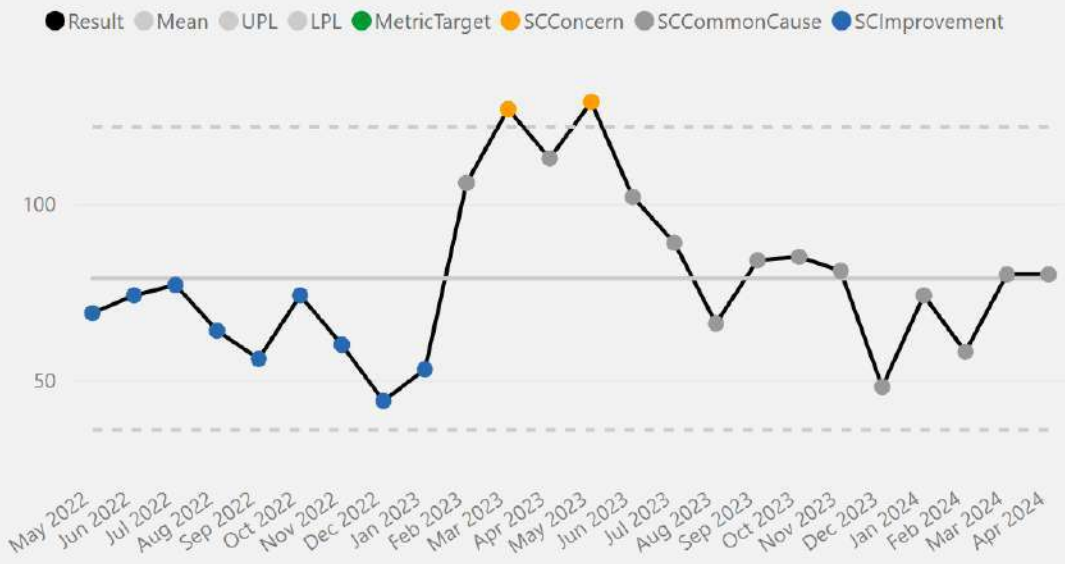
80 Result
N/A Target

122 UPL
79 Mean
36 LPL

Analytical Commentary

Variation is Common Cause

Complaints (Trust)



Assurance Commentary

76 complaints have been confirmed of the 120 received.
Clinical treatment (n20) and patient care, including nutrition and hydration (n16) were the most common subjects within the complaints.
4 complaints were reopened (also known as rebounds) in the month reported.
4 cases backlog cases remain open.

Improvement Actions

To close the 4 remaining cases from the previously reported backlog to allow the team to focus on service improvement (Closing the Gap).
Await the outcome from the business planning cycle regarding finances and resource levels required, as bank staff are being used to support phased return and 'Closing the Gap' project.

Supplementary Metrics

Metric Name	Date	Result	Variation	Assurance
Complaints - Acknowledgement	Apr 2024	99%	Common Cause	Inconsistent
Complaints - Response Times - Trust	Apr 2024	65%	Common Cause	Inconsistent
Post-investigation enquiries	Apr 2024	4	Common Cause	Capable

Palliative Care

NNUH Digital Health
business intelligence

Palliative Care Seen Within 48 Hours

Apr 2024

Variation | Assurance

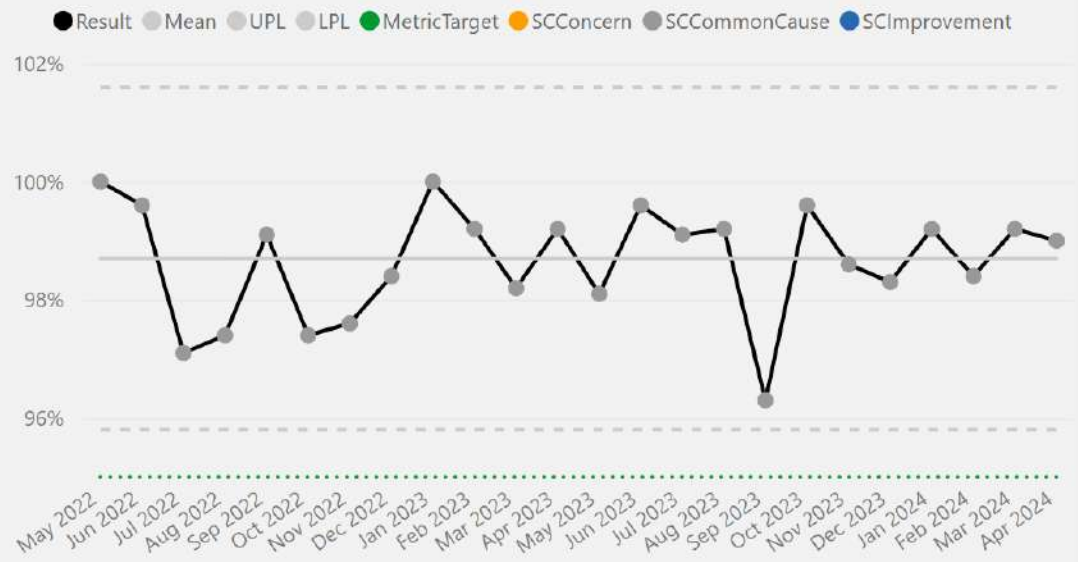
99.0% Result
95.0% Target

101.6% UPL
98.7% Mean
95.8% LPL

Analytical Commentary

Variation is Common Cause

Palliative Care Seen Within 48 Hours



Assurance Commentary

To ensure every patient recieves the best possible end of life care, we are aiming to ensure as many patients as possible have an individualised plan of care to reflect their wishes at this time and that families are supported. The admin team are working hard to review data collection processes to ensure only relevant data is collected and processes are streamlined. Two attempts to recruit a new Band 3 medical secretary have been unsuccessful, recruitment continues.

Improvement Actions

Continue end of life education for all. Most band 7s have completed the 2 part leadership in EOl care (1 module ward based care and module 2 communications skills training) and now band 6 nurses are being offered the opportunity to undertake the training as a rolling programme. We are developing comfort boxes for patients rooms alongside comfort packs. Data collection for the National Audit of Care at the End of Life (NACEL) is 50% completed, staff have a survey to complete by June.

Supplementary Metrics

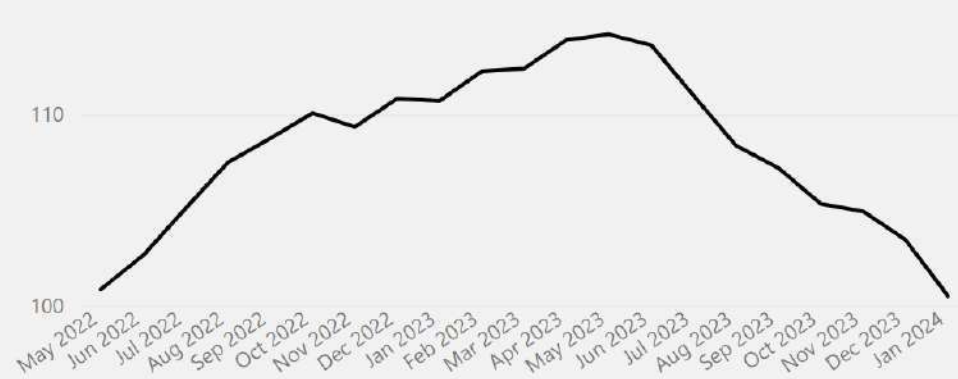
Metric Name	Date	Result	Variation	Assurance
Palliative Care Died in Trust and Seen by SPCT	Apr 2024	52.7%	Common Cause	No Target
Palliative Care IP Referrals Accepted	Apr 2024	201.0	Common Cause	No Target

Mortality Rate

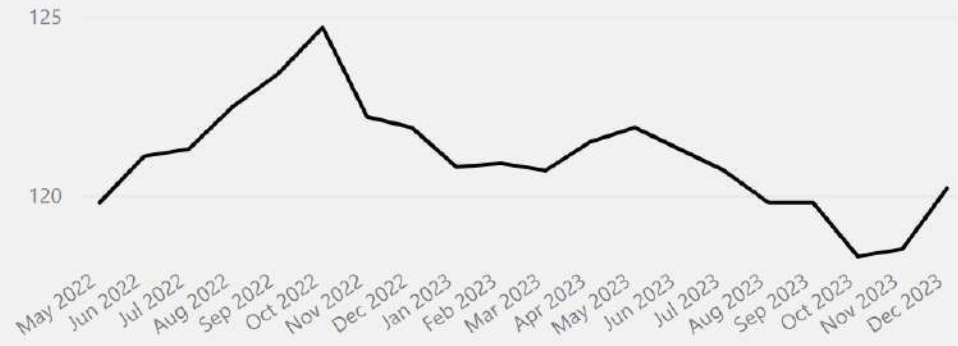
NNUH Digital Health
business intelligence

MetricName	Date	Result
HSMR	Jan 2024	100.49
SHMI	Dec 2023	120

HSMR



SHMI



Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Crude Mortality Rate	Mar 2024	5.00%		Common Cause		No Target

Assurance Commentary

Various aspects of the SHMI methodology have been updated and introduced from this month. Key changes include inclusion of all Covid 19 activity with a discharge date on or after September 2021 (previously excluded from SHMI), an update to the methodology for spells consisting of multiple episodes to use the first primary diagnosis that isn't a symptom or sign (previously restricted to the first or second episode) and a new diagnosis group for spells with an invalid primary diagnosis. These changes do not appear to have had a significant impact on the NNUH SHMI. SHMI is 120 and remains statistically 'higher than expected'. Of the 10 (high volume) diagnosis groups which have a SHMI value and banding calculated, two diagnosis groups - Septicaemia and Fracture neck of femur are banded as higher than expected.

HSMR is 103.4 and remains statistically 'within expected'.
There is one new CUSUM alert in this latest reporting cycle: Cancer of other GI organs, peritoneum. This is undergoing investigation. The three HSMR diagnosis groups with relative risks identified as 'higher than expected', have been or are currently being reviewed. There are Septicaemia, Deficiency and other anaemia and Senility and organic mental disorders.

Improvement Actions

To develop an overarching action plan to address the recommendations for the completed clinical coding review and to incorporate any recommendations made by the RCP once available.
To continue with the various workstreams reviewing morality alerts and improving documentation.

Safer Staffing

NNUH Digital Health
business intelligence

Safe Staffing Fill Rates

Apr 2024

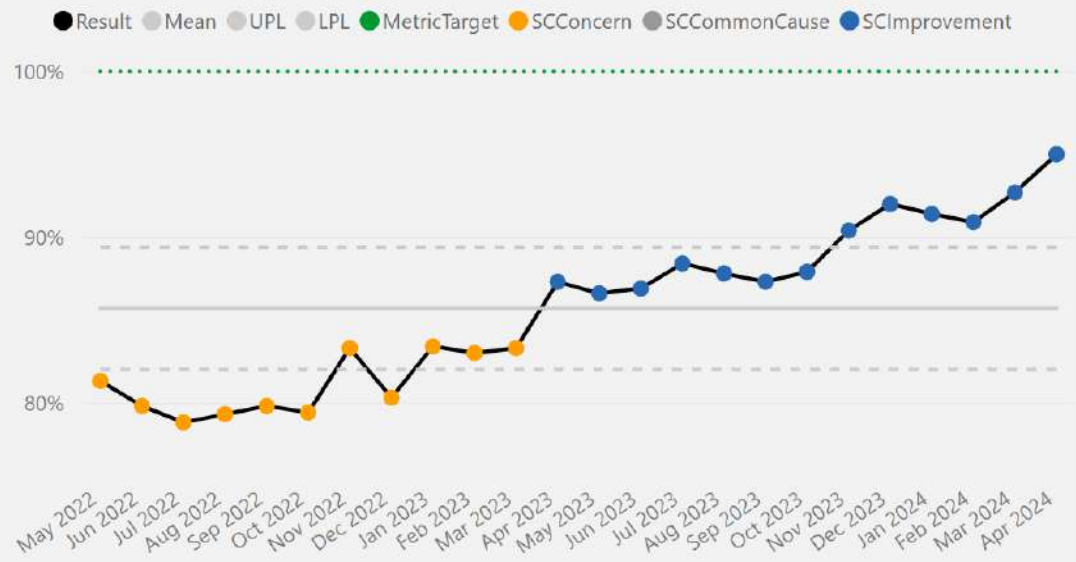
Variation	Assurance
H	F

95.00% Result	89.40% UPL
100.00% Target	85.70% Mean
	82.00% 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)

Safe Staffing Fill Rates



Assurance Commentary

Assurance comments
The Trust-wide vacancy rate for registered staff has decreased from 8.0% (n=218.1) in March to 7.6% (206.6) in April and has been steadily declining over the last 3 months, for unregistered staff the rate has decreased from 16.9% (n=249.9) in March to 14.3% (n=205.0) in April.
Trust wide fill rates were 97%. CHPPD was 7.5 in April which is above the average of 7.2 over the past 12 months.
Red flags decreased by 21 in April to 1,632 with 77% remaining open. 320 were resolved, 55 reviewed and 60 raised in error. Gateley (82/95), Heydon (76/78) and Intwood (72/125) are the top three areas with the highest open red flags. The hours deployed to escalation has increased to 1375.50 (from 1050.00 in April), however the overall hours for redeployment have greatly reduced. Discharge Suite, Escalation and Denton were the top 3 areas staff were redeployed from.
Occupancy of surge beds has reduced from 80 to a daily average of 45 in May 2024.

Improvement Actions

Ongoing improvement work to improve safer staffing metrics and roster compliance across Midwifery Services and AHPs.
The Safe Staffing and Escalation Policy is currently under review.
Work continues to reduce Agency Spend in line with 24/25 guidance. Divisions have been set improvement trajectories to reduce Agency spend to less than 3.2% which will be monitored at Divisional Performance Committee.

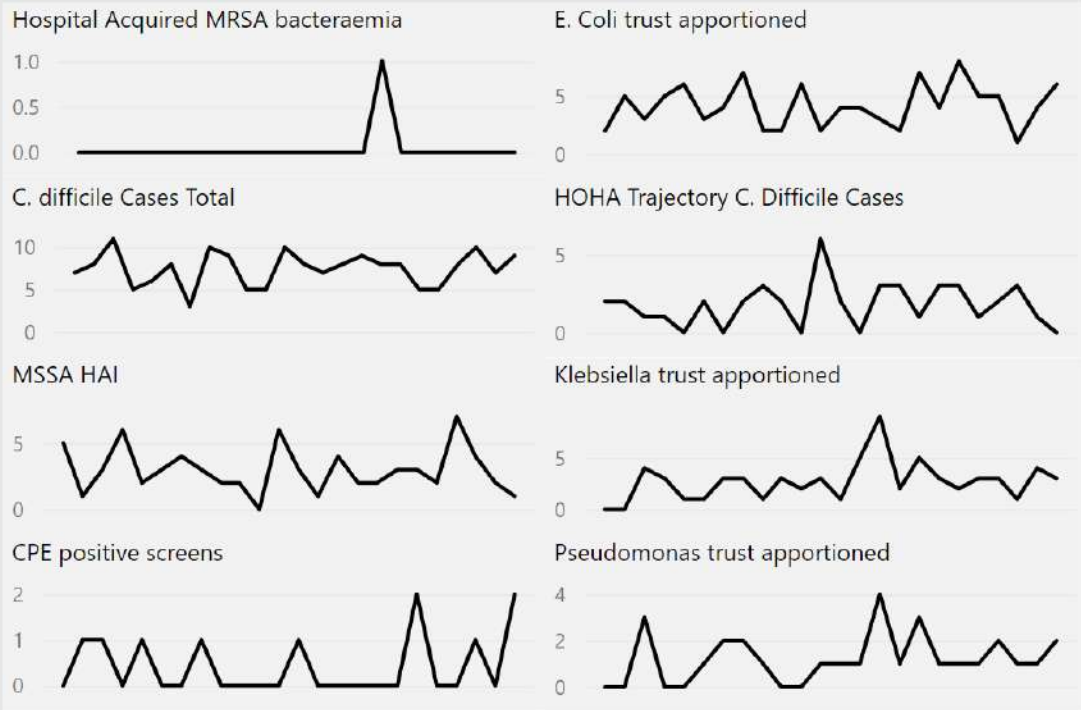
Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance

Infection Prevention & Control

NNUH Digital Health
business intelligence

MetricName	Date	Result	Target	Mean
C. difficile Cases Total	Apr 2024	9	77	7
CPE positive screens	Apr 2024	2	N/A	0
E. Coli trust apportioned	Apr 2024	6	91	4
HOHA Trajectory C. Difficile Cases	Apr 2024	0	0	2
Hospital Acquired MRSA bacteraemia	Apr 2024	0	0	0
Klebsiella trust apportioned	Apr 2024	3	24	3
MSSA HAI	Apr 2024	1	N/A	3
Pseudomonas trust apportioned	Apr 2024	2	19	1



Assurance Commentary

C. difficile = Total 9: 7 x HOHA, 2X COHA . 7 x HOHA cases pending PIR. 1 x COHA non trajectory, 1 COHA case pending PIR. Gram negative surveillance.
E. coli = Total 7: 6 x HOHA cases -source: 3 x unknown, 2 x lower urinary tract, 1 x upper urinary tract. 1 x COHA case- source: 1 x lower urinary tract.
Klebsiella = Total 3: 3 x HOHA cases- source: 1x unknown, 1 x hepatobiliary, 1 x lower urinary tract.
Pseudomonas aeruginosa = Total 2: 2 x HOHA cases – source: 1 x unknown, 1 x lower urinary tract.
COVID-19 (SARS CoV-2) – 1 outbreak reported in April (Brundall)
MSSA HAI Total cases x 1 – source: 1 x unknown source. CPE – 1 new case, source urine, overseas visitor.
Measles – Nil cases. No ward closures for Norovirus or Influenza, no beddays lost. MRSA Blood stream infections – Nil
Supportive measures (Period of Increased Incidence):
E. coli ESBL – NICU – commenced 23.02.2024 – completed 19.04.2024. C.diff – Docking ward – commenced 16.04.2024 – 2 hospital acquired C. diff toxin cases within 28 days - ongoing.
C.diff - Kimberley ward – commenced 17.04.2024 – 3 hospital acquired C. diff toxin cases within 28 days - ongoing.

Improvement Actions

C. difficile Post Infection Review (PIR) meetings held monthly with clinical staff and Norfolk & Waveney ICB to establish lapses in care. Lapses are disseminated in the monthly OWL and is now integrated within Datix. Providing access to divisional governance teams, ensuring actions and learning is discussed and disseminated appropriately.
Incident Management Team meetings conducted for Docking and Kimberley – due to increased incidence of C.diff.
A review of the current PIR process is currently ongoing with colleagues across Norfolk and Waveney to align with introduction of the Patient Safety Incident Response Plan (PSIRF).
Surveillance undertaken on each Healthcare Associated Gram-negative Blood Stream Infection to ascertain the potential sources.
COVID-19 national outbreak reporting/monitoring no longer required from the beginning of April 2024.

