

MEETING OF THE TRUST BOARD IN PUBLIC

THURSDAY 24 MARCH 2016

A meeting of the Trust Board in public will take place at 9am on Thursday 24 March 2016 in the Boardroom of the Norfolk and Norwich University Hospital

AGENDA

	Item	Lead Director	Purpose	Page No
1	Apologies			
2	Minutes of the Board meeting held in public on 29.01.2016		Approval	3
3	Matters arising		Discussion	
4	Chief Executive's Report	CEO	Information	13
5	Integrated Performance Report	All	Information	19
6	Feedback from Council of Governors	Chair	Information	
7	Any other business			

Date and Time of next Board meeting in public

The next Board meeting in public will be at 9am on Friday 27 May 2016 in the Boardroom of the Norfolk and Norwich University Hospital

MINUTES OF TRUST BOARD MEETING IN PUBLIC

HELD ON FRIDAY 29 JANUARY 2016

Present:	Mr J Fry	- Chairman
	Mrs S Budd	- Acting Director of Finance
	Mr P Chapman	- Interim Medical Director
	Mr M Davies	- Chief Executive
	Mr M Fleming	- Non-Executive Director
	Mr T How	- Non-Executive Director
	Mr M Jeffries	- Non-Executive Director
	Mrs E McKay	- Director of Nursing
	Mr J Over	- Director of Workforce
	Mr R Parker	- Chief Operating Officer
	Professor D Richardson	- Non-Executive Director
	Mrs A Robson	- Non-Executive Director
	Ms S Smith QC	- Non-Executive Director
In attendance:	Ms F Devine	- Director of Communications
	Mr J P Garside	- Board Secretary
	Ms V Rant	- Assistant to Board Secretary

16/001 **APOLOGIES**

No apologies were received.

16/002 **MINUTES OF PREVIOUS MEETING HELD ON FRIDAY 27 NOVEMBER 2015**

The minutes of the meeting held on 27 November 2015 were agreed as a true record and signed by the Chairman.

16/003 **MATTERS ARISING**

The Board reviewed the Action Points arising from its meeting held on 27 November 2015 as follows:

15/079 Mrs McKay updated the Board concerning the ongoing work with PWC concerning review of the Trust's Risk Management structures and Strategy. Dates are planned for an updated draft Strategy to be reviewed by the Management Board and Audit Committee in March.

15/081 Carried forward. The monthly summary template in the IPR will be revised to include relevant targets for ease of reference. **Action: Mr Garside**

15/081 At item 16/005 the Board was updated with regard to the Vanguard theatre and the RTT trajectory.

15/081 Mr Over confirmed that the mandatory training target has been revised to 90%. This makes an allowance for non-compliance associated with maternity leave, sick leave and new starters. It was suggested that the way we record compliance with the mandatory training target should be revised to exclude these groups and this will be reviewed. **Action: Mr Over**

15/081 Mrs Budd explained the differentiation between BAF risk 17 and BAF risk 12 and it was agreed that the wording of these should be revised to make clear that the former relates to the financial and CIP risk whereas the latter concerns operational risk.

Action: Mrs Budd

16/004 **CHIEF EXECUTIVE REPORT**

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

(a) Care Quality Commission (CQC)

Mr Davies informed the Board that the CQC report is expected in February. We will have 10 days to check the report for factual accuracy and submit our feedback to the CQC. The next stage in the process will be a Quality Summit in private and then publication of the report.

(b) Senior Appointments

A number of key appointments have been made to leadership positions within the new divisions. The next steps in the divisional restructuring will be the appointment of teams to report to the divisional leads. The new teams will be supported through an Organisational Development Programme in conjunction with Aston University. The new Chiefs of Division attended the first Management Board meeting and this is a positive step in our reorganisation and cultural change. This is however a long-term project.

The Board was updated on a number of consultant appointments. Three appointments have been made in the Emergency Medicine, one in Radiology and one in Anaesthetics. Data concerning consultant vacancies will be enhanced in future reports to indicate whether these are new or replacement posts. **Action: Mr Garside**

An Open Day for Specialist Registrars and Consultants is being held in February. The Open Day is being held to attract staff to work in a number of specialties and to 'showcase' the opportunities available at this Trust.

Regular Viewpoint sessions continue to be held at NNUH and Cromer Hospital. The sessions are intended to provide staff with an update on developments within the Trust and a question and answer session with the Executive team. They have been well attended and well received.

(c) Norfolk Provider Partnership

Mr Davies informed the Board that there was positive publicity following establishment of the Norfolk Provider Partnership (NPP). The NPP is led by the Chief Executives of each of the partners meeting every month. This is the first time that providers have agreed to work together in such a structured way. Clinicians will be involved in developing ideas to transform care provision across Norfolk.

The descriptor for the strategic priority relating to the pathway for frail elderly patients will be revised to make clear that this is not confined to focus on "step-down".

Action: Mr Hackwell

(d) Strategy

The Trust's outline Strategy has been sent to Monitor in accordance with the Licence Undertakings with agreed areas of priority being:

- development of an elective ambulatory care centre;
- investment in stroke, heart attack and cancer services;
- redesign of the hospital's "front door";
- development of the patient pathway for frail elderly patients;

- development of the Norfolk Provider Partnership.

Monitor guidance also requires all providers and commissioners to submit two further interconnected plans. The first is a draft 2016/17 Operational Plan which is due to be submitted by 8 February 2016. The second is a strategic, local health and care system Sustainability and Transformation Plan (October 2016 to March 2021) which is due to be submitted in June 2016.

It has been decided that the footprint of the Sustainability and Transformation Plan (STP) should cover Norfolk and the Waveney Valley. The work of the NPP will feed into the work of the STP. The CCG for West Norfolk has not yet confirmed its agreement to be one of the partner organisations of the STP.

The work taking place in the development of the STP will satisfy our Licence Undertaking to develop a health economy-wide strategy by March 2016. Development of the STP will however be a significant challenge for all partners and this work is required within a relatively short timescale.

Progress is being made towards our own strategy which is focusing on three key areas: providing a local service for the local population, to be a tertiary provider in Norfolk, and developing the academic mission of the Trust.

Cardiology, stroke and cancer have been agreed as the clinical priorities for development and the Chiefs of Divisions will be engaging with clinical staff to explore ideas.

Development of projects under the Future NNUH Programme will be overseen by the Management Board and will be developing business cases for the three key priorities in relation to ambulatory elective centre; front door redesign; and clinical services.

The work in relation to 'step down' for frail elderly will be developed under the Sustainability and Transformation Plan.

(e) Nursing Education

Professor Richardson reminded the Board that from 2017/18 nurse education will be funded via a system of loans, rather than bursaries and this will come into effect in the academic year which starts in September 2017.

The current system has obliged universities to limit student numbers even though this has led to national graduate shortages.

Professor Richardson explained that we will need to explore how we could support students under the new system and to find ways of attracting/retaining greater numbers of student nurses. The Government has also been asked to explore options to attract staff to work for the NHS for example, by looking at repayment of part of a student's loan after a given period of time or awarding retention bonuses.

Mrs McKay explained that liaison has commenced with the UEA and HEE to look at potential opportunities. It will be necessary to establish relatively soon the detail of our offer to students, so that this is clear when advertising the 2017 courses.

At its meeting in March, the Board will receive an assessment of the potential growth in nursing student numbers following the proposed change in funding arrangements and of the Trust's capacity to offer increased clinical placements.

Action: Mrs McKay and Mr Over

Some institutions may offer a broad based course whilst others may focus on particular specialisms.

(f) Research

Mr Davies informed the Board that an advert has been placed for the post of Director of Research and Innovation. Interviews are expected to take place at the end of February and the postholder will play an integral part in development of a Research Directorate in the Trust to promote a culture of research and increase research activity.

(g) Electronic Prescribing and Medicines Administration (EPMA)

The EPMA has been rolled out to all medical wards and will be introduced to surgical wards in the week commencing 22 February.

(h) Council of Governor Elections

Mr Davies expressed congratulations to Janet King, Peter Kemp, Erica Betts and Nina Duddleston following their appointment as public governors on the Council of Governors and to Mr Ed Aldus who had been re-elected as staff governor in the clinical support constituency.

16/005 **INTEGRATED PERFORMANCE REPORT**

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

(a) Operational Performance

The 31 day cancer target has been achieved over the last four months in Quarter 3 as a whole.

Performance against the stroke indicators has improved but access to a HASU bed has been compromised by bed congestion. Performance in relation to a CT scan within 60 minutes is being closely monitored following a decline in November.

The 62 day cancer target performance has deteriorated as expected due to the work being undertaken to clear the backlog of patients. The backlog has been reduced from 190 patients to 35 patients to date and that is expected to reduce to 20 in February. Weekly meetings continue to be held with commissioners and NHS England to review patients and specialty pathways. The Board was informed that urology remains the most challenged specialty.

Diagnostic 6 week wait performance has been challenged by high numbers of endoscopy referrals. Medinet have been commissioned to increase capacity and performance is expected to return to compliance by the end of March 2016.

A revised recovery plan for the 18 Week RTT performance was submitted to NHS England at the end of December 2015. Key challenges affecting our ability to achieve 18 Week RTT performance are increased activity and displacement of work due to clearance of the cancer backlog. There has also historically been a high reliance on flexible capacity and replacement of this with substantive solutions cannot be achieved immediately.

A review of the top 5 most challenged specialties has highlighted the capacity challenges that we are currently facing and a number of high impact recovery interventions are being implemented in five key areas: workforce, Vanguard Theatre, increased Day Procedure Unit capacity, outsourcing and additional outpatient capacity.

Additional substantive posts are being put in place to reduce reliance on additional sessions and overtime.

DPU capacity is being increased by 16 additional procedures per week at the weekends and additional staff are being recruited to deliver this work. By creating this additional capacity we will be able to undertake this work ourselves which will increase income and reduce WLI work.

The high impact recovery interventions are expected to move the RTT recovery trajectory forward to recover performance in July 2016.

An option under consideration is an additional Vanguard mobile cath-lab which would release capacity for interventional radiology. The facility would utilise the theatre at weekends and would clear the current backlog of c.100 patients.

An outpatient waiting list validation exercise is underway to ensure that patients are booked in the right order and to identify any spare capacity that is not being utilised. Additional clinic space with external providers is also being explored.

Mr How asked if there were enough consultants being trained nationally. Mr Chapman said that in some specialties there is an oversupply and in others there is a lack of numbers. There are some specialties that find it particularly difficult to recruit.

Although A&E 4 hour performance has remained lower than target, the measures implemented over Christmas and New Year period were successful. We were able to maintain flow during this period, creating 80 empty beds and were able to provide assistance to other local Trusts during this time. Subsequently, we saw a high number of frail and elderly patients being admitted to hospital. There are 292 patients that have been in hospital for more than a fortnight and work is being undertaken both internally and externally to resolve delays in their pathways.

The East of England Ambulance Service Trust (EEAST) reported that there were over 30,000 patients transported by ambulance to NNUH in 2014/15. Comparing the yearly volume we have seen a 10.2% increase in ambulance arrivals at this Trust. We are working closely with the Ambulance Trust to look at schemes that would reduce the number of conveyances and ways to reduce handover delays.

Ms Smith asked if the location of the hospital site outside of Norwich had an impact on the number of ambulance conveyances. Mr Parker said that it was difficult to determine the reasons for growth of ambulance demand, it is inevitably a mixed picture.

(b) Workforce

The Board was informed that work continues to try to reduce expenditure on temporary staff. Spend on agency staff has decreased to 9% in December 2015 (target 8%). This has been achieved following the recruitment drive during the Autumn, careful negotiation with agencies and adhering to the new price cap rules. With the increase in usage of government approved agencies to 80% and closer monitoring we are on track to achieve the target trajectory of 8% by the end of 2015/16.

Recruitment plans are in place to continue to drive recruitment which will reduce our need to rely on agency staff. Information in the IPR concerning anticipated reduction in agency usage will be enhanced to include a trajectory. **Action: Mr Over**

Mr Jeffries queried if the number of nurses at night needed to be increased as the number reported on the NHS Options Statistics graph appeared to be low. Mrs McKay confirmed that the number of Healthcare Assistants is increased to help manage higher acuity patients on the wards.

A centralised reporting system for appraisals was introduced in July 2015 and 1,561 appraisals have been completed to date using the new system. Trust-wide compliance is still low at 56% and work continues to prompt all areas to complete appraisals for staff.

Organisational culture development work is ongoing with the introduction of a number of actions including introduction of a Staff Experience & Wellbeing Committee, chaired by Mr Over. The Committee will be reviewing staff experience and the role of the Freedom to Speak Up Guardian.

(c) Quality and Safety

Mr Chapman informed the Board that the HSMR was 92.6 in September. For the year to September 2015 HSMR was 109.8 due to an increase in December 2014 and January 2015. It has been quite difficult to pinpoint why there is such a significant change in the HSMR following Dr Foster's rebasing. The lack of insight available from the Dr Foster system as to the dramatic swings resulting from rebasing call the value of the system into question. Over the year however there is a gradual downward trend which is positive.

The numbers of falls and pressure ulcers has remained consistent with the number reported in previous months and in line with the numbers reported in other local Trusts.

The Maternity Dashboard is being reviewed in order to construct a simplified version and this will be reviewed by the Quality and Safety Committee at its next meeting. The MBRACE-UK Perinatal Mortality Surveillance Report showed that the NNUH performs well and is one of 4 hospitals with a mortality rate more than 10% lower than average for comparator group.

Applications for use of high cost drugs are reviewed by the Drugs, Therapeutics and Medicines Management Committee. A number of applications were not approved as they are not supported by NICE, not funded by the CCGs and carrying significant cost.

There have been 19 C Difficile infections reported in the year to date against the annual ceiling of 49 cases and we are on track to achieve the target.

The NHS Safety Thermometer Dashboard indicates that we have higher numbers of patients being admitted to NNUH with existing pressure ulcers than most other Trusts in this region.

The national FAIRI Dementia CQUIN has been maintained at 90%. Learning and dementia care is being incorporated into Tier 2 dementia training and staff have been attending a Tier 3 dementia training course.

The need to enhance awareness/training in relation to the Mental Capacity Act has been highlighted from audits of learning disability and autism. Provision of training is being reviewed and workshops are being provided. Policies and documentation are also being reviewed to enhance best practice.

A number of low risk Hospital Food Standards are not being achieved and a review is being undertaken to determine what action needs to be taken.

Performance towards the requirement for Electronic Discharge Letters to be sent within 24 hours is at 74.5% in the year to date. Mr Jeffries asked if this would cause delays to patient discharge. Mr Chapman confirmed that this would not cause delay in

a patient's discharge but this is an area that needs improvement and we are aiming to achieve 95% compliance for this requirement.

Mrs McKay highlighted the revised format of the Ward Dashboard which has been adjusted to remove ward level detail.

(d) Finance

Mrs Budd informed the Board that clinical income had been behind plan in December at £34.4m (plan £35m) and this had been mainly due to the need to free up beds for the Christmas period which had impacted on outpatient activity. At month 9 the financial position is an adverse variance of £4,061k due to clinical income, pay costs, clinical/non-clinical supplies. Agency and locum costs have remained higher than expected but have been lower than in previous months. The revised forecast deficit of £14.4m remains unchanged with key risks being clinical income and the impact of emergency demand. The forecast does not reflect the financial risk for penalties or CQUINs.

(e) Effectiveness

Mr Chapman informed the Board that recruitment to research studies is expected to be more than 4,000 in 2015/16 and that we will achieve the CRN target of 4,134. This is up from 3,500 last year.

The Board was updated on the 100,000 Genomes Project. Eleven Genome Medicine Centres from across the country are leading the way in delivering the three-year project which was launched by the Department of Health earlier this year. The Project is expected to transform diagnosis and treatment for patients with cancer and rare diseases.

The initiative involves collecting and decoding 100,000 human genomes to enable scientists and doctors to understand more about specific conditions. The Project in Norwich is being led by Professor Cooper and Professor Sethia and will collect samples from 625 patients between 2016 and 2019. It will also play a significant role in establishing the Biorepository and NNUH as an academic centre.

16/006 **LORD CARTER REVIEW OF OPERATIONAL PRODUCTIVITY AND PERFORMANCE**

The Board received a report from Mrs Budd concerning Lord Carter's review of operational productivity and performance in NHS hospitals.

The potential opportunities for efficiency gains in the NHS were published in a letter from Lord Carter to the Secretary of State in January 2016. Lord Carter emphasised the need for the NHS to make 2-3% efficiency savings over the next 5 years.

Lord Carter's team are developing metrics that can be used to monitor and improve operational productivity in the NHS. Following publication of Lord Carter's report, the Adjusted Treatment Cost (ATC) metric has been produced to allow Trusts to compare variability in their efficiency and to identify efficiency opportunities.

The initial analysis has found that our ATC is 93 pence, 7 pence less per £1 than the national Cost Weighted Output.

Our potential ATC savings opportunity was calculated to be £25.8m (6.2% of total clinical expenditure). The areas identified as having the highest potential savings opportunity are Emergency Medicine, Intensive/Critical Care, Trauma and Orthopaedics, Endocrinology, Respiratory Medicine, Obstetrics/Gynaecology, Geriatric Medicine, General Medicine, Cardiology and General Surgery. Efficiency savings in these areas are estimated to generate combined savings of £10.5m.

Each Division will be asked to review the findings of the report to identify efficiency opportunities within their areas.

Mr How noted that the report was based on 2014/15 data and expressed concern that staffing costs have increased in 2015/16. Mr Garside confirmed that this had been highlighted at the meeting with Lord Carter's team and they will be sending through some updated data to include staffing costs.

Lord Carter's team were supportive of the restructuring that was being undertaken in the Trust and made one specific recommendation for investment in electronic job planning technology.

It is intended that we should produce a 'Carter Plan' and the Board will be updated regularly in relation to the work arising out of the efficiency and productivity review.

16/007 **USE OF TRUST SEAL**

The Board received for information a report detailing the use of the Trust Seal since June 2015.

16/008 **FEEDBACK FROM THE COUNCIL OF GOVERNORS**

The Board was informed that four Governors had been appointed to fill vacant constituency positions and Mr Ed Aldus had been re-elected as staff governor (clinical support).

16/009 **ANY OTHER BUSINESS**

(a) Quarterly Governance Return

The Board considered a paper from Mrs Budd with a draft quarterly return to Monitor which was **approved**.

(b) Deputy Director of Nursing

Mrs McKay informed the Board that the Deputy Director of Nursing had been appointed and is due to commence in post on Monday. Mr Pádraig Ó Lúanaigh trained in Ireland and is moving to Norwich from his current position in Australia.

16/010 **DATE AND TIME OF NEXT MEETING**

The next meeting of the Trust Board in public will be at 9am on Thursday 24 March 2016 in the Boardroom of the Norfolk and Norwich University Hospital.

Signed by the Chairman: Date:

Action Points Arising:

	Action
16/003	Carried forward. The monthly summary template in the IPR will be revised to include relevant targets for ease of reference. Action: Mr Garside
16/003	It was suggested that the way we record compliance with the mandatory training target should be revised to exclude these groups and this will be reviewed. Action: Mr Over
16/003	Mrs Budd explained the differentiation between BAF risk 17 and BAF risk 12 and it was agreed that the wording of these should be revised to make clear

	that the former relates to the financial and CIP risk whereas the latter concerns operational risk. Action: Mrs Budd
16/004(b)	Data concerning consultant vacancies will be enhanced in future reports to indicate whether these are new or replacement posts. Action: Mr Garside
16/004(c)	The descriptor for the strategic priority relating to the pathway for frail elderly patients will be revised to make clear that this is not confined to focus on “step-down”. Action: Mr Hackwell
16/004(e)	At its meeting in March, the Board will receive an assessment of the potential growth in nursing student numbers following the proposed change in funding arrangements and of the Trust’s capacity to offer increased clinical placements. Action: Mrs McKay and Mr Over
16/005(b)	Information in the IPR concerning anticipated reduction in agency usage will be enhanced to include a trajectory. Action: Mr Over

REPORT TO THE TRUST BOARD	
Date	24 March 2016
Title	Chief Executive's Report
Author(s)	Mark Davies, Chief Executive
Purpose	To update the Board on matters relating to the Trust that are not covered elsewhere in the papers.
Summary including Key Performance Issues/Risks	Key points are noted regarding: <ul style="list-style-type: none"> - External Assessment - Staff matters - Strategic context - Education and Training - Research - Infrastructure Development - Liaison with Governors and Members
Action Required (✓)	FOR INFORMATION ✓

CHIEF EXECUTIVE'S REPORT TO TRUST BOARD 24 March 2016

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

1. EXTERNAL ASSESSMENTS

1.1 Care Quality Commission Inspection

Last week saw publication of the CQC report following the inspection of the hospital in November 2015. The report highlights the caring nature of the service provided by our staff across the Trust. No part of our service was judged to be inadequate and the overall rating of 'requires improvement' was in line with our own self-assessment as submitted to the CQC in October.

Our response to the report has been consistent with our approach from the outset of the inspection – we welcome the opportunity to learn and improve and we have focussed on the root causes underlying issues highlighted by the CQC. Overwhelmingly the common theme is one of pressure on our staff and our facilities. Put simply, the level of demand for our services is placing great pressure on all aspects of our capacity. We have an obligation to try to relieve this pressure because it is placing our hospital and staff under considerable strain. Our response is reflected in the strategic intentions established by the Board, particularly

- Development of increased capacity for day case procedures and diagnostics;
- Enhanced facilities for specialist services in stroke, cardiology and cancer;
- Expansion of our capacity in Interventional Radiology and critical care;
- Development and relocation of endoscopy capacity to the Quadram Institute.

We will be discussing the report and our response to it at a Quality Summit to be held on 21 March. The Summit involves a number of key 'stakeholders' including our CCGs, Monitor and NHS England. We will be seeking support for our strategic plans and the Board will be updated on those discussions at its meeting.

In consultation with our staff we will prepare a detailed action plan in response to the CQC report and the Board will be updated regularly as to progress in implementing those actions.

2. STAFF MATTERS

2.1 Senior Appointments

(i) A number of consultant appointments have been confirmed since the last report, as below. We look forward to welcoming these new doctors to our team:

Mr Simranjeev Johal	T&O (Hip)
Dr Sulfi	Cardiology
Dr Angela Collins	Haematology
Dr Parvez Moondi	Anaesthetics

(ii) A number of consultant vacancies remain as below:

Specialty	No of posts	Position	Replacement or New Post
Neurology	2	Shortlisting	Replacement
Respiratory	2	Shortlisting	1 replacement

Specialty	No of posts	Position	Replacement or New Post
			1 new
Restorative Dentistry	2	Recruitment underway	Replacement
Renal	1	Dept relooking at advert and job description	New post
Radiology	3	Out to advert	1 replacement (IRU) 2 new
Haematology	1	Recruitment underway	Replacement
ED	1	Interviews on 18/3/2016	New post
T&O (Shoulder)	1	Interviews on 7/4/2016	New post
Microbiology	1	Applicant offered post - awaiting acceptance	Replacement
Urology	1	Out to advert	New post
Gastroenterology	2	Out to advert	1 replacement 1 new
Anaesthetics with pain management	1	Out to advert	New post
AMU	4	Out to advert	New post
Plastics	3	Out to advert	Replacement

2.3 Staff engagement and communication:

Our Staff Survey results and CQC report have both supported the emphasis that we have placed on increased staff engagement and clearer internal communication. There is further work to do but the regular 'Viewpoint' staff sessions, both at NNUH and Cromer, continue to provide an opportunity for staff to be updated on developments in the Trust, with a Q&A session with the executive team. An additional Viewpoint session was held the day before the CQC report was published – to brief staff and to say 'thank you' for all their efforts. The Gooch Lecture Theatre was again full to standing, reflecting the engagement and commitment of staff to the Trust and its services for our patients.

