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

Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

MEETING OF THE TRUST BOARD IN PUBLIC

FRIDAY 31 MARCH 2017

A meeting of the Trust Board in public will take place at 9am on Friday 31 March 2017 in the Boardroom of the Norfolk and Norwich University Hospital

AGENDA

	Item	Lead Director	Purpose	Page No
1	Apologies and Declarations of Interest			
2	Minutes of the Board meeting held in public on 27.01.17		Approval	**2**
3	Matters arising		Discussion	
4	Chief Executive's Report	CEO	Discussion	**10**
5	Integrated Performance Report: - Quality & Safety - Caring & Patient Experience - Performance & Productivity - Workforce - Finance - High Risk Tracker	Execs	Discussion	**28**
6	National Staff Survey Results	JO	Discussion	**Presentation**
7	Feedback from Council of Governors	Chair	Information	
8	Any other business			

Date and Time of next Board meeting in public

The next Board meeting in public will be at 9am on Friday 26 May 2017 in the Boardroom of the Norfolk and Norwich University Hospital

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Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

MINUTES OF TRUST BOARD MEETING IN PUBLIC

HELD ON FRIDAY 27 JANUARY 2017

Present:	Mr J Fry	- Chairman
	Mr P Chapman	- Medical Director
	Mr M Davies	- Chief Executive
	Mr T How	- Non-Executive Director
	Mr M Jeffries	- Non-Executive Director
	Mrs E McKay	- Director of Nursing
	Mr J Norman	- Chief Finance Officer
	Dr G O'Sullivan	- Non-Executive Director
	Mr J Over	- Director of Workforce
	Mr R Parker	- Chief Operating Officer
	Mrs A Robson	- Non-Executive Director
	Miss S Smith QC	- Non-Executive Director
In attendance:	Ms F Devine	- Director of Communications
	Mr J P Garside	- Board Secretary
	Mr S Hackwell	- Director of Strategy
	Ms V Rant	- Assistant to Board Secretary
	Members of the public	

17/001 **APOLOGIES AND DECLARATIONS OF INTEREST**

Apologies were received from Professor Richardson. No conflicts of Interest were declared in relation to matters scheduled for consideration by the Board.

Mr Norman was welcomed to his first meeting of the Board.

17/002 **MINUTES OF PREVIOUS MEETING HELD ON FRIDAY 25 NOVEMBER 2016**

The minutes of the meeting held on Friday 25 November 2016 were agreed as a true record and signed by the Chairman.

17/003 **MATTERS ARISING**

The Board reviewed the Action Points arising from its meeting held on 25 November 2016 as follows:

16/046 Carried forward. Mr Over informed the Board that training for non-clinical staff has been reviewed to identify options for improvement/enhancement. Training has been grouped into skills based training, personal development and leadership/management. Our apprenticeship training programme is also being reviewed to gain access to national funding which has been made available for apprenticeship schemes and the Board will be updated on further progress at its meeting in February. **Action: Mr Over**

16/046 At item P17/004 the Board received a presentation from Mr Richard Smith (Consultant Obstetrician & Director of Medical Education) providing an update on postgraduate medical education within the Trust. Action closed.

16/048(a) Carried forward. Mr Fry referred to Core Slide 13 and asked if the targets which had been set at 100% should be revised to give a fairer reflection of good

performance which is near to 100%. A more sophisticated target will also allow for monitoring of improvement. Mrs McKay explained that we do wish to achieve complete compliance particular in relation to infection control. Dr O'Sullivan suggested that a suitable target might be for example '>99%'. This will be reviewed.

Action: Mrs McKay

16/048(c) Mr Parker explained that further analysis is ongoing in relation to the causes of cancellation of admissions and operations. A report on cancellations will be prepared for the next meeting of the Board. **Action: Mr Parker**

16/048(e) At item 17/005 the Board was provided with an update on how capacity arising from the reduction in the number of emergency admissions, is being used to benefit patients on the waiting list. Action closed.

17/004 **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.

Mr Davies noted that since the meeting in November, key areas of focus have concerned delivery of service to patients whilst maintaining safe care during times of peak pressure. Mr Davies said that he wanted to put on public record thanks and praise for staff for their hard work and commitment to keeping patients safe. It is recognised that demand has continually increased and this is driving the need to grow our capacity.