Maternity: Mothers

NNUH Digital Health
business intelligence

Mothers Delivered

Apr 2024

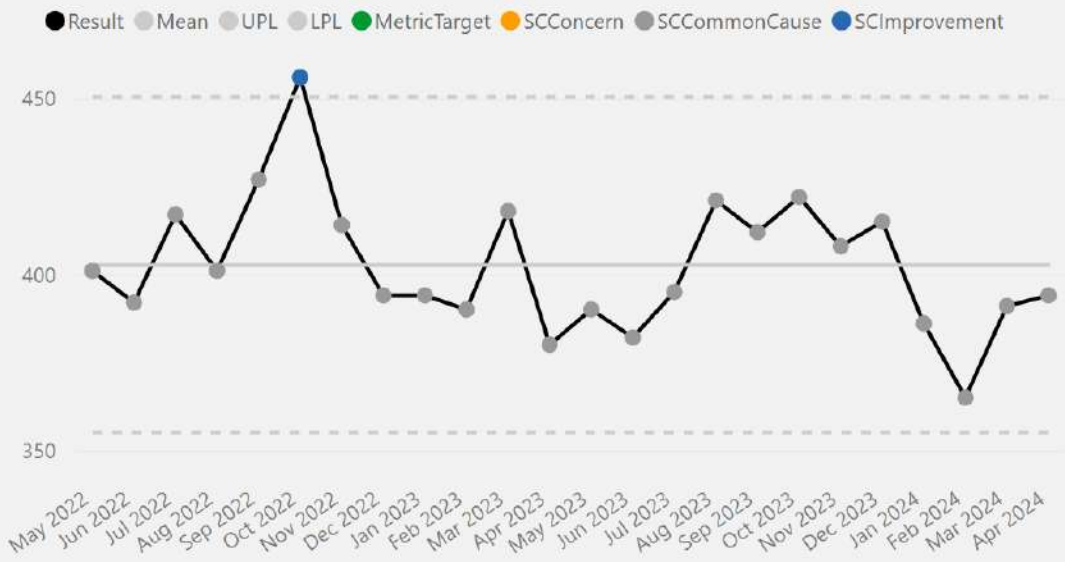
Variation | Assurance

394 Result
N/A Target
450 UPL
403 Mean
355 LPL

Analytical Commentary

Variation is Common Cause

Mothers Delivered



Assurance Commentary

In April 394 women were delivered, 335 on delivery suite, 44 on MLBU and 15 at home. There were 5 born before arrivals (BBA's), these have all had a datix/triage review and are investigated by the community matron and community team leaders. We performed 77 emergency cesarian section and 76 elective sections, 153 in total. There was a 34% IOL rate which remains static from March. The Postpartum haemorrhage rate was 3.8% compared to 3.1% in March. The 3/4th degree tear rate was 2.5% compared to 3.6% in March.
91.2% of women were booked before 13 weeks. There were 9 readmissions within 30 days, 1 transfer out of the unit and 1 admisssion to critical are as a planned event.

Improvement Actions

An education package is being developed for episiotomy and hands on delivery, with the aim to reduce the number of 3rd/4th degree tears.
To progress with consideration of implementing an Obstetric Anal Sphincter Injury (OASI) care package.
To review the various reports within PowerBI to address the data inaccuracies and improve reporting.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
1:1 Care in Labour	Apr 2024	99.3%		Common Cause		No Target
3rd & 4th Degree Tears	Apr 2024	2.5%		Common Cause		Inconsistent
Births Before Arrival	Apr 2024	5		Common Cause		No Target
Post Partum Haemorrhage ≥1500mls	Apr 2024	3.8%		Common Cause		No Target

Mothers Delivered
394
Babies Delivered
401

Maternity: Babies

NNUH Digital Health
business intelligence

Unplanned NICU ≥37 week Admissions (E3)

Apr 2024

Variation	Assurance
	

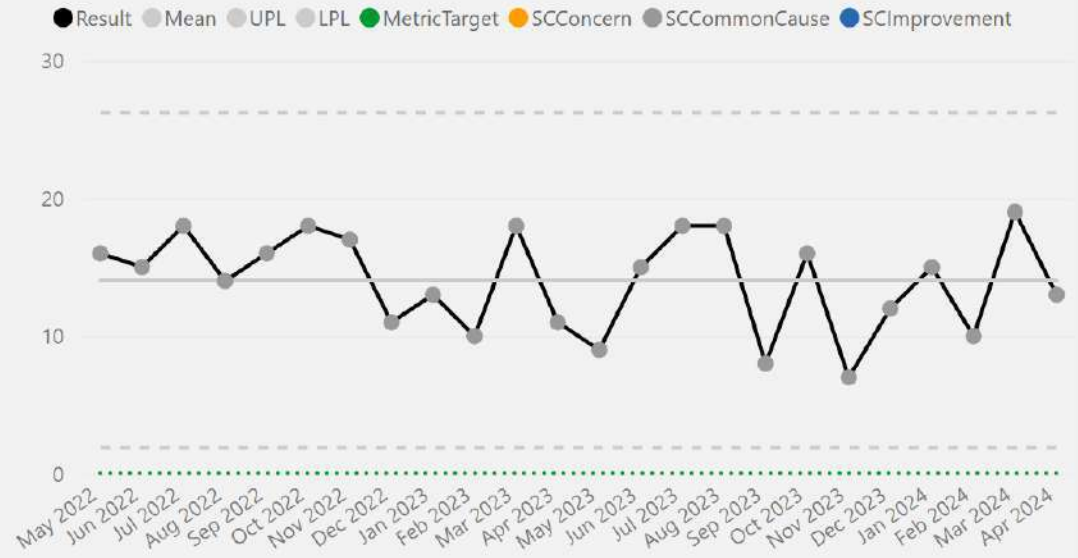
13 Result
0 Target

26 UPL
14 Mean
2 LPL

Analytical Commentary

Variation is Common Cause

Unplanned NICU ≥37 week Admissions (E3)



Assurance Commentary

In April the NNUH had 401 babies delivered. Of these there was 1 early neonatal death and 1 stillbirth. Both cases are being reviewed. There were 13 unplanned admissions to NICU compared to 19 in March. There were no HIE 111/cooled babies. 6.7% deliveries were preterm.

Improvement Actions

To review the 19 unplanned admissions to NICU at the monthly Avoiding Term Admissions into NICU (ATAIN) meeting. To identify and explore any themes, trends or learning for each admission and the increased number from the previous month.

To complete the review for the neonatal death and stillbirth.

Supplementary Metrics

Metric Name	Date	Result		Variation		Assurance
Adjusted Still Births	Apr 2024	1		Not Applicable		No Target
Apgar score <7 @5, ≥37 weeks	Apr 2024	10		Common Cause		No Target
Early Neonatal Death	Apr 2024	1		Not Applicable		No Target
Mothers Transferred Out of Unit	Apr 2024	1		Common Cause		No Target

Saving Babies Lives

NNUH Digital Health
business intelligence

Topic	Metric Name	Date	Result		Variation		Assurance
Smoking Awareness	Smoking Status at Delivery	Apr 2024	6.1%		Common Cause		Inconsistent
Fetal Growth Restriction	Less Than 3rd centile born > 37+6 weeks	Apr 2024	1%		Common Cause		Not capable
Fetal Growth Restriction	SGA detected Antenatally	Apr 2024	84%		Common Cause		No Target
Reducing Preterm Birth	Singleton Births Preterm	Apr 2024	7%		Common Cause		Inconsistent
Reducing Preterm Birth	Singleton live births < 34 wks (AN corticosteroids within 7 days PN)	Apr 2024	25%		Common Cause		Inconsistent

Assurance Commentary

Our SBLCB3 programme is continuing at pace. There were 6.3% women smoking at booking and 6.1% smoking at delivery. We continue our supportive work with women and families to achieve smoking cessation. There were 6.7% preterm deliveries. 95.8% compliance for our fetal monitoring training and 89.3% compliance for our SBLCB3 training. We have achieved 99.6% compliance for IAA training - all this training activity is essential to be fully compliant with the SBLCB3.

Improvement Actions

For the diabetes midwifery and consultant team to complete the compliance review of Element 6 (management of pre-existing diabetes) of Version 3 of the Saving Babies Lives Care Bundle (SBLCB).
To complete the series of audits related to pregnancies at risk of fetal growth restriction.
To continue partnership working with the Local Maternity and Neonatal System (LMNS) workstream for smoking cessation (Element 1) to support the new advisors within each Trust.

Adult Safeguarding

NNUH Digital Health
business intelligence

Safeguarding Adults Referrals

Apr 2024

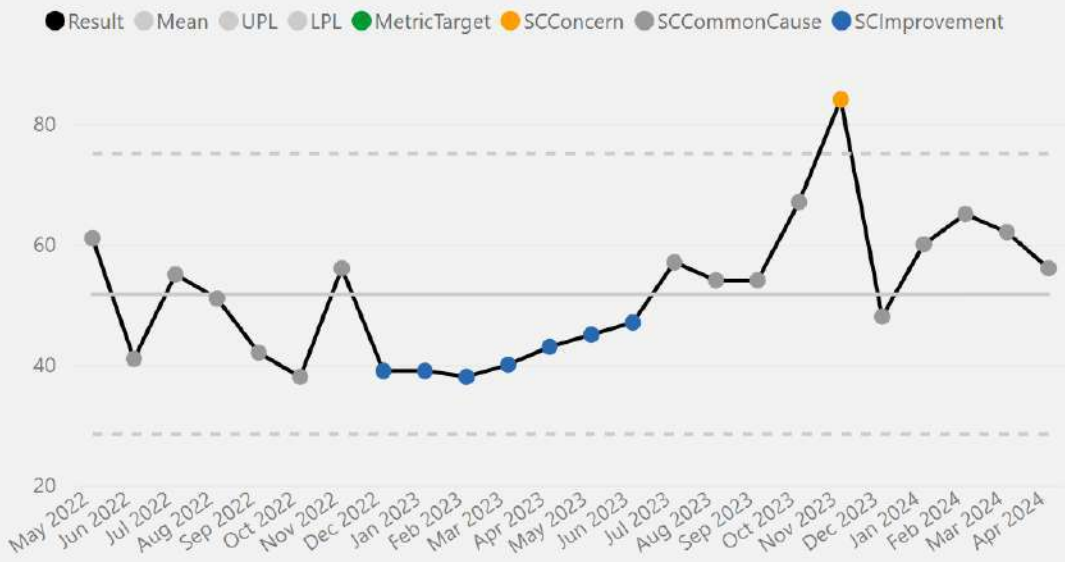
Variation | Assurance

56 Result	75 UPL
N/A Target	52 Mean
	29 LPL

Analytical Commentary

Variation is Common Cause

Safeguarding Adults Referrals



Assurance Commentary

The safeguarding team has been joined by a Health Independent Domestic Violence Advocate (IDVA), employed by NIDAS but based at NNUH. They have been employed to support with domestic abuse matters within the trust. Their portfolio will cover both patients and staff and their role will encompass advice, support, follow up in the community, signposting and completing assessments to determine the level of risk. This is a great benefit to the Trust with regards to supporting our domestic abuse agenda but also a contribution to the Trust`s objective to reducing domestic abuse and sexual violence within the workplace.

Improvement Actions

Proposed Local Authority and Health Framework pilot: An evaluater was identified a couple of months ago. A meeting took place with the 3 acutes and NSAB to identify what data is required prior to launching the pilot. Some challenges have been identified in that we all collate different data, however, the evaluater is now looking at how to move forward utilising the different data. The NNUH Safeguarding Team is proposing that the pilot of the framework is introduced on the 5 OPM wards as this is the area most likely to encounter aspects in the framework such as falls and pressure areas.

Children & Midwifery Safeguarding

NNUH Digital Health
business intelligence

Safeguarding Children and Midwife...

Apr 2024

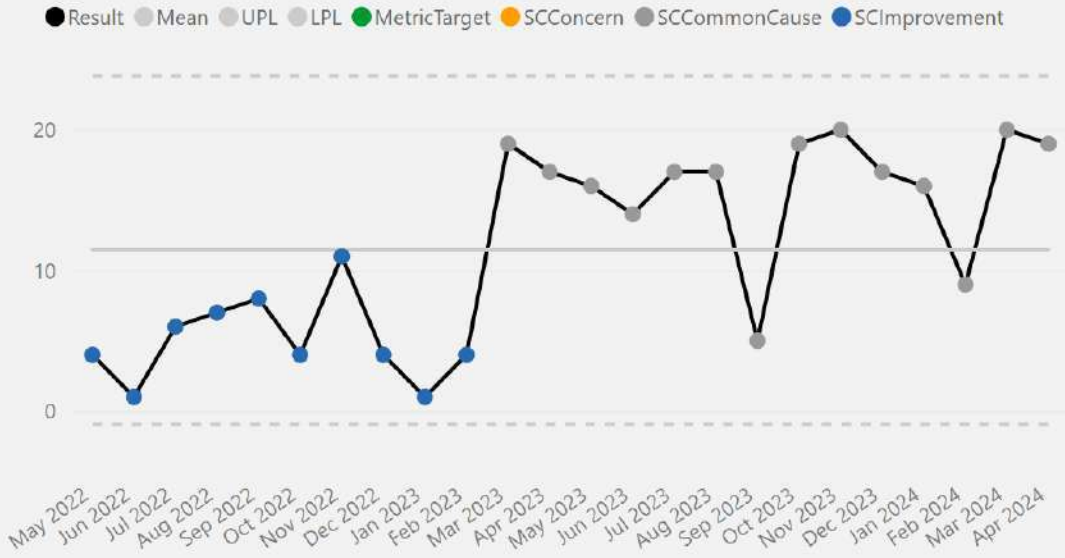
Variation	Assurance
	

19 Result	24 UPL
N/A Target	11 Mean
	-1 LPL

Analytical Commentary

Variation is Common Cause

Safeguarding Children and Midwifery Referrals



Assurance Commentary

NNUH has been included in the panel for a new safeguarding practice review, case AM, whereby a child came to serious harm as a result of possible Fabricated Induced Illness (FII). NNUH did not cause harm, however, as part of the process, we are contributing to the multi-agency and multi-organisation forum. The panel is represented by the Lead Professional for Safeguarding, and at the end of the process there will be learning and recommendations to be shared, in particular around FII. This process is also being supported by the Named Dr for Safeguarding Children.

Improvement Actions

Supervision within paediatrics and midwifery continue to be offered by the Named Midwife for Safeguarding and the Named Nurse for Safeguarding Children. This has been received extremely well and staff have found it beneficial to their practice and well-being. At present it is offered as a group to enable more staff to be captured . The safeguarding team also continue to offer bespoke sessions on the different aspects and topics of safeguarding. Having a Health IDVA on site will also support this work.

Supplementary Metrics

Metric Name	Date	Result	Variation	Assurance
Safeguarding Children Referrals	Apr 2024	13	Common Cause	No Target
Safeguarding Midwifery Referrals	Apr 2024	6	Common Cause	No Target

Our Vision
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Norfolk and Norwich University Hospitals NHS Foundation Trust

REPORT TO THE TRUST BOARD

Date	05.06.24
Title	Chair's Key Issues Report from Finance, Investment and Performance Committee
Lead	Nikki Gray – Non-Executive and Committee Chair
Purpose	For Information

1 Background/Context

The Finance, Investment and Performance Committee met on 29 May 2024 and discussed matters in accordance with its Terms of Reference. Papers for the meeting have been made available to all Board members for information in the usual way via Admin Control. The meeting was quorate and it was attended by Dr Bruce Fleming and Mr Chris Hind (Public Governors) as Observers.

2 Key Issues/Risks/Actions

In addition to reviewing standard reports in accordance with its Terms of Reference, the Committee identified the following matters to bring to highlight to the Board:

	Issues considered	Outcomes/decisions/actions
1	Operational performance	The Committee was updated on Operational Performance and congratulated the team on excellent performance against the ED waiting time standard – with NNUH in the top decile against this standard and the highest in-month performance for 6 years. Most importantly, this was alongside continued progress in reduced use of escalation spaces. It was noted that the number of No Criteria to Reside patients remains higher than the planning target and this will have an ongoing detrimental impact on the Trust in increased cost, reduced elective capacity and increased pressure on escalation. The need for ongoing system support is apparent if we are to effectively reduce the operational pressure within the hospital as committed to our staff and patients.
2	Financial challenge	The Committee discussed the ongoing challenge to achieve our financial plan, especially regarding pay control. Professor Dwyer has offered to organise a discussion for Committee members between our formal meetings in order to review options for further action.
3	Review of SBS services	The Committee received an update regarding transition to a common procurement system across the five provider organisations in the ICS. Phase 1 of this transition began in 2022 and outsourced transactional procurement services to NHS Shared Business Services (SBS). Implementation of Phase 2 is scheduled for July and will involve standardisation of processes across ICS providers and transition to a new procurement system.

		As Board members are aware, a number of service quality issues have been encountered following Phase 1 and the Committee was advised that these are being addressed as part of implementation of the replacement procurement system in Phase 2. Introduction of the new system is accompanied by an extensive communication programme and training for all staff who will be using it.
4	Modelling decant options	The Committee received an update with regard to proposed development of the NNUH estate – to allow for cyclical emptying of space within the hospital in order to allow for refurbishment work. This is increasingly pressing and the Committee requested modelling of various options in terms of size & specification for decant space, so that the implications can be assessed. At the same time, the Committee approved a proposal for development of an Estates Strategy for the Trust with a target or completion by April '25 and an update report to the Committee in September.

3 Conclusions/Outcome/Next steps

The Committee is scheduled to meet again on 26 June 2024, at which meeting the Committee is due to consider:

- the regular suite of reports regarding financial performance, operational performance & estates assurance
- updates on our Green Plan
- review of Committee Annual Report.

Recommendation: The Board is recommended to note the work of its Finance, Investment and Performance Committee.

REPORT TO FINANCE, INVESTMENTS AND PERFORMANCE COMMITTEE

Date	**29th May 2024**		
Title	**Performance and 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✓**	

Background/Context

The attached report provides an update on compliance against the Operational Priorities 2024-25:

Urgent and Emergency Care:

- A&E Waiting Times – '*Improve A&E waiting times compared to 2023/24, with a minimum of 78% of patients seen within 4 hours'*: On Track – The NNUH continues to perform in the top decile against this standard. April 2024 was the highest in-month performance for 6 years.

Elective Care:

- 78 Week Waits – '*Eliminate waits of over 78 weeks for elective care*': Off Track – The 78-week position on 30th April was 368 patient breaches. The forecasted number of patient breaches on 31st May is 310 patients. The Trust remains reliant on support from the Independent Sector as demand in Theatres exceeds capacity.

- 65 Week Waits – '*Eliminate waits of over 65 weeks for elective care by September 2024 (except where patients choose to wait longer or in specific specialties)':* Off Track – The current forecast identifies 1,893 patient breaches on 30th September. The forecast has reduced by 400 patients. The Trust remains reliant on support from the Independent Sector as demand in Theatres exceeds capacity.

- Theatre Utilisation – '*Meet the 85% theatre utilisation expectations, using GIRFT and moving procedures to the most appropriate settings*': Off Track but an improving position. Main Theatres achieved 84.4% in April – the highest performance since June 2023. Total Theatre Utilisation achieved 82.1% in April – this is the same performance as March and is an improvement from the 8 months previously.

- Day Case – '*Meet the 85%-day case expectations using GIRFT and moving procedures to the most appropriate setting*': On Track – Consistent delivery.

- Outpatients – '*Increase the proportion of all outpatient attendances that are for first appointments or follow up appointments attracting a procedure tariff*': Off Track – Performance is behind trajectory. Action taken on 15th April to increase percentage of outpatients with procedures as part of activity stretch.

Cancer:

- 28-Day Faster Diagnosis Standard – '*Improve performance against the 28-day Faster Diagnosis Standard to 77% by March 2025':* Off Track – March performance achieved the 75% target. Provisional unvalidated April performance is 65.8% - this is below trajectory but is predicted to slightly increase following validation.