3 STRATEGIC CONTEXT

3.1 Strategy Update

Our recently agreed strategy contained four priorities for immediate implementation. These are summarised below with a note on current progress. For a number of these the next key milestone will be the May Board meeting.

(i) Development of ACAD (Ambulatory Care and Diagnostics).

- Project Board in existence;
- 4 models are being developed;
- Alternative site locations are being evaluated;
- Two 'drop-in' workshops for all staff will be held in April;
- Strategic Outline Case containing an assessment of the 4 options will be ready for end of April and will be presented to the Board at its May meeting;
- Subject to the Board's input, work will commence on identifying the preferred option over the summer with an Outline Business Case ready for September.

(ii) Investment in stroke, heart attack and cancer services

- A preferred estates solution has been identified for development of interventional radiology, cardiology and critical care;
- An outline business case will be presented to the May Board meeting;
- We have asked that work be accelerated in identifying an appropriate location *within the hospital* for the permanent PET/CT scanner. Our aim is to secure a location and agreement between the different parties within the next three months.

(iii) Development of improved discharge arrangements for elderly patients

- Work has commenced on assessing the case for development of a virtual ward / hospital at home model;
- A review of the Henderson Ward service is near completion;
- We are continuing to press commissioners on the use of the Better Care Fund and in particular the requirement (as part of BCF) to produce a plan on delayed transfers of care. This will be an item for discussion with NPP colleagues at our next meeting;
- In May we will bring a plan covering all these initiatives to the Board for consideration.

(iv) Development of the Norfolk Provider Partnership

- A plan of work has been agreed by the NPP partners;
- Initial focus will be on office and clinical support services (most notably radiology and breast screening, pharmacy, procurement);
- Work on front line clinical services is at an earlier stage but includes an assessment of future demand for cancer services and exploring further shared medical resources across a number of specialties;
- Over the next few months it will be necessary to focus some of our energies on the Norfolk and Waveney Sustainability and Transformation Plan.

4. EDUCATION AND TRAINING

4.1 Plans for Expanding Undergraduate Nursing, Midwifery & AHP education – 2017/18 changes

The Board will recall that the national structure for financing undergraduate non-medical healthcare education is changing, with a move from bursaries to student loans. From 2017/18, new students on nursing, midwifery and AHP pre-registration courses (which lead on to qualification with one of the health professional regulators) in England will be eligible for maintenance and tuition loans, like other students, rather than receiving a bursary. Associated with this is a removal on the cap of overall student numbers allowing HEI's to consider growing the size of their academic programmes.

Our academic mission at NNUH underpins the crucial role we have in supporting the development of the future healthcare workforce and we will want to consider all opportunities to strengthen our partnership with local HEIs, most notably the University of East Anglia – as well as assessing the extent to which any further increase in supply is required in light of our future strategy, growth in services, non-availability of qualified staff and consequent over-reliance on temporary workforce.

Clinical placement capacity in organisations such as ours amounts for around half of an undergraduate programme, and acts as a limiting factor in terms of the overall number of students that can be hosted at any one time. We are currently assessing the extent to which our current placement capacity could be expanded, including identifying the barriers that

may need to be overcome, whilst at the same time seeking to maintain the quality of undergraduate education experience that we offer.

NNUH is working with other health, social care and HEI partners through the Norfolk and Suffolk Workforce Partnership (H.E.E) to assess the opportunities and risks that these changes present at system level, with the aim of working collaboratively. It is also noteworthy that Health Education England are currently consulting on a role of Associate Nurse and this emerging role will likely have an impact on the profile of the overall nursing workforce. This will need to be factored in to our overall assessment.

We recognise the important opportunity that this development represents in terms of strengthening the future supply of key elements of our workforce. It is a potential part of the longer term solution to over-reliance on temporary staff. The Management Board is scheduled to discuss our assessment and plans in April and the Board will be updated thereafter.

5. RESEARCH

5.1 Research Strategy and NNUH/University of East Anglia Joint Board

We have been very pleased to announce to our staff that Professor Alastair Forbes has been appointed in a joint appointment with the University of East Anglia as Director of Research and Innovation. This was the outcome of a competitive recruitment process following open advert.

The Board will recall that Professor Forbes recently led production of our bid for recognition as a Bio-Medical Research Centre (BMRC). He is also leading on creation of the Clinical Research Facility in the Quadram Institute.

The Director of Research and Innovation will join the Hospital Management Board as a member and we hope and expect that this joint appointment will mark a significant step forwards in the development of the Trust's academic mission and its partnership with the University.

6. INFRASTRUCTURE DEVELOPMENT

6.1 Electronic Prescribing and Medicines Administration (EPMA)

The EPMA has now been introduced across our surgical wards and the Management Board has received a timetable from Professor Farrow for its introduction to out-patient areas and ED during 2016/17. This is a major programme of infrastructure development of benefit patients and enhance efficiency opportunities. Its introduction to date has been a credit to all involved.

We are due to move to extend the system into James Paget University Hospital during April but the dates suggested may not be ideal and this is subject to finalisation.

6.2 Henderson Ward

As previously discussed by the Board, we are continuing to review the services offered through Henderson Ward and whether it is possible to improve the effectiveness of its contribution to relieving our problems with delayed discharges from NNUH.

7. LIAISON WITH GOVERNORS AND MEMBERS

We have been notified that Professor Jim Gazzard (Partner Governor nominated by the University of East Anglia) is leaving the University and therefore will stand down from our Council of Governors. We have been grateful for Jim's contribution to the Council and its Appointments and Remuneration Committee and we wish him well in Cambridge. We will liaise with the University of East Anglia with regard to nomination of a replacement governor.

8. RECOMMENDATION

The Board is asked to note the content of this report for information.

REPORT TO THE TRUST BOARD

Date	24 March 2016
Title	Integrated Performance Report
Author(s)	John Paul Garside, Board Secretary
Purpose	For discussion

Summary including Key Performance Issues/Risks

- As previously discussed the Executives have endeavoured to refine and improve the IPR.
- We are working to achieve a report with consistent contents to enable comparison of performance over time.
- It is helpful for the report to identify areas of positive, not just negative, performance.
- As it stands, we have 43 substantive core 'slides' plus financial appendices and the Risk Register High Risk Tracker.
- There is a balance between ensuring that the report is appropriately comprehensive without obscuring visibility of the most important issues. Remembering that the section summaries allow for identification of those metrics on which additional detail is required on an exception basis, when reviewing the IPR this month, the Board is invited to identify any of the current 'core slides' that are considered unnecessary for inclusion on a routine monthly basis.

Next steps:

1. The basic IPR should follow the current established format of core slides;
2. Additional 'slides'(to be labelled as such) may be added for particular reasons, namely:
 - performance outside normal or expected range;
 - relevance to an issue highlighted on the Risk Register; or
 - some other reason – to be explicitly stated.

Having said the above, we will need to consider revision of the IPR next month – to allow for reporting of the Quality Priorities +/- CQUINS for 2016/17.

Recommendations:

The Board is asked to receive the IPR and to identify any particular items that are considered superfluous, so that a standard format can be adopted for future reports.



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Norfolk and Norwich University Hospitals





NHS Foundation Trust

Integrated Performance Report


















March 2016

Core Slide 1 IPR Summary – February 2016

				
	Feb-16	Target	Feb-16	Target
Quality	Grade 4 pressure ulcers 0 HSMR (November 2015) 98.4 100.0 Patient FFT scores inpatients 97% MRSA 0 0 C. difficile Cases 0		Serious Incidents (which include Grade 3 pressure ulcers) 14 Grade 2 pressure ulcers 22 Grade 3 pressure ulcers 5 Patient falls causing harm 3	
Performance/ Productivity	Cancer 2 WW - all 98.6% 93.0% Cancer 31 day target compliance 97.8% 96.0% Cancer 2WW - Breast Symptomatic 98.2% 93.0% Cancer 31 day target - ACD 99.3% 98.0%		Cancer 62 day target - GP Referral 77.1% 85.0% 18 week RTT target - incomplete 86.7% 92.0% A&E four hour compliance 72.8% 95.0% RTT Admitted Backlog 2868 981 RTT Non-admitted Backlog 1887 1000 Monthly Average DTOC 63 30	
Workforce	Vacancy Rate 7.8% 10.0% % unregistered ward staff filled as planned 111.6% Staff recommendation of NNUH as place to receive care 70%		Non-Medical Appraisals Completed 58.5% 80.0% Staff Turnover 10.3% 10.0%	
Finance			In month deficit £2.0m (£0.7m worse than plan for month) In month pay overspend (agency/locum) £0.8m Cumulative CIP under delivery £5.1m Full year penalty ,CQUIN risk & activity challenges are @ £15.2m They will have a direct impact on cash and the 16/17 plan £14.4m	

Core Slide 2

Quality and Safety Summary

Quality	Outturn 14/15	Feb-16 Actual	6 month trend	YTD 14/15	YTD 15/16
Morbidity - See Core Slide 3					
1 HSMR (November 2015)	109.8	98.4		104.9	110.9
2 Deaths / 100 admissions	1.35	1.51		1.36	1.24
Incidents - See Core Slide 4 to 5					
3 Serious Incidents	99	14		94	138
4 Incident Reporting	-	1345		-	14062
5 Insulin incidents causing moderate harm or above	-	0		-	3
6 Medication Errors	-	122		-	-
7 Patient Falls causing moderate harm or above	30	3		29	40
8 Never Events	0	0		0	4
Pressure Ulcers - See Core Slide 6					
9 Grade 2 hospital acquired pressure ulcers	190	22		167	136
10 Grade 3 hospital acquired pressure ulcers	53	5		49	51
11 Grade 4 hospital acquired pressure ulcers	1	0		1	1
Infection Control - See Core Slide 7					
12 C. difficile Cases (excluding successful appeals)	57	0		53	24
13 MRSA bacteraemias	0	0		0	0
Other - See Core Slide 8					
14 Electronic Discharge Letters - within 24 hours	-	74.3%		-	74.4%
15 Harm Free Care - NHS Safety Thermometer	-	91.3%		-	91.4%
16 Patient FFT score inpatients	83.8%	97%		83.7%	90.4%
17 Complaints	1,078	94		987	838
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	
18 Review by Senior clinician	-	87.8%	87.8%		
19 Screening for sepsis	79.0%	82.5%	88.2%		

Key points:

- HSMR for Nov-15 is 98.4 and for the whole year is 110.9 (higher than expected due to high HSMR earlier in the year and rebasing of previous months)
- Rates of incident reporting per bed day are high and remain in the top 25% for all Acute Trusts for the most recently reported quarter.
- Q3 Sepsis Screening within 15 minutes of arrival was 88.2%. (Improved from Q1 (79%) and Q2 (80.5%)); Q4 Target = 90%.
- Q3 Senior Clinician daily review of acute admissions within 12 hours is 87.8% (Unchanged from Q2); Q4 Target = 90%.

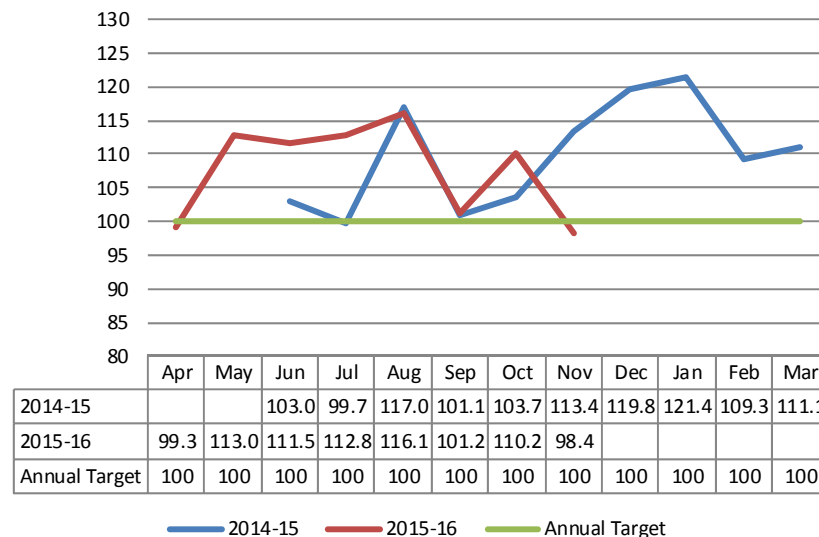


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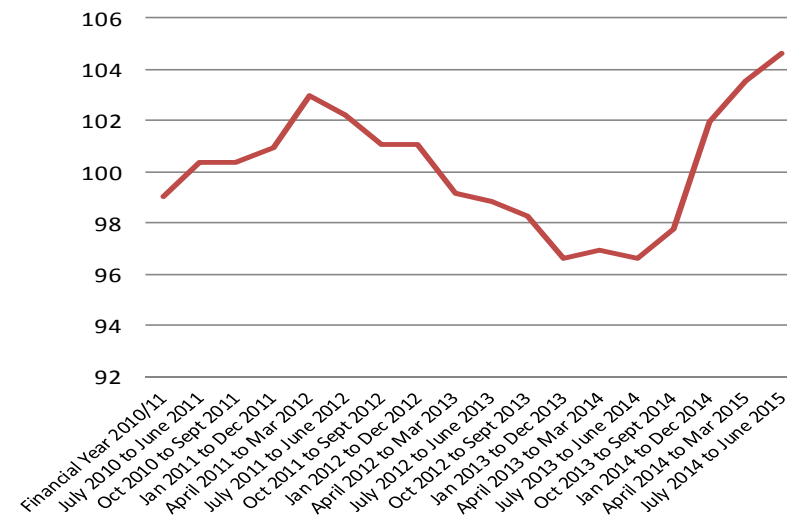
Core Slide 3

Quality & Safety (Morbidity) – Lead Director Peter Chapman

HSMR (November 2015)



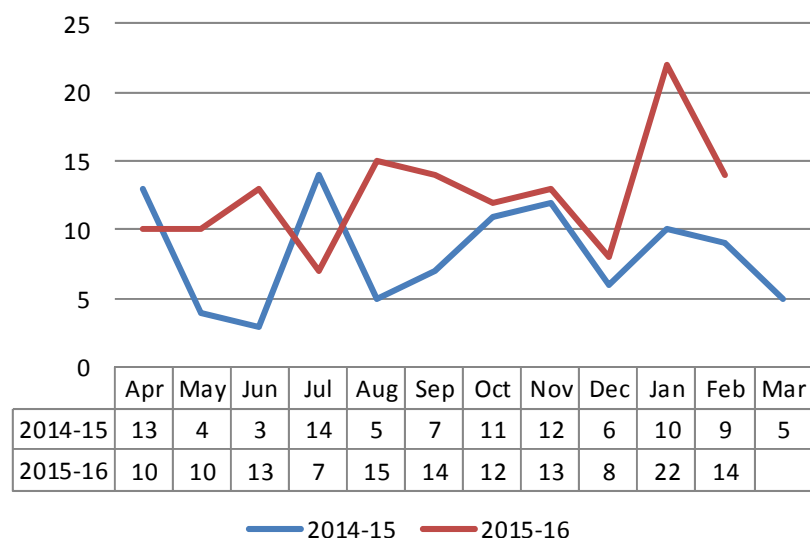
SHMI



- HSMR is the risk adjusted ratio of observed to expected in-hospital deaths within 56 clinical groups. Rebased each month.
 - HSMR is below expected (98.4) for November 2015 but still remains above expected for the year
 - Note the readjustment (rebasng) of the previously reported HSMRs from below to above expected.
- SHMI is the ratio between the actual number of people who die following hospitalisation at a Trust and the number who would be expected to die on the basis of England average figures given the characteristics of patients treated there
 - SHMI has risen from below 100 to above 100 for the year to June 2015 consistent with rise in HSMR during this period
- Changes to the mortality review system are being introduced to improve our own reporting and review of preventable deaths - Global Trigger Tool analysis and Preventable death analysis. The template for preventable death review is being changed and reviewed through the mortality committee. The recent report from Imperial College London highlights the importance of improved recording and analysis of preventable deaths.
- The Director of Nursing will provide senior nurse support and membership of the mortality committee to strengthen its membership in view of its increased commitment. The Board Secretary and a Governor have agreed to join the committee.
- A required project to review deaths in those with learning disabilities is underway.
- The mortality group is also developing benchmarking of mortality data against national audit program outputs in conjunction with the audit department in order to develop a rational and joined up approach to our understanding of mortality. NNUH has performed well against national means for ICNARC (ICU) / TARN (Trauma) / SSNAP (Stroke) / NELA (emergency laparotomy) / MINAP (PCI STEMI) / MBACE (Neonatal) / NCAA (inpatient cardiac arrest)

Core Slide 4 **Quality & Safety (Incidents)** – Lead Director Peter Chapman / Emma McKay

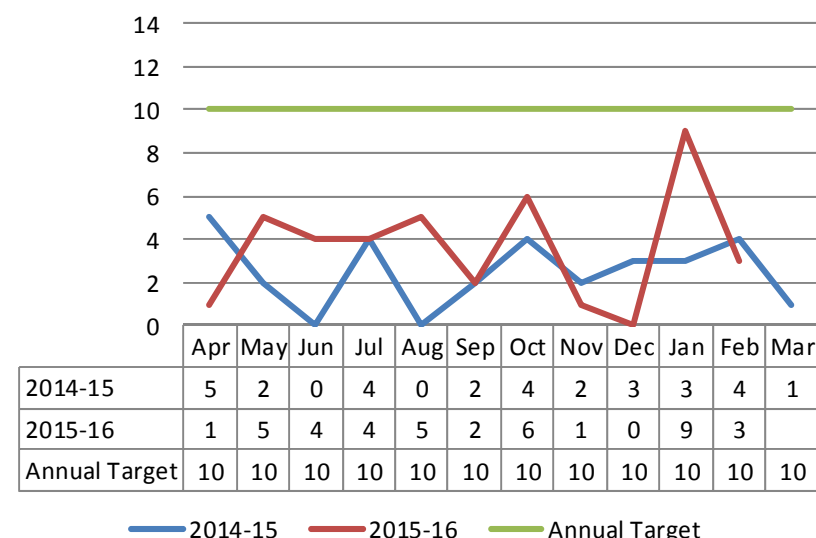
Total Serious incidents (which include falls with moderate harm or above and Grade 3 or above HAPU's)



Serious Incidents and Never Events

- There were 0 Never Events to report in February 2016
- There were 6 Serious Incidents reported in January in addition to falls and Pressure Ulcers
 - 1 death of child critically ill with sepsis on admission
 - 1 death following bleeding after tongue biopsy
 - 1 Patient with marked weight loss due to nutritional problems
 - 1 Unexpected death following self-discharge
 - 1 Urinary Incontinence immediately after delivery
 - 1 Serious failure to achieve 4 hour ED target (51.2% - 7/2/16)
 - Duty of candour has been confirmed and RCAs are undertaken for all

Patient Falls causing moderate harm or above



Falls causing harm

- There were a total of 249 inpatient falls in February 2016 – of these falls.
- There were 3 patient falls in February that caused Moderate Harm
- All 3 patients sustained a fractured neck of femur.

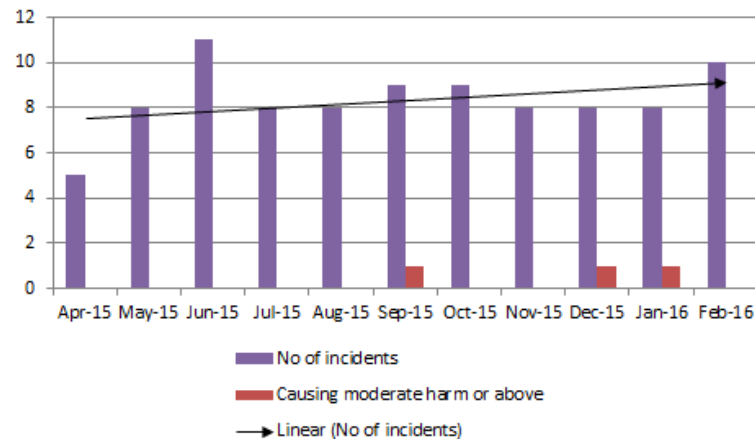
Actions

- In one case there was poor communication from specialist nurse to ward nurses re patients reported symptoms. There will be learning shared regarding this.
- It is clear that L/S BP recording on all OPM admissions has still not been embedded into practice. The Matrons for the admission areas have been requested to ensure this is embedded into routine.
- It is currently not possible to benchmark Falls in this Trust against other organisations.
- Inpatient activity in the Trust has increased in the last 12 months and there is an increase in the number of falls accordingly.

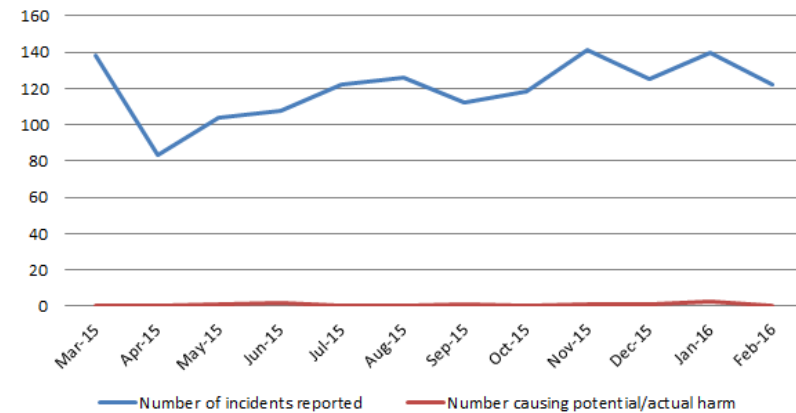
Core Slide 5

Quality & Safety (Incidents) – Lead Director Peter Chapman

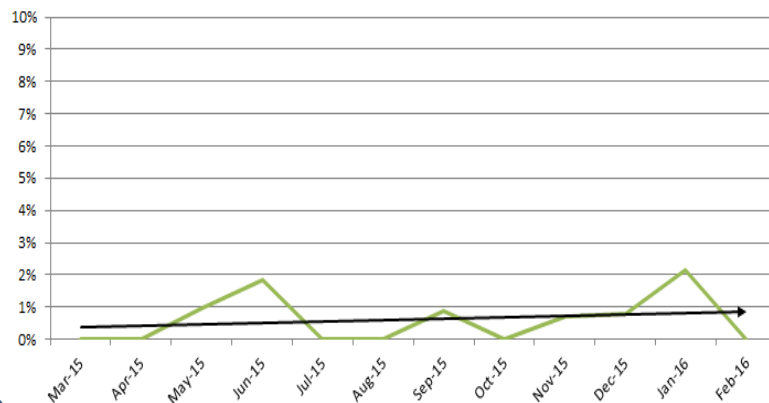
Insulin incidents by month - 2015/16



Medication Incidents – March 2015 to February 2016



Medication Incidents causing potential/actual harm as a % of total

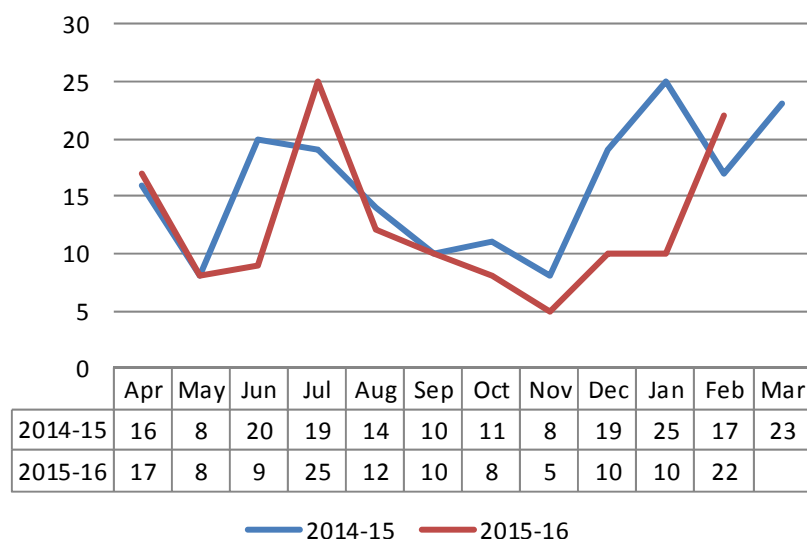


- We will focus on increasing reporting of medication errors whilst reducing those causing harm and those in relation to insulin. This has been agreed as part of our local quality schedule for 2015-16.
- 0 Medication incidents causing moderate harm or above have been recorded in Feb 2016.
- Previous insulin errors resulting in temporary harm were in Dec '15 (1), Sept '15 (1), Jan '15 (2), Oct '14 (2)
- The National Diabetes In-Patient Audit results for 2015 will be presented to the Management Board shortly together with a strategy, and business case to improve the management of in-patient diabetes at NNUH.