(a) Sustainability and Transformation Plan (STP)

Mr Davies explained that the STP partners have been working together to explore how to improve services across Norfolk and Waveney. We have asked the other Norfolk hospitals whether they have any additional capacity for patients waiting for treatment but it has become apparent that there is no additional capacity available.

In order to provide facilities for patients requiring treatment, the Trust is progressing plans to develop an Ambulatory Care and Diagnostic Centre (ACAD). Proposals are being developed for the Board to consider. As soon as plans are clearer it will be possible to explore options for funding. Both NHSI and NHSE have recognised that there is a need for additional capacity and there is an imperative to deliver this as soon as possible, to open the facility to avoid patients having to wait.

(b) Financial Special Measures (FSM)

The Board was informed that the Trust is on track to deliver the £25m planned deficit for 2016/17. The Trust will be meeting with representatives of NHSI in the coming weeks to discuss the next steps in the FSM regime. Our assessment is that we have done everything expected in order to be released from FSM and we look forward to explaining that to NHSI.

(c) UK Accreditation Service (UKAS)

Mr Davies informed the Board that the Cellular Pathology Department has received UKAS accreditation. This is testament of the quality of service provided by the department and will provide confidence to potential customers in the market place and enhance our attractiveness as an employer.

(d) Joint Appointments with the University of East Anglia

The Board was informed that we are working with the UEA to establish a number of additional joint senior medical appointments. The posts will be funded on a shared basis and will serve not only to strengthen our academic workforce but also improve our collaborative working with the UEA. The appointments will be focussed on areas

of research interest and clinical need. Mr Davies highlighted that this will be a significant boost for the region and marks a further step in strengthening the Trust's academic reputation. It will also strengthen the workforce in anticipation of expanding our capacity to meet increasing demand.

(e) Lakenheath Appointment

The Board was informed the Board that the Trust has agreed to host medical staff from RAF Lakenheath in order that they can maintain their clinical skills. An honorary contract has been agreed for a senior surgeon to work in the General Surgery Department and opportunities for further posts are being explored.

Miss Smith asked about the regulatory framework in place for this type of appointment. Mr Chapman explained that all the surgeons placed in NNUH must be registered with the GMC. This is a really positive initiative – enabling force personnel to maintain their clinical skills whilst providing a valuable service to our patients.

(f) Senior Appointments

Mr Jeffries asked about actions being taken to address consultant vacancies that have proved difficult to fill. Mr Parker explained that where posts are difficult to recruit to, services are asked to explore alternatives. This might involve changing job profiles or looking for alternative roles for senior nurses.

17/005 **INTEGRATED PERFORMANCE REPORT**

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

(a) Quality and Safety

Mr Chapman informed the Board that the HSMR for the year to September 2016 remains higher than expected at 115. The SHMI to June 2016 is within the expected range at 108. Dr O'Sullivan asked about progress in relation to review of our mortality review processes. Mr Chapman confirmed that we are awaiting further contact from NHSI but this may be influenced by a broader review of this subject nationally.

Data production for performance monitoring of the Quality Priorities for 2016/17 is improving. Proposed Quality Priorities for 2017/18 are being prepared for review by the Quality and Safety Committee.

Mr Chapman informed the Board that 6 insulin related medication incidents had been reported in December 2016. The figures in the report were corrected as there have been 2 cases of incorrect dose and 2 cases of incorrect insulin.

12 Serious incidents were reported in December 2016. 4 incidents were in relation to pressure ulcers. 2 other incidents reported in December were ward closures due to Norovirus. Mr Parker confirmed that the wards had now reopened but this had been an additional challenge in the run up to the Christmas period.

Mr How noted the downward trend in performance of EDLs completed within 24 hours of discharge. Mr Chapman confirmed this is a concern and the issue had been highlighted with individual teams so that improvements can be made. The standard contract for 2017/18 requires the Trust to deliver improved performance in this area. Increased use of non-medical support staff in some teams has been effective.

(b) Caring and Patient Experience

Mrs McKay informed the Board that there had been 2 C Difficile infections reported in December 2016. Both cases were reported on the same ward and increased

surveillance and supportive measures have been put in place. The year to date total is 31 which is on track to remain below the annual ceiling of 49.