- 62-Day Performance – '*Improve performance against the headline 62-day standard to 70% by March 2025'*: Off Track – March performance was in line with trajectory. Provisional unvalidated April performance is 46.4% - this is below trajectory but is predicted to slightly increase following validation.

- Lower GI Referrals with a FIT Test – '*Implement and maintain priority pathway changes for lower GI (at least 80% of FDS lower GI referrals are accompanied by a FIT result), Skin (Teledermatology) and Prostate Cancer (best practice timed pathway)':* On Track – Consistently delivered target in 2023/24 and April 2024.

Diagnostics:

- Diagnostic Test Within 6 Weeks – '*Increase the percentage of patients that receive a diagnostic test within 6 weeks in line with the March 2025 ambition of 95%':* On Track – in line with trajectory to achieve 95% target by 31st March 2025.

Recommendations:
The Finance, Investments and Performance Committee is recommended to **Acknowledge** the paper and latest position for information.

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Norfolk and Norwich University Hospitals
NHS Foundation Trust

Integrated Performance Report:

Performance & Activity Domains

April 2024

Key 2024-25 Operational Priorities

Operational Priorities	Description	Target	Deadline	April 2024 Position	Commentary	RAG Rating
Urgent and Emergency Care						
A&E Waiting Times	Improve A&E waiting times compared to 2023/24, with a minimum of 78% of patients seen within 4 hours	78%	March 2025	82.9%	The NNUH continues to perform in the top decile against this standard. April 2024 was the highest performance for 6 years.	
Elective Care						
78 Week Waits	Eliminate waits of over 78 weeks for elective care	0	May 2024	368 patient breaches on 30th April. Forecasted number of breaches on 31st May is 310 patients.	The Trust remains reliant on support from the Independent Sector as demand in Theatres exceeds capacity.	
65 Week Waits	Eliminate waits of over 65 weeks for elective care	0	September 2024	Forecasted number of breaches on 30th September is 1,893.	The forecast has reduced by 400 patients. The Trust remains reliant on support from the Independent Sector as demand in Theatres exceeds capacity.	
Theatre Utilisation	Capped theatre touch time utilisation	85%	March 2025	82.0%	Improving position. Main Theatres achieved 84.4% in April.	
Day Case	Elective surgery delivered as either a day case or outpatient procedure (BADS)	85%	March 2025	89.3%	Consistently delivered.	
Outpatients	Increase the proportion of all outpatient attendances that are for first appointments or follow up appointments attracting a procedure tariff	47.7%	March 2025	44.2%	Action taken on 15th April to increase percentage of Outpatients with procedures as part of activity stretch.	

Key 2024-25 Operational Priorities

Operational Priorities	Description	Target	Deadline	April 2024 Position	Commentary	RAG Rating
Cancer						
28-Day Faster Diagnosis Standard	Improve performance against the 28-day Faster Diagnosis Standard	77%	March 2025	March 2024 = 75.3% (closed performance). April 2024 = 65.8% (unvalidated performance)	March performance achieved 75% target by 31st March 2024 and was in line to achieve the 77% target by March 2025. Provisional unvalidated April performance is 65.8%. This is predicted to slightly increase following validation.	
62-Day Performance	Improve performance against the headline 62-day standard	70%	March 2025	March 2024 = 54.3% (closed performance). April 2024 = 46.4% (unvalidated performance)	March performance was in line with trajectory to achieve the 70% target by March 2025. Provisional unvalidated April performance is 46.4%. This is predicted to slightly increase following validation.	
Lower GI Referrals with a FIT Test	Implement and maintain priority pathway changes for Lower GI (at least 80% of FDS Lower GI referrals are accompanied by a FIT result), Skin (Teledermatology) and Prostate Cancer (best practice timed pathway)	80%	March 2025	89.1%	Consistently delivered.	
Diagnostics						
Diagnostic Test Within 6 Weeks	Increase the percentage of patients that receive a diagnostic test within 6 weeks	95%	March 2025	65.1%	In line with trajectory to achieve 95% target by 31st March 2025.	

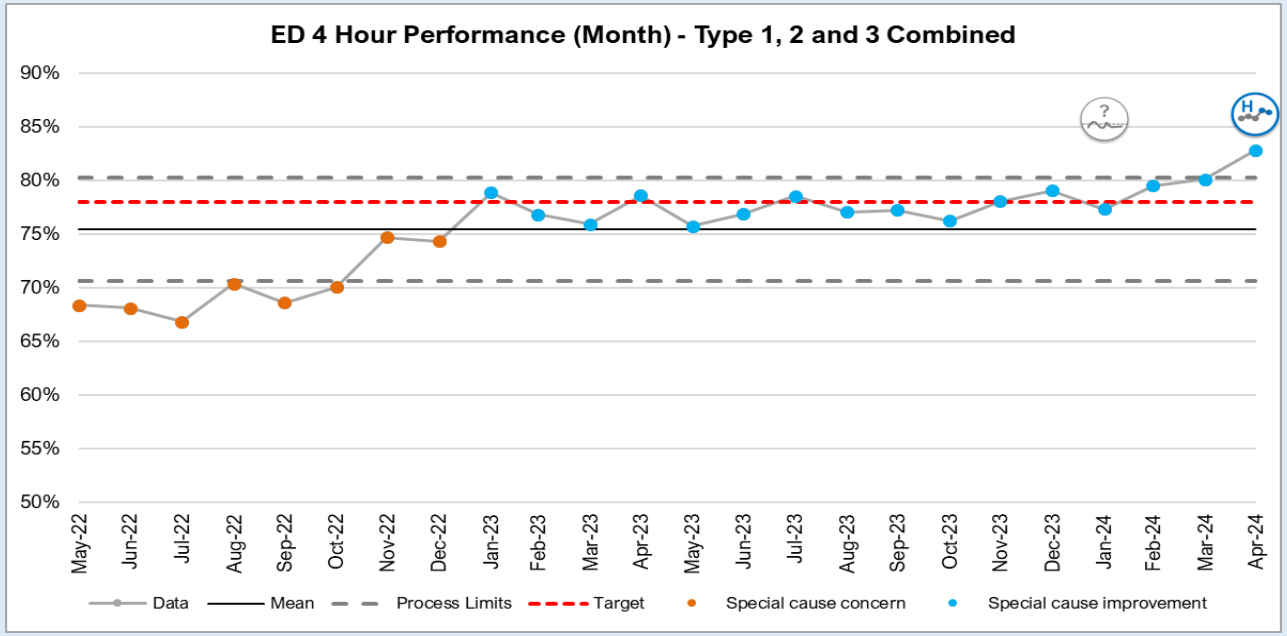
Urgent and Emergency Care

Performance – ED 4 Hour Performance

Commentary

Combined 4-hour performance for April 2024 = **82.9%** - this was the highest combined (Type 1, 2 and 3) monthly performance since November 2018 (85.6%) and above the 78% target to achieve by March 2025.

Type 1 4-hour performance for April 2024 = 69.9% - this was the highest Type 1 monthly performance since June 2020 (71.5%).



4 Hour Performance - April 2024: 82.9%

Category	Type	Mon Apr 01	Tue Apr 02	Wed Apr 03	Thu Apr 04	Fri Apr 05	Sat Apr 06	Sun Apr 07	Mon Apr 08	Tue Apr 09	Wed Apr 10	Thu Apr 11	Fri Apr 12	Sat Apr 13	Sun Apr 14	Mon Apr 15	Tue Apr 16	Wed Apr 17	Thu Apr 18	Fri Apr 19	Sat Apr 20	Sun Apr 21	Mon Apr 22	Tue Apr 23	Wed Apr 24	Thu Apr 25	Fri Apr 26	Sat Apr 27	Sun Apr 28	Mon Apr 29	Tue Apr 30	April Avg.
Type 1 Breaches	ED Admitted	40	40	74	75	60	61	57	40	45	66	60	64	59	40	51	56	34	43	57	56	43	55	82	68	60	76	52	58	37	70	56
	ED Non-Admitted	36	44	96	50	69	65	98	58	60	46	40	32	49	39	58	70	41	55	83	76	48	53	86	71	74	72	51	57	92	52	61
	Type 1 Breaches	**76**	**84**	**170**	**125**	**129**	**126**	**155**	**98**	**105**	**112**	**100**	**96**	**108**	**79**	**109**	**126**	**75**	**98**	**140**	**132**	**91**	**108**	**168**	**139**	**134**	**148**	**103**	**115**	**129**	**122**	**117**
Type 1 Attendances	ED Admitted	90	65	97	96	78	81	89	75	68	86	84	96	89	74	84	82	78	76	91	81	74	74	106	93	83	105	87	88	65	83	84
	ED Non-Admitted	316	327	317	284	319	287	370	337	312	282	284	280	285	325	331	276	280	300	307	281	272	333	300	280	288	271	262	312	387	289	303
	Type 1 Attendances	**406**	**392**	**414**	**380**	**397**	**368**	**459**	**412**	**380**	**368**	**368**	**376**	**374**	**399**	**415**	**358**	**358**	**376**	**398**	**362**	**346**	**407**	**406**	**373**	**371**	**376**	**349**	**400**	**452**	**372**	**387**
Type 1 (ED) Admitted		55.6%	38.5%	23.7%	21.9%	23.1%	24.7%	36.0%	46.7%	33.8%	23.3%	28.6%	33.3%	33.7%	45.9%	39.3%	31.7%	56.4%	43.4%	37.4%	30.9%	41.9%	25.7%	22.6%	26.9%	27.7%	27.6%	40.2%	34.1%	43.1%	15.7%	**33.3%**
Type 1 (ED) Non-Admitted		88.6%	86.5%	69.7%	82.4%	78.4%	77.4%	73.5%	82.8%	80.8%	83.7%	85.9%	88.6%	82.8%	88.0%	82.5%	74.6%	85.4%	81.7%	73.0%	73.0%	82.4%	84.1%	71.3%	74.6%	74.3%	73.4%	80.5%	81.7%	76.2%	82.0%	**80.0%**
Type 1 (ED) Combined		81.3%	78.6%	58.9%	67.1%	67.5%	65.8%	66.2%	76.2%	72.4%	69.6%	72.8%	74.5%	71.1%	80.2%	73.7%	64.8%	79.1%	73.9%	64.8%	63.5%	73.7%	73.5%	58.6%	62.7%	63.9%	60.6%	70.5%	71.3%	71.5%	67.2%	**69.9%**
Type 1, 2 and 3 Combined		89.9%	88.6%	76.7%	81.5%	80.7%	81.8%	78.3%	86.7%	83.0%	82.9%	84.7%	85.7%	85.5%	89.0%	84.8%	79.6%	88.3%	85.3%	79.3%	79.8%	85.8%	85.6%	75.3%	78.7%	78.1%	76.7%	84.1%	82.6%	82.6%	82.2%	**82.9%**

The NNUH 4 Hour Target includes attendances for ED, Cromer MIU, GP Streaming and the Walk in Centre.

Our Vision
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ED Waiting Times <4 hours – National Position (April 2024)

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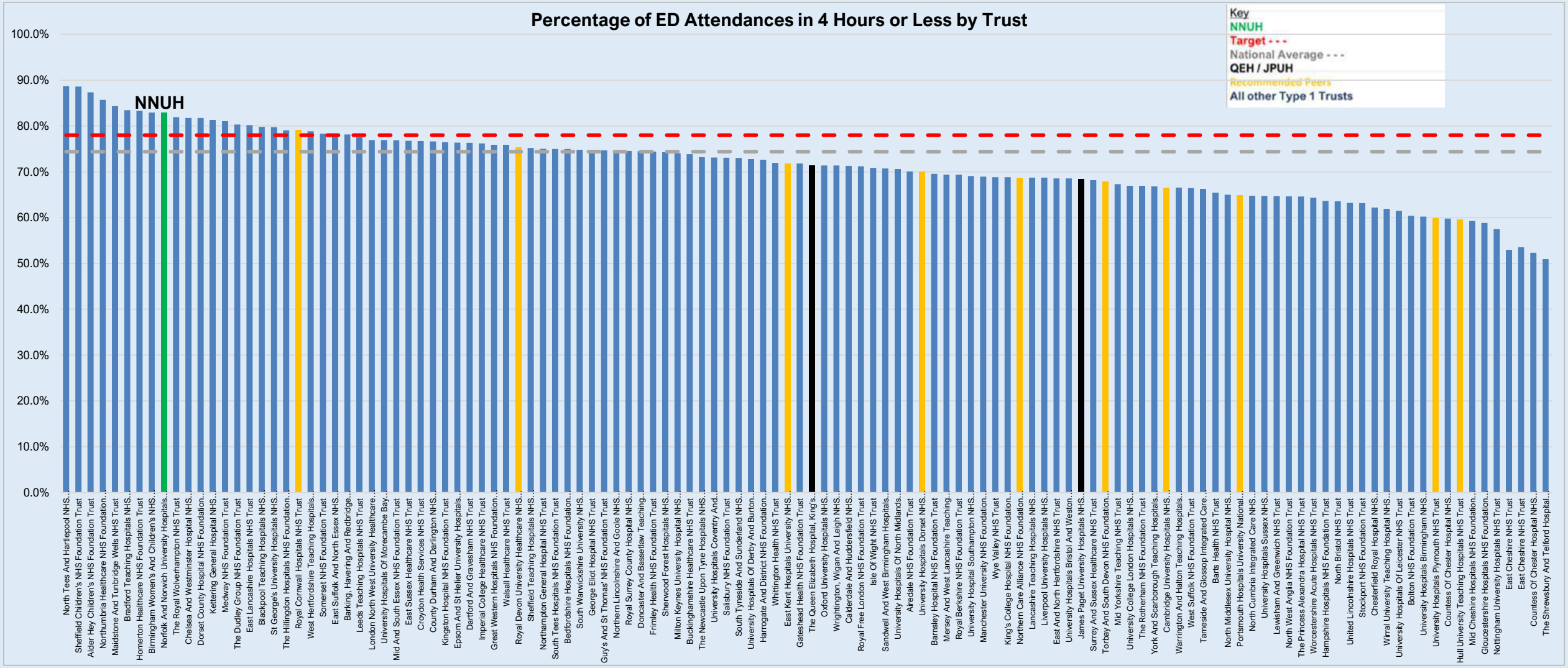

Commentary

In April, NNUH were ranked 9th across all Type 1 NHS Trusts and the best performing amongst our recommended peers (for most similar attributes) with 82.9% of ED patients either admitted, transferred or discharged within 4 hours of arrival. This was ahead of the national target of 78%, and well ahead of the national average of 74%.

Elective Care

Our Vision
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78 Weeks – Specialty Level Forecast to 31st May 2024 (Based on TCIs)

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

Specialty		Weekly Averages	22/03/2024	29/03/2024 (Public Holiday)	05/04/2024 (Public Holiday)	12/04/2024 (Half Term)	19/04/2024	26/04/2024	03/05/2024	10/05/2024 (Public Holiday)	17/05/2024	24/05/2024	31/05/2024 (Public Holiday)	TCI	Interventions							Net
														350	NNUH Capacity	Spire	Nuffield	Bromsgrove	Other IS	Other NHS	Total Interventions	310
110 - Trauma and Orthopaedic	Starting Cohort	-	8,714	8,714	8,714	8,714	8,714	8,714	8,714	8,714	8,714	8,714	8,714									
	Will Breach	-	518	433	404	358	298	258	213	196	158	140	108	108								108
	Weekly Removals	52	96	85	29	46	60	40	45	17	38	36	20									
	Target	65	781	704	627	550	473	396	319	242	165	88	11									
	Difference	-	-263	-271	-223	-192	-175	-138	-106	-46												
	Future TCIs	94									38	36	20									
	Provisional TCIs	10									4	3	3									
502 - Gynaecology	Starting Cohort	-	6,703	6,703	6,703	6,703	6,703	6,703	6,703	6,703	6,703	6,703	6,703									
	Will Breach	-	406	340	328	308	280	245	209	182	162	123	88	88					40		40	48
	Weekly Removals	32	35	66	12	20	28	35	36	27	20	39	26									
	Target	61	601	542	482	423	364	305	245	186	127	68	8									
	Difference	-	-195	-202	-154	-115	-84	-60	-36	-4												
	Future TCIs	85									20	39	26									
	Provisional TCIs	81									23	39	19									
100 - General Surgery	Starting Cohort	-	5,186	5,186	5,186	5,186	5,186	5,186	5,186	5,186	5,186	5,186	5,186									
	Will Breach	-	152	129	123	105	86	75	67	59	58	54	45	45								45
	Weekly Removals	15	25	23	6	18	19	11	8	8	1	4	4									
	Target	20	465	419	373	327	282	236	190	144	98	52	7									
	Difference	-	-313	-290	-250	-222	-196	-161	-123	-85												
	Future TCIs	9									1	4	4									
	Provisional TCIs	0									0	0	0									
130 - Ophthalmology	Starting Cohort	-	5,980	5,980	5,980	5,980	5,980	5,980	5,980	5,980	5,980	5,980	5,980									
	Will Breach	-	119	99	99	88	76	68	57	47	38	36	30	30								30
	Weekly Removals	11	18	20	0	11	12	8	11	10	9	2	2									
	Target	16	536	483	430	378	325	272	219	166	113	60	8									
	Difference	-	-417	-384	-331	-290	-249	-204	-162	-119												
	Future TCIs	13									9	2	2									
	Provisional TCIs	2									1	0	1									
108 - Spinal Surgery	Starting Cohort	-	1,354	1,354	1,354	1,354	1,354	1,354	1,354	1,354	1,354	1,354	1,354									
	Will Breach	-	82	72	68	63	55	51	48	46	42	31	29	28								28
	Weekly Removals	5	5	10	4	5	8	4	3	2	4	11	8									
	Target	15	121	109	97	85	74	62	50	38	26	14	2									
	Difference	-	-39	-37	-29	-22	-19	-11	-2	8												
	Future TCIs	23									4	11	8									
	Provisional TCIs	0									0	0	0									
160 - Plastic Surgery	Starting Cohort	-	1,847	1,847	1,847	1,847	1,847	1,847	1,847	1,847	1,847	1,847	1,847									
	Will Breach	-	88	72	62	57	51	41	36	32	29	26	17	17								17
	Weekly Removals	9	14	16	10	5	6	10	5	4	3	3	2									
	Target	11	166	149	133	117	100	84	68	51	35	19	2									
	Difference	-	-78	-77	-71	-60	-49	-43	-32	-19												
	Future TCIs	8									3	3	2									
	Provisional TCIs	3									2	1	0									
120 - Ear Nose and Throat	Starting Cohort	-	7,256	7,256	7,256	7,256	7,256	7,256	7,256	7,256	7,256	7,256	7,256									
	Will Breach	-	66	50	49	35	26	23	21	16	15	15	14	14								14
	Weekly Removals	10	28	16	1	14	9	3	2	5	2	4	2									
	Target	5	650	586	522	458	394	330	266	202	137	73	9									
	Difference	-	-584	-538	-473	-423	-368	-307	-245	-186												
	Future TCIs	8									2	4	2									
	Provisional TCIs	0									0	0	0									
																			7 other specialties			20

Commentary

The Trust has forecasted a net position of 310 patients breaching 78-weeks on 31st May 2024.