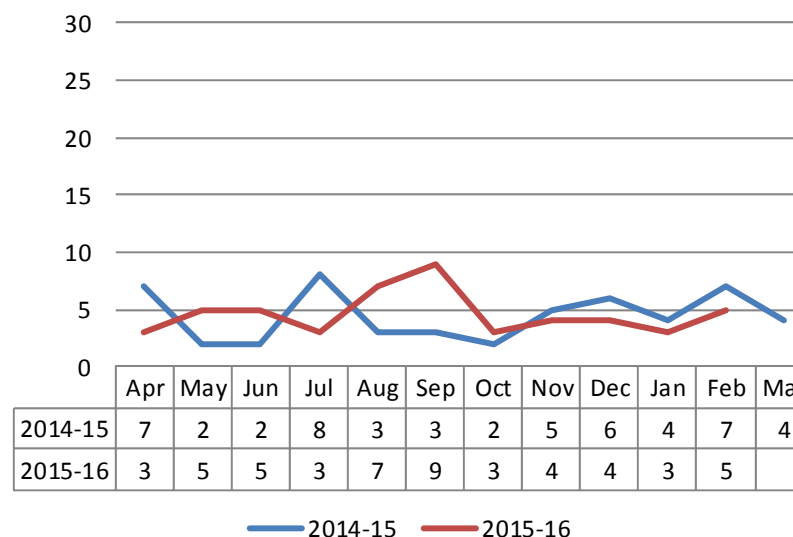
Core Slide 6

Quality & Safety (Pressure Ulcers) – Lead Director Emma McKay

Grade 2 hospital acquired pressure ulcers



Grade 3 hospital acquired pressure ulcers



Issues

- There were 6 Grade 3 HAPU's originally reported in February. One has been requested to be void as an SI as it was found to be a Grade 2 Deep Tissue Injury (DTI). Of the remaining 5, following RCA investigations, 3 were found to be Avoidable and 2 Unavoidable.
- There were 22 HAPU G2 reported in February 2016. 10 are awaiting RCA. Of the remaining 12, 4 were **UNAVOIDABLE** and 8 were **AVOIDABLE**.
- There is little change in the rates of HAPU's over the last three years.
- There were a total of 243 patients admitted in Feb 2016 with Community Acquired PU's – there were with **60** patients with CAPU1, **130** patients with CAPU2, **45** patients with CAPU3 & **8** patients with CAPU4.

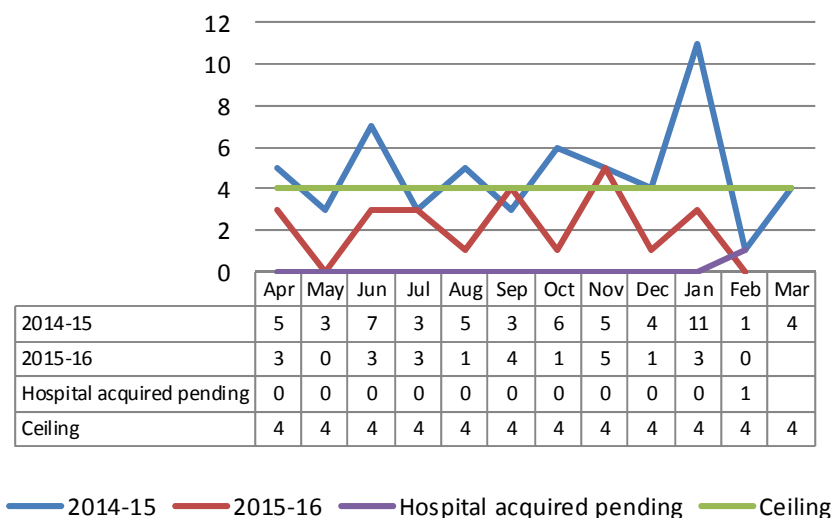
Actions

- To be completed once all RCA's complete.

Core Slide 7

Quality & Safety (Infection Control) – Lead Director Emma McKay

**C. difficile Cases (excluding
successful appeals)**



Issues

- 1 case of C. difficile was identified as Hospital acquired in February and is pending the post infection review appeal process

Actions

- Teams are reminded to be vigilant in their detection, sampling and isolation of patients presenting with symptoms

Summary Table		Non-Trajectory	Trajectory	Pending	Total
Quarter	4 (To date)	1	3	1	5
	3	11	7	0	18
	2	5	8	0	13
	1	6	6	0	12
Year		23	24	1	48









Core Slide 8

Quality & Safety – Lead Director Emma McKay

NNUH	Norfolk & Norwich University Hospital
CAT	Cambridge Acute Trust
JPH	James Paget Hospital, GY
QEKL	Queen Elizabeth, KL

	All Acute	NNUH	CAT	JPH	QEKL
Feb-16					
Harm Free	93.78	91.30	96.89	94.37	93.26
Pressure Ulcers - All	4.29	6.26	1.20	2.05	5.17
Pressure Ulcers - New	0.82	0.78	0.12	0.51	0.90
Falls with Harm	0.46	0.39	0.36	0.26	0.22
Catheters & UTI's	1.12	2.05	0.60	3.07	1.35
Catheters & New UTI's	0.43	0.20	0.00	1.02	0.67
New VTE's	0.58	0.10	0.96	0.26	0.22
New Harms	2.25	1.47	1.44	2.05	2.02

NNUH Safety Thermometer Dashboard

		2015											2016	
		Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Harm Free		90.95	92.88	91.22	90.44	89.88	90.68	92.03	91.57	89.93	92.53	92.80	92.51	91.30
Pressure Ulcers - All		7.45	5.78	7.35	7.63	7.45	7.30	6.50	6.50	7.40	5.39	5.38	5.90	6.26
Pressure Ulcers - New		1.60	0.80	0.71	1.10	0.74	1.06	0.98	1.12	1.09	0.47	0.86	0.84	0.78
Falls with Harm		0.85	0.44	0.20	0.37	0.64	0.58	0.20	0.10	1.18	0.28	0.38	0.37	0.39
Catheters & UTI's		1.04	0.89	1.12	1.38	1.38	1.92	1.18	1.83	1.68	1.99	0.96	1.22	2.05
Catheters & New UTI's		0.00	1.18	0.31	0.37	0.18	1.06	0.10	0.20	0.30	0.66	0.19	0.19	0.20
New VTE's		0.00	0.30	0.20	0.64	0.92	0.48	0.20	0.30	0.20	0.47	0.67	0.09	0.10
New Harms		2.36	1.78	1.43	2.30	2.48	3.17	1.48	1.73	2.76	1.89	2.11	1.50	1.47

- This table shows comparative performance against other acute Trusts in the region, against all acute Trusts and over the last 6 months.
- The NNUH continue to have a higher rate of ALL pressure ulcers but the percentage of NEW pressure ulcer has dropped for the third month in a row.
- The NNUH New VTE rate for January and February are the lowest over the 12 month period.
- The NNUH data for NEW harms in January and February also indicate the two lowest percentages of NEW harm over the last 12 months.

Core Slide 9

Quality & Safety – Lead Director Peter Chapman

Issues arising from the Safety Sub-Board

Policy approval

- The revised point of care testing policy was approved by the Clinical Safety Sub-Board (CSSB). The revision was necessary to reflect the roles of the POCT coordinator and the change of laboratory name to the Eastern Pathology Alliance.

Risk Register - Safety

- The CSSB reviews in detail all relevant risks 12 and above. All risks have been updated or are in the process of being updated.
- There are within medicine a number of risks which require updating and for which further clarification is required. This has been pursued with the divisional team through the executive performance review meeting.
- The raised risk (16) in relation to the use of DPU as an escalation area particularly for more than 17 patients and for patients unsuitable for transfer continues to cause concern. There is triangulation of this risk through recent adverse QAAs and through a rise in reported incidents on DPU. The use of DPU as an escalation area and the criteria under which this may happen will be addressed through the revised escalation policy.

Drugs, Therapeutics and Medicines Management

- EPMA. Roll-out in surgery has been successful in terms of wards. The rates of completion of TRA for all wards is now high and above the required 95%. There have been logistical difficulties in relation to SDAU which are being addressed through the division. The uptake of training within some surgical departments (in particular those with little in-patient work eg ophthalmology) has been low and this is being addressed through direct discussions with the clinical directors of those departments.
- The CSSB has agreed that in the light of recently published advice from NICE in relation to NOACs (Novel Oral Anti Coagulants more recently referred to as Direct Oral Anti Coagulants - DOACs) the Trust should not change its current policy in relation to their use pending a further discussion and commissioning decision from the CCGs as a result of this advice.
- The CSSB declined to support the use of Fingolimod (for relapsing multiple sclerosis) on the compassionate use programme for patients who are coming to the end of the clinical trial comparing the use of this with interferon beta-1a. This use is not commissioned by NHS England and this indication does not fall within the NICE indication for use only as a second line agent. This decision not to allow this compassionate use is consistent with the approach taken for previous compassionate use applications.

Core Slide 10

Quality & Safety – Lead Director Peter Chapman

Issues arising from the Safety Sub-Board

Divisional Board Reports

Surgery

- Highlight increased risk and incidents in relation to the current use pattern of DPU as an escalation area.

Women and Children

Diagnostics and Clinical Support Services

- The IRU project group met with all interested parties to agree a temporary solution is unsuitable, and the best solution will be to agree a definitive plan to increase facilities and pending this to increase out of hours working through current facilities through the employment of additional staff.

Infection Control

- There has been a significant increase in admissions with influenza (H1N1) causing increased capacity pressures in some areas particularly CCC. The numbers of new cases continue to rise – 19 in the week to 12/3/16 compared to 9 the week before. Appropriate infection control measures have been taken and communication to all staff has taken place in particular in relation to enabling single room availability.
- Pseudomonas Aeruginosa has been isolated from Cromer washbasin water samples in the dialysis unit – note not in water for dialysis which is separate. Site is managed by NORSE. Control measures are being adopted and other areas of the site risk are being risk assessed for testing and action if required.
- Both are closely supervised by the Director of Infection Prevention and Control Dr Elumogo.

Safeguarding

- There is concern in relation to the lower level of compliance with both children and adults safeguarding particular in medical and dental staff.
- Clinical and Operational Managers must follow up individuals who are not compliant and the CoDs will reinforce this.
- 100% compliance with mandatory training must be enforced at job planning and available penalties enforced (loss of pay progression / inability to apply for CEA)
- PREVENT training is being successfully rolled out to all staff now with excellent uptake for sessions.
- MCA and DoLs training continues to be a concern. An e-learning package is being developed.
- Mental Health pathways for children in ED are under review.



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Core Slide 11

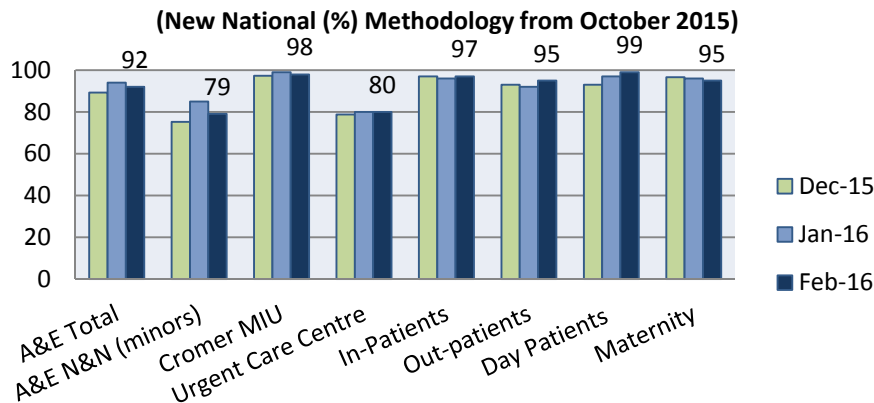
Quality & Safety – Lead Director Peter Chapman

Maternity Dashboard 2015-16																
Maternity Dashboard 2015/16		Norfolk and Norwich University Hospitals												NHS		
		NHS Foundation Trust														
	Measure	Goal	Red	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Women Delivered	Number of women	≤526	≥559	476	471	491	524	525	485	528	473	486	480	459		5398
Caesarean Sections	Caesarean section births % of all deliveries	≤ 25.5%	>27.6%	23.7%	23.8%	27.5%	22.1%	22.7%	26.4%	26.1%	27.1%	24.5%	26.7%	25.5%		25.1%
Induction Rates	% of all deliveries	≤26.4%	≥29%	28.2%	29.9%	27.9%	26.0%	30.5%	29.9%	27.7%	32.3%	34.8%	33.8%	32.7%		27.0%
Unit Diversions	Number of occasions	0	≥1	0	3	4	2	2	2	2	3	0	0	1		19
Midwife : Birth Ratio inc. band 3 MCA's (funded)	Ratio	≤1:28	>1:30	1:29.91	1:29.89	1:29.73	1:29.96	1:30.20	1:29.92	1:30.40	1:30.47	1:30.37	1:30.6	1:30.6		
Unplanned NICU Admissions at Term >24hrs requiring ventilation	Number of babies			1	1	3	3	1	0	0	2	1	2	1		15
Number of SI's	Number per month	0	≥1	1	0	0	0	1	2	1	3	1	3	1		13
3rd & 4th Degree Tears	% of all deliveries	<3.5%	>5%	3.57%	4.03%	4.07%	3.05%	3.05%	3.09%	2.84%	3.17%	2.88%	3.54%	1.74%		3.19%

- This summary maternity dashboard has been revised this month to include additional relevant measures.
- There are currently no national guidelines for a maternity dashboard and units including NNUH have used locally determined figures and statistics to develop their own RAG ratings. It has been agreed within the strategic clinical network that an agreed regional dashboard will be developed. There is no time-line associated with this intent though so in the meantime the local parameters will be reviewed and revised against national standards to set challenging goals in order to improve the service. This work should be completed by the end of March 2016.
- The maternity department has again been successful with a “Sign-up to Safety” bid to prevent avoidable harm in maternity care. £15,000 will enable the purchase of community use CTG monitors.
- Small For Gestational Age (SFGA) scanning. Currently 16 risk on register due to non-compliance with RCOG guidance. Midwife now trained and is being released to scan. A second midwife will begin training in March 2016 after which it is anticipated this risk will reduce.
- Note that the Midwife to Birth ratios remain higher than recommended following a further recalculation.
- RCA training for O&G staff will be improved through 7 members attending a 2 day RCA course in March. This will improve the ability of the department to respond to the larger numbers of RCAs required in this service compared to others.

Core Slide 12 Caring and Patient Experience – Lead Director Emma McKay

Friends & Family Test Dec. 2015 - Feb. 2016



Patient Feedback

The In-patient Friends & Family (FFT) rating was 97%. Within out-patient areas 17 areas received more than 8 responses. Of these 17 areas, the range of scores was from 78% - 100%. The Day patients score was 99%.

#hellomynameis

Feedback from patients was that 98.9% of Trust staff gave their name, role and description of planned care.

Patient Opinion & NHS Choices

- There were 18 Patient Opinion posts in February. Only one comment was rated above 0. This was a Level 2 comment which concerned delays within clinic and the level of care provided.
- Eleven patients commented on NHS Choices; four giving the highest rating of five stars.
- Responses to the posts made were reviewed and are much improved in terms of personalisation of content.

Support for Parents in Maternity Services

- The Maternity Services Liaison Committee will hold its annual general meeting here at the NNUH. This meeting will focus on the recent National Maternity Services Review report where small groups will review each of the seven elements highlighted in the NMSR and local & regional strategies to meet relevant recommendations will be agreed.
- The facilitation of partners staying overnight has now been in place for 5 months. A survey in relation to this will be available in April 2016.

Dignity Day

- We again celebrated national 'Dignity Day' on the 1st February. Members of staff, supported by external patient representatives visited wards and out-patient areas and asked patients for feedback on how effectively they feel their privacy and dignity is preserved. All feedback will be reviewed and actioned via the Patient Experience Working Group.

Quality Assurance Audits

- There were 14 Quality Assurance Audits (13 supported by external auditors) undertaken during February 2016.
- This month the programme again highlighted improvements that were required for patients 'stepped down' to the Day Procedure Unit. A full action plan of improvements is in place and being monitored and actioned through the Division.

Patient Transfers

- The percentage of our patients who experienced 3, 4 and 5+ bed moves during their stay all increased in February. Further analysis of this will be undertaken; initially by reviewing notes of a sample of patients experiencing the highest number of moves.

National Patient Experience Surveys

The 2 national CQC surveys for 2016 will be for In-patients and ED.

Core Slide 13

Caring and Patient Experience – Lead Director Emma McKay

Dementia Carers' & FAIRI CQUINs

- In January there were many positive carers' comments including references to the helpful use of the blue forget-me-not flower and the 'This is Me' book. Within negative themes, the impact of staff shortages was frequently raised; always tempered with praise for how hard staff worked.
- Feedback from October to December 2015 when viewed collectively, confirmed that increased staff : patient ratios, alongside better sleeping facilities for carers staying were among areas identified for improvement.
- The 90% compliance target across all elements of the process within the FAIRI National Dementia CQUIN has been maintained.
- The audit required as part of the 2015/16 extended Dementia FAIRI CQUIN was conducted to see if we inform GPs of changes in care plans for patients with known dementia. The audit standard was met in 100% of appropriate cases.
- We have been advised that funding for the Norfolk & Suffolk Dementia Alliance is likely to cease.

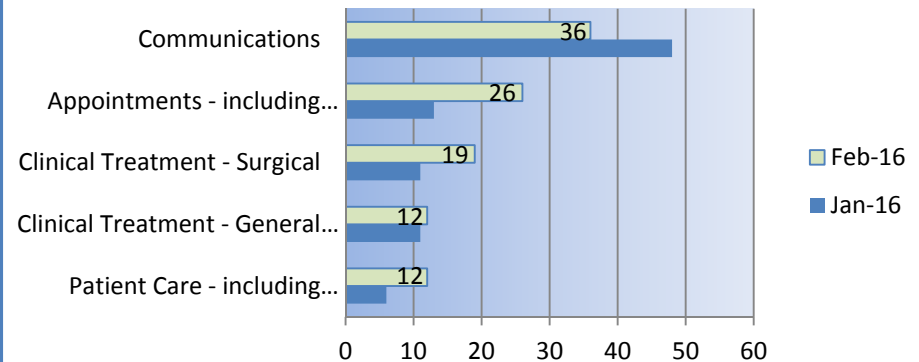
Patient Advice & Liaison Service Queries

- There were 304 PALS contacts during February 2016; the highest number since 2010.
- Excluding 'General Queries' and 'Thank You / Best wishes', 'Clinical Treatment' n.47 (n.33 Jan 2016) and 'Appointments / Delays' n. 29 (n.31 Jan 2016) were the highest criteria reported.
- Of all queries, 18% related to in-patient care.
- There were 5 PALS contacts in relation to the Day Procedure Unit; 2 categorised as 'concerns', 1 as 'enquiry' and one, 'Thank you'.
- It was noted that there were 10 contacts to thank the Emergency Department (ED) for care received.

Patient Information

The Patient Information Forum approved 164 leaflets between December 2015 and February 2016. This has included leaflets in languages other than English and in other accessible formats.

Top 5 Number of Complaints by Subject



Complaints

- Ninety-four complaints were received in February, the largest single total since November 2014 but broadly in line with 91 in February 2015.
- There has been an increase in complaints relating to 'Appointments, including delays and cancellations' which echoes with PALS queries and the Trust's on-going operational pressure.
- The highest number of complaints (n.14) related to the Emergency Dept.
- Analysis of complaints in relation to communication indicates that 'staff attitude' in February (n.11) was the most commonly cited route cause. Deeper analysis of this and ED Complaints will be undertaken.

Death Certification Process

Some relatives are experiencing prolonged waits of up to a week before we can issue death certificates as a result of Coroner Officer opinion delays. Communication with the Coroner is ongoing to try and resolve this issue.

Risks

There are no new risks of 12 or more on the Risk Register primarily in relation to caring & patient experience, but a risk will be added in the context of the high levels of patient bed moves during their stay.