The Board was informed that the number of new harms reported in December on the NHS Patient Safety Thermometer remains significantly lower than the national average (2.19%) at 1.84%.

Concerning the Maternity Dashboard, the Trust's induction rate is not considered to be an outlier following a comparative review of induction rates at other local Trusts. Further work is now being undertaken to look at other Trusts with a lower induction rate to determine if there are any actions that can be introduced.

The Friends and Family Test Score remains high and work continues in order to increase the response rate. An audit of learning disabilities, autism and mental capacity in the Trust has highlighted a number of areas of good practice. Areas identified for improvement were: learning/development methods and staff resources to ensure application of requirements under the Mental Capacity Act; and documentation.

NNUH has 675 volunteers working across 7 sites providing support for the settle-in service, palliative care and dementia patients. An Older People's Medicine support role is also under development to help our elderly patients and a support role for patients with learning disabilities is also being introduced.

A review of a sample of patients who had been discharged from hospital between 11pm and 6am highlighted no cause for concern with no patients discharged due to operational/non-clinical reasons.

There has been an increase in the number of fundamental standards audited under the Quality Assurance Audit programme in 2016 This is an important part of our quality assurance processes, which has been strengthened and enhanced this year.

(c) Effectiveness

Mr Chapman informed the Board that we are on target to achieve the CRN recruitment target for 2016/17. Achievement of the CRN target will be key in maintaining our funding for 2017/18.

Mrs Robson noted that there had been an increase in the number of patients who had been detained under the Mental Health Act in 2016/17 and asked what the contributing factors were to cause this increase. Mr Chapman explained that this may be due to a number of factors including increased activity and increased awareness of the Mental Health Act. Mr Garside confirmed that mental health liaison cover in the Trust had also been increased.

(d) Performance

Mr Parker informed the Board that a number of actions taken through 2016 had significantly assisted through the Christmas period. Despite increased numbers of patients attending A&E and ambulance arrivals, our staff coped well with this higher demand. Measures introduced at the 'front door' helped to ease pressure by reducing the conversion rate to admission rom 32% to 25%.

The Board was informed that there remain challenges in relation to achievement of cancer targets. There has been an 11% rise in cancer referrals. The three most challenged specialties are Urology, Gynae-oncology and Colorectal. A number of actions are being taken to minimise delays and increase capacity by extending working days.

Mr Parker explained that Emergency Department demand has been very high. Ambulance arrivals have peaked at 30 within one hour. We continue to work closely with the ambulance service and this collaboration is working well.

Mrs Robson asked if technology is available to track capacity and ambulance journeys across the acute hospitals in this region. Mr Davies confirmed that our Operations Centre has a monitoring system that tracks capacity and ambulances across the hospitals in Norfolk. Our A&E remains significantly busier than that in other hospitals.

Mr Davies explained that the geography of Norfolk is such that demand naturally comes to NNUH. This issue has been discussed with both NHSI and NHS England and reinforces the need to build additional capacity at the Trust and to introduce changes that will enable better utilisation of our facilities.

Mr Parker informed the Board that a project is underway to introduce a facility at Cromer Hospital to treat a small number of emergency patients arriving by ambulance.

Dr O'Sullivan asked if it is possible to predict peak times of ambulance arrivals. Mr Parker explained that it is possible to anticipate to some degree. A number of patients will be directed to A&E by the 999 service and almost 50% of patients may be referred to hospital by their GPs. Work is underway to promote other ways to better manage this particular demand.

Dr O'Sullivan asked how our workforce had been adapted to cope with demand at peak times of pressure. Mr Parker explained that the A&E consultant team are currently exploring ways to provide cover on key nights but in order to do this, it will be necessary to look at how their day time activity will be reconfigured.

Mr Davies informed the Board that the A&E Governance Board had been commended on its structure, minuting and follow-up on actions.

Mr Parker reminded the Board that the IST's review of elective capacity has been ongoing in order to provide assurance to our Regulators that we are exploring all opportunities to tackle the backlog of patients on the 18 week RTT pathway. The review has highlighted the need for additional capacity and reinforces the proposal to increase capacity through the ACAD facility. The waiting list is reducing but progress is hindered as capacity is used to treat increasing numbers of urgent and cancer patients and the numbers of non-urgent patients on the backlog is increasing.