Our Vision
The best care for every patient

65 Weeks – Specialty Level Forecast to 30th September 2024

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

65 Week Wait Position up to end of May + September 2024

Cohort ending May 2024

Removals based on booked TCIs

Specialty		Weekly Averages	22/03/2024	29/03/2024 (Public Holiday)	05/04/2024 (Public Holiday)	12/04/2024 (Half Term)	19/04/2024	26/04/2024	03/05/2024	10/05/2024 (Public Holiday)	17/05/2024	24/05/2024	31/05/2024 (Public Holiday)	2,204
110 - Trauma and Orthopaedic	Starting Cohort	-	8,714	8,714	8,714	8,714	8,714	8,714	8,714	8,714	8,714	8,714	8,714	
	Will Breach	-	1,430	1,306	1,260	1,189	1,075	984	902	851	785	715	676	676
	Weekly Removals	88	127	124	46	71	114	91	82	51	66	70	39	
	Difference													
	Future TCIs	175									66	70	39	
	Provisional TCIs	10									4	3	3	
502 - Gynaecology	Starting Cohort	-	6,703	6,703	6,703	6,703	6,703	6,703	6,703	6,703	6,703	6,703	6,703	
	Will Breach	-	760	694	673	640	605	566	516	479	452	405	378	378
	Weekly Removals	40	42	66	21	33	35	39	50	37	27	47	27	
	Difference													
	Future TCIs	101									27	47	27	
	Provisional TCIs	90									24	45	21	
100 - General Surgery	Starting Cohort	-	5,186	5,186	5,186	5,186	5,186	5,186	5,186	5,186	5,186	5,186	5,186	
	Will Breach	-	479	450	440	392	345	318	297	275	261	248	237	237
	Weekly Removals	31	40	29	10	48	47	27	21	22	14	13	11	
	Difference													
	Future TCIs	38									14	13	11	
	Provisional TCIs	2									0	2	0	
130 - Ophthalmology	Starting Cohort	-	5,980	5,980	5,980	5,980	5,980	5,980	5,980	5,980	5,980	5,980	5,980	
	Will Breach	-	333	307	306	290	262	244	210	187	173	165	157	157
	Weekly Removals	23	36	26	1	16	28	18	34	23	14	8	8	
	Difference													
	Future TCIs	30									14	8	8	
	Provisional TCIs	6									2	3	1	
120 - Ear Nose and Throat	Starting Cohort	-	7,256	7,256	7,256	7,256	7,256	7,256	7,256	7,256	7,256	7,256	7,256	
	Will Breach	-	283	257	247	224	198	189	177	161	149	132	124	124
	Weekly Removals	20	34	26	10	23	26	9	12	16	12	17	8	
	Difference													
	Future TCIs	37									12	17	8	
	Provisional TCIs	2									0	1	1	
330 - Dermatology	Starting Cohort	-	7,179	7,179	7,179	7,179	7,179	7,179	7,179	7,179	7,179	7,179	7,179	
	Will Breach	-	480	426	381	352	319	251	195	156	116	95	76	76
	Weekly Removals	50	73	54	45	29	33	68	56	39	40	21	19	
	Difference													
	Future TCIs	80									40	21	19	
	Provisional TCIs	0									0	0	0	
													Other specialties	556

Cohort ending September 2024

Removals based on prior long wait cohort of equivalent size

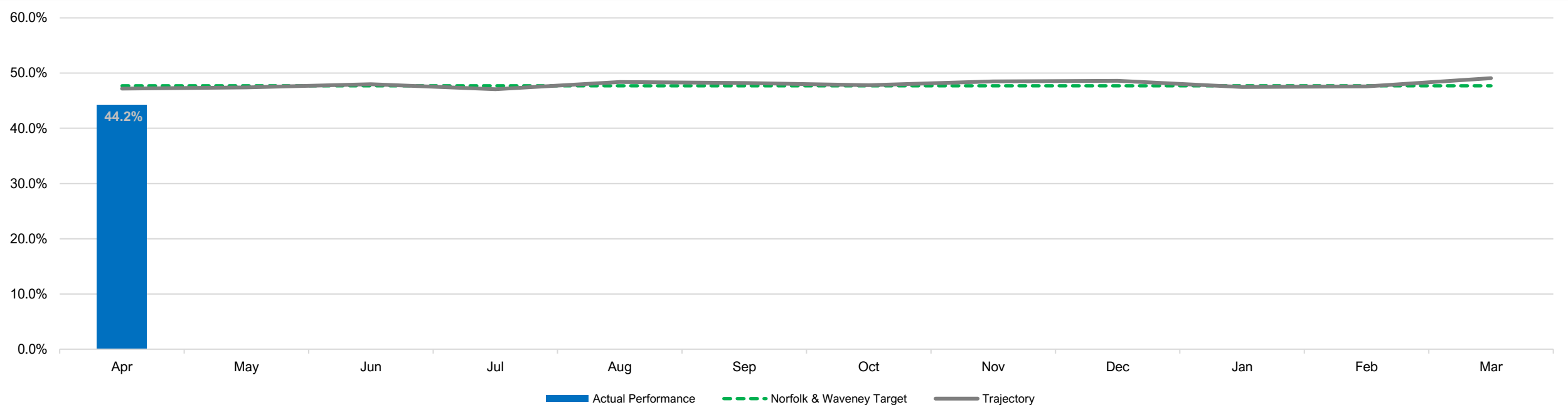
07/06/24	14/06/24	21/06/24	28/06/24	05/07/24	12/07/24	19/07/24	26/07/24	02/08/24	09/08/24	16/08/24	23/08/24	30/08/2024 (Public Holiday	06/09/24	13/09/24	20/09/24	27/09/24	30/09/24	1,893
9,787	9,787	9,787	9,787	9,787	9,787	9,787	9,787	9,787	9,787	9,787	9,787	9,787	9,787	9,787	9,787	9,787	9,787	
2,297	2,209	2,099	1,979	1,877	1,767	1,643	1,569	1,495	1,427	1,364	1,290	1,241	1,165	1,089	994	920	830	830
98	88	110	100	102	110	124	74	74	68	63	74	69	76	76	95	54	70	
6,497	6,497	6,497	6,497	6,497	6,497	6,497	6,497	6,497	6,497	6,497	6,497	6,497	6,497	6,497	6,497	6,497	6,497	
1,072	1,031	980	906	850	784	730	692	648	606	579	562	551	528	500	475	451	423	423
29	41	51	59	56	36	54	38	44	42	27	17	26	23	28	25	4	8	
6,786	6,786	6,786	6,786	6,786	6,786	6,786	6,786	6,786	6,786	6,786	6,786	6,786	6,786	6,786	6,786	6,786	6,786	
922	869	820	767	714	689	631	573	532	486	442	395	367	339	305	277	263	232	232
41	53	49	48	38	25	58	48	41	31	44	47	43	28	34	28	14	31	
6,290	6,290	6,290	6,290	6,290	6,290	6,290	6,290	6,290	6,290	6,290	6,290	6,290	6,290	6,290	6,290	6,290	6,290	
478	411	378	336	293	246	211	197	170	150	117	99	91	73	54	38	15	7	7
39	67	33	42	43	47	35	14	27	20	33	3	8	18	19	16	23	8	
7,670	7,670	7,670	7,670	7,670	7,670	7,670	7,670	7,670	7,670	7,670	7,670	7,670	7,670	7,670	7,670	7,670	7,670	
459	422	390	356	326	291	259	234	200	180	160	141	132	115	90	70	60	46	46
46	37	32	34	30	35	32	25	34	5	12	19	14	17	25	20	10	14	
7,557	7,557	7,557	7,557	7,557	7,557	7,557	7,557	7,557	7,557	7,557	7,557	7,557	7,557	7,557	7,557	7,557	7,557	
606	532	435	369	313	257	212	168	132	119	69	6	0	0	0	0	0	0	0
114	74	97	66	56	51	15	29	36	13	50	63	55	52	34	24	37	19	

Other specialties 355

Commentary

The Trust has forecasted 1,893 patients to be breaching 65-weeks at the end of September 2024, with 0 breaches forecasted to be achieved by December 2024.

Performance – Percentage of News / Procedures of Total Outpatients



Commentary

April 2024 Performance

The 2024/25 priorities and operational planning guidance includes a new metric measuring the proportion of all outpatient attendances that are for first or follow-up appointments attracting a procedure tariff (the proportion of activity that is pathway completing). The target for Norfolk and Waveney to achieve by March 2025 is 47.7%. The provisional Trust wide performance for April was 44.2%.

Risk To Delivery

AMBER

Performance – 85% Day Case

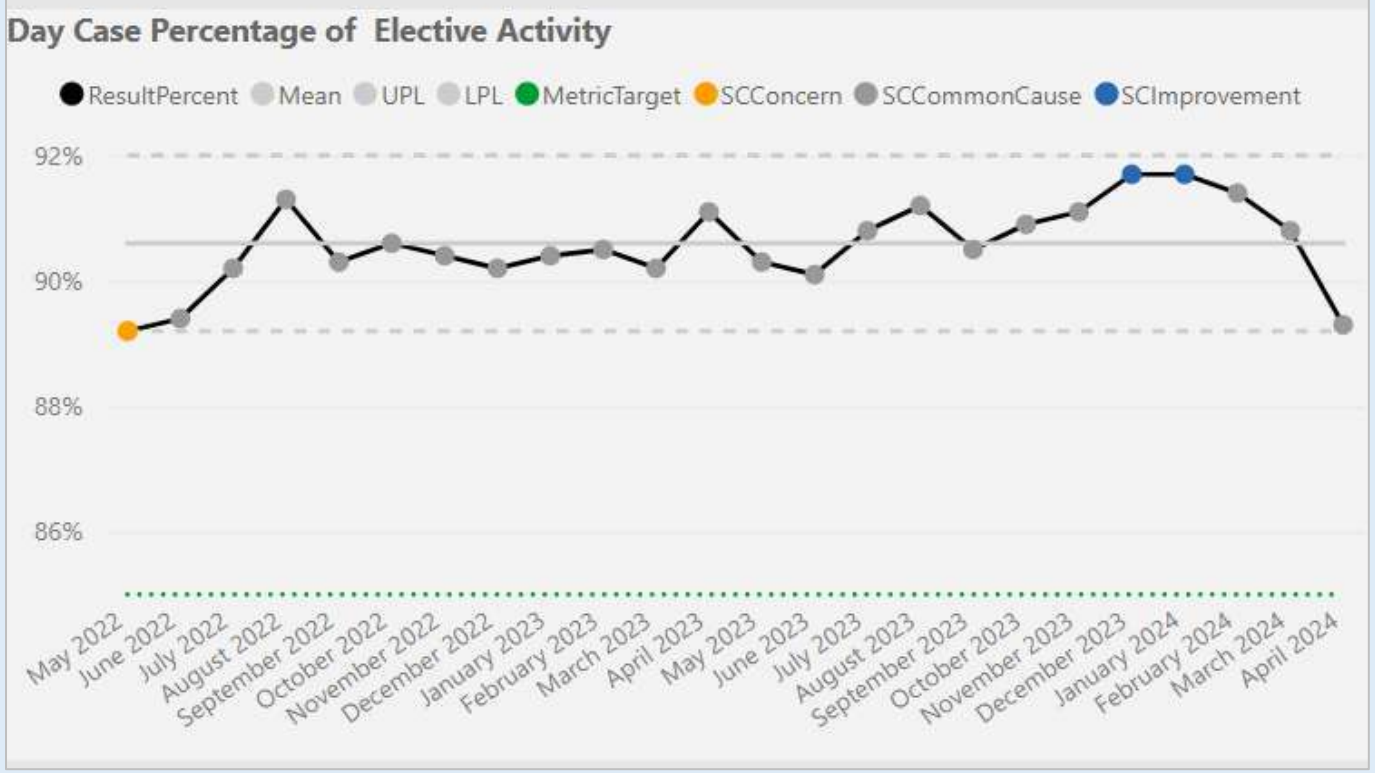
Day Case Percentage of Elective Activity

April 2024

Variation | Assurance

89.3% Result
85.0% Target

92.0% UPL
90.6% Mean
89.2% LPL



Commentary

April 2024 Performance

In April, NNUH delivered 89.3% of elective activity as day cases. This is a reduction from previous months but remains above the 85% target.

Risk To Delivery

GREEN

Performance – Theatre Utilisation

Commentary

April 2024 Performance

Touch time delivery across all Theatres in April remained at the same level as March (82.1%) – this figure includes Paediatrics data. This is an improvement from the 8 months previously but remains below the 85% target. The table below highlights the shortage in NNUH surgical capacity compared to recommended peers and nationally, subsequently impacting activity levels.

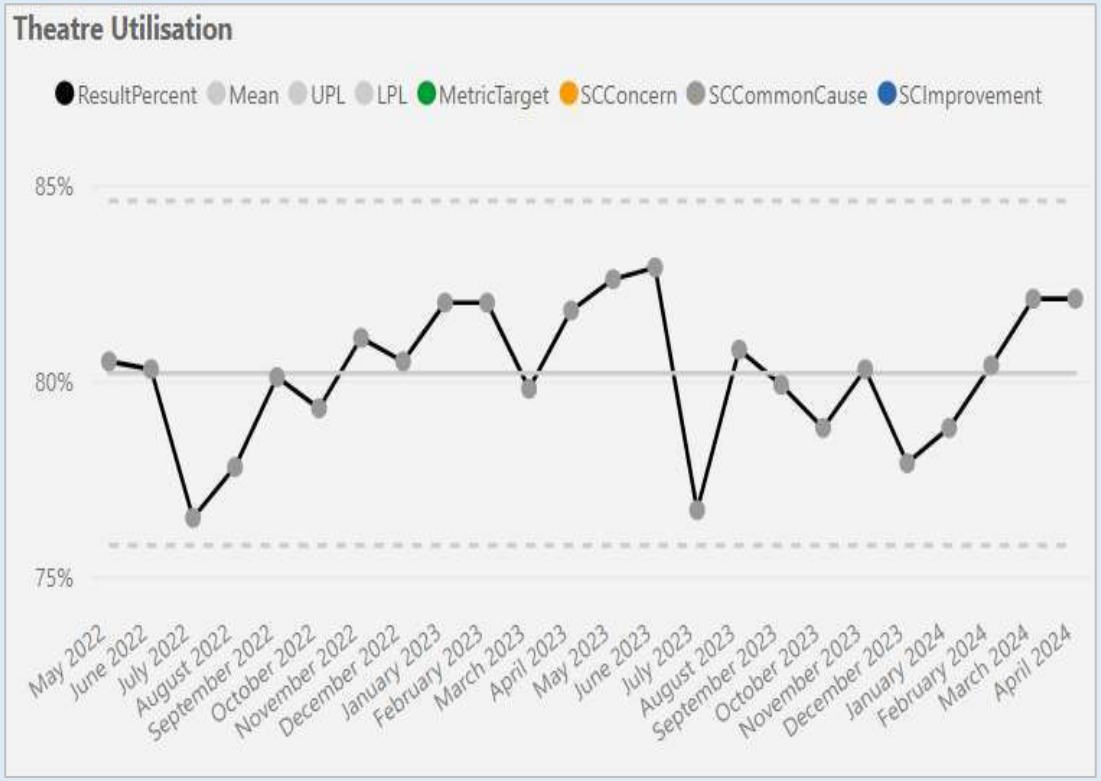
Utilisation levels for Level 2 Theatres reduced in month at 75.1% compared to 75.7% in March but improved from the 2 months prior to this. Conversely, Level 3 Theatre utilisation improved in month at 80.5% - higher than the previous 12 months. Across all Theatres, a total of 1,083 sessions ran in month, compared to 1,090 sessions in March. Besides March 2024, this is the highest number of sessions in month since March 2023. The number of on the day cancellations reduced to 124 in April – lower than the 3 months previously. This was despite the number of sessions supported in month being higher than both January and February. 50 (40%) of the cancellations were for clinical reasons, such as the treatment being deferred (27), or the procedure no longer being required (16). 47 (38%) were for non-clinical reasons primarily due to lists overrunning (19) or emergency admissions (8) and 27 (22%) due to patient reasons, including the patient being unfit for procedure (10) or did not attend (8).

Improvement Actions

1. POA remains a significant challenge due to ongoing workforce challenges. Additional clinics have now been added during the week and on Saturdays. Demand and capacity work is underway, including requirement for physical capacity, and capacity improvements that can be delivered through Digital POA. Additional staff have been allocated to support NaNOC increases in POA demand.
2. The first 1,100 patients have been pre-screened by the digital POA system; these are all long waiting patients that hadn't been POA'd. Bulk uploads of longest waiting patients to continue across all specialties. Phase 2 of the plan (regular use of the system within clinic) is ongoing through May.
3. Theatre productivity board reestablished (20th May) with specialty specific trajectories and action plans in place. NHSE (EoE) working with NNUH Theatres team on week commencing 20th May focussing on alignment of NNUH metrics with Model Health System and supporting audit and action plans for improving utilisation (focussing on Orthopaedics).
4. "Urology productivity week" scheduled for week commencing 17th June – focus on booking to 100% with patients at home on standby to mitigate loss of utilisation from on-the-day cancellations. Review of lessons learned with a view to embedded standby process.

Risk To Delivery

AMBER

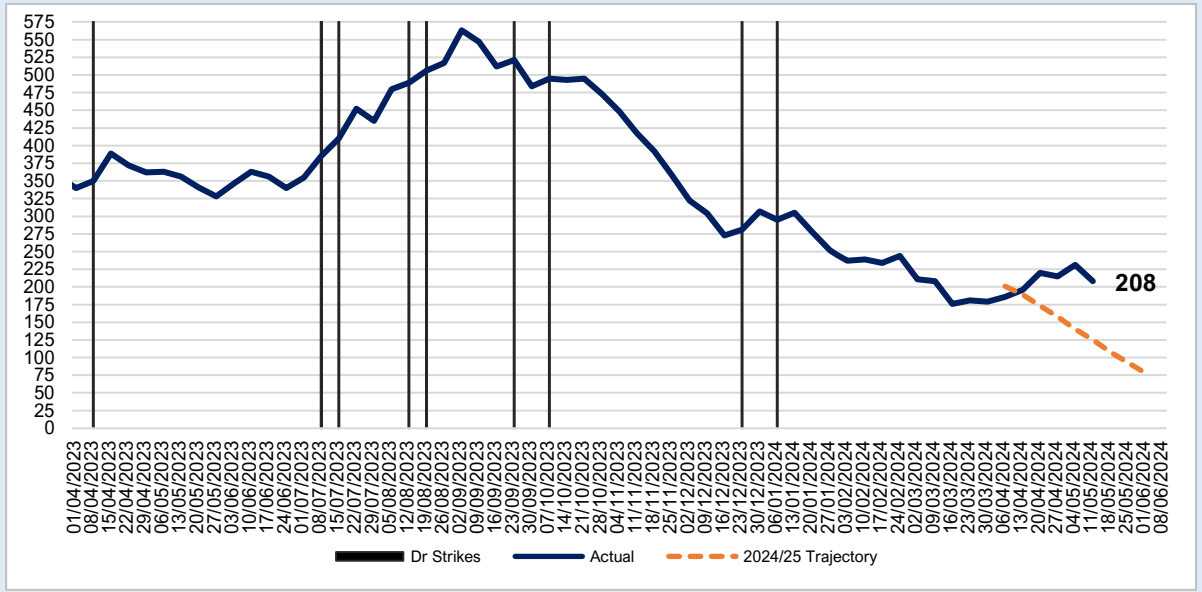


Volumes Reporting is weekly and the date displayed represents the Week Ending Date.	Data period	Provider value	Peer average	National value	National value method	Chart
Number of theatres	21/04/2024	22	46	18	Provider median	
Number of sessions	21/04/2024	125	195	94	Provider median	
Planned number of equivalent 4 hour sessions	21/04/2024	240	383	147	Provider median	
Number of cases	21/04/2024	396	633	325	Provider median	
Average number of cases per 4 hour session	21/04/2024	1.6	1.7	2.3	Provider median	

Cancer

Cancer – 62-Day Backlog Profile

62 Day Backlog – NNUH Actuals Vs Trajectory (12th May 2024)



Suspected Tumour Type	Past day 62	Change in last week	Change in 4 weeks
Brain	0	0	0
Breast	4	+1	+3
Children's	0	0	-1
Gynaecological	21	-13	-6
Haematological	2	0	-4
Head & Neck	26	+3	+9
Lower Gastrointestinal	40	-4	+4
Lung	11	0	+2
Sarcoma	7	0	-6
Skin	30	-9	-9
Upper Gastrointestinal	11	-2	+3
Urological	55	+1	+16
Other	1	0	+1
All Suspected Cancers	**208**	**-23**	**+12**

Commentary

Performance Update

The 62-day backlog saw a net decrease of 23 patients waiting over 62 days up to 12th May compared to the previous week but a net increase of 12 patients compared to the prior 4-week period (below left) on 14th April.