Core Slide 14

Nursing Dashboard – Lead Director Emma McKay

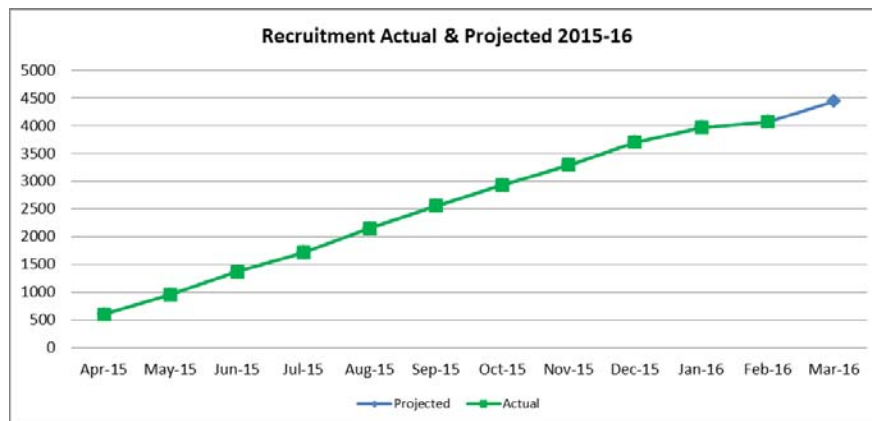
Clinical Safety	Outturn 2014/15	Annual Target	Jan-16	6 month trend	YTD 2014/15	YTD 2015/16
C Diff cases (hospital acquired)	57	37	4		52	45
MRSA bacteraemias (hospital acquired)	0	0	0		0	0
Norovirus (confirmed cases)	84	1	33		72	112
Elective MRSA Screening Breaches	333	0	44		289	336
Emergency MRSA Screening Breaches (Provisional)	1943	0	152		1596	1693
Hand Hygiene Compliance	98%	100%	99.3%		97.9%	98.1%
Dress Code Compliance	98%	100%	99.6%		98.0%	99.1%
Commode Audits	96%	100%	96.8%		95.7%	94.0%
Needlestick Incidents	106	0	6		91	80
Medication Incidents (total reported)	1043	N/A	108		832	947
Medication incidents with potential to cause harm (IHI)	24	0	2		18	7
Total Number of Datix Incidents in month	11663	N/A	1107		9805	10395
Datix Incidents (reported in month) Finally Approved within 14 Days	6764	N/A	695		5694	6509
Number of Datix Incidents reported in month not closed within 14 Days	4913	0	412		4095	3470
Total Open Datix Incidents: 2010 to month end (incl incidents that have been open for under 14 days)	7863	N/A	917		6272	6694
C4C Audit Results	95%	95%	95.9%		95.4%	95.7%
C4C Audit Results if Re-Audited	96%	95%	95.7%		96.3%	96.3%
Day Wandsworth Call Bell: Patient Call (total if not separated)	02:47:50	N/A	00:03:14		02:45:51	02:38:40
Day Wandsworth Call Bell: Bathroom Call (total if not separated)	01:52:39	N/A	00:02:01		01:50:12	01:43:04
Night Wandsworth Call Bell: Patient Call	01:54:28	N/A	00:02:00		01:53:46	01:43:15
Night Wandsworth Call Bell: Bathroom Call	01:20:20	N/A	00:01:13		01:19:40	01:08:13

Core Slide 15

Effectiveness - Lead Director Peter Chapman

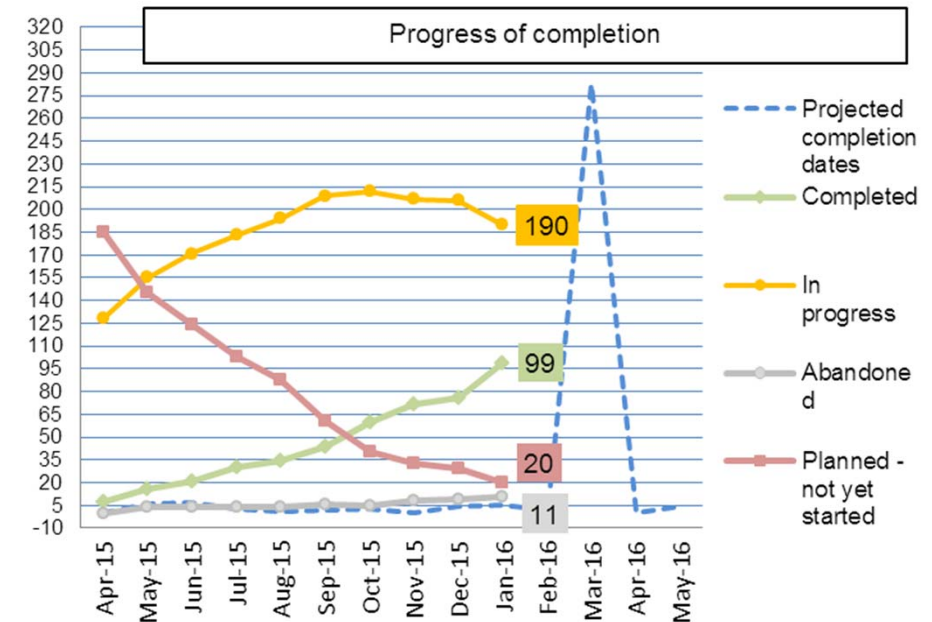
RESEARCH AND DEVELOPMENT

- YTD recruitment 4075. Data incomplete for February.
- Projected 2015-16 ~4500 (2014-15 3535 / NNUH Target 5000 / CRN Target 4300)
- Professor Alastair Forbes has been appointed as Chief of Research and Innovation and will take up his post after Easter 2016.
- NNUH grant awards in previous quarter £306,954
- Genomics Medical Centre study. Dry run completed successfully. First tissue collection April.
- 12 new Serious Adverse Events reported in February
 - None classified as attributable to research study
 - None reportable as SIs.



Audit and Clinical Standards

- Progress as expected against clinical audit plan
- All relevant audits from the Quality Accounts Audit List 2016/17 have been included on the draft audit plan for 2016/17.
- Divisions should report results of national audits within their specialties. To be discussed through divisional governance.
- Following constructive meetings with CoDs the Divisional Boards will improve review and reporting of NICE compliance.



Core Slide 16

Effectiveness - Lead Director Peter Chapman

Risks and Division Reporting

Women and Children

- 15 risk – lack of compliance with RCOG for SGFA sonography. Action plan in place.

Clinical Services

- 2 CT vans will be on site to improve radiology CT capacity issues.
- New consultant radiologist starting shortly and further interviews planned April
- IRU project group have met and agreed action plan for increasing provision under leadership of COO.

Policies

- Policy for Management of Screening and Diagnostic Procedures approved. Responsibility for ensuring compliance should rest through divisional governance reporting. Is present as a field on the directorate reporting template.

PROMs

- NNUH no longer negative outlier in respect of Primary Knee Replacement PROMs
- Some changes arising out of the review undertaken and previously reported have been introduced. Others – community physio and nurse practitioner follow-up – require further work.
- Further work through division (?benchmarking through Civil Eyes) to understand high numbers of hernia repairs at NNUH. Not outlier in terms of PROMs

Core Slide 17

Performance – Monitor KPI's - Lead Director Richard Parker

Performance	Outturn 14/15	Annual Target	Feb-16 Actual	6 month trend	YTD 15/16
Cancer - See Core Slide 19 to 21					
1 Cancer 31 day target for subsequent treatments - Surgery *	86.6%	94.0%	92.9%		91.3%
2 Cancer 31 day target for subsequent treatments - Anti Cancer Drugs *	98.6%	98.0%	99.3%		99.3%
3 Cancer 31 day target for subsequent treatments - Radiotherapy *	96.7%	94.0%	98.6%		97.9%
4 Cancer 62 day target for referral to treatment- GP Referral *	73.0%	85.0%	77.1%		76.5%
5 Cancer 62 day target for referral to treatment - Screening *	94.2%	90.0%	86.7%		93.1%
6 Cancer 31 day target compliance *	95.7%	96.0%	97.8%		97.4%
7 Cancer 2 week wait - all cancers *	94.9%	93.0%	98.6%		96.2%
8 Cancer 2 week wait - symptomatic breast cancers *	96.2%	93.0%	98.2%		98.7%
A&E - See Core Slide 23					
9 A&E 4 hour target compliance	90.1%	95.0%	72.8%		85.9%
10 Number of 30 minute handover breaches	102	0	72		276
11 Number of 60 minute handover breaches	8	0	19		112
12 Recording of Handover Times	95.2%	95.0%	90.8%		96.6%
14 Arrival to Handover time (>15 minutes)	73.0%	100.0%	65.6%		78.3%
RTT - See Core Slide 22 to 23					
15 18 week RTT target - Patients on an incomplete pathway	91.6%	92.0%	86.7%		87.7%
16 Admitted Backlog	1870	981	2868		2868
17 Incomplete Non Admitted Backlog	1690	1000	1887		1887
Stroke - See Core Slide 25 to 26					
18 Percentage of patients with 90% of their length of stay on the stroke unit	79.6%		69.4%		79.7%
19 Patients with primary diagnosis of stroke admitted to a HASU within 4 hrs	74.6%	80.0%	60.9%		74.3%
20 % of urgent Stroke patients with access to brain scan within 60 mins	84.5%	90.0%	89.5%		85.4%
21 % Door to needle time of <= 60 minutes for eligible thrombolysis patients	76.7%	75.0%	78.6%		79.1%
22 % of high risk TIA patients treated within 24 hour of first contact	94.0%	90.0%	88.5%		93.2%
Patient Flow - See Core Slide 24					
23 Diagnostics	98.3%	99.0%	96.0%		95.7%
24 Cancelled Operations	1503		259		1241
25 Number of 28 day breaches	199	0	65		215
26 Monthly Average DTOC	52	30	63		45
27 28 Day Readmission Rates **	6.9%		6.6%		7.2%
28 Length of Stay (Elective)	3.13		3.58		3.18
29 Length of Stay (Non-Elective)	5.30		5.83		5.14

* Please note these figures are provisional

** January Figure

Core Slide 18

Performance - Lead Director Richard Parker

Performance – key issues

1. Cancer

- 62-day GP referral performance remains a priority for recovery – despite a number of influenza related critical care cancellations we remain on track to achieve the 62-day target in March.
- A spike in sentinel lymph node cases has affected 31-day subsequent surgery performance – plans are in place to resolve this and the risk to persistent failure is low.

2. A&E - ED transit time performance has been poor. A revised System Wide plan is in place and beginning to show signs of performance stabilisation. Key issues continue to be Exit Block and ED systems and processes and robust improvement plans are in place to address both.

3. RTT recovery is subject to a formal contractual remedial action plan process; agreement of a recovery trajectory is a key part of that process and current agreed trajectories place aggregated achievement of 8% open pathways at July 2016 and all specialties by September 2016. Progress is beginning to become evident in terms of both overall waiting list size & open pathways.

4. Stroke - Whilst significant progress had been made against the Stroke care standards, bed congestion has affected timely access to a HASU bed but again this is subject to case by case scrutiny and action.

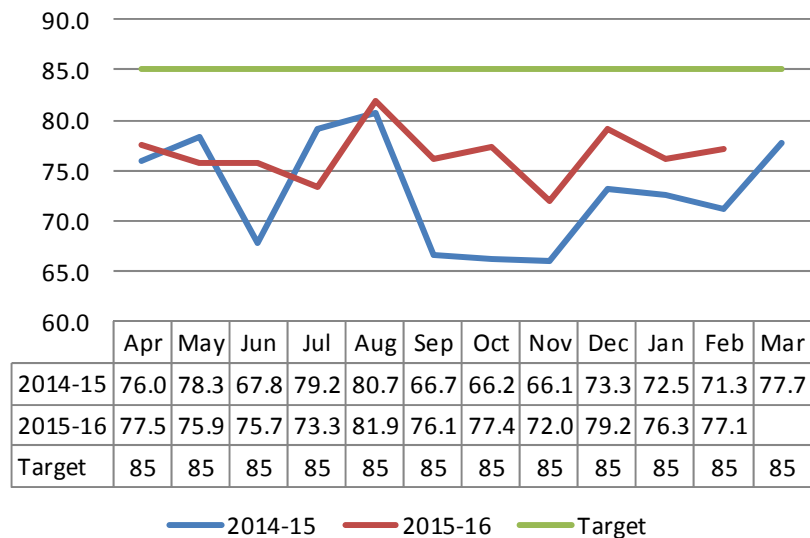
5. Diagnostics

- The capacity challenge initially affected achievement of the diagnostic 6-week standard related to endoscopy. A solution using a third-party provider (Medinet) has made good progress and this issue is resolving. Sustainability through using Turnstone court plus the Quadram Institute endoscopy facility will solve this issue.
- A shift of CT capacity from routine work to cancer produced a CT backlog however addition mobile scanners are in place and will reduce this backlog in line with the recovery trajectory (31 March 2016).

Core Slide 19

Performance (Cancer) - Lead Director Richard Parker

Cancer 62 day target for referral to treatment- GP Referral *



Issues

- Backlog clearance remains a priority for achieving the 62 day target
- Drop in performance expected as part of **planned backlog clearance**.

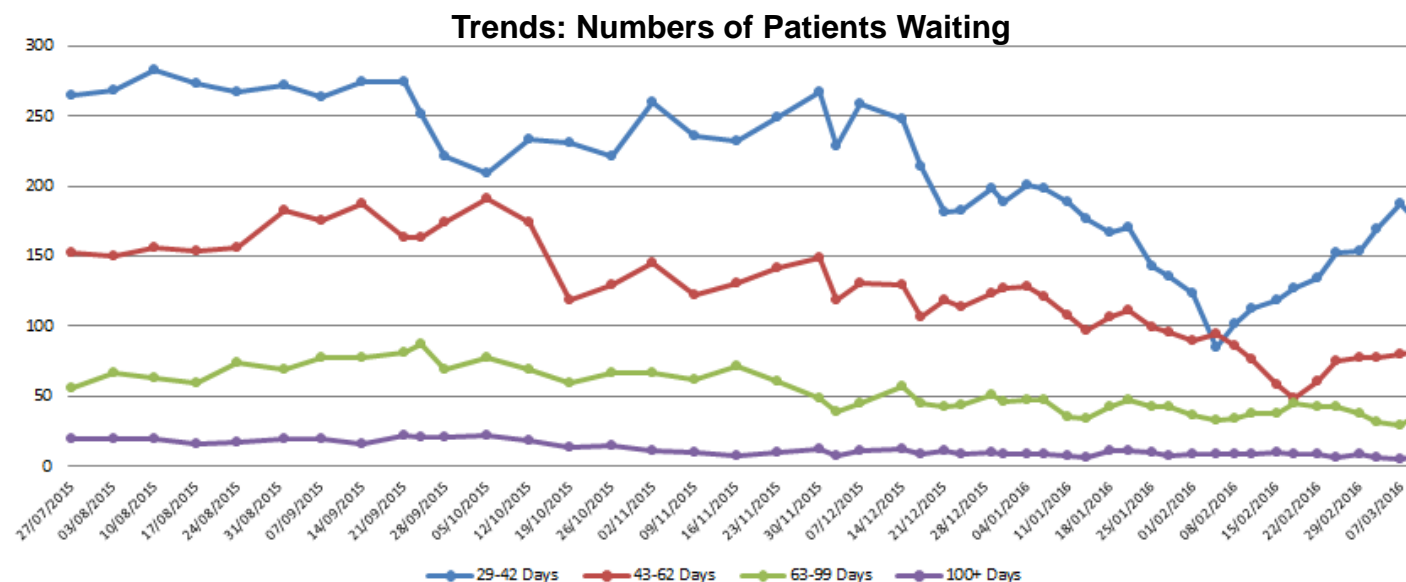
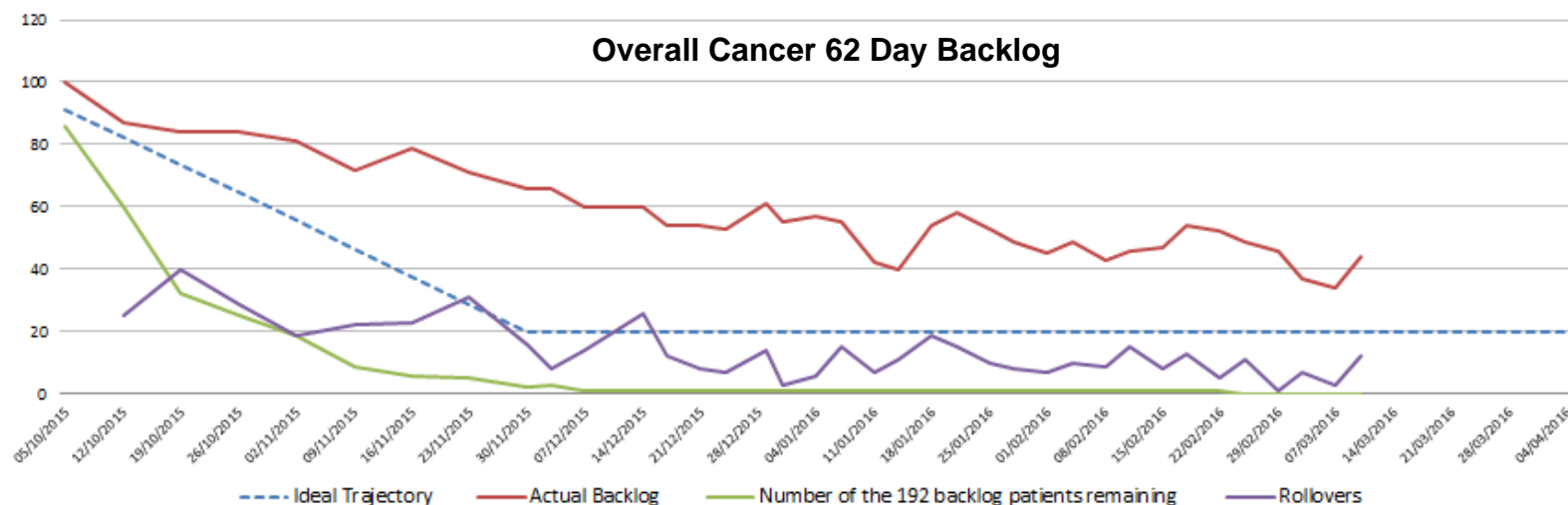
Actions

- Backlog clearance continues - currently on track to achieve in March
- Cancer cases are being prioritised in theatre for a number of specialities
- Significant number of cancellations due to lack of Critical care capacity, interim solution being developed whilst plans for extended unit are worked up.

*Denotes provisional figure for previous month

Core Slide 20

Performance (Cancer) - Lead Director Richard Parker



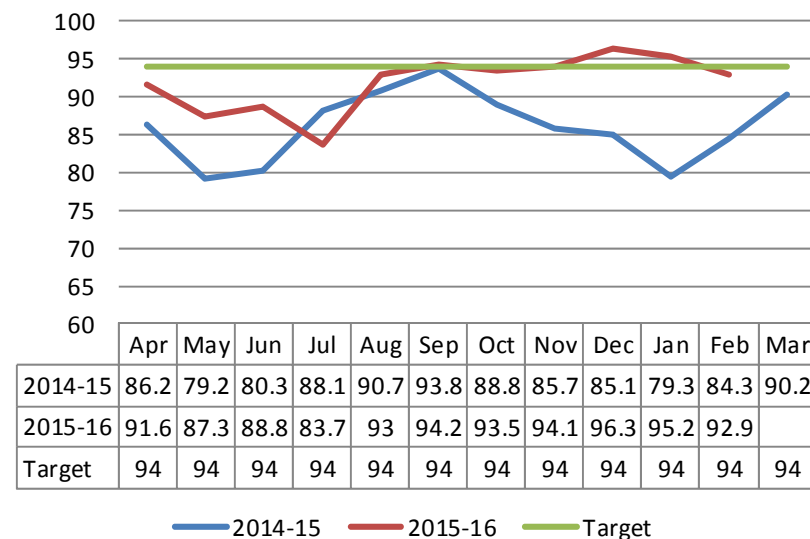


Our Vision
To provide every patient
with the care we want
for those we love the most

Core Slide 21

Performance (Cancer) – Lead Director Richard Parker

Cancer 31 day target for subsequent treatments - Surgery *



Issues

- Increase in demand for Sentinel Lymph node biopsies and wider excision, insufficient capacity to respond, places this target at risk for the quarter
- CCC capacity impacting in Urology

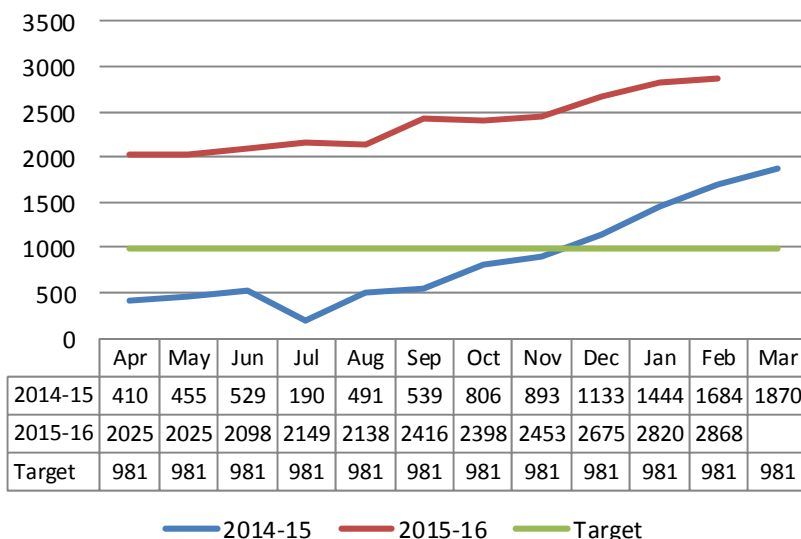
Actions

- Additional nuclear medicine/plastics capacity being put in place
- Interim plan being developed for CCC capacity

Core Slide 22

Performance (RTT) – Lead Director Richard Parker

RTT Admitted Backlog



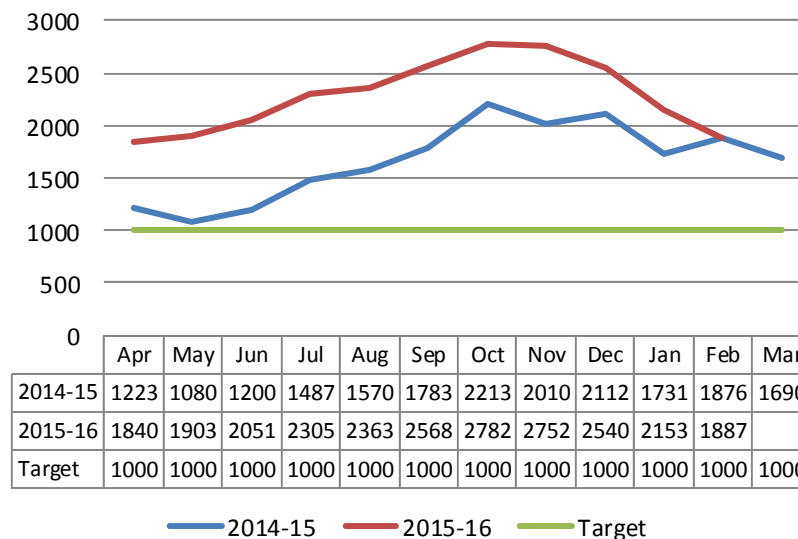
Issues

- Increasing number of cancellations due to bed pressures impacting on elective activity
- Limitations on procedures within Vanguard and lack of staffing to provide weekend lists

Actions

- Baseline theatre weekend working
- Recruitment into posts identified in RTT recovery business case to reduce reliance on WLI spend.

RTT Incomplete Non Admitted Backlog



Issues

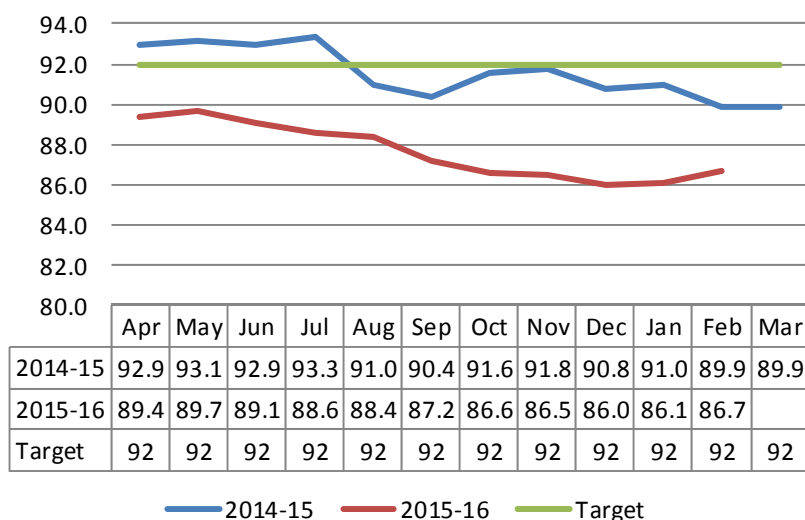
- Additional clinics in T&O, general surgery, gynaecology
- Medinet in ENT
- External validation reduced overall waiting list size .