Mr Jeffries asked about the waiting list numbers in the IPR. Mr Parker confirmed that the number of patients on the waiting list had decreased from 40,000 to 39,000. Mr Fry asked about actions being taken to reduce this backlog of patients. Mr Parker explained that, in the long term, additional capacity will be required and in the meantime waiting lists are being managed closely Additional capacity is being sourced both internally and externally with focus being targeted to those areas with the longest waits. Mr Chapman assured the Board that patient safety is of paramount importance and robust processes are in place to review patients who are waiting to ensure they do not come to harm.

Mr Davies explained that we have continued to work closely with NHSI to look at how to address the backlog of patients waiting for treatment. The IST review of capacity/demand has provided assurance that our data is accurate and confirms the scale of the waiting list. Addressing the backlog of patients will require significant cost but it is unclear how commissioners are budgeting for this. Historically, commissioners have apparently planned for zero growth in demand but all projections are that this will

increase. Our contract for services is PBR (payment by results) so the Trust will be paid for work undertaken.

Mr Jeffries asked how many bed days are being lost due to delayed discharges. Mr Parker explained that this number is relatively small as the Trust has been working well with partner organisations to reduce the number of delayed discharges. The work to reduce non-elective demand has been successful and this additional capacity has been ring-fenced in DPU to treat more patients. The DPU has treated 500 more day case patients in December 2016 compared to December 2015.

The Board was informed that work to reduce non-elective admissions has been extremely successful but this has impacted on non-elective income. There has been a significant improvement in diagnostic performance which was 99% in December 2016. Outpatient activity was lower in December due to a change in the way patients are seen. This has reduced follow-up appointments and increased the number of 'new' patient appointments which use longer appointment slots.

Mr Jeffries asked what progress is being made in improving performance in meeting the stroke indicators. Mr Parker explained that performance in some areas, such as admission to HASU, has suffered as a result of increased demand for beds. NNUH is one of the largest stroke centres in the country and more work needs to be undertaken to address internal processes to improve performance.

Dr O'Sullivan noted that stroke 'door to needle' time in December was poor. An update on actions to improve stroke performance and in particular 'door to needle time' will be provided to a future meeting of the Board. **Action: Mr Parker**

(e) Workforce

Mr Over informed the Board that pay spend continues to reduce, with cumulative pay expenditure at £240m against the forecast of £241m. The reduction in temporary staffing costs has been the biggest contributor to this saving. NNUH processes are being used in other Trusts as the gold standard for reducing temporary pay spend.

The reduction in agency demand and costs continues. Demand/expenditure for Registered Nursing/Midwifery agency staff had reduced by around 50% in December 2016, at £363k compared to £1.03m in July 2016. Compliance against the price cap has improved significantly and is now at 75%. Pay expenditure in theatres is being tightly managed and work is being undertaken to look at ways to reduce this demand by recruiting/reshaping the workforce in theatres.

The Board was informed that there had been a small improvement in appraisal and mandatory training compliance. The importance of appraisal and mandatory training completion is highlighted regularly within the relevant divisions in order that this can be addressed accordingly.

Sickness absence is in line with levels recorded in the previous year at 4.7%. Provisional figures for December indicate a small reduction at 4.6%. Sickness absence levels will have been affected by the recent outbreak of Norovirus. Mr How asked how the Trust compares to other NHS Trusts. Mr Over indicated that on published figures, the Trust was 75th out of 150 hospital trusts. The flu vaccination rate this year is up to 79% at the end of December which is a significant achievement.

Mr Over informed the Board that a number of sessions have been held with our staff to gain feedback on the draft NNUH Behaviour Framework. Four overarching objectives have been identified and a detailed action plan is being prepared for the Board to review at its next meeting.

The results of the 2016 Staff Survey are due to be released in February. It is expected that the Board will receive a preliminary briefing at its meeting in February with a more detailed update in March.

Dr O'Sullivan referred to the ward nursing fill-rate analysis asking what processes are in place for ensuring adequate levels of Registered Nursing staff on wards. Mrs McKay explained that there is an establishment level for each ward. It is not always possible to fill each shift with the planned numbers due to staff sickness or vacancies. There is also a national shortage of Registered Nursing staff. Wards flex levels of staff in accordance with their patients' needs and use of Healthcare Assistants may be higher on some wards to provide additional support for the Registered Nurses and to provide additional care where necessary.