The largest contributors to the 62-day backlog remain Urology, Skin and Lower GI. The backlog has increased in Urology and Lower GI by a total of 25 patients over the last 4 weeks. However, the backlog in Skin has reduced by 9 patients over the same period.

Ceasing of Primary Care FIT negative service for 10 weeks has put pressure in front end of pathway for CNS time in Lower GI, causing extended delay for review and now causing increased numbers of rollovers onto the 62-day backlog.

Improvement Actions

1. Skin insourcing recommended on 11/12th May. Additional OPA and Excision capacity in place between now and end of May and will bring Skin in line with trajectory by end of May.
2. Primary Care Fit service recommenced Primary Care service reinstated from 29/04/24. Backlog reduced over the last week.
3. Weekend Robotic Surgery contract agreed. 7 lists now in place.
4. High volume of Histology returned and additional OPA capacity for Oncology over the next 2 weeks. Backlog to reduce in May.

Risk To Delivery

AMBER

Cancer – 62-Day Backlog Recovery

62 Day Trajectory	6 Week Average		07/04/2024	14/04/2024	21/04/2024	28/04/2024	05/05/2024	12/05/2024	19/05/2024	26/05/2024	02/06/2024
Total		Target Backlog	191	190	172	157	139	124	107	92	78
		Actual Backlog	189	196	220	215	231	208			
	46	Actual Rollovers	58	0	0	0	0	0	0	0	0
		Actual Removals	44								
		Removals Required		44							
		Actual Backlog Difference	14								
Urology		Target Backlog	39	39	36	33	30	27	24	22	20
		Actual Backlog	37	39	45	54	54	55			
	9	Actual Rollovers									
		Actual Removals									
		Removals Required	6	6							
		Actual Backlog Difference									
Skin		Target Backlog	32	32	28	26	24	22	20	17	17
		Actual Backlog	32	39	46	38	39	30			
	12	Actual Rollovers									
		Actual Removals									
		Removals Required	13	13							
		Actual Backlog Difference									
Lower GI		Target Backlog	38	36	33	30	27	24	21	18	15
		Actual Backlog	38	36	46	37	44	40			
	8	Actual Rollovers									
		Actual Removals									
		Removals Required	8	8							
		Actual Backlog Difference									
Gynaecology		Target Backlog	21	20	18	16	14	12	10	8	5
		Actual Backlog	21	27	27	30	34	21			
	6	Actual Rollovers									
		Actual Removals									
		Removals Required	4	4							
		Actual Backlog Difference									

Commentary

Internal stretch target created in April to reduce the backlog to 78 patients by June 2024. Backlog off track against this trajectory, actions in place (detailed in the previous slide) predicted to reduce backlog in coming weeks.

Cancer – 28-Day Faster Diagnosis Standard

Commentary

April 2024 Performance

Closed March 2024 performance was 75.3% - above the national target of 75%.
Provisional unvalidated April performance is 65.8%. This is predicted to slightly increase following validation.

Reduction in Breast and Skin FDS in April due to Easter break.

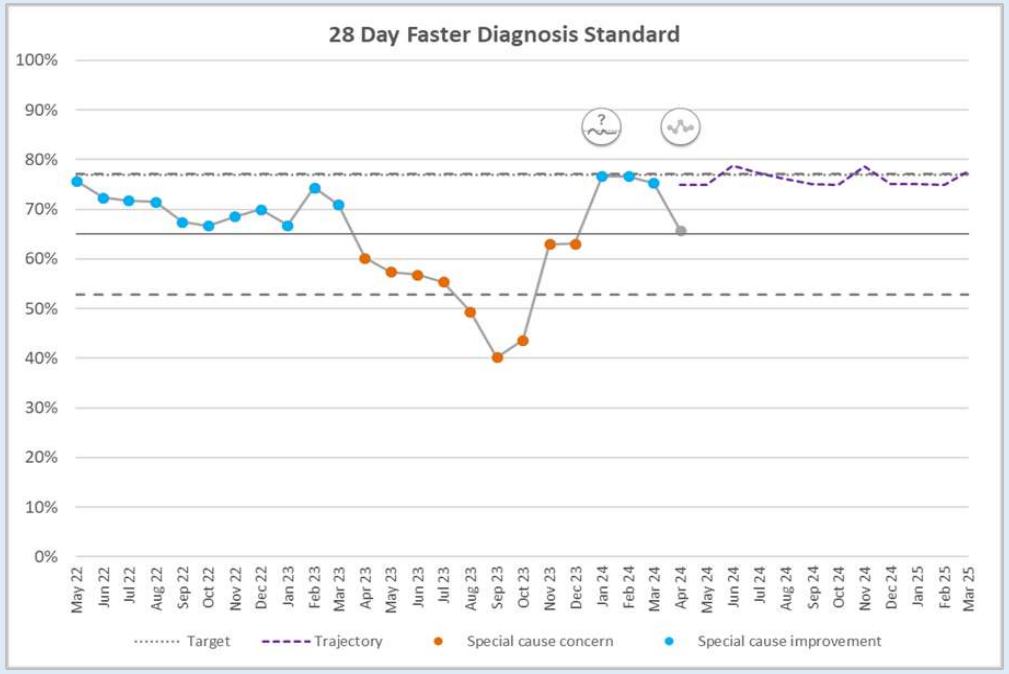
Improvement Actions

1. Additional Skin and Breast first appointment activity planned through to mid-June will show improvement in performance in May and June.
2. Ongoing validation training to ensure robust data collection
3. Continued focus on Histopathology turnaround through weekly escalation processes and outsourcing of work

Risk To Delivery

AMBER

Body Site	Mar-24	Apr-24 (Provisional)
Brain	66.7%	57.1%
Breast	95.5%	69.2%
Gynaecology	71.7%	48.4%
Haematology	42.3%	45.0%
Head and Neck	80.5%	75.9%
Lower GI	59.6%	52.2%
Lung	69.1%	63.3%
Paediatric	56.3%	81.0%
Sarcoma	37.5%	28.1%
Skin	72.1%	54.3%
Testicular	100.0%	100.0%
Upper GI	89.7%	89.6%
Urology	65.2%	57.0%
Total	**75.3%**	**65.8%**



Key	
	Above trajectory
	Within 5% below trajectory
	More than 5% below trajectory

Cancer – 62-Day Performance

Commentary

April 2024 Performance

Closed performance in March was 54.1% and the highest level since 2022/23.

Provisional unvalidated April performance is 46.4%. This is predicted to slightly increase following validation but will remain off trajectory, impacted by patient choice and Easter break.

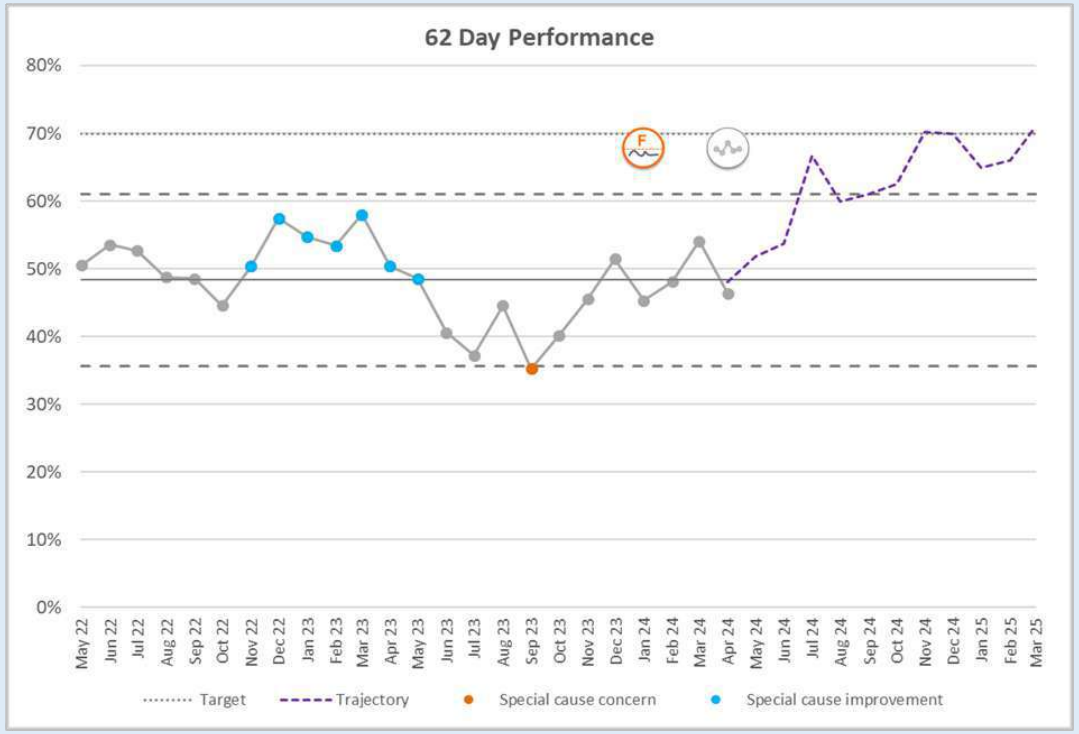
Improvement Actions

1. Increased operational focus with Red to Green meetings in place to address increased backlog and reduction in line with trajectory, with a focus to return performance in line with trajectory by June.

Risk To Delivery

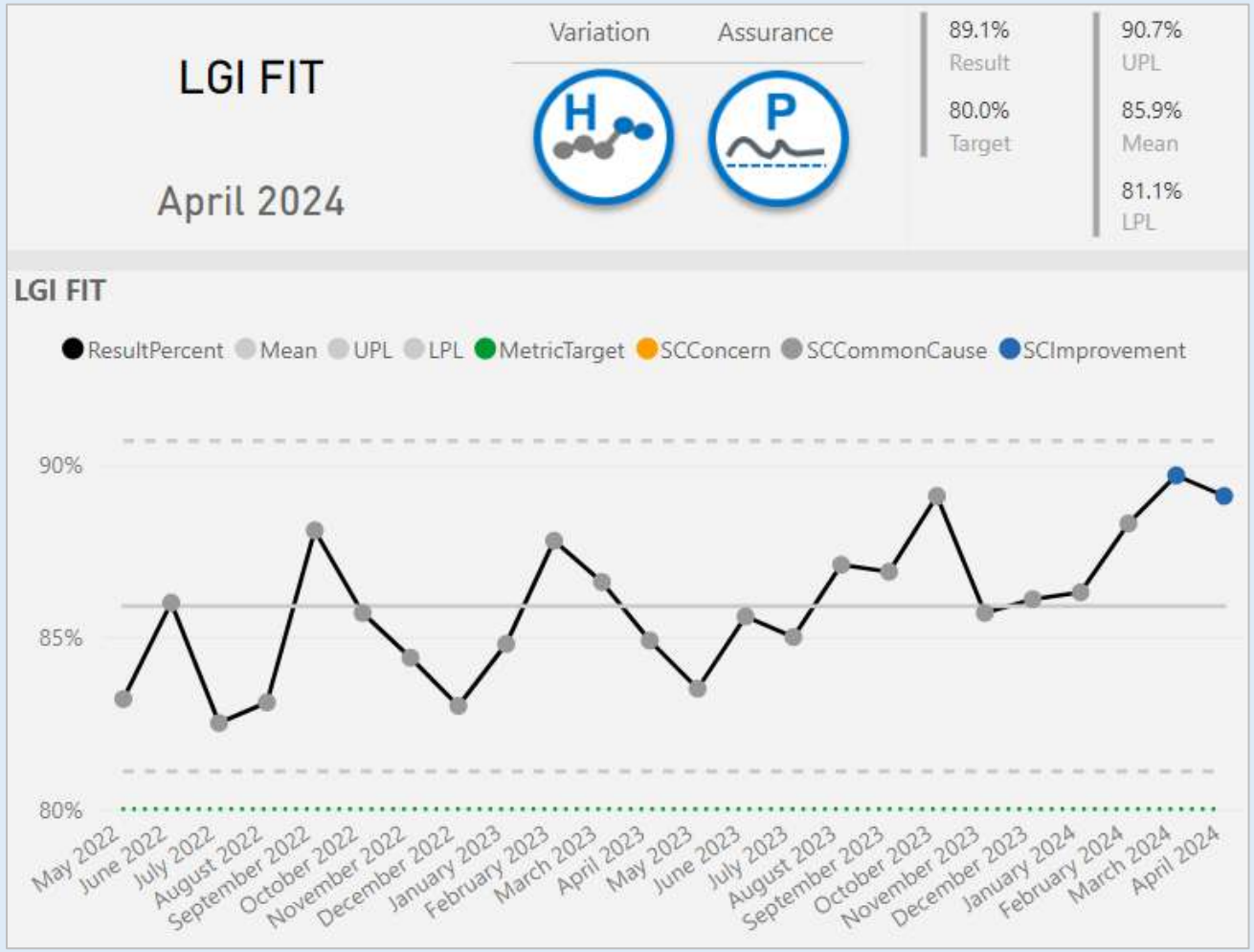
AMBER

Body Site	Mar-24	Apr-24 (Provisional)
Breast	70.8%	75.8%
Gynaecology	42.9%	38.7%
Haematology	50.0%	50.0%
Head and Neck	46.7%	29.4%
Lower GI	36.0%	16.5%
Lung	45.5%	29.8%
Skin	84.3%	59.5%
Testicular	33.3%	50.0%
Upper GI	60.0%	53.3%
Urology	34.0%	40.7%
Total	**54.1%**	**46.4%**



Key	
	Above trajectory
	Within 5% below trajectory
	More than 5% below trajectory

Cancer – Lower GI Referrals with a FIT Test



Commentary

April 2024 Performance

Performance reduced to 89.1% in April compared to 89.7% in March. Though, this remained higher than the 4 months prior to this and remains ahead of target for all LGI referrals having an accompanying FIT result, enabling effective triage and straight to test investigations where criteria met.

Improvement Actions

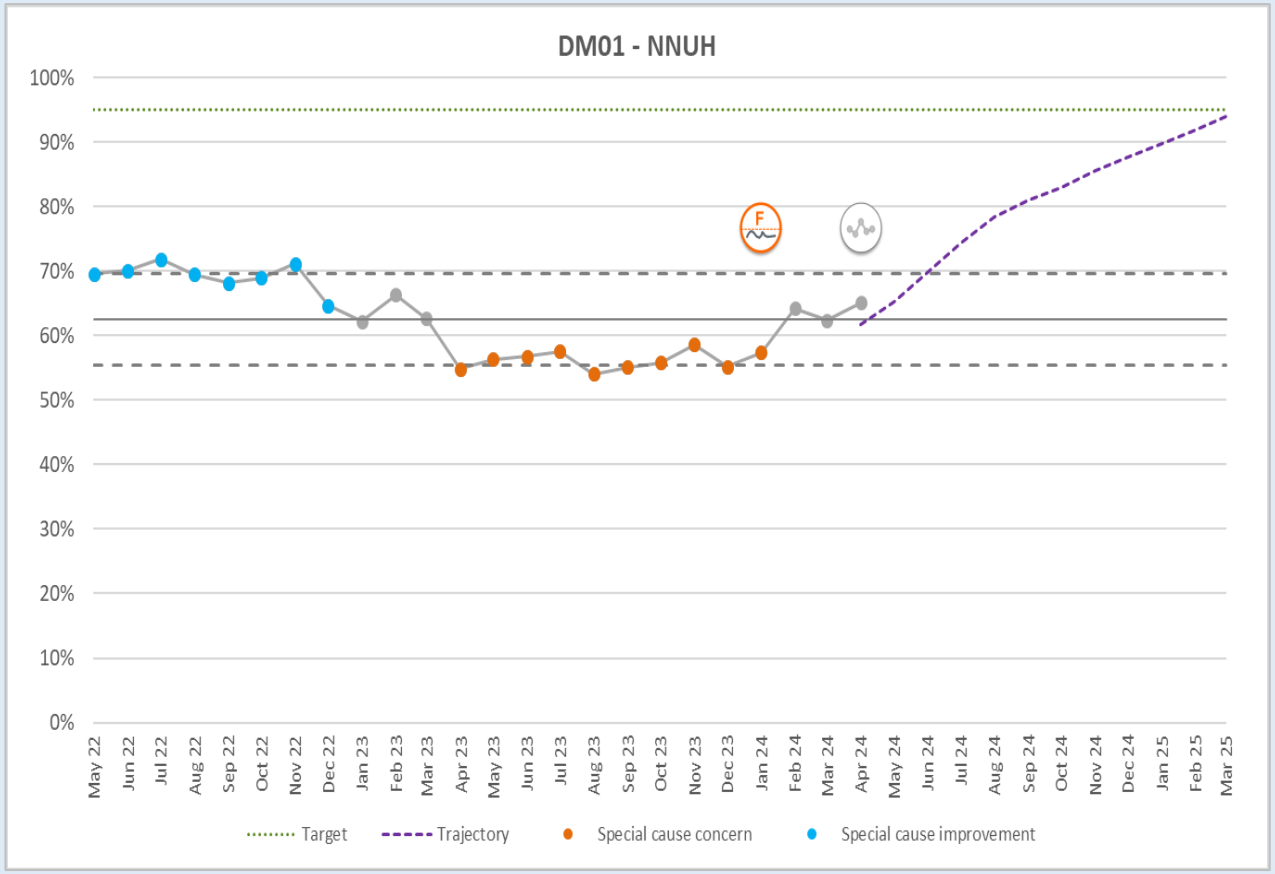
1. FIT negative service led in Primary Care ceased due to funding.
2. Process in place to ensure FIT negative patients are safety netted in Primary Care.

Risk To Delivery

GREEN

Diagnostics

Diagnostic Test Within 6 Weeks (DM01)



Commentary

April 2024 Performance

Performance increased to 65.1% in April – its highest level since February 2023 and above trajectory to achieve the 95% target by March 2025.

MRI deterioration (highlighted in the table below) in April was due to long term staff sickness absence and equipment failure.