Actions

- Continue to plan Increased Outpatient activity, key specialities
- Medinet to provide weekend clinics throughout March/April Feb for ENT
- Other agencies being considered for other specialities.

Core Slide 23 Performance (RTT and A&E) – Lead Director Richard Parker

18 week RTT target - Patients on an incomplete pathway



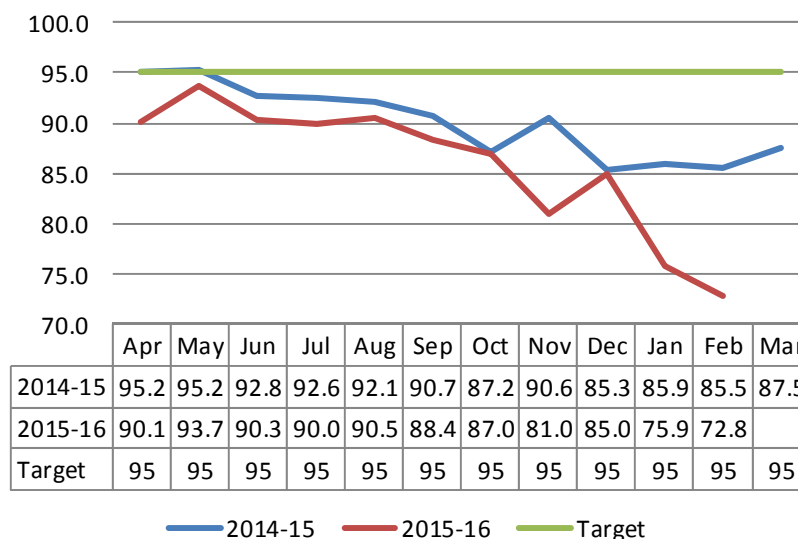
Issues

- Remedial action plan signed of by CCG
- Delay to recruitment in key specialities will further delay recovery
- Significant number of cancellations during Jan/Feb
- Medinet commenced in ENT
- External validators in place reduced overall waiting list

Actions

- Discussion on going with Medinet/18 week solution s for other specialities
- Specialities reviewing recovery plans and taking additional actions
- Baseline weekend operating for theatre staff, revisit anaesthetic criteria

A&E 4 hour target compliance



Issues

- Bed availability main reason for failure.
- ED inconsistency also an issue.
- DTOC & complex discharge issues continue to impact upon the flow out of ED and increased breaches due to bed availability.

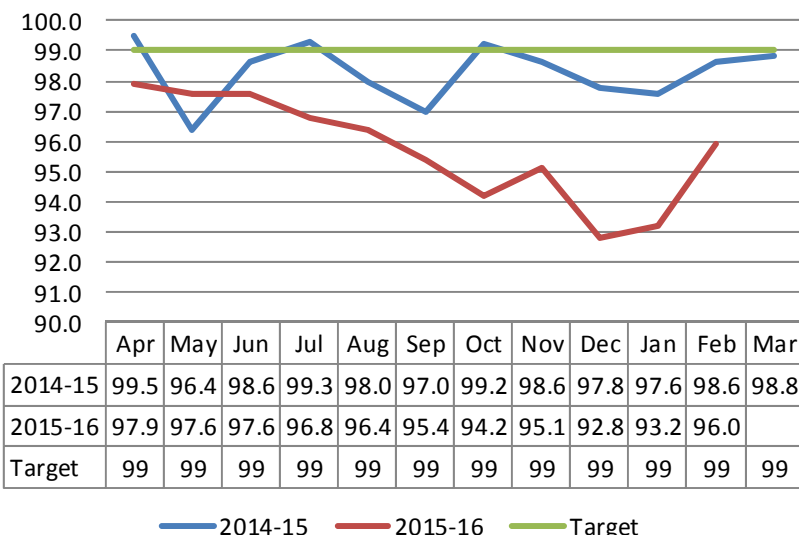
Actions

- Revised System Recovery Plan developed.
- Associate Director of Urgent Care Recovery appointed.
- Focus on ED inconsistency.
- Focus on delayed discharge.

Core Slide 24

Performance (Patient Flow) – Lead Director Richard Parker

Diagnostics



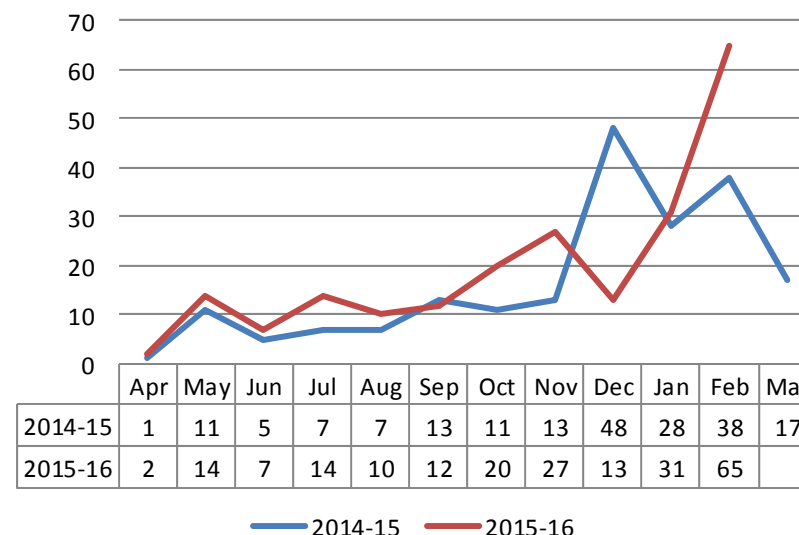
Issues

- A formal Remedial Action Plan (with weekly commissioner scrutiny) has been submitted to and accepted by the Commissioners.
- Prioritisation of cancer patients impact on CT diagnostic performance

Actions

- Recruitment to fill vacancies in Urology, Audiology and Gastro continues
- Mobile CT scanner installed on 7th March
- Gastro to expand into Turnstone court once staffing in place
- On track to meet trajectory by end of March

Number of Cancelled Op 28 day breaches



Issues

- The number of 28-day cancellations failing to be re-booked in time is partly a consequence of increase in cancellations but also as a consequence of capacity being prioritised for clinical urgent & cancer patients

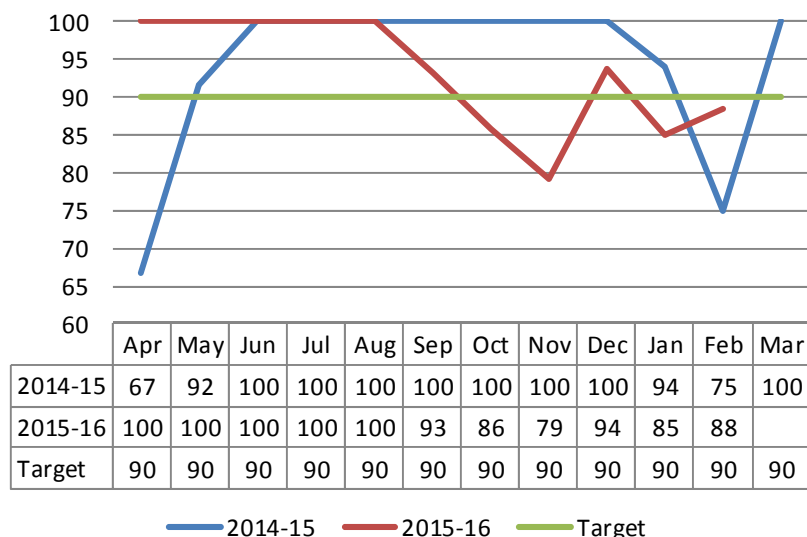
Actions

- Pre-emptive cancellations, day before being considered in accordance with hospital escalation plan
- RCA process for none bed related cancellations
- Cancer cases prioritised above 'operationally urgent' cases

Core Slide 25

Performance (Stroke) – Lead Director Richard Parker

% of high risk TIA patients treated within 24 hour of first contact



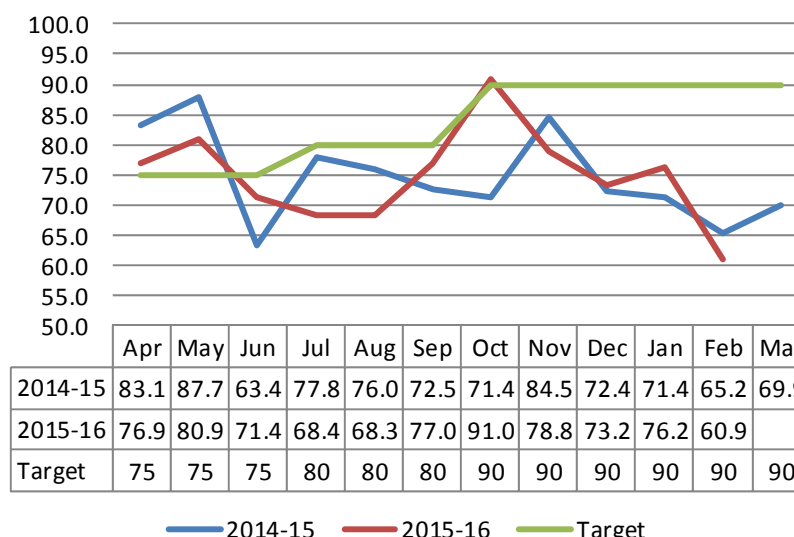
Issues

- 3 patients out of 26 did not receive radiological investigations within 24 hours. These were all High risk inpatient TIAs. All High risk TIA's seen in out patient clinic received diagnosis and treatment in 24 hours.

Actions

- Daily reporting and case by case review of failure points with associated actions

Patients with primary diagnosis of stroke admitted to a HASU within 4 hrs



Issues

- 34 of 87 patients were not admitted within 4 hours.
 - 19 – No Beds
 - 2 – Not diagnosed as stroke by Stroke team
 - 9 – Stroke not alerted in time (A&E and wards)
 - 3 – Stroke team busy with multiple patients
 - 1- Delay in getting a porter

Actions

- Review RCAs and agree actions to address process failures

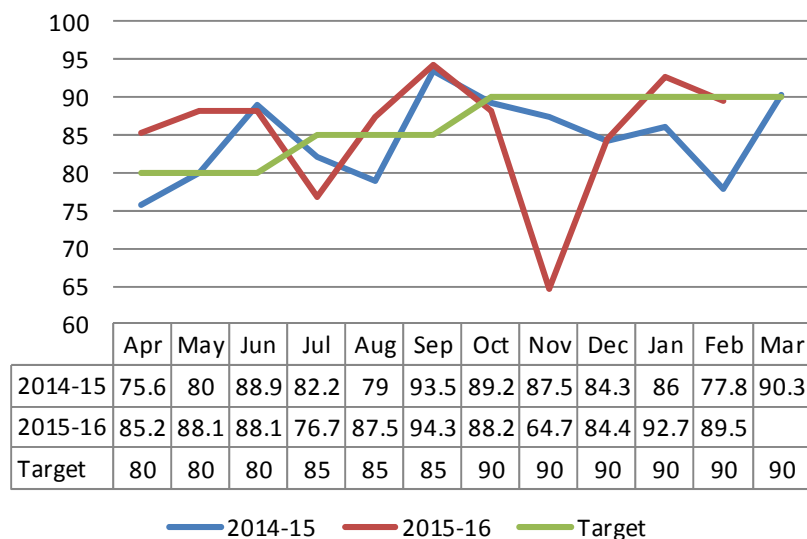


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with the care we want
for those we love the most

Core Slide 26

Performance (Stroke) – Lead Director Richard Parker

% of urgent Stroke patients with access to brain scan within 60 mins



Issues







4 out of 38 patients did not get an urgent scan

- 1- CT busy
- 1- Inpatient stroke, late alert
- 1- GP referral to A&E, late alert to stroke team
- 1- No beds available in A&E for assessment

Actions

Core Slide 27

Performance (Productivity)

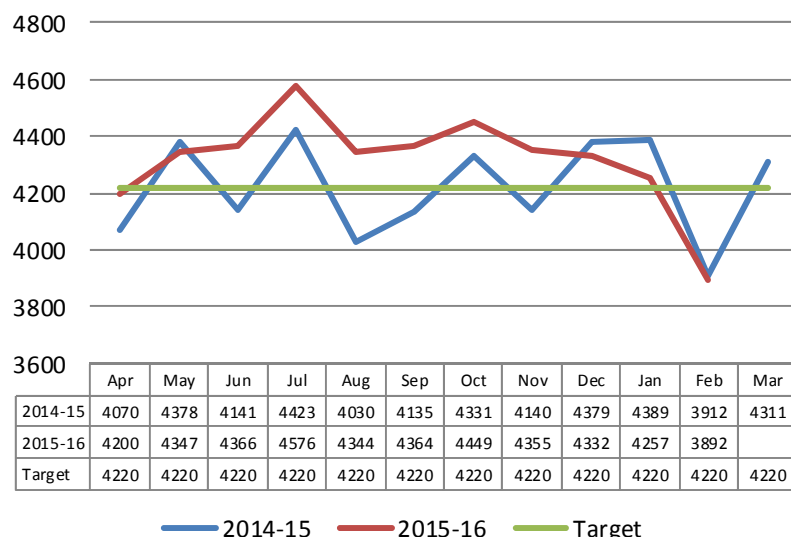
Productivity		Outturn 14/15	Full Year Plan	Feb-16 Actual	6 month trend	YTD 14/15	YTD 15/16
1	Theatre Utilisation		90.0%	89.6%		86.6%	88.1%
2	A&E Activity (attendances)	111,958	119,869	9,535		94,029	109,415
3	Emergency Admissions *	50,639	50,639	3,892		42,416	47,482
4	Elective Activity - Day case spells *	83,719	85,578	7,028		69,826	76,693
5	Elective Activity - Elective inpatient spells *	14,898	15,339	1,197		12,556	12,947
6	Outpatient Activity (consultant led & non-consultant led) *	693,149	690,093	58,438		578,004	630,774
*Please note these figures are provisional							

- Bed congestion through February continues to impact upon theatre utilisation and elective in-patient spells. It should be noted that in-patient cancer work remains the highest-priority and so, whilst the overall number of elective in-patient work undertaken was below plan, the complexity (& associate income) was closer to that expected.
- Day-case activity has been maintained and, allowing for the impact of the ophthalmology injection re-classification (to an out patient procedure from a day-case), the impact of the Vanguard plus focus on day-case work is positive.
- The sustained reduction in non-elective admissions reflects improvements in ambulatory emergency care. Whilst the positive effect of this has been offset by increased lengths of stay for more complex patients, it is anticipated that work to improve discharge management and practice will gain traction in February and March

Core Slide 28

Performance (Productivity) – Lead Director Richard Parker

Emergency Admissions *



Issues

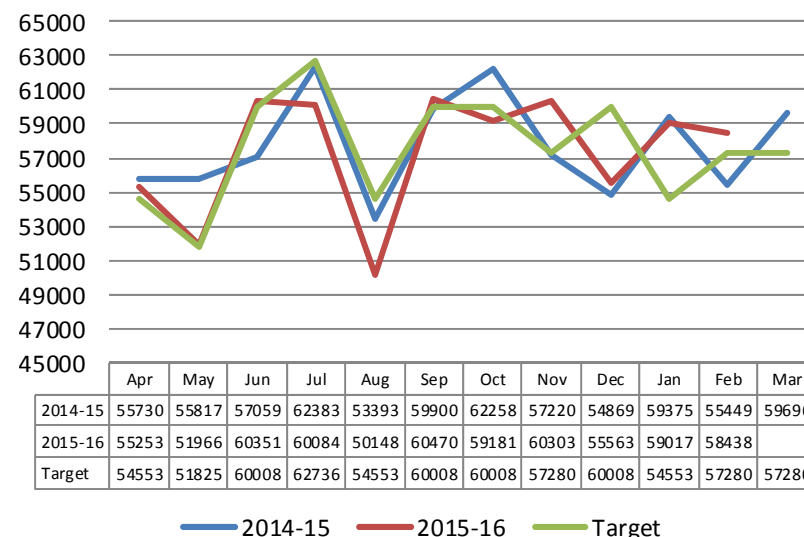
- 0% variation in Emergency Admissions - Feb 15 v Feb 16.
- 6.7% increase in ED attendances
- Conversion rate of ED attendance to admission was 25.7%: an improvement of 3.1% on Feb 15.

Actions

Review of Admissions:

- ED : 2448 below average. Continue to reduce conversion rate.
- AMU 654: below average. AEC to be extended to 7 days.
- EAUS : 689 average.
- Direct to wards : 306 above average.

Outpatient Activity (consultant led & non-consultant led) *



Issues

- Activity tracking broadly ahead of 2014/15.

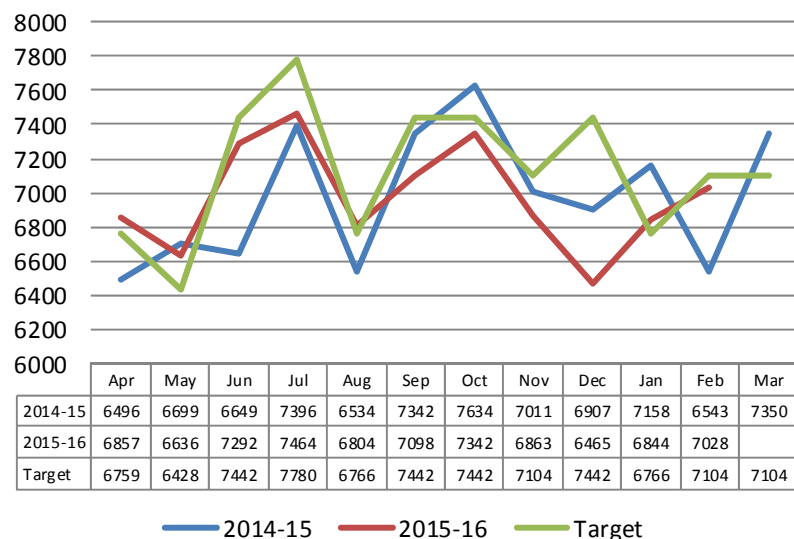
Actions

- Recovery plan agreed to baseline flexible capacity and increase the overall capacity quantum.
- Medinet providing outpatient capacity for ENT

Core Slide 29

Performance (Productivity) – Lead Director Richard Parker

Elective Activity - Day case spells *



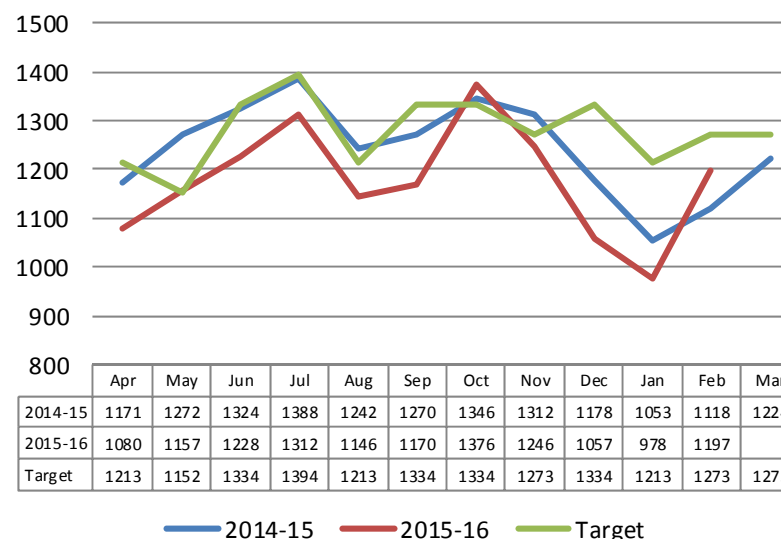
Issues

- Vanguard fully on line from January.
- Increased levels of day-case activity are being masked by the ophthalmology reclassification
- DPU activity being impacted upon as using DPU as escalation area.

Actions

- Investigating use of Medinet/Vanguard to provide increased day case capacity at weekends.
- Roll out theatre efficiencies tool and performance process to Cromer and Ophthalmology theatres.

Elective Activity - Elective inpatient spells *



Issues













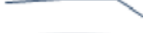




- Significant number of elective cancellations as a result of emergency bed pressures throughout January/February.
- Cancer cases and urgent cases prioritised. These are complex cases so less overall activity as a result.

Actions

- Actions to resolve delays in discharge as set out in earlier performance slides

Core Slide 30

Workforce Summary – Lead Director Jeremy Over

Workforce	Outturn 14/15	Annual Threshold	Feb-16 Actual	6 month trend	YTD 15/16
Payroll					
1 Planned establishment (WTE) *	6529	6722	6811		6811
2 Actual Substantive (WTE)	6328	6346	6278		6278
3 Vacancy maximum (%)	3.1%	10.0%	7.8%		7.8%
Pay Spend					
4 Pay spend - % employed (%) *	92.6%		86.9%		88.5%
5 Pay spend - % bank (%) *	2.4%		2.4%		2.3%
6 Pay spend - % agency (%) *	2.8%		6.0%		5.4%
7 Pay Spend - % locum (%) *	2.2%		4.8%		3.8%
Staffing Numbers					
8 % of registered nurse day hours filled as planned	Data		92.5%		93.3%
9 % of unregistered care staff day hours filled as planned	not		111.6%		105.0%
10 % of registered nurse night hours filled as planned	available		93.2%		91.0%
11 % of unregistered care staff night hours filled as planned	for 14/15		121.3%		113.5%
Other					
12 Non-Medical Appraisals Completed (%)	72.0%	80.0%	58.5%		58.5%
13 Sickness Levels **	4.3%	3.5%	5.0%		4.2%
14 Mandatory Training (%)	72.1%	90.0%	73.3%		73.3%
15 Staff Turnover (%)	9.7%	10.0%	10.3%		10.3%
16 Staff FFT – recommendation of NNUH as a place to receive care **			70%		
17 Staff FFT – recommendation of NNUH as a place to work **			41%		
* Please note these figures are provisional					
** January Figure					

Core Slide 31

Quality & Safety – Lead Director Emma McKay

Nurse Staffing ('Red Flags')

The common themes across all red flags are level of vacancies and inability to provide specials.

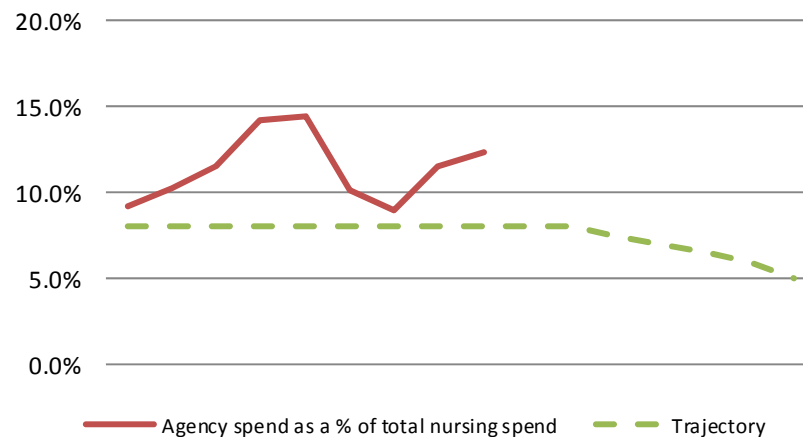
In order to address these issues, the following measures are recommended:

- Re-evaluate the provision of bank nurse cover and HCA specials to ensure sufficient resource is available as required.
- Continual review of recruitment processes to ensure the time elapsed between advert, interview, references and pre-employment checks is reduced as far as is practicable.