Mr How asked about progress towards introduction of the 'safe care' system which will assist in monitoring staffing requirements in relation to patient acuity on the wards. Mrs McKay confirmed that implementation of the system is due to commence in February and support is being put in place for its roll-out. The system will provide real-time recording of ward staffing and provide centralised data to monitor the use of HCAs across the organisation.

(f) Finance

Mr Norman informed the Board that clinical income in the year to date is £4.3m behind plan. This is balanced by other income which is above plan and £1,145k underspend in pay costs.

The closing cash at the end of month 9 is behind plan at £3.7m. It is expected that the Trust will require funding support in February. The Trust can apply for a working capital facility loan through the Department of Health but the interest rate will be significantly higher if the Trust secures this loan whilst under Financial Special Measures. The saving achieved by not borrowing in January is £80k. Careful cash management continues.

The Board was informed that good progress is being made towards the £24.6m savings under the CIP plans and we remain on target to achieve the planned deficit of £25m.

Planning has commenced for 2017/18 and the divisional teams have responded very well. They are engaged and taking ownership of the challenge to meet their targets and have been putting forward proposals to make savings in the coming year.

Mr Jeffries asked about cash management. Mr Norman explained that a number of simple measures have been taken, for example change to one payment run a week. The CCGs have also proved receptive in helping with payment timing.

With regard to clinical income, Mr How suggested that it would be helpful to add the previous year value to the graph on Core Slide 45. **Action: Mr Norman**

17/006 **FEEDBACK FROM THE COUNCIL OF GOVERNORS**

Mr Fry informed the Board that an induction session was held for the three new governors, as detailed in the CEO report. The next meeting is to be held on Tuesday 31 January. A list of the additional informal meetings with governors has been circulated previously. These sessions are a useful opportunity for contact between non-executives and governors and the dates for informal meetings with Governors will be circulated again so that non-executives can identify dates on which they are available to attend. **Action: Mr Garside**

17/007 **ANY OTHER BUSINESS**

Mr Jeffries noted that in the same way that Mr Davies has recorded thanks to all the Trust staff for the ongoing improvement in the Trust, it is right that the whole executive team should be congratulated on leading this improvement and all that has been achieved over recent months.

17/008 **DATE AND TIME OF NEXT MEETING**

The next meeting of the Trust Board in public will be at 9am on Friday 31 March 2017 in the Boardroom of the Norfolk and Norwich University Hospital.

Signed by the Chairman: …… Date: ……

Action Points Arising:

	Action
17/003	Carried forward. Mr Over informed the Board that training for non-clinical staff has been reviewed to identify options for improvement/enhancement. Training has been grouped into skills based training, personal development and leadership/management. Our apprenticeship training programme is also being reviewed to gain access to national funding which has been made available for apprenticeship schemes and the Board will be updated on further progress at its meeting in February. **Action: Mr Over**
17/003	Carried forward. Mr Fry referred to Core Slide 13 and asked if the targets which had been set at 100% should be revised to achieve a more fair reflection of good performance which is near to 100%. A more sophisticated target will also allow for monitoring of improvement. Dr O'Sullivan suggested that a suitable target might be for example '>99%'. This will be reviewed. **Action: Mrs McKay**
17/003	Carried forward. Mr Parker explained that further analysis is ongoing in relation to the causes of cancellation of admissions and operations. A report on cancellations will be prepared for the next meeting of the Board. **Action: Mr Parker**
17/005	An update on actions to improve stroke performance and in particular 'door to needle time' will be provided to a future meeting of the Board. **Action: Mr Parker**
17/005	With regard to clinical income, Mr How suggested that it would be helpful to add the previous year value to the graph on Core Slide 45. **Action: Mr Norman**
17/006	The dates for informal meetings with Governors will be circulated again so that non-executives can identify dates on which they are available to attend. **Action: Mr Garside**

REPORT TO THE TRUST BOARD

Date	**31 March 2017**
Title	**Chief Executive's Report**
Purpose	**To update the Board on matters relating to the Trust that are not covered elsewhere in the papers.**

Summary

Key points are noted regarding:

1. *Financial challenge:*
   - We are now out of Financial Special Measures due