MRI Improvement Actions

1. Switch in case mix to less complex cases
2. Request for mutual aid
3. Offer of overtime

Risk To Delivery

GREEN

Exam	April Performance
Magnetic Resonance Imaging	49.5%
Computed Tomography	70.1%
Non-Obstetric Ultrasound	71.8%
DEXA Scan	89.1%
Cardiology - echocardiography	59.3%
Colonoscopy	80.2%
Flexi sigmoidoscopy	93.9%
Gastroscopy	90.2%
Grand Total	**65.1%**

NNUH 24/25 Trajectory Key	
Above trajectory	
Within 5% below trajectory	
More than 5% below trajectory	

Supplementary Information

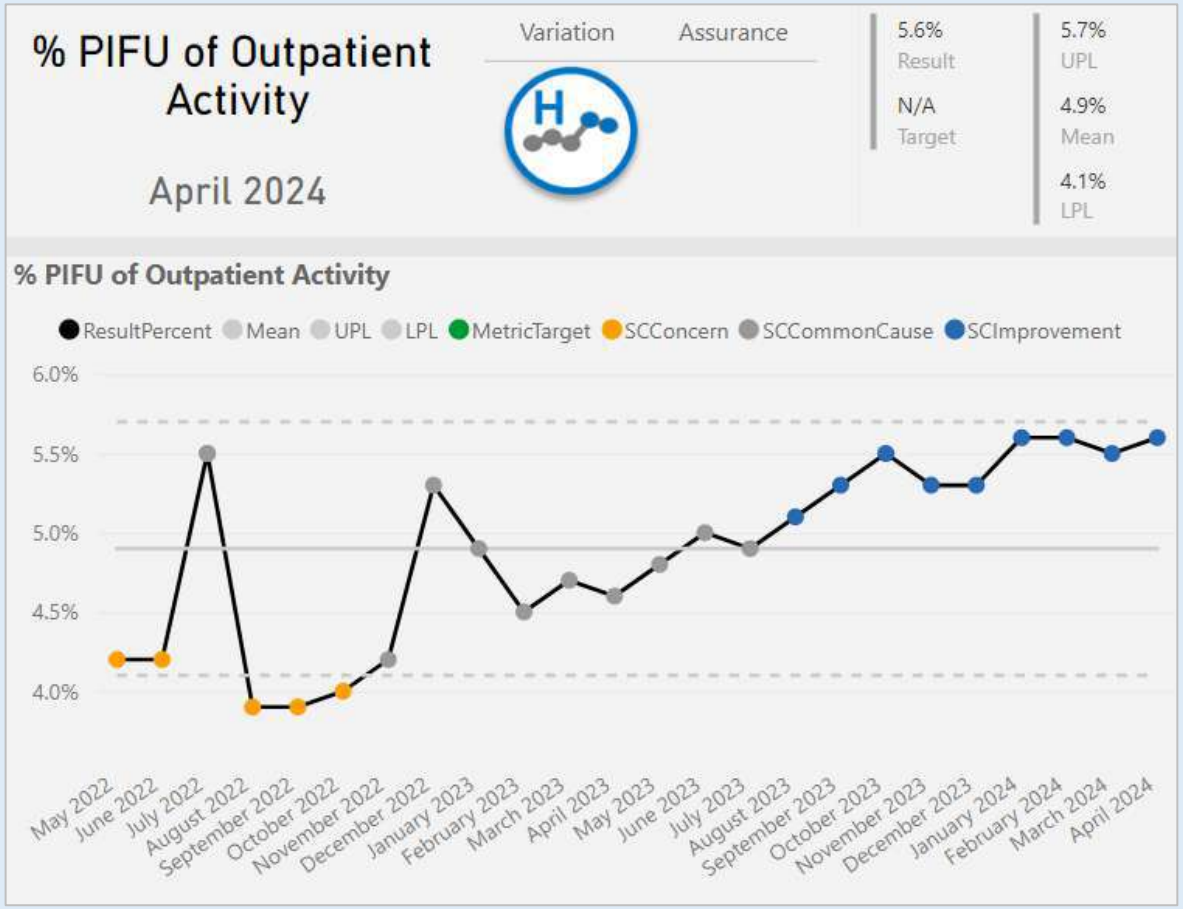
Patient Initiated Follow Up

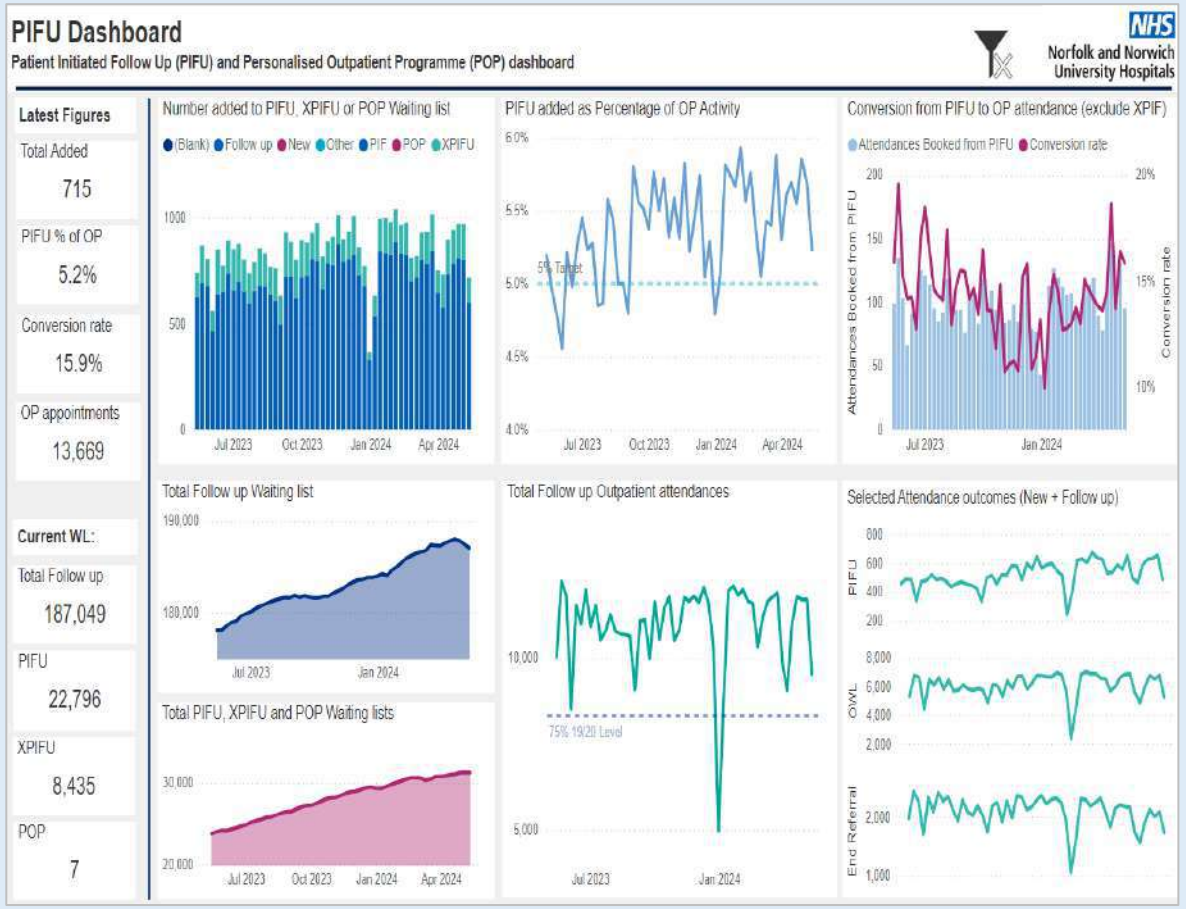
Commentary

April 2024 Performance

The number of patients added to a PIFU list as a percentage of the monthly outpatient activity increased from 5.5% in March to 5.6% in April and the joint highest ever in-month performance.

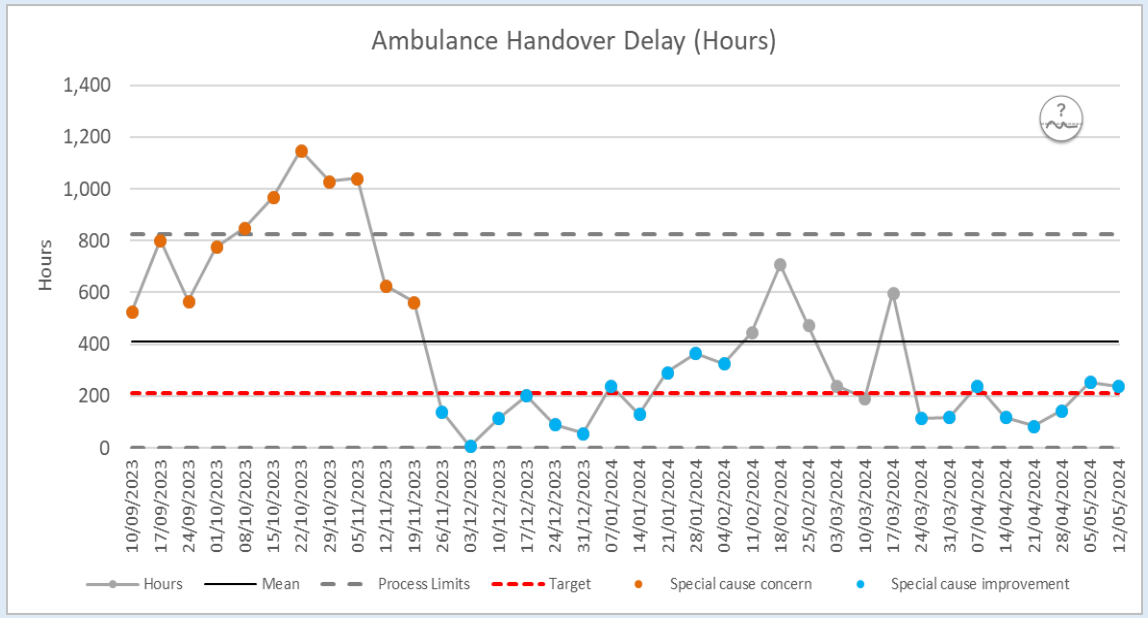
The most recent position (14th May) illustrates reduced performance to 5.2%, with a 15.9% conversion from PIFU to Outpatient attendance (below right).

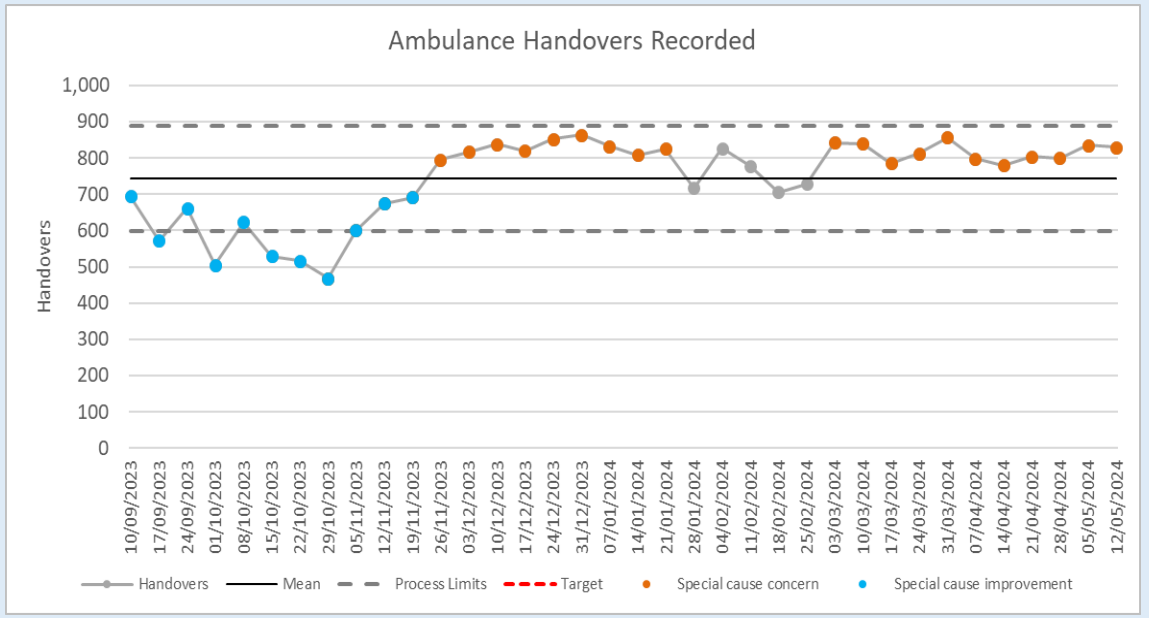




Performance – Ambulance Handovers

Week Ending	24-Mar	31-Mar	07-Apr	14-Apr	21-Apr	28-Apr	05-May	12-May
Ambulance handover delays (hours)	**115**	**118**	**241**	**118**	**84**	**144**	**254**	**238**
Ambulance handovers recorded	812	857	798	780	804	800	836	829
Average handover delay duration (mins)	8	8	18	9	6	11	18	17
Difference from baseline of 505 handovers	62%	59%	63%	65%	63%	63%	60%	61%





Commentary

April 2024 Performance

The total number of ambulance handover delays (hours) in April 2024 reduced by 478 hours compared to March, though there were 223 fewer ambulance handovers recorded in April. The charts above illustrate the increase in the number of Ambulance Handovers since November 2023 but the reduction in ambulance handover delays over the same period.

Performance – Ambulance Performance < 30 and > 60 Minutes

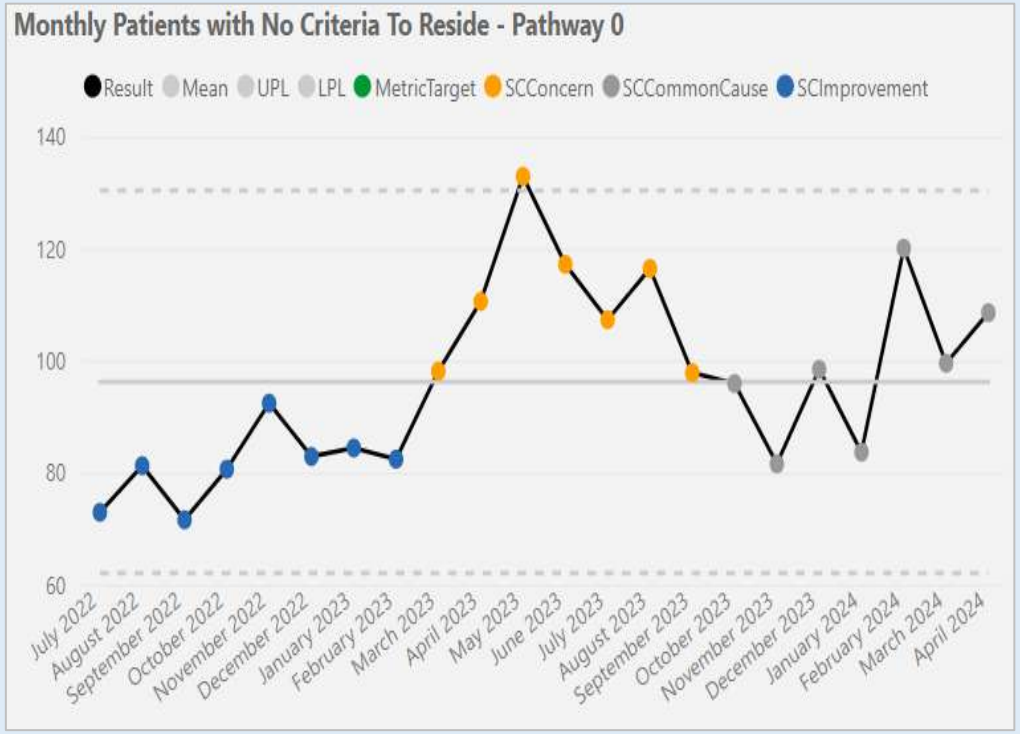
< 30 Minute Performance	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	Total
Addenbrookes Hospital	93.34%	98.54%	97.64%	99.31%	95.92%	98.30%	92.00%	92.45%	77.72%	72.79%	76.93%	85.83%	73.26%	88.77%
Basildon & Thurrock Hospital	70.33%	74.18%	79.41%	84.79%	81.15%	88.18%	78.03%	83.84%	72.64%	74.20%	85.83%	83.72%	88.01%	80.33%
Bedford Hospital South Wing	96.84%	96.69%	91.98%	97.77%	97.31%	94.84%	93.85%	92.25%	86.91%	84.87%	92.42%	93.74%	93.65%	93.32%
Broomfield Hospital	87.42%	91.19%	87.42%	84.80%	76.99%	78.17%	74.77%	73.96%	72.03%	82.82%	79.26%	81.42%	91.03%	81.64%
Colchester General Hospital	85.30%	91.02%	81.15%	89.91%	72.21%	84.89%	73.75%	80.03%	64.71%	61.87%	65.34%	74.70%	76.86%	77.06%
Hinchingbrooke Hospital	87.60%	87.97%	91.24%	92.67%	93.47%	91.61%	80.92%	65.57%	69.31%	80.08%	87.57%	88.54%	84.21%	84.67%
Ipswich Hospital	73.41%	75.60%	69.37%	76.96%	76.83%	74.91%	59.89%	60.11%	53.55%	54.22%	50.90%	73.74%	67.28%	66.67%
James Paget Hospital	67.25%	56.43%	69.14%	79.86%	51.68%	48.67%	49.33%	65.37%	57.56%	52.93%	56.40%	48.97%	50.57%	58.01%
Lister Hospital	51.42%	43.52%	43.32%	62.68%	51.62%	49.64%	47.02%	47.20%	39.54%	54.08%	54.32%	64.93%	59.33%	51.43%
Luton And Dunstable Hospital	73.35%	70.38%	69.31%	70.04%	68.68%	68.15%	65.41%	67.59%	58.05%	59.36%	59.43%	66.65%	66.62%	66.39%
Norfolk & Norwich University Hospital	41.40%	32.70%	44.70%	38.90%	34.00%	43.90%	23.40%	61.40%	82.80%	66.40%	55.20%	67.06%	72.99%	50.37%
Peterborough City Hospital	56.88%	62.27%	69.74%	65.25%	70.48%	63.36%	46.58%	41.32%	53.14%	57.74%	57.36%	63.84%	39.46%	57.49%
Princess Alexandra Hospital	60.43%	50.86%	52.66%	48.27%	45.06%	44.36%	34.64%	39.46%	48.72%	46.69%	46.16%	67.40%	53.04%	49.06%
Queen Elizabeth Hospital	62.29%	47.58%	45.01%	55.33%	49.14%	47.68%	40.92%	60.10%	67.64%	43.29%	71.77%	69.37%	72.04%	56.32%
Southend University Hospital	74.19%	65.77%	61.10%	67.36%	80.62%	86.11%	71.79%	75.77%	68.49%	71.59%	81.87%	84.96%	95.50%	75.78%
Watford General Hospital	59.29%	72.22%	77.57%	76.10%	69.97%	70.81%	73.87%	66.76%	62.51%	64.29%	70.37%	69.17%	69.27%	69.40%
West Suffolk Hospital	91.57%	92.28%	93.24%	93.59%	87.59%	82.53%	76.31%	85.18%	70.88%	59.30%	81.32%	87.03%	77.56%	82.95%
Total	**72.43%**	**71.09%**	**71.97%**	**75.42%**	**70.71%**	**71.43%**	**63.59%**	**68.05%**	**65.06%**	**63.87%**	**68.27%**	**74.43%**	**72.39%**	**69.98%**