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16
Division 1	281	299	384	386	660	431	404	345	321	346	322
Division 2	197	183	244	398	868	629	746	519	630	533	694
Division 3	43	32	31	67	84	72	68	66	66	81	91
Maternity	-	321	481	496	683	523	722	568	376	431	487

Core Slide 32 **Workforce (Pay Spend)** - Lead Director Jeremy Over

Registered Nursing - Agency Spend



Issues

- Although registered nursing agency expenditure has reduced from over £1m per month in both September and October, and with significant reductions in November and December, the number of shifts has increased in January and February (as a result of the opening of additional inpatient escalation areas), resulting in a higher percentage spend.

Actions

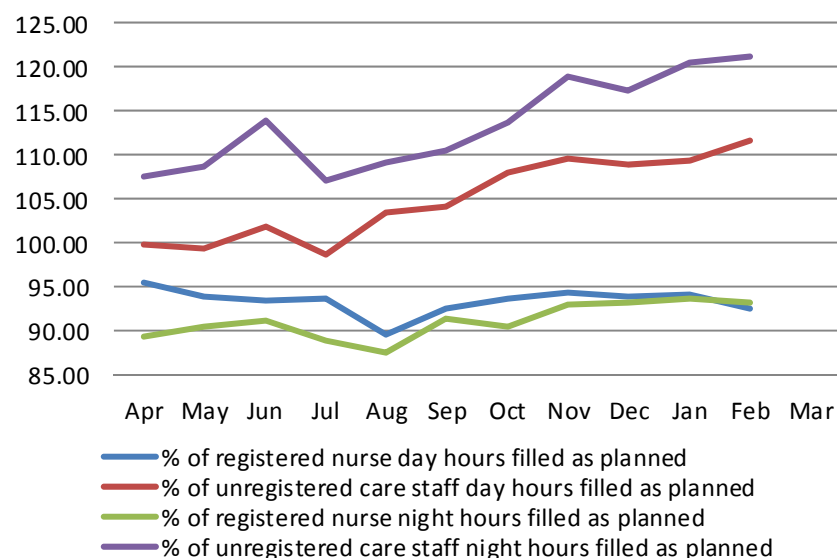
- Framework compliance (including temporary Monitor approval to engage two agencies) is nearly 100%. However, the challenges are that this temporary arrangement ceases from April and we will seeking to move from non-framework agencies (currently two agencies account for 20% of all shifts) and seek best possible prices for any deployments

	Apr 15 - Jun 15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
Agency spend as a % of total nursing spend	9.2%	10.3%	11.5%	14.2%	14.4%	10.2%	9.0%	11.5%	12.4%							
Trajectory	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	8.0%	7.5%	7.0%	6.5%	6.0%	5.0%

Core Slide 33

Workforce - Lead Director Jeremy

Ward nursing fill-rate analysis



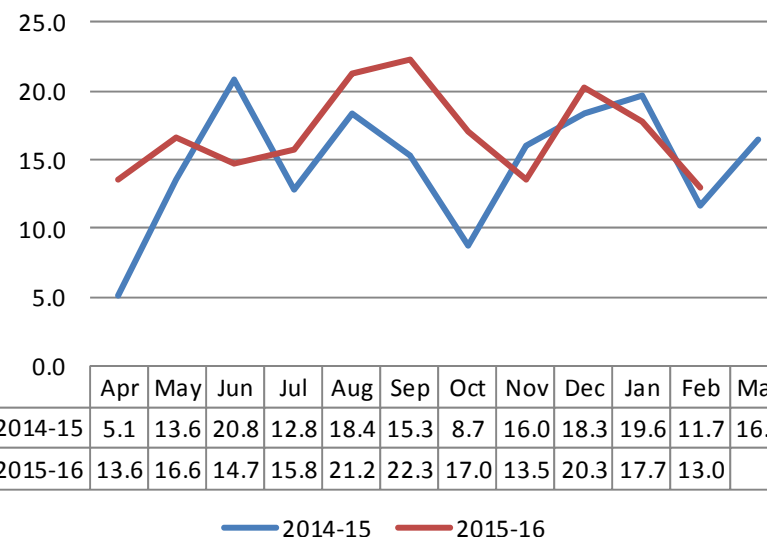
Issues

- The graph shows our nursing planned versus actual staffing levels.
- The percentage of shift hours worked versus planned may be greater than 100% where additional staff have been deployed to meet the needs of patients requiring 1-to-1 care

Actions

- The impact of the nursing agency price cap/ rules are being closely monitored by HR and Senior Nurses

Turnover - Registered Nursing & Midwives



Issues

- The number of nursing/ midwifery leavers is averaging 17 per month.
- In the last 12 months, where reasons for leaving are known, there remains a consistency in reporting: two-thirds are related to retirement, promotion or relocation with 15% stating work/life balance.

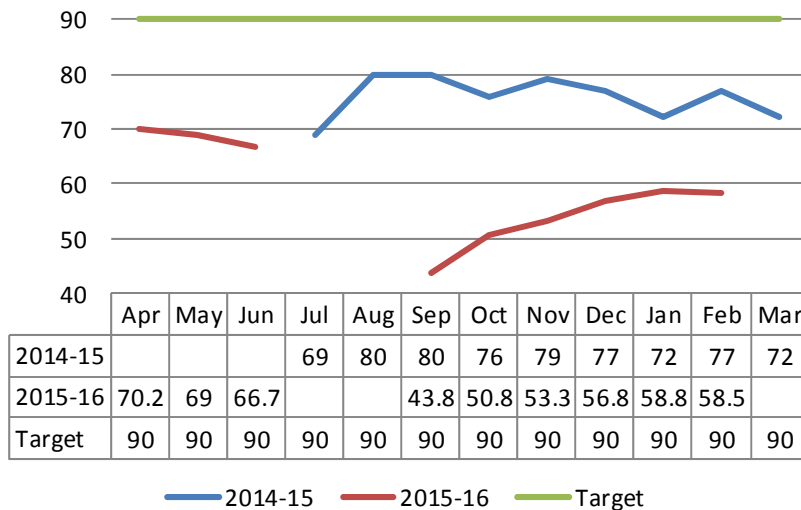
Action

- Recruitment pipelines are closely monitored.
- International nurse recruitment is being developed with a view to securing a pipeline from the summer
- Targeted interventions for Gastro nurse recruitment are on-going

Core Slide 34

Workforce - Lead Director Jeremy Over

Non-Medical Appraisals Completed (%)



Non-Medical Appraisal Completion Compliance %

Trustwide 58.5%

Cancer Services Division	76.8%
Corporate Areas	57.2%
<i>Nursing & Education</i>	39.1%
<i>Research & Development</i>	40.0%
<i>Resources</i>	67.2%
<i>Strategy & Planning</i>	89.4%
<i>Workforce</i>	67.3%
Emergency Services	29.9%
Medicine & Clinical Support	58.8%
Surgery & Cromer Division	56.3%
Women, Children & Sexual Health Division	70.9%

Issues

- The new appraisal system went live on 6 July 2015.
- To date, 2,028 appraisals have been completed using the new appraisal system.
- In total, 3,185 appraisals have been undertaken within timescales.

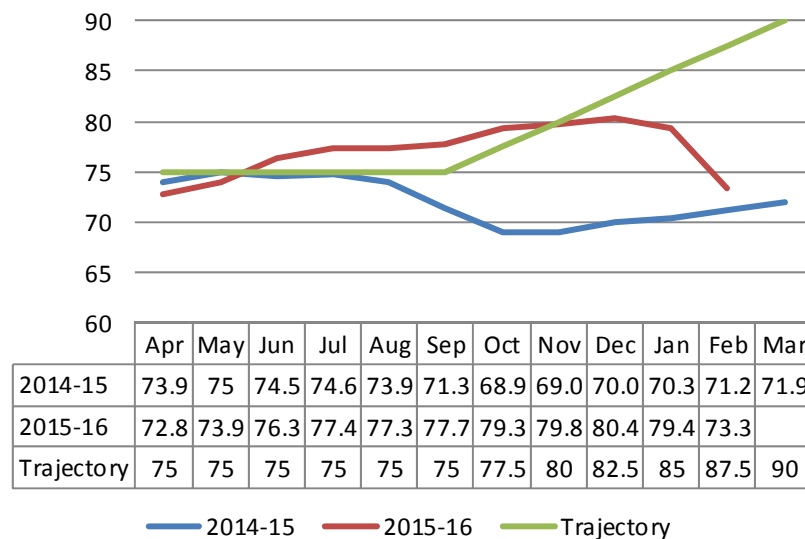
Actions

- Appraisal rates are discussed with divisions at monthly performance committee meetings.
- The CEO has taken every opportunity to press the importance of the appraisal experience, including at Viewpoint and with the staff representatives at the JSCC.

Core Slide 35

Workforce - Lead Director Jeremy Over

Mandatory Training (%)



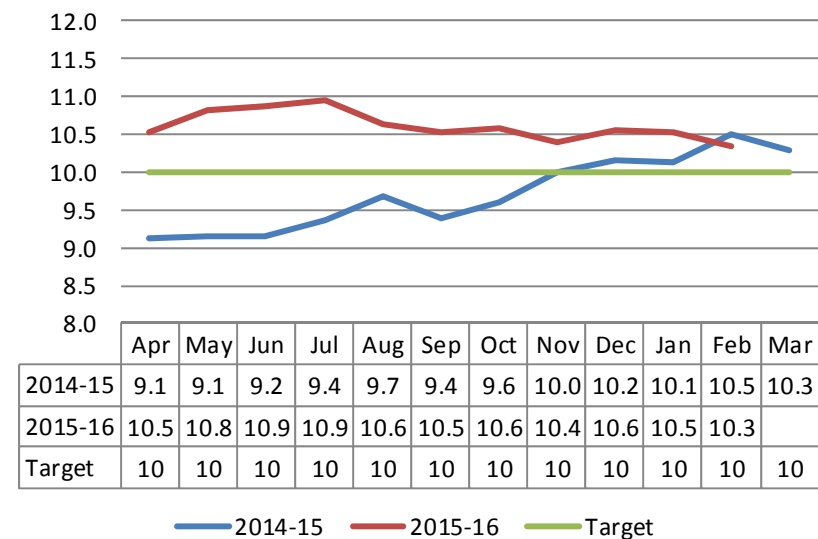
Issues

- The overall compliance rate has dipped significantly. This is due to a change in the training requirements for Safeguarding Adults, with the addition of 'level 2' for clinical staff, which introduces some additional learning outcomes.

Actions

- Divisional level mandatory training rates are discussed at executive performance committee.
- Further work will be undertaken by HR to provide assurance around data accuracy and reporting transparency.

Staff Turnover (%)



Issues

- Staff turnover has continued in the range 10.3% to 10.6% from August 2015.
- This is down from the peak of 10.9% in June and July.
- It is currently 0.2% lower than at this stage last year

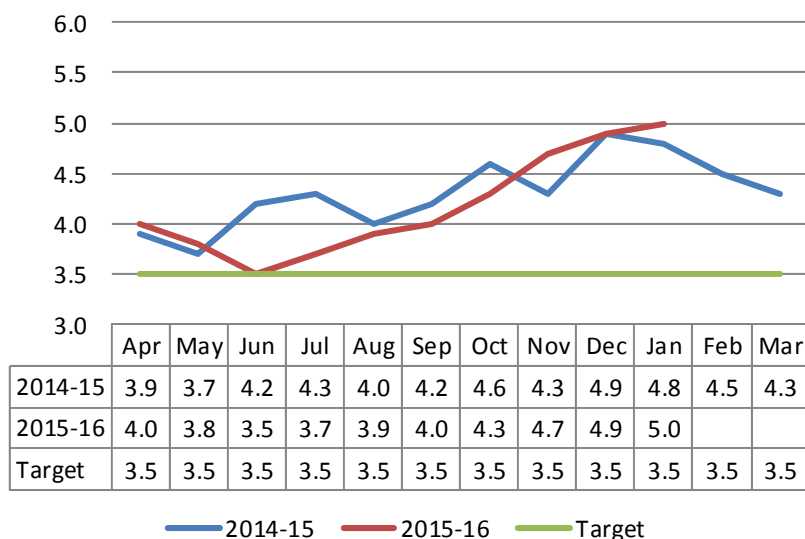
Actions

- The current trajectory is consistent, as Turnover moves towards the target of 10%
- The newly-formed Staff Experience Working Group has a mandate to focus on Turnover
- Of the known reasons for leaving, two-thirds are for or promotion/relocation-related reasons.

Core Slide 36

Workforce - Lead Director Jeremy Over

Sickness Levels



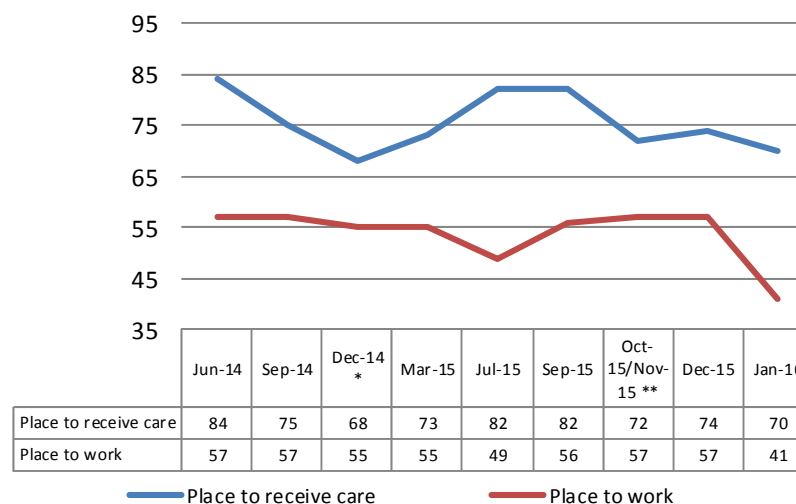
Issues

- For data accuracy purposes, sickness figures are reported one-month in arrears.
- The 12 month seasonally adjusted figure is 4.2%, and is identical to the previous month and lower than the position 12 months ago.

Actions

- Sickness is discussed in detail at divisional Performance Committees
- Managers are encouraged to intervene at every opportunity in order to maximise attendance at work

Friends and Family Test Scores



Issues

- Place to receive care has dipped significantly although this arose from a relatively small response rate (161 responses).

* December 14 – National Staff Survey

** Combined metric due to National Staff Survey

Actions

- The results of the national staff survey, released in February, also underline the importance of addressing staff's views regarding NNUH as a place to work. Separate proposals are being put forward at hospital management board in relation to this.



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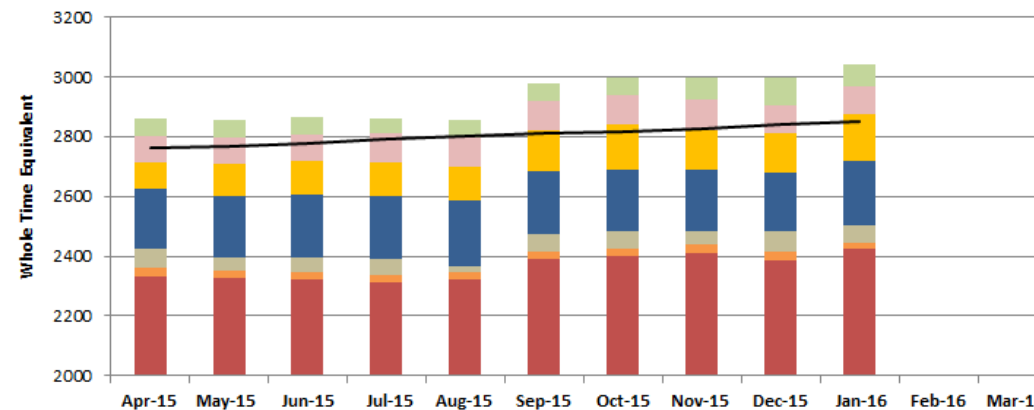
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Core Slide 37

Workforce - Lead Director Jeremy Over Registered nursing metrics – all areas



Establishment	2763.8	2767.3	2778.5	2792.6	2803.0	2809.3	2814.0	2824.6	2842.3	2848.8		
Resourcing - surplus(+) gap(-)	+97.8	+90.0	+86.2	+70.1	+52.3	+166.5	+183.2	+172.0	+153.2	+190.9		
SIP - Long Term Sick*1	62.1	58.5	58.8	50.4	61.0	56.1	57.6	72.0	89.0	72.5		
SIP - Maternity & Other*2	87.4	91.7	89.5	98.5	95.9	100.4	100.5	101.0	95.4	91.9		
Agency*3	88.9	105.4	109.6	113.0	111.6	135.8	148.3	134.6	130.9	157.9		
Bank*3	198.2	204.5	210.2	211.6	218.6	211.0	206.1	206.4	198.1	214.0		
Overtime*3	63.0	45.8	50.6	51.8	23.9	57.1	59.7	43.0	68.9	56.8		
Excess Hours*3	27.7	23.9	21.8	23.5	23.5	23.8	26.8	28.0	25.7	22.4		
'Attending' Staff in Post *4	2334.3	2327.5	2324.2	2314.1	2320.9	2391.7	2398.2	2411.6	2387.6	2424.3		
Staff in Post (SIP)	2483.8	2477.8	2472.6	2462.9	2477.8	2548.2	2556.3	2584.6	2572.1	2588.6		
'Vacancy' level interpretations												
Establishment less SIP	280.0	289.6	305.9	329.7	325.2	261.1	257.7	240.0	270.3	260.3		
Establishment less attending SIP	429.5	439.8	454.2	478.5	482.0	417.6	415.8	413.0	454.7	424.6		

*1 Long term sick defined as 28+ calendar days *2 Figure includes maternity leave, career break and external secondments

*3 Bank, Overtime, Excess Hours and Agency figures are illustrative, based on a conversion to WTE

*4 The 'attending' figure includes all staff in post, with the exception of those on Maternity or LTS, but includes staff absent on short term sickness

Source - Establishment from Finance 17/2/2016, Staff in post from ESR 19/2/2016, Bank & Agency from e-Roster 5/2/2016, OT & excess hours from Finance 5/2/2016

- This analysis reflects nursing workforce data incorporating equivalent figures for employed, bank, agency, overtime and excess hours. February data is not available at the time these slides were produced.
- Reliance on agency nurses remains high.

Core Slide 38

Finance Summary – Lead Director Sheila Budd

Finance	Full Year Plan 15/16	Feb-16 Actual	YTD 15/16	YTD Plan	Full Year Forecast
1 Total income excluding interest	£542,786k	£46,502k	£498,902k	£496,738k	£546,639k
2 Total Pay Costs	£299,229k	£26,142k	£277,828k	£273,864k	£304,066k
3 Other Operating Expenditure	£208,974k	£18,740k	£195,249k	£191,458k	£213,509k
4 EBITDA	£34,585k	£1,620k	£25,825k	£31,381k	£29,064k
5 CIP Savings Achieved	£21,265k	£1,400k	£14,300k	£19,362k	£15,174k
6 Closing Cash balance	£46,875k	£39,311k	£39,311k	£49,804k	£33,164k
7 Capital expenditure	£12,373k	£195k	£6,125k	£8,655k	£10,020k
8 Non-Elective Activity - marginal rate - Financial Impact *	£6,493k	£680k	£6,471k	£5,943k	
9 Emergency readmissions penalties: Following Elective *	£1,128k	£73k	£976k	£1,034k	
10 Emergency readmissions penalties: Following Non Elective *	£468k	£40k	£854k	£429k	

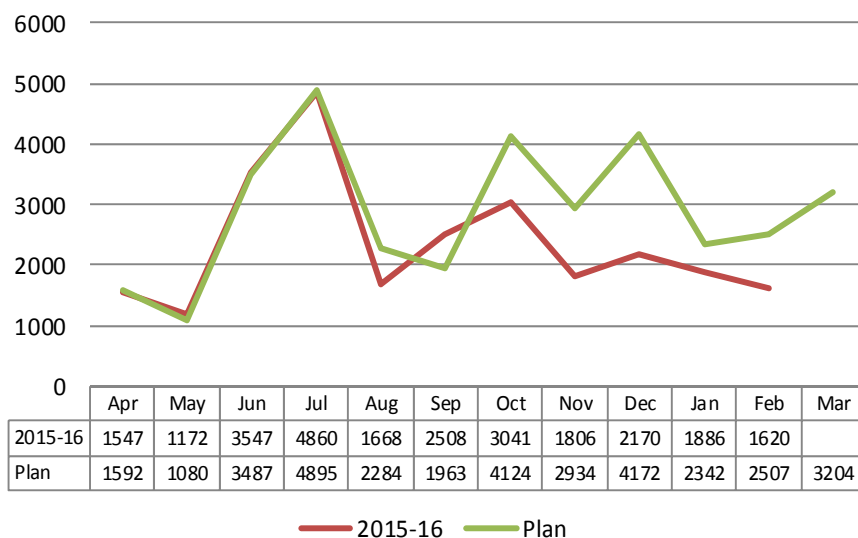
*Please note these figures are provisional

- For February, Clinical Income plan was £33.3m, and the fast track income for the month was £33.0m, overall being £0.3m behind plan.
- The in month result was an adverse variance of £0.7m, bringing the cumulative financial position at month 11 to an adverse variance of £5.1m – i.e. worse than plan.
- The main drivers in month are Clinical Income being £0.3m lower than plan, Pay £0.8m and Non-Clinical Supplies £0.6m higher than plan, against a favourable variance in Other Income of £0.8m. Non-Clinical Supplies were driven by £0.2m Ramsay Healthcare (Fitzwilliam Hospital), £0.2m Medinet within Gastro, £0.1m waiting list validation costs.
- Agency costs were £1,564k in month being £119k more than month 10 and £220k more than month 9 (see graph for more details).
- Locum costs were £1,170k in month being £352k less than in month 10 and but £229k higher than month 9. (see graph for more details).
- Cash is £10,493k behind plan. This is a combination of Capital expenditure being £2,528k behind plan, offset by Pay overspends, use of non recurrent funding, and movements in working capital balances (including CCGs withholding payment re queries, disputes and penalties).
- The forecast deficit position of £14.4m has overall, not changed. The key risks to the forecast are delivery of the activity underpinning Clinical Income, impact of emergency demand, and the rising pay costs – see graphs for more details .
- The forecast does not reflect penalty and CQUIN risks, which together with activity validation challenges could be @ £15.2m. Monitor has asked for an updated forecast reflecting our assessment of all likely risks. We have a planned meeting with the CCGs to conclude on this aspect and will update the Board at the meeting. The final position will have a direct impact on - reduction in cash, which will also directly affect the 2016/17 plan.

Core Slide 39

Finance – Lead Director Sheila Budd

EBITDA



Issues

- At the end of month 11, EBITDA is £5,556k behind plan due to costs being greater than plan, mainly Pay costs and clinical income falling behind plan. The key pay items are agency and locum costs - please see graphs on the next page.

Actions

- Locum costs were lower than the peak seen in January, but still were the second highest month at £1,170k and continue to require attention by divisions. This is in progress.

Cost Improvement Plan

Issues

- At month 11 the CIP has achieved savings of £14.3m compared to a plan of £19.4m.
- The main reason is slippage in timing on the theatres (£2.2m) and Radiology (£0.7m). The Patient Flow project has over-achieved against plan (£0.5m).
- The remaining £2.5m shortfall is reflective of Outpatients (£1m) and 1% budgetary savings QIPP (£0.8m) under performance.

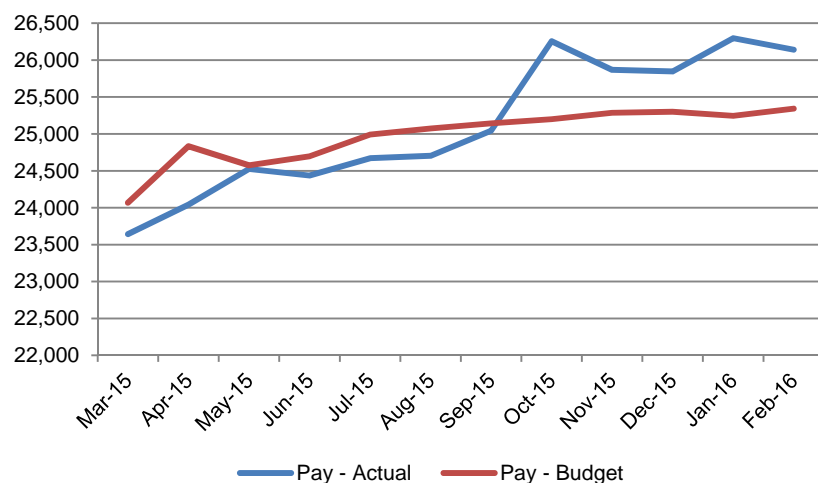
Actions

- Our cost improvement target for 2015/16 is £21.2m (3.9% of turnover). This target is supported by a number of specific projects, with £9m relating to the transformation projects alongside Newton.
- The transformation teams are aware of their target and need to deliver the plan.
- Review and challenge of CIP performance will be emphasized in the forthcoming Performance Meetings
- As part of preparing for 2016/17, the organization has set itself the target of a focused reduction in Pay costs compared to forecast outturn for 2015/16. The Divisions are working on this, with detailed proposals on a specialty basis due end March. This will largely displace premium costs.
- There is a significant focus on cost reduction to deliver savings.

Core Slide 40

Finance – Lead Director Sheila Budd

Pay – Budget & Actuals rolling 12 months



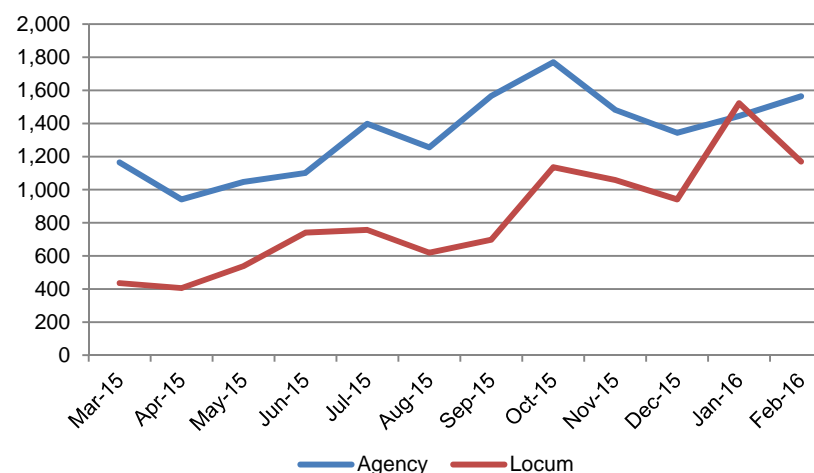
Issues

- Pay costs have historically been under budget as a result of slippage on business cases within Reserves.
- In February, Pay was overspent by £800k.
- The drivers for this were continued high levels of expenditure within Locums and Agency – see graph.

Planned Actions

- Continued recruitment to vacant posts to limit reliance on locums, agency & other premium payroll costs
- Active planning for every locum post in order to displace with substantive cost

Pay – Locums & Agency (actuals) rolling 12 months



Issues

- Agency spend in M11 was £1,564k. The average cost of agency (month 1-10) for 15/16 has been £1,335k pm.
- Agency spend in M11 increased compared to M09-10 which is counter to expectation given the savings anticipated from the framework agreement.
- Locums have reduced from the significant increase seen in M10.
- Locum spend in M11 was £1,170k, lower than M10 but still the second highest in the year. The main area is ED

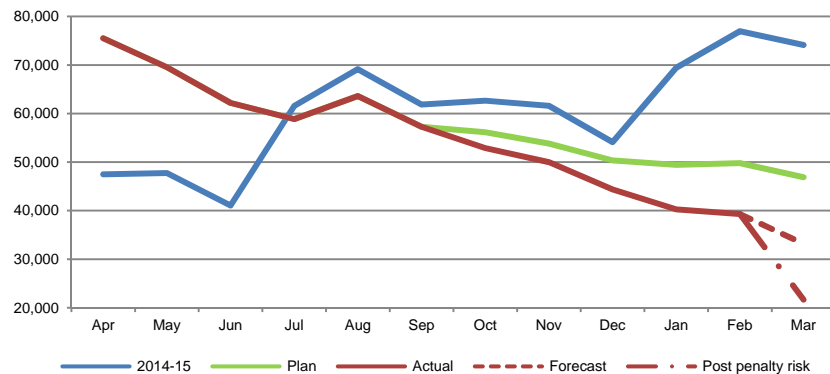
Planned Actions

- Continued focus to move towards the use of framework agencies to minimize premium payments
- Locum spend remains an issue, there needs to be a drive towards usage of internal locums and recruitment to vacancies
- Active planning for every locum post in order to displace with substantive cost

Core Slide 41

Finance – Lead Director Sheila Budd

Closing Cash balance



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2014-15	47490	47727	41036	61565	69145	61856	62654	61599	54101	69432	76964	74138
2015-16	75506	69552	62183	58846	63594	57282	52898	49995	44354	40248	39311	
Plan	75,506	69,552	62,183	58,846	63,594	57,282	56,162	53,805	50,353	49,435	49,804	46,875

Key Risks to Financial Plan

- Failure to deliver planned clinical activity has significant financial consequences – penalties and additional pay costs in particular.
- The current assessment of penalty costs is £9.0m
- Our assessment of CQUIN risk is @ £2m
- The CCGs are challenging @ £4.2m of activity income coding, which we are disputing.
- The total clinical income risk re penalties CQUIN and challenges is @ £15.2m, of which £3.7m cash has been withheld. If this all materialises, our forecast position and cash will deteriorate accordingly. We have a planned meeting with the CCGs to conclude on this.
- Locum and agency costs are not managed and continue at current rates and volumes. M11 has seen a reduction in the Locum but Agency is continuing to rise.

Issues

- Closing cash at the end of M11 is £39.3m compared to the planned position of £49.8m being a difference of £10.5m. This is a combination of working capital movements and the YTD deficit being £5.1m worse than plan.
- Forecast closing cash reflects two scenarios – (i) the forecast deficit of £14.4m and increased in year use of non recurrent funding **excluding** penalties and CQUIN risk and (ii) **including** current estimate of CQUIN and penalty risk

Actions

- Tight focus and controls over cash are required especially in the light of our forecast deficit and pressures for 2016/17.

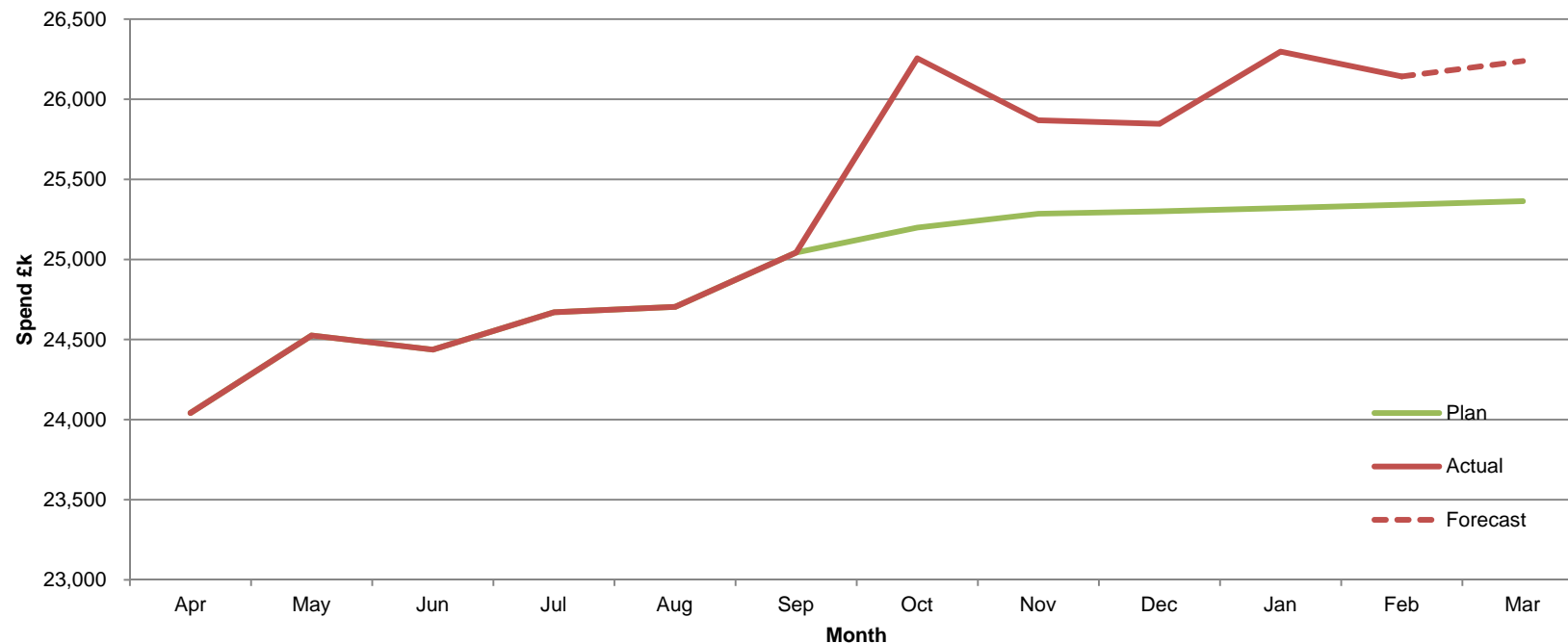
Forecast

- The draft forecast position remains a deficit of £14.4m.
- We have not reflected the penalty and CQUIN risk described above pending the outcome of CCG discussions
- The forecast is dependent on delivery of the activity plan for March 2016 underpinning Clinical Income, whilst managing the impact of emergency demand, and controlling pay costs.

Core Slide 42

Finance – Lead Director Sheila Budd

Pay Forecast

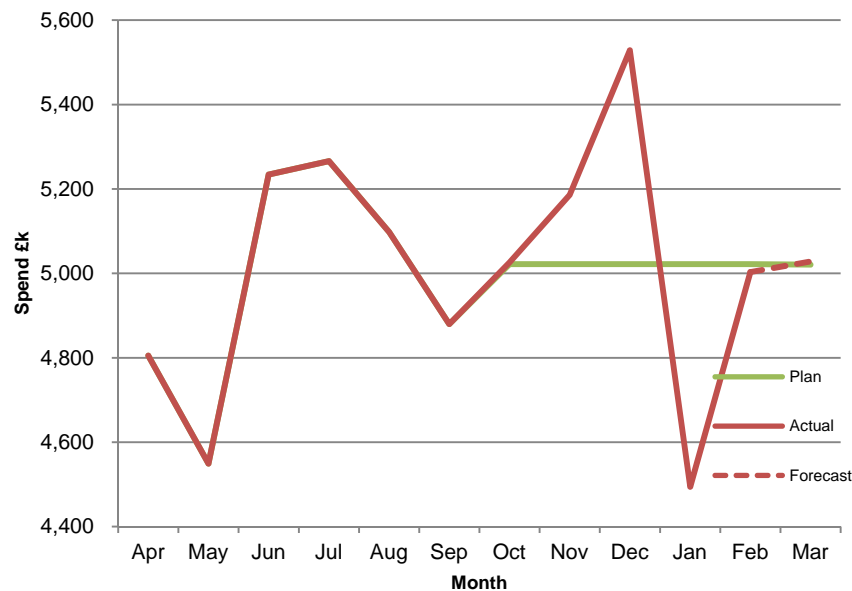


- The projection for Pay for M12 assumes that the expenditure will be equivalent to that seen in January 2016, being the highest in the year to date.

Core Slide 43

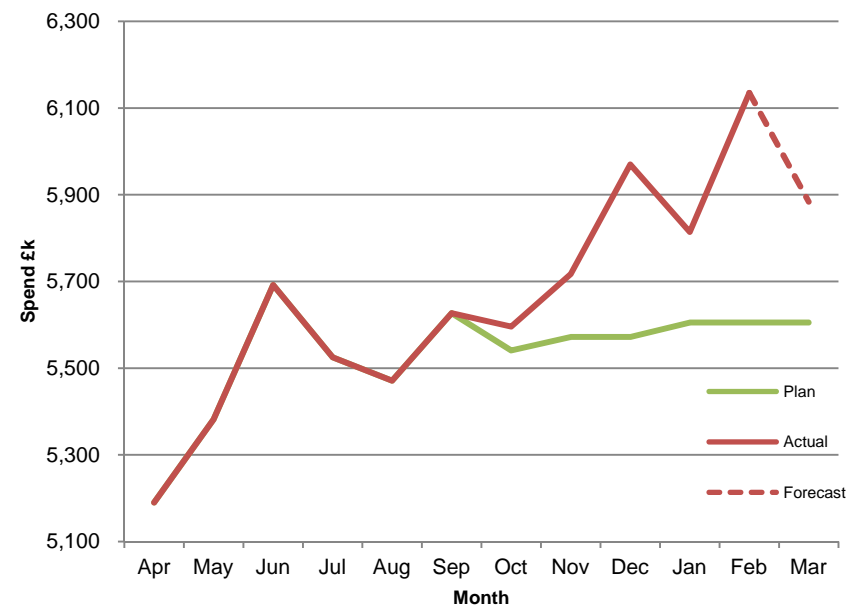
Finance – Lead Director Sheila Budd

Clinical Supplies Forecast



- M11 was in line with the plan for the month.
- The projection for M12 assumes that the expenditure will be at the level of the average of M09-11.

Non Clinical Supplies Forecast

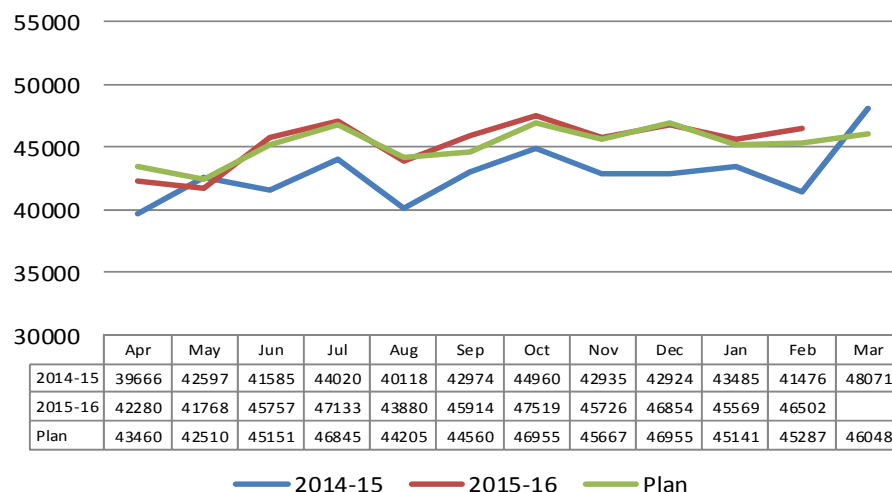


- The projection for M12 assumes current trends in expenditure will continue in line with the average of M08-11.
- The increase in M11 results from @ £200k Ramsay Healthcare Fitzwilliam Hospital unexpected invoices. This is being discussed but reflected prudently.

Core Slide 44

Finance – Lead Director Sheila Budd

Total income excluding interest



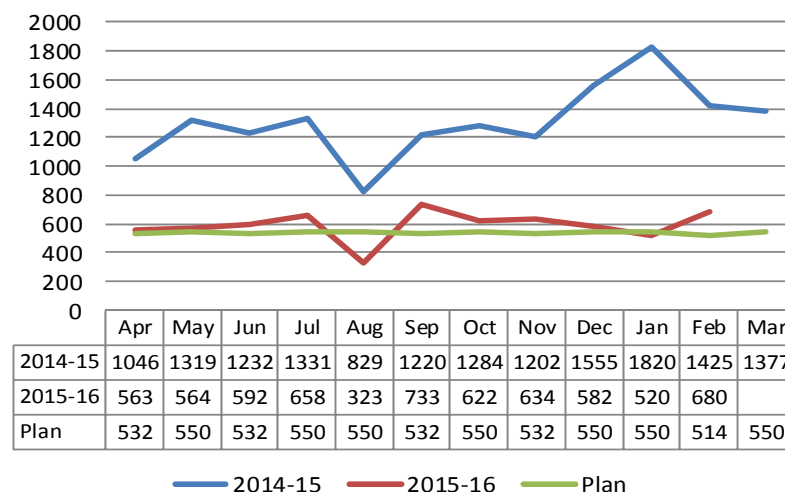
Issues

- Total income at £498.9m is £2.2m ahead of plan of which £1.8m relates to non-tariff drugs, largely offset by additional drug costs.
- Clinical income is less than plan.

Actions

- Focus on delivering activity to meet access targets, minimise penalties and maximise contribution.
- Maximise use of Vanguard day case facility.

Non-Elective Activity - marginal rate - Financial Impact *



Issues

- The reduction in income relating to the marginal rate associated with the volume of non-elective admissions is £6,471k to date. This is £528k worse than plan.
- The reduction in income relating to readmissions within 30 days is £1,830k to date. This is £367k worse than plan.

Actions

- Consideration should be given to analysing the cause of readmissions and determining whether the loss of income can be reduced.

* Denotes provisional figure for most recent month



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APPENDICES HERE –

before high risk tracker



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High Risk Tracker – 17/03/2016 – Lead Director Emma McKay

This high risk tracker highlights all current risks on the Risk Register that have a Residual Risk Rating of 15+.

Ref	Risk Name	Current RR score			RRR Score			Date Risk added	Executive Lead	Governance Domain	Date of Last review on REGISTER
		C	L	R	1mth ago	2mth ago	3mth ago				
BAF 17	BAF Achievement of the financial plan	4	5	20	20	20	16	13/10/2015	S.Budd	Responsiveness	09/03/2016
BAF 12	BAF Key local and national operational performance targets	4	4	16	16	16	16	13/10/2015	R.Parker	Responsiveness	09/03/2016
BAF.18	BAF.18 Ensure sufficient numbers of staff are in place to deliver the services.	4	4	16	16	16	16	03/04/2014	J. Over	Workforce	17/03/2016
RR 359	Outpatient capacity Ophthalmology	4	4	16	16	16	16	29/04/2015	R.Parker	Responsiveness	14/03/2016
RR 384	Chemotherapy demand & capacity	4	4	16	16	16	16	26/06/2013	R.Parker	Responsiveness	14/03/2016
RR 393	Vascular waits for IRU	4	4	16	12	12	12	03/06/2014	R.Parker	Responsiveness	14/03/2016
RR 476	IRU capacity	4	4	16	16	16	16	03/06/2014	R.Parker	Responsiveness	11/03/2016
RR 604	Inpatient diabetes insulin errors	4	4	16	16	16	16	06/11/2015	P.Chapman	Clinical Safety	10/03/2016
RR 605	Renal fistula waits for IRU	4	4	16	16	16	16	06/11/2015	P.Chapman	Clinical Safety	14/03/2016
RR.355	Increased use of DPU as an escalation area for	4	4	16	12	12	12	10/02/2016	P.Chapman	Clinical Safety	14/03/2016
RR 509	Deferral of annual refurbishment programme A&E	3	5	15	15	15	15	06/11/2014	J.Over	Non Clinical Safety	17/03/2016
RR 510	Deferral of annual refurbishment programme - Pharmacy production	3	5	15	15	15	15	06/11/2014	J.Over	Non Clinical Safety	17/03/2016
RR 511	Deferral of annual refurbishment programme - Wards	3	5	15	15	15	15	06/11/2014	J.Over	Non Clinical Safety	17/03/2016
RR 538	Waiting times for pacemaker implantation - Cardiology	5	3	15	15	15	15	03/06/2015	R.Parker	Responsiveness	11/03/2016
RR 624	Space in Paediatric area of ED	3	5	15	15	15	15	06/11/2015	P.Chapman	Clinical Safety	11/03/2016
RR 635	Capacity for O&G Ultrasound	3	5	15	15	15		12/12/2015	P. Chapman	Effectiveness	11/03/2016

Income Statement

Eleven month position to 29 February 2016

	Ledger Plan £'000	YT Feb-15 Actual £'000	Year to date			Forecast to 31st March 2016		
			Actual £'000	Budget £'000	Variance £'000	Forecast £'000	Budget £'000	Variance £'000
INCOME								
NHS clinical income								
Clinical Income	403,655	354,410	367,242	369,592	(2,350)	401,492	403,655	(2,163)
NT Drugs	52,266	42,084	49,756	47,910	1,846	54,731	52,266	2,465
Total NHS clinical income	455,921	396,494	416,998	417,502	(504)	456,223	455,921	302
Non NHS clinical income								
Private patients	1,930	1,757	1,837	1,769	68	2,039	1,930	109
Other - RTA	1,378	1,494	1,174	1,263	(89)	1,295	1,378	(83)
Total Non NHS clinical income	3,308	3,251	3,011	3,032	(21)	3,334	3,308	26
Other Income								
R&D	22,813	20,355	20,672	20,864	(192)	22,637	22,813	(177)
Education & Training	19,643	17,066	17,900	17,977	(77)	19,565	19,643	(78)
Other non patient care income	41,101	29,574	40,321	37,363	2,958	44,880	41,101	3,779
Total other Income	83,557	66,995	78,893	76,204	2,689	87,082	83,557	3,525
TOTAL OPERATING INCOME	542,786	466,740	498,902	496,738	2,164	546,639	542,786	3,853
EXPENDITURE								
Employee benefit expenses	(299,227)	(260,475)	(277,828)	(273,864)	(3,964)	(304,066)	(299,227)	(4,839)
Drugs	(62,140)	(50,514)	(59,504)	(56,979)	(2,525)	(65,157)	(62,140)	(3,017)
Clinical supplies	(59,961)	(52,361)	(55,070)	(54,940)	(130)	(60,098)	(59,961)	(137)
Non clinical supplies	(66,309)	(55,527)	(62,119)	(60,740)	(1,379)	(68,003)	(66,309)	(1,694)
PFI operating expenses	(20,564)	(18,617)	(18,556)	(18,834)	278	(20,252)	(20,564)	313
TOTAL OPERATING EXPENSES	(508,201)	(437,494)	(473,077)	(465,357)	(7,720)	(517,575)	(508,201)	(9,374)
Profit/(loss) from operations	34,585	29,246	25,825	31,381	(5,556)	29,064	34,585	(5,521)
Non-operating income								
Interest	227	203	223	212	11	239	227	12
Profit/(loss) on asset disposals	(15)	7	(2)	(12)	10	(4)	(15)	11
Total non-operating income	212	210	221	200	21	236	212	24
Non-operating expenses								
Interest on PFI and Finance leases	(17,918)	(16,662)	(16,408)	(16,423)	15	(17,899)	(17,918)	19
Depreciation	(14,168)	(12,405)	(12,563)	(12,902)	339	(13,775)	(14,168)	394
PDC	(2,260)	(1,038)	(1,965)	(2,071)	106	(2,101)	(2,260)	159
Other - Contingent Rent	(9,946)	(8,960)	(9,105)	(9,104)	(1)	(9,946)	(9,946)	
Total non operating expenses	(44,292)	(39,065)	(40,041)	(40,500)	459	(43,720)	(44,292)	572
Surplus (deficit) after tax from continuing operations	(9,495)	(9,609)	(13,995)	(8,919)	(5,076)	(14,421)	(9,495)	(4,926)
Memo:								
Donated Asset Additions	192	273	492	192	300	492	192	300
Surplus (deficit) after tax and Donated Asset Additions	(9,303)	(9,336)	(13,503)	(8,727)	(4,776)	(13,929)	(9,303)	(4,626)

Important Note:

The forecast excludes fines & penalties, challenges, and CQUIN risk of circa £15.2m per the latest data from the CCGs. This will become more clear by the end of March.