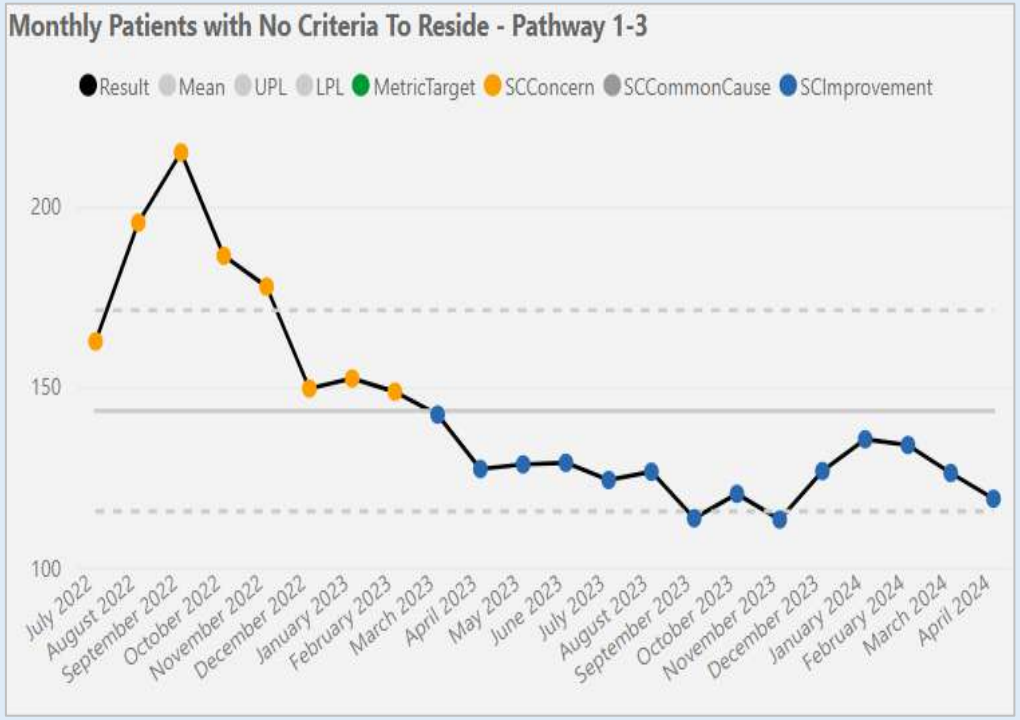
> 60 Minute Performance	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	Total
Addenbrookes Hospital	1.21%	0.00%	0.08%	0.00%	0.73%	0.24%	2.22%	2.70%	13.82%	17.47%	11.64%	6.67%	15.78%	4.73%
Basildon & Thurrock Hospital	12.90%	9.25%	6.64%	3.01%	6.61%	2.58%	8.24%	4.93%	13.98%	11.14%	4.01%	6.44%	2.30%	7.48%
Bedford Hospital South Wing	1.24%	0.48%	2.67%	0.56%	0.67%	1.52%	1.82%	2.86%	5.26%	7.17%	3.33%	1.76%	2.82%	2.45%
Broomfield Hospital	5.20%	1.96%	3.61%	4.53%	7.64%	5.99%	10.17%	11.33%	12.35%	5.90%	5.04%	5.76%	1.62%	6.62%
Colchester General Hospital	3.33%	1.56%	9.50%	3.22%	11.21%	3.81%	9.94%	6.01%	16.52%	16.46%	13.39%	9.08%	7.78%	8.67%
Hinchingbrooke Hospital	4.35%	4.83%	2.40%	2.49%	1.55%	3.65%	9.14%	20.49%	18.95%	11.85%	5.51%	4.42%	7.21%	7.47%
Ipswich Hospital	10.99%	10.45%	14.82%	8.06%	7.97%	10.59%	21.41%	21.71%	25.15%	25.13%	28.69%	9.18%	16.13%	16.18%
James Paget Hospital	16.35%	26.33%	15.14%	9.11%	31.34%	34.58%	35.04%	19.12%	27.06%	32.72%	27.92%	34.45%	34.16%	25.76%
Lister Hospital	19.62%	25.98%	26.58%	10.45%	17.85%	22.78%	24.59%	22.83%	32.25%	19.65%	17.53%	7.59%	14.52%	20.64%
Luton And Dunstable Hospital	8.60%	11.49%	12.05%	10.97%	11.53%	11.78%	15.44%	12.81%	19.35%	16.97%	16.81%	12.44%	14.88%	13.35%
Norfolk & Norwich University Hospital	41.20%	50.40%	37.40%	43.30%	45.00%	39.70%	61.90%	28.60%	8.60%	18.80%	31.60%	19.09%	14.30%	33.84%
Peterborough City Hospital	11.86%	12.01%	9.09%	8.51%	7.07%	10.79%	26.68%	32.45%	26.54%	21.19%	21.50%	13.73%	36.80%	16.79%
Princess Alexandra Hospital	16.60%	23.65%	22.42%	25.20%	26.70%	27.85%	43.47%	34.59%	24.85%	25.11%	27.44%	10.12%	20.63%	25.67%
Queen Elizabeth Hospital	20.94%	37.80%	37.60%	28.28%	33.99%	34.65%	40.33%	17.19%	12.89%	34.79%	10.34%	12.09%	11.52%	26.74%
Southend University Hospital	7.45%	13.20%	12.82%	10.32%	6.04%	2.75%	14.10%	7.89%	15.51%	13.57%	6.87%	4.21%	0.99%	9.56%
Watford General Hospital	12.72%	4.04%	2.20%	2.25%	4.61%	4.28%	1.79%	5.98%	8.01%	9.89%	5.33%	3.94%	5.71%	5.42%
West Suffolk Hospital	0.18%	0.99%	0.59%	0.65%	1.94%	4.13%	9.28%	3.37%	15.77%	24.76%	7.39%	4.48%	8.95%	6.13%
Total	**11.46%**	**13.79%**	**12.68%**	**10.05%**	**13.09%**	**13.04%**	**19.74%**	**14.99%**	**17.46%**	**18.39%**	**14.37%**	**9.73%**	**12.71%**	**13.97%**

Commentary

- < 30 minutes: Ranking 9th out of 17 in the region for April 2024 – this is the best in-month performance since December 2023. NNUH were ranked 16th in the region for the period from April 2023 to April 2024.
- > 60 minutes: Ranking 10th out of 17 in the region for April 2024 – this is the best in-month performance since December 2023. NNUH were ranked 17th in the region for the period from April 2023 to April 2024..
- However, both 30-minute and 60-minute ambulance performance has improved compared to April 2023.

No Criteria to Reside





Commentary

April 2024 Performance

No Criteria to Reside D2A Pathway 0 (P0) in April was 109 patients – an increase to its second highest average in the last 8 months but lower than April 2023 (112).

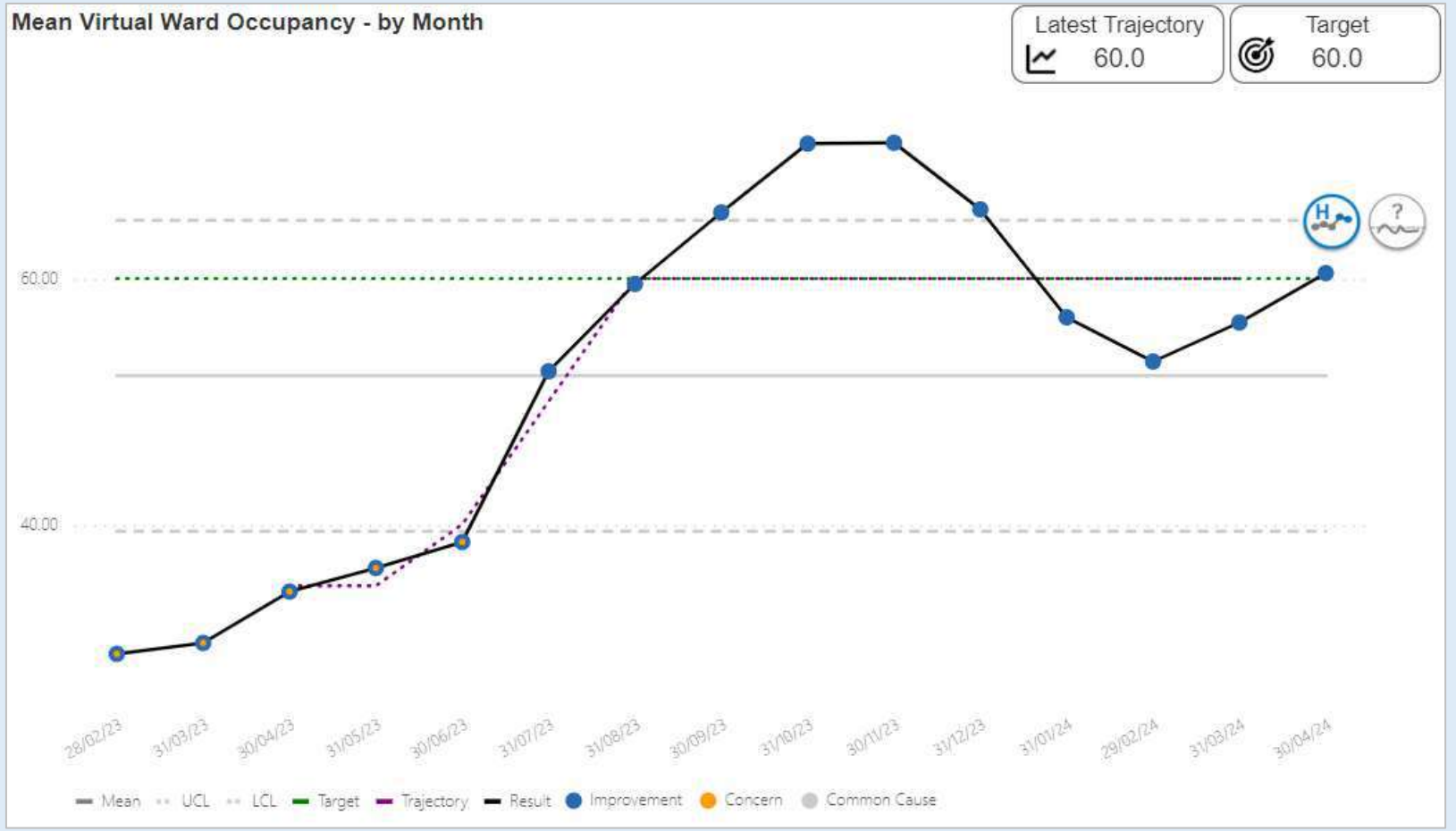
No Criteria to Reside D2A Pathway 1-3 (P1-3) in April was 119 patients – a reduction for the 3rd successive month.

Virtual Ward Activity

Commentary

April 2024 Performance

In April, the mean number of patients on the Virtual Ward was 60 – higher than the previous 3 months.

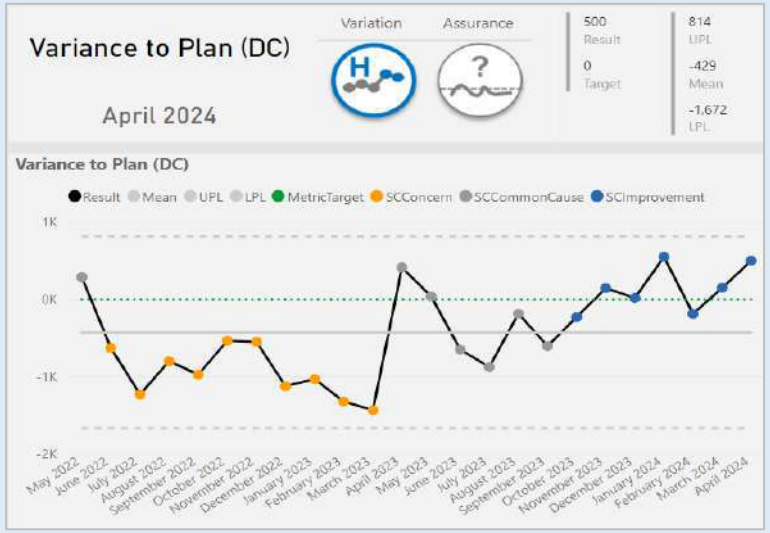


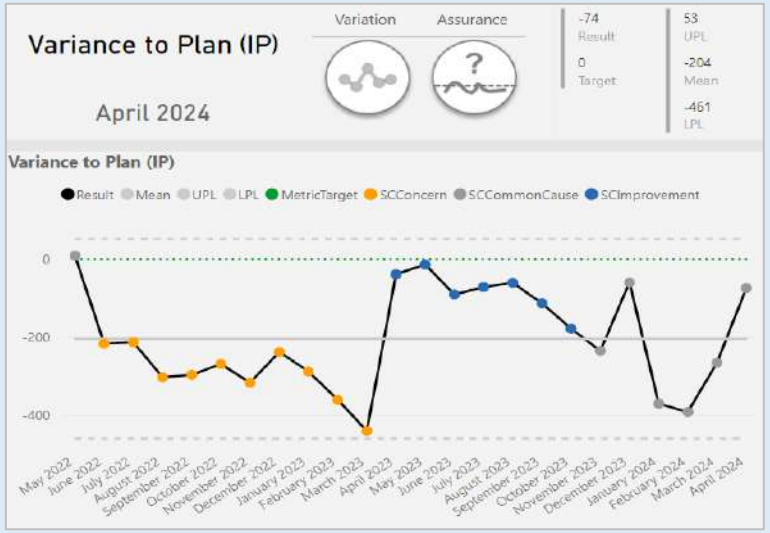
Activity Planning Run Rate

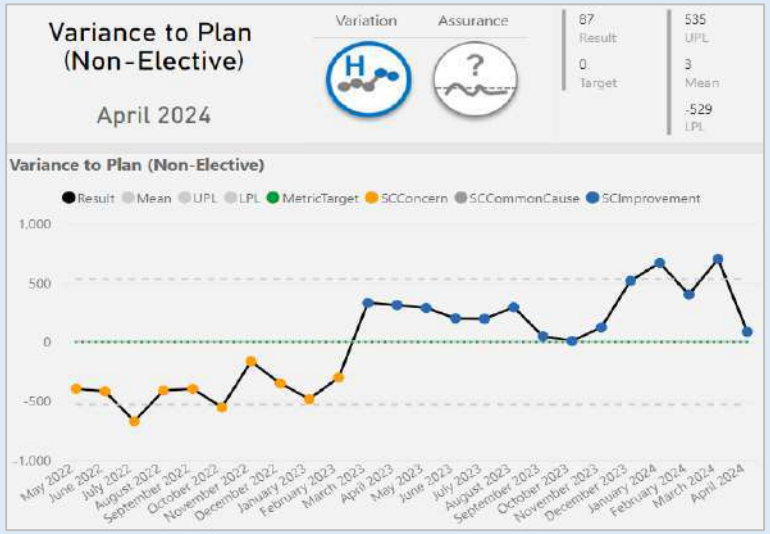
Commentary

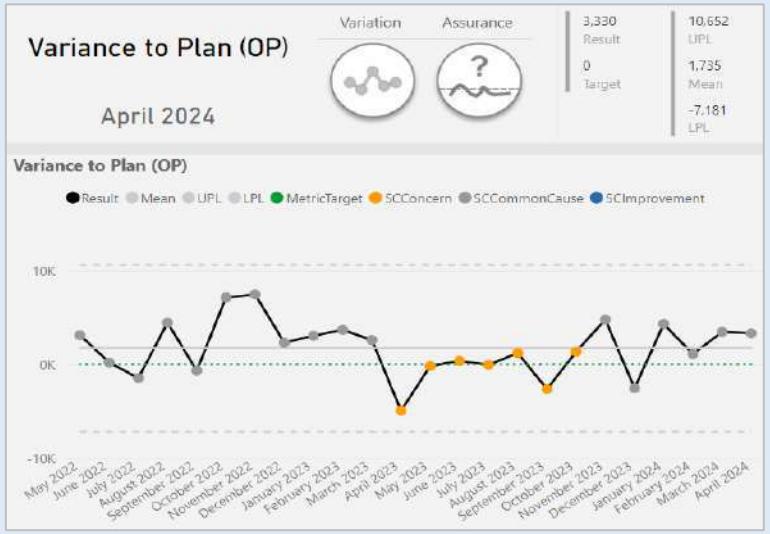
April 2024 Performance (provisional)

The graphs below summarise the activity variance to plan for Day Case, Outpatients, Non-Elective and Inpatients.









REPORT TO TRUST BOARD

Date	**5th June 2024**
Title	**Month 1 IPR – Finance**
Author & Exec Lead	**Liz Sanford (Interim Chief Finance Officer)**
Purpose	**For Information**
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: HMB and Finance, Investments & Performance Committee**		**Outcome: Report for information only, no decisions required.**

1 Background/Context

The Trust operational plan excluding the technical impact of PFI remeasurement for FY24/25 as outlined in Cycle 4 of the 2024/25 planning process is breakeven. In line with national guidance, the Trust has implemented the transition from accounting for PFI under IAS17 to IFRS16. As a result of the transition, the Trust operational plan is a £5.5m deficit and as such Trust performance will be measured against this planned deficit.

2 Key issues, risks and actions

April position is a £2.5m deficit on a control total basis, £0.1m favourable to the planned £2.6m deficit. Recurrent performance is a £5.6m deficit, £3.0m adverse to Plan.

CIP under delivery is £0.7m adverse, divisional pay expenditure is £1.8m adverse, activity is £0.6m and net drugs expenditure of £0.1m adverse, offset by favourable interest income of £0.2m. This has been offset by non-recurrent mitigations of £3.1m of which £1.3m is non pay divisional underspends, £2.2m reserve utilisation, reduced by £0.4m additional expenditure required for independent capacity support and discharge suite/escalation.

Activity: Value-based activity performance for April was £0.6m adverse to plan equating to 96% of planed activity levels. The elective elements were £0.7m adverse (95%) offset by £0.1m favourable delivery of other chargeable API (Chemotherapy Delivery and Diagnostic Imaging) activity.
Forecast Outturn: Year to date £3.7m of crystalised is risk offset by £3.8m of crystallised mitigations. The further crystallisation of risk is forecast to be £55.5m offset by forecast mitigation of £1.7m, leaving a downside forecast outturn of £53.8m deficit, requiring additional mitigations of £53.7m to achieve the Cycle 4 deficit plan of £5.5m.

Cash: Cash held at 30th April 2024 was £103.3m, £8.6m lower than the FY24/25 submitted forecast as a result of working capital movements

Capital Expenditure: Year to date total capital spend is £3.2m, a £3.6m underspend against the planned £6.8m. **Forecast Outturn** for the total capital plan is £102.4m, a £9.2m overspend against the Trust's CDEL allocation of £93.2m due to the IFRS16 impact of leases. This is in line with Plan, but remains a significant risk for the Trust.

3 Conclusions/Outcome/Next steps

Year to date, the Trust has delivered a £2.5m deficit against the planned £2.6m deficit, £0.1m favourable to plan. Forecast Outturn remains Breakeven. The Trust underspent Capital Expenditure by £3.6m for the month. Forecast Outturn for the total capital plan is £102.4m, a £9.2m overspend against the Trust's CDEL allocation of £93.2m.

Recommendations: The Board is recommended to **NOTE** the contents of the report.

Norfolk and Norwich University Hospitals NHS Foundation Trust

Finance Report
April 2024

5 June 2024

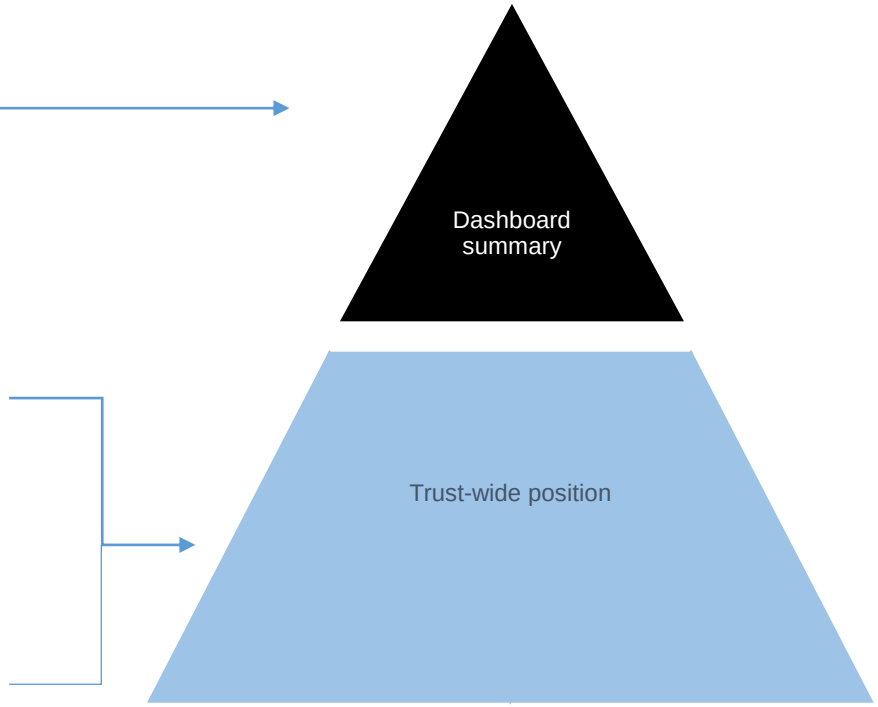
Liz Sanford, Interim Chief Finance Officer

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 excluding the technical impact of PFI remeasurement for FY24/25 as outlined in Cycle 4 of the 2024/25 planning process is breakeven. In line with national guidance, the Trust has implemented the transition from accounting for PFI under IAS17 to IFRS16. As a result of the transition, the Trust operational plan is a £5.5m deficit and as such Trust performance will be measured against this planned deficit.

April position is a £2.5m deficit on a control total basis, £0.1m favourable to the planned £2.6m deficit. Recurrent performance is a £5.6m deficit, £3.0m adverse to Plan.

CIP under delivery is £0.7m adverse, divisional pay expenditure is £1.8m adverse, activity is £0.6m and net drugs expenditure of £0.1m adverse, offset by favourable interest income of £0.2m. This has been offset by non-recurrent mitigations of £3.1m of which £1.3m is non pay divisional underspends, £2.2m reserve utilisation, reduced by £0.4m additional expenditure required for independent capacity support and discharge suite/escalation.

Activity: Value-based activity performance for April was £0.6m adverse to plan equating to 96% of planed activity levels. The elective elements were £0.7m adverse (95%) offset by £0.1m favourable delivery of other chargeable API (Chemotherapy Delivery and Diagnostic Imaging) activity.

Forecast Outturn: Year to date £3.7m of crystalised is risk offset by £3.8m of crystallised mitigations. The further crystallisation of risk is forecast to be £55.5m offset by forecast mitigation of £1.7m, leaving a downside forecast outturn of £53.8m deficit, requiring additional mitigations of £53.7m to achieve the Cycle 4 deficit plan of £5.5m.

Cash: Cash held at 30th April 2024 was £103.3m, £8.6m lower than the FY24/25 submitted forecast as a result of working capital movements.

Capital Expenditure: Year to date total capital spend is £3.2m, a £3.6m underspend against the planned £6.8m. **Forecast Outturn** for the total capital plan is £102.4, a £9.2m overspend against the Trust's CDEL allocation of £93.2m due to the IFRS16 impact of leases. This is in line with Plan, but remains a significant risk for the Trust.

	In Month		
	Actual	Plan	Variance
SOCI	£m	£m	£m
Clinical Income	63.7	63.7	0.0
Other Income	8.9	8.2	0.6
TOTAL INCOME	**72.6**	**72.0**	**0.6**
Pay	(46.4)	(43.9)	(2.5)
Non Pay	(19.6)	(20.6)	1.0
Drugs (Net Expenditure)	(3.2)	(3.1)	(0.1)
TOTAL EXPENDITURE	**(69.2)**	**(67.6)**	**(1.6)**
Non Opex	(6.0)	(7.0)	1.0
Control Total Surplus / (Deficit)	(2.5)	(2.6)	0.1
Statutory Surplus / (Deficit)	(1.7)	(1.4)	(0.3)

Other Financial Metrics	£m	£m	£m
Cash at Bank (before support funding)	103.3	111.9	(8.6)
Capital Programme Expenditure	3.2	6.8	(3.6)
CIP Delivery	0.2	0.9	(0.7)

Activity Metrics			
Day Case	5.4	5.7	(0.3)
Elective Inpatient	4.0	4.4	(0.3)
Outpatients - New & Procedures	5.4	5.5	(0.1)
Other Chargeable activity included within API	1.8	1.7	0.1
TOTAL	16.6	17.2	(0.6)

1.2 Executive Dashboard

Norfolk and Norwich University Hospitals NHS Foundation Trust

Risk

The strategic financial risks remain the same as at Cycle 4 of the Business Planning Process with no changes in risk scoring this month.

As part of FY24/25 annual planning there were 14 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 nine risks rated as 'Extreme' on the risk register which had a potential risk assessed financial impact of £70.3m at Cycle of the Business Planning process. This has been revised upwards to £89.5 at Month 1, of which £3.7m crystalised in Month 1.

The Month 1 crystalised risks are:

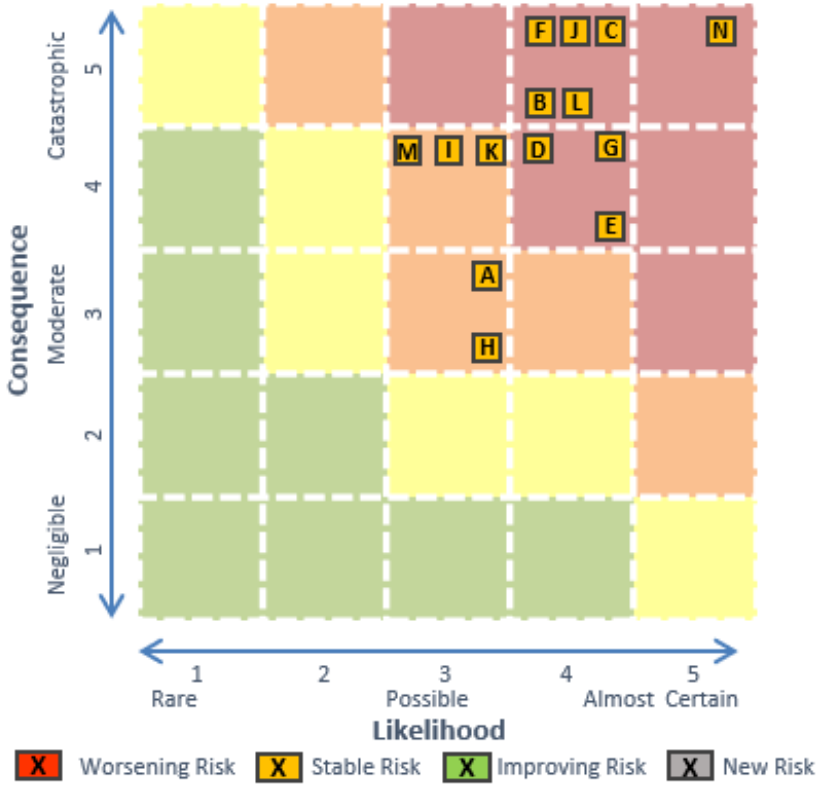
CIP Under Delivery (Risk B) was £0.7m adverse - £0.2m delivered against the budgeted plan of £0.9m, comprising of a planning variance of £0.6m and an adverse performance variance of £0.1m, which equates to an underperformance of c. 80%.

Failure to control expenditure in line with plan (Risk C) had a crystalised impact of £1.9m in month, comprising of overspends in Divisional Pay (£1.8m) and Drugs (£0.1m).

Failure to deliver weighted Elective activity in the with the plan (Risk F) had a crystalised impact of £0.6m in month, comprising of an under performance in the Elective Elements of £0.7m offset by overperformance in Chemo & Radiology of £0.1m

The Trust creating further capacity at additional cost beyond the level allowed for in the plan (Risk G) had a crystalised impact of £0.4m in month. This is as a result of increased use of the Independent Sector to support the Elective activity plan (£0.1m) and continued opening of the Discharge Suite and Escalation (£0.3m).

Risk Rating		Risks	Financial Impact FY24/25 £m	Financial Impact FY24/25 (Revised) £m	YTD Crystallised Impact £m
Extreme	15+	B, C, D, E, F, G, J, L, N	70.3	82.3	3.7
High	9-14	A, H, I, K, M	7.2	7.2	0.0
Moderate	5-8	-		0.0	0.0
Low	1-4	-		0.0	0.0
Total			77.5	89.5	3.7
Risk mitigated through control of Crystalised Risk				(30.4)	0.0
Net Total Risk Assessed Impact				59.1	3.7
Total Risk Assessed Impact				(5.3)	(3.8)
Total			77.5	53.8	(0.1)



2.1 Financial Performance – April 2024

Norfolk and Norwich University Hospitals NHS Foundation Trust

April position is a £2.5m deficit on a control total basis, £0.1m favourable to the planed £2.6m deficit. Recurrent performance is a £5.6m deficit, £3.0m adverse to plan. CIP under delivery is £0.7m adverse, divisional pay expenditure is £1.8m adverse, activity is £0.6m adverse and net drugs expenditure is £0.1m adverse, offset by favourable interest income of £0.2m. This has been offset by non-recurrent mitigations of £3.1m, of which £1.3m is non pay divisional underspends, £2.2m reserve utilisation reduced by £0.4m additional expenditure required for independent capacity support and discharge suite / escalation.

Income: Income is reporting a favourable variance of £0.6m in April. Specialised commissioning growth income of £0.1m was received in month along with £0.1m of additional clinical income for Radiology and Chemotherapy. The remaining variance is due to pass through income for R&D of £0.3m and devices of £0.1m which are both offset with expenditure.

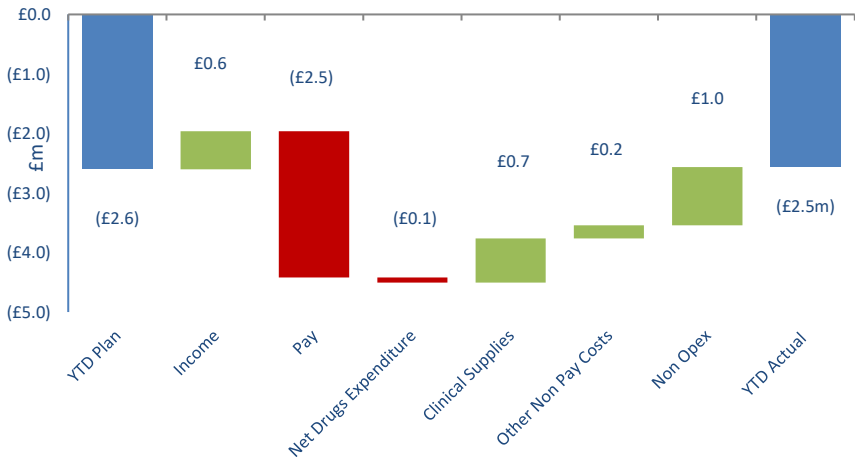
Pay: Pay is overspent by £2.5m year to date. This is due to £0.3m of unidentified CIP, £1.0m overspend in nursing (£0.6m of this is in Medicine), and £1.3m overspend in medical.

Agency spend in April is 2.7%, 0.5% lower than the set threshold of 3.2%. Registered Nursing is the largest user of agency spend, being 5.3% of total nursing spend.

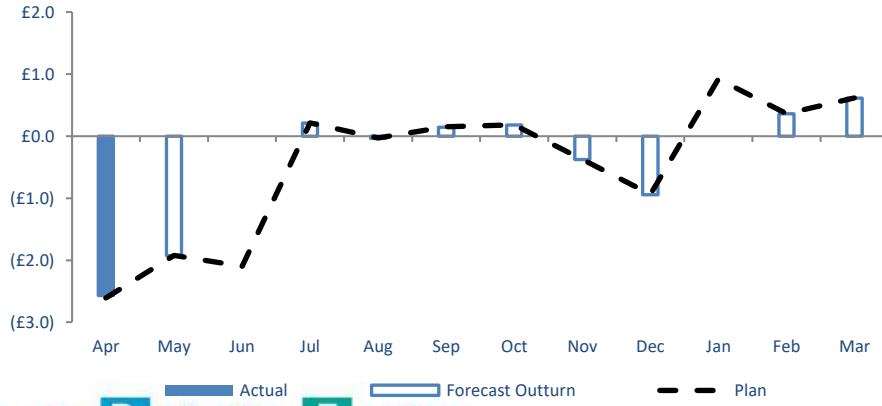
Net Drugs Cost: Year to date net drugs position is £0.1m adverse.

Non-Pay: Non pay is favourable by £0.9m. This is due to underspends of clinical supplies across Surgery of £0.5m, £0.2m in CSS, and £0.5m of unutilised reserves in non-clinical supplies, offset by unidentified CIP of £0.3m.

Non-Operating Expenditure: April non-operating expenditure is showing a £1.0m favourable variance £0.2m of interest income received due to higher cash balances, £0.6m reduction in interest payable on the PFI and £0.2m due to lower depreciation charges in month.



Monthly Actual/Forecast Surplus/(Deficit) v Plan

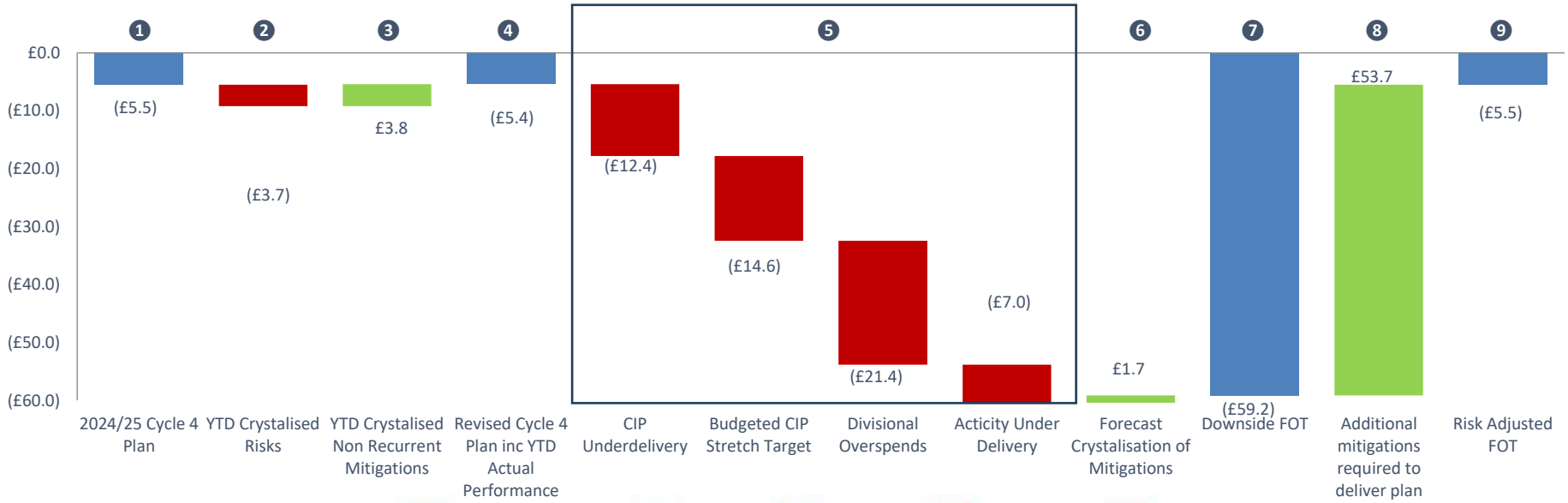


2.2 Forecast Outturn

Norfolk and Norwich University Hospitals NHS Foundation Trust

Year-to-date, £3.7m of risks and £3.8m of mitigations have crystalised, resulting in a £0.1m favourable variance to plan at Month 1. For the remainder of the year, further risk crystallisation is forecast at £55.5m, offset by a further £1.7m of identified mitigations resulting in a downside forecast outturn of a £59.2m deficit, £53.7m adverse to the £5.5m deficit plan. Additional mitigations totalling £53.7m are required to deliver the £5.5m deficit plan.

1. The Trust operational plan including the technical impact of PFI remeasurement for FY24/25 as outlined in Cycle 4 of the 2024/25 planning process is a deficit of £5.5m.
2. Year to date crystalised risks of £3.7m, of which £1.8m relates to divisional pay overspends, £0.7m relates to under delivery of CIP and £0.6m relates to under delivery of activity.
3. Year to date crystalised mitigations of £3.8m, of which £1.4m relates Non-Recurrent Risk Mitigation, £0.8m unutilised reserve and £0.2m of interest income.
4. Revised Cycle 4 plan with impact of YTD actual performance of a £5.4m deficit, £0.1m favourable to plan
5. Further run rate risk of £55.5m forecast to crystallise through remainder of the year based on current run rates.
6. Further mitigations of £1.7m forecast to crystallise through remainder of the year based on current run rates.
7. Downside Forecast Outturn of a £59.2m, £53.7m adverse to the £5.5m deficit plan.
8. Additional mitigations totalling £53.7m required to deliver £5.5m deficit plan
9. Risk Adjusted Forecast Outturn of £5.5m, nil variance to the £5.5m deficit plan.



Our Vision
The best care for every patient

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REPORT TO THE TRUST BOARD

Date	29.05.24
Title	Chair's Key Issues Report from Major Projects Assurance Committee
Lead	Nikki Gray – Non Executive and Committee Chair
Purpose	**For Information**

1 Background/Context

The Major Projects Assurance Committee met on 29 May 2024 and discussed matters in accordance with its Terms of Reference. Papers for the meeting have been made available to all Board members for information in the usual way via Admin Control. The Meeting was quorate and was attended by Dr Fleming as Governor Observer.

2 Key Issues/Risks/Actions

In addition to reviewing standard reports in accordance with its Terms of Reference, the Committee identified the following matters of note to bring to the attention of the Board:

	Issues considered	Outcomes/decisions/actions
1	Norfolk & Norwich Orthopaedic Centre (NANOC)	The Committee was extremely pleased to learn that the development of the NANOC has now passed the milestone of Building Control Sign-off and the Trust has taken handover of the building. Final commissioning is taking place in anticipation of operational readiness for patients in July.
2	NNUH Diagnostic Centre	The Committee was advised that the NNUH Diagnostic Centre project remains Green-rated for expenditure and timetable. The overall N&W CDC Programme is rated mid-Amber and the Committee has requested confirmation that any underspend on the NNUH contingency will be retained by the Trust.

3 Conclusions/Outcome/Next steps

The Committee is scheduled to meet again on 26 June 2024, at which meeting the Committee is due to consider:

- next steps in EPR programme
- Committee Annual Report

Recommendation: The Board is recommended to note the work of its Major Projects Assurance Committee.