Statement of Position

Position as at 29 February 2016

	2015/16		2015/16	2014/15
	£'000	£'000	£'000	£'000
	Actual Year to Date	Budget Year to Date	Plan Full Year	Audited Actual Full Year
Assets				
Assets, Non-Current				
Property, Plant and Equipment, Net	73,392	74,485	77,599	72,112
PFI: Property, Plant and Equipment, Net	212,078	211,818	211,193	218,692
NHS Trade Receivables, Non-Current				
Non NHS Trade Receivables, Non-Current	1,498	1,886	1,886	2,001
Prepayments, Non-Current	61,982	62,191	62,727	56,252
Assets, Non-Current, Total	348,950	350,380	353,405	349,057
Assets, Current				
Inventories	8,583	8,244	8,244	8,244
NHS Trade Receivables, Current	11,771	8,528	8,528	7,314
Non NHS Trade Receivables, Current	3,977	4,167	4,167	4,167
PDC Receivables, Current				147
Accrued Income	9,164	5,024	2,944	2,944
Prepayments, Current, non-PFI related	3,295	2,567	2,067	2,067
Cash	39,311	49,804	46,875	74,138
Assets, Current, Total	76,101	78,334	72,825	99,021
ASSETS, TOTAL	425,051	428,714	426,230	448,078
Liabilities				
Liabilities, Current				
Deferred Income, Current	(24,029)	(22,832)	(22,241)	(29,532)
Provisions, Current	(855)	(884)	(884)	(884)
Current Tax Payables	(5,606)	(5,594)	(5,594)	(5,440)
Trade Creditors, Current	(10,679)	(15,418)	(15,664)	(16,724)
Other Creditors, Current	(6,096)	(4,846)	(4,846)	(4,846)
Capital Creditors, Current	(1,677)	(994)	(994)	(994)
Accruals, Current	(33,511)	(27,675)	(26,451)	(26,451)
Finance Leases, Current	(172)	(172)	(162)	(172)
PFI leases, Current	(3,540)	(3,540)	(3,360)	(3,540)
Liabilities, Current, Total	(86,165)	(81,955)	(80,196)	(88,583)
NET CURRENT ASSETS (LIABILITIES)	(10,064)	(3,621)	(7,371)	10,438
Liabilities, Non-Current				
Deferred Income, Non-Current	(5,648)	(7,342)	(7,333)	(7,802)
Provisions, Non-Current	(2,418)	(3,817)	(3,803)	(3,971)
Finance Leases, Non-current	(339)	(340)	(335)	(497)
PFI leases, Non-Current	(199,196)	(199,199)	(199,079)	(202,437)
Liabilities, Non-Current, Total	(207,601)	(210,698)	(210,550)	(214,707)
TOTAL ASSETS EMPLOYED	131,285	136,061	135,484	144,788
Taxpayers' and Others' Equity				
Taxpayers Equity				
Public dividend capital	25,090	25,090	25,090	25,090
Retained Earnings (Accumulated Losses)	38,689	43,232	42,655	51,780
Revaluation Reserve	67,506	67,739	67,739	67,918
TAXPAYERS EQUITY, TOTAL	131,285	136,061	135,484	144,788
TOTAL ASSETS EMPLOYED	131,285	136,061	135,484	144,788

Cash Flow Statement

Position as at 29 February 2016

	£'000	2015/16 £'000	£'000	2015/16 £'000	2014/15 £'000
	Actual Year to Date	Budget Year to Date	Variance Year to Date	Plan Full Year	Audited Actual Full Year
(Deficit) after tax including donated assets	(13,503)	(8,727)	(4,776)	(9,301)	(9,615)
Non-cash flows in operating surplus					
Finance income/charges	25,290	25,315	(25)	27,637	27,636
Depreciation and amortisation, total	12,563	12,902	(339)	14,168	13,844
Gain on disposal of property plant and equipment	2	12	(10)	15	539
PDC dividend expense	1,965	2,071	(106)	2,260	891
Non-cash flows in operating surplus, Total	39,820	40,300	(480)	44,080	42,910
Operating Cash flows before movements in working capital	26,317	31,573	(5,256)	34,779	33,295
Increase/(Decrease) in working capital					
(Increase) in inventories	(339)	0	(339)	0	(532)
(Increase) in NHS Trade Receivables	(4,457)	(1,214)	(3,243)	(1,214)	3,288
Decrease in Non NHS Trade Receivables	190	0	190	0	(1,236)
(Increase) in accrued income	(6,220)	(2,080)	(4,140)	0	(380)
(Increase) in prepayments	(1,228)	(488)	(740)	110	(228)
(Decrease) in Deferred Income (excluding Donated Assets)	(7,657)	(7,160)	(497)	(7,760)	9,761
(Decrease) in provisions	(1,582)	(154)	(1,428)	(168)	(254)
Increase in tax payable	166	154	12	154	(81)
(Decrease) in Trade Creditors	(6,817)	(2,193)	(4,624)	(1,058)	5,742
Increase in Other Creditors	1,250	0	1,250	0	(1,813)
Increase in accruals	7,060	1,222	5,838	(0)	1,177
Increase in other Other Financial liabilities	0	0	0	0	324
(Decrease) in working capital, Total	(19,634)	(11,913)	(7,721)	(9,936)	15,768
Net cash inflow/(outflow) from operating activities	6,683	19,660	(12,977)	24,843	49,063
Net cash flow from investing activities					
Property, plant and equipment - non-maintenance expenditure	(6,125)	(8,430)	2,305	(12,182)	(3,297)
Proceeds on disposal of property, plant and equipment	10	10	0	10	22
(Decrease) in Capital Creditors	(433)	0	(433)	0	(886)
Other cash flows from investing activities	(5,730)	(5,929)	199	(6,474)	(6,182)
Net cash (outflow) from investing activities, Total	(12,278)	(14,349)	2,071	(18,646)	(10,343)
Net cash inflow/(outflow) before financing	(5,595)	5,311	(10,906)	6,197	38,720
Net cash inflow/(outflow) from financing activities					
PDC Dividends paid	(1,046)	(1,046)	0	(2,113)	(815)
Interest element of finance lease rental payments - <i>other</i>	(16)	(18)	2	(19)	(24)
Interest element of finance lease rental payments - <i>On-balance sheet PFI</i>	(16,392)	(16,411)	19	(17,900)	(18,145)
Capital element of finance lease rental payments - <i>other</i>	(158)	(156)	(2)	(171)	(490)
Capital element of finance lease rental payments - <i>On-balance sheet PFI</i>	(3,241)	(3,239)	(2)	(3,539)	(3,354)
Interest received on cash and cash equivalents	223	213	10	228	228
Movement in Other grants/Capital received	0	0	0	0	1,233
Decrease in non-current receivables	503	115	388	0	(239)
Other cash flows from financing activities	(9,105)	(9,103)	(2)	(9,946)	(9,695)
Net cash (outflow) from financing activities, Total	(29,232)	(29,645)	413	(33,460)	(31,301)
Net increase/(decrease) in cash and cash equivalents	(34,827)	(24,334)	(10,493)	(27,263)	7,419
Closing cash and cash equivalents	39,311	49,804	(10,493)	46,875	74,138

CASH FLOW FORECAST ROLLING 12 MONTHS SUMMARY

	2015/16		2016/17										
	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Opening Cash balance	40,248	39,311	33,164	28,920	26,331	24,847	23,275	20,165	20,605	18,968	16,860	17,114	14,850
Receipts													
Clinical Income	39,626	39,415	38,891	41,380	40,618	43,006	40,758	41,531	43,292	42,369	40,484	42,208	40,254
Other Income	6,880	9,370	7,202	7,202	7,203	7,202	7,202	7,212	7,211	7,211	7,223	7,222	7,222
Interest	15	14	15	15	15	14	15	15	15	14	15	15	15
Total Receipts	46,521	48,799	46,108	48,597	47,836	50,222	47,975	48,758	50,518	49,594	47,722	49,445	47,491
Payments													
Pay Expenditure	26,082	26,151	27,079	27,083	27,100	27,119	27,217	27,217	27,408	27,397	27,434	27,450	27,466
Non Pay Expenditure	21,188	23,985	22,817	23,717	19,834	24,289	23,482	19,281	24,389	24,055	19,784	24,009	22,171
Capital	188	3,902	456	386	2,386	386	386	387	358	250	250	250	250
PDC Dividends	0	908	0	0	0	0	0	1,433	0	0	0	0	0
Total Payments	47,458	54,946	50,352	51,186	49,320	51,794	51,085	48,318	52,155	51,702	47,468	51,709	49,887
Closing Cashbook Balance	39,311	33,164	28,920	26,331	24,847	23,275	20,165	20,605	18,968	16,860	17,114	14,850	12,454

Notes to cash flow:

The Trust is currently experiencing considerable time delays in the settlement of key NHS invoices including drugs by CCGs.

Consistent with the forecast outturn position, the above cash flow does not reflect any cash risk for penalties.

The fines & penalties, challenges, and CQUIN risk is circa £15.2m per the latest data from the CCGs.

£3.7m of cash has already been withheld re the above. Accordingly the cash position could reduce by £11.5m, if the whole £15.2m is imposed.

2015/16 Capital Programme - Reforecast in Month 6

Reforecast Capital Plan

Position as at 29 February 2016

	Original Plan	Reforecast Plan	Draft Plan for 2016/17	2015/16 Planned Spend - Reforecast Phasing					Actual Spend YTD 2015/16 £'000	Variance to Reforecast Plan (over) / under £'000
				Q1 £'000	Q2 £'000	Q3 £'000	Q4 £'000	Total 2015/16 £'000		
Strategic Projects										
Improving the quality of emergency care: A&E	8,500	74		-	-	53	21	74	65	9
Space Labs Monitoring Equipment	2,000	2,000		-	-	-	2,000	2,000	-	-
Pathology (Eastern Pathology Alliance - EPA)	636	240		-	57	73	110	240	57	146
WDU expansion	881	705		-	-	176	529	705	3	526
eHealth Record / ePatient Record *	3,700	87		-	-	27	60	87	-	64
Theatres stacks *	600	-		-	-	-	-	-	68	(68)
IRU	2,000	-		-	-	-	-	-	-	-
Institute of Food, Health and Gut *	-	-		-	-	-	-	-	-	-
Fit out / convert Mattishall ward	3,000	78		-	-	78	-	78	43	35
Satellites *	-	-		-	-	-	-	-	-	-
Urgent Care Centre	750	745		201	353	77	114	745	554	153
Urgent Care Centre - 'Transformation Funding'	(750)									
Total Strategic Projects	21,317	3,929	-	201	410	484	2,834	3,929	790	866
Capital - Business as usual										
IT	1,479	1,077		92	372	49	564	1,077	474	415
Med & Surg	5,287	5,407		100	1,020	2,109	2,178	5,407	3,744	485
Estates including £0.5m for AMU Expansion	1,821	1,391		1	38	1,311	41	1,391	297	1,082
Other - to include movements in Contingency	227	377		25	14	135	203	377	328	(19)
Draft budget for 2016/17**			6,000							
Total - Trust Funded Capital	30,131	12,181	6,000	419	1,854	4,088	5,820	12,181	5,633	2,830
Charitable or Other Funded Items										
Donated Assets	-	192	-	27	165	-	-	192	492	(300)
TOTAL CAPITAL	30,131	12,373	6,000	446	2,019	4,088	5,820	12,373	6,125	2,530

Note: Reassessment of the 2016/17 capital plan is ongoing.

* These projects span more than 1 year - only the original 2015/16 component is shown above

2016/17 has been reset in line with the data in the Draft Annual Plan submitted to Monitor in February.

2015/16 closing cash, plus any changes to the Draft Annual Plan will have consequences for this, as the budget is a function of available cash.

** Allocation of the Draft Budget for 16/17 is a matter for the Capital Committee.

Application of ratings system to current NNUH Performance

FSRR Metrics

Financial criteria		Weight (%)	Metric	Rating categories**			
				1*	2***	3	4
Continuity of services	Balance sheet sustainability	25	Capital service capacity (times)	<1.25x	1.25 - 1.75x	1.75- 2.5x	>2.5x
	Liquidity	25	Liquidity (days)	<(14) days	(14)-(7) days	(7)-0 days	>0 days
Financial efficiency	Underlying performance	25	I&E margin (%)	≤(1)%	(1)- 0%	0-1%	>1%
	Variance from plan	25	Variance in I&E margin as a % of income	≤(2)%	(2)-(1)%	(1)-0%	≥0%

What This Means

Net Current Assets Excluding Inventories x 360
Total Operating Expenses
Profit/(loss) from operations + Interest Receivable
Non-Operating Expenses (Excluding Depreciation) + Capital Elements of Finance & PFI Leases
Surplus/(Deficit) + (Gains)/losses on Asset Disposal
Operating Income + Non-operating Income
Actual I&E Margin - Planned I&E Margin

Calculation of a FSRR score

Financial sustainability risk rating	Description	Regulatory activity
4	No evident concerns	None
3	Emerging or minor concern potentially requiring scrutiny	Potential enhanced monitoring
2*	Level of risk is material but stable	Potential enhanced monitoring
2	Material risk	Potential investigation (see Chapter 5)
1	Significant risk	Likely investigation (see Chapter 5) Potential appointment of contingency planning team

Current Performance to 29 February 2016

Capital Service Capacity Metric

Profit / Loss from Operations	(Appendix 1)	25,825	Revenue generated covers commitments 0.84 times
Interest Receivable	(Appendix 1)	223	
Total		26,048	
Non-Operating Costs	(Appendix 1)	40,041	
Less: Depreciation	(Appendix 1)	(12,563)	
Add: Capital Elements of Lease Payments	(Appendix 3)	3,399	
Total		30,877	

Liquidity Metric

Net Current Assets	(Appendix 2)	(10,064)	
Less: Inventories	(Appendix 2)	(8,583)	
Total		(18,647)	
Total Operating Expenses	(Appendix 1)	473,077	-13 Days worth of expenses held as cash equivalents
Annualised (x 12/11)		516,084	

I&E Margin Metric

Surplus/(Deficit)	(Appendix 1)	(13,503)	Actual I&E Margin is -2.7%
(Gains)/losses on Asset Disposal	(Appendix 1)	2	
Total		(13,501)	
Operating Income	(Appendix 1)	499,394	Planned I&E Margin is -1.75%
Non- Operating Income	(Appendix 1)	221	
Total		499,615	

Variance in I&E Margin Metric

Surplus/(Deficit)	(Appendix 1)	(8,727)	I&E Margin Variance is -0.95%
(Gains)/losses on Asset Disposal	(Appendix 1)	12	
Total		(8,715)	
Operating Income	(Appendix 1)	496,930	
Non- Operating Income	(Appendix 1)	200	
Total		497,130	

Summary - Score is 2/2*

Current Capital service capacity of 0.84 gives a score of 1 for this metric.
 Current Liquidity of -13 days gives a score of 2 for this metric.
 Current I&E Margin of -2.7% gives a score of 1 for this metric.
 Current Variance in I&E Margin of -0.95% gives a score of 3 for this metric.

The overall score is 2/2*, resulting in either potential enhanced monitoring or a potential investigation depending on Monitor's assessment.

Capital service capacity is hard to change the rating due to the high level of fixed financial commitment in relation to revenue generated by the business.

Liquidity is more prone to change as it is influenced by any change in financial performance, or additional cash outgoings such as capital.

Income Statement Comparison - for the Month of February

	For the month			Variances Fav / (Adv)			
	Actual	Budget	Prior year	To budget		To prior year	
	£'000	£'000	£'000	£'000	%	£'000	%
INCOME							
NHS clinical income							
Clinical Income	32,984	33,301	31,008	(317)	(1%)	1,976	6%
NT Drugs	5,083	4,355	3,664	728	17%	1,419	39%
Total NHS clinical income	38,067	37,656	34,672	411	1%	3,395	10%
Non NHS clinical income							
Private patients	145	161	172	(16)	(10%)	(27)	(16%)
Other - RTA	129	115	75	14	12%	54	72%
Total Non NHS clinical income	274	276	247	(2)	(1%)	27	11%
Other Income							
R&D	1,954	1,949	1,893	5	0%	61	3%
Education & Training	1,648	1,667	1,539	(19)	(1%)	109	7%
Other non patient care income	4,559	3,739	3,125	820	22%	1,434	46%
Total other Income	8,161	7,355	6,557	806	11%	1,604	24%
TOTAL OPERATING INCOME	46,502	45,287	41,476	1,215	3%	5,026	12%
EXPENDITURE							
Employee benefit expenses	(26,142)	(25,342)	(23,749)	(800)	(3%)	(2,393)	(10%)
Drugs	(5,893)	(5,160)	(4,384)	(733)	(14%)	(1,509)	(34%)
Clinical supplies	(5,003)	(5,022)	(5,404)	19	0%	401	7%
Non clinical supplies	(6,135)	(5,563)	(5,419)	(572)	(10%)	(716)	(13%)
PFI operating expenses	(1,709)	(1,694)	(1,679)	(15)	(1%)	(30)	(2%)
TOTAL OPERATING EXPENSES	(44,882)	(42,781)	(40,635)	(2,101)	(5%)	(4,247)	(10%)
Profit/(loss) from operations	1,620	2,506	841	(886)	(35%)	779	93%
Non-operating income							
Interest	15	14	26	1	7%	(11)	(42%)
Profit/(loss) on asset disposals	(7)	(4)	(14)	(3)	(75%)	7	(50%)
Total non-operating income	8	10	12	(2)	(20%)	(4)	(33%)
Non-operating expenses							
Interest on PFI and Finance leases	(1,486)	(1,494)	(1,511)	8	1%	25	2%
Depreciation	(1,149)	(1,266)	(1,163)	117	9%	14	1%
PDC	(135)	(188)		53	28%	(135)	#DIV/0!
Other - Contingent Rent	(841)	(840)	(635)	(1)	(0%)	(206)	(32%)
Total non operating expenses	(3,611)	(3,788)	(3,309)	177	5%	(302)	9%
Surplus (deficit) after tax from continuing operations	(1,983)	(1,272)	(2,456)	(711)	(56%)	473	19%
Memo:							
Donated Asset Additions	11		16	11		(5)	(31%)
Surplus (deficit) after tax and Donated Asset Additions	(1,972)	(1,272)	(2,440)	(700)	(55%)	468	19%

Notes:

Calendar Days	29	29	28
Working Days	21	21	20

Income Statement Comparison - Eleven month position to 29 February 2016

	Year to Date			Variances Fav / (Adv)			
	Actual	Budget	Prior year	To budget		To prior year	
	£'000	£'000	£'000	£'000	%	£'000	%
INCOME							
NHS clinical income							
Clinical Income	367,242	369,592	354,410	(2,350)	(1%)	12,832	4%
NT Drugs	49,756	47,910	42,084	1,846	4%	7,672	18%
Total NHS clinical income	416,998	417,502	396,494	(504)	(0%)	20,504	5%
Non NHS clinical income							
Private patients	1,837	1,769	1,757	68	4%	80	5%
Other - RTA	1,174	1,263	1,494	(89)	(7%)	(320)	(21%)
Total Non NHS clinical income	3,011	3,032	3,251	(21)	(1%)	(240)	(7%)
Other Income							
R&D	20,672	20,864	20,355	(192)	(1%)	317	2%
Education & Training	17,900	17,977	17,066	(77)	(0%)	834	5%
Other non patient care income	40,321	37,363	29,574	2,958	8%	10,747	36%
Total other Income	78,893	76,204	66,995	2,689	4%	11,898	18%
TOTAL OPERATING INCOME	498,902	496,738	466,740	2,164	0%	32,162	7%
EXPENDITURE							
Employee benefit expenses	(277,828)	(273,864)	(260,475)	(3,964)	(1%)	(17,353)	(7%)
Drugs	(59,504)	(56,979)	(50,514)	(2,525)	(4%)	(8,990)	(18%)
Clinical supplies	(55,070)	(54,940)	(52,361)	(130)	(0%)	(2,709)	(5%)
Non clinical supplies	(62,119)	(60,740)	(55,527)	(1,379)	(2%)	(6,592)	(12%)
PFI operating expenses	(18,556)	(18,834)	(18,617)	278	1%	61	0%
TOTAL OPERATING EXPENSES	(473,077)	(465,357)	(437,494)	(7,720)	(2%)	(35,583)	(8%)
Profit/(loss) from operations	25,825	31,381	29,246	(5,556)	(18%)	(3,421)	(12%)
Non-operating income							
Interest	223	212	203	11	5%	20	10%
Profit/(loss) on asset disposals	(2)	(12)	7	10	83%	(9)	(129%)
Total non-operating income	221	200	210	21	11%	11	5%
Non-operating expenses							
Interest on PFI and Finance leases	(16,408)	(16,423)	(16,662)	15	0%	254	2%
Depreciation	(12,563)	(12,902)	(12,405)	339	3%	(158)	(1%)
PDC	(1,965)	(2,071)	(1,038)	106	5%	(927)	(89%)
Other - Contingent Rent	(9,105)	(9,104)	(8,960)	(1)	(0%)	(145)	(2%)
Total non operating expenses	(40,041)	(40,500)	(39,065)	459	1%	(976)	(2%)
Surplus (deficit) after tax from continuing operations	(13,995)	(8,919)	(9,609)	(5,076)	(57%)	(4,386)	(46%)
Memo:							
Donated Asset Additions	492	192	273	300	156%	219	80%
Surplus (deficit) after tax and Donated Asset Additions	(13,503)	(8,727)	(9,336)	(4,776)	(55%)	(4,167)	(45%)

Notes:

Calendar Days to Date	335	335	334
Working Days to Date	231	231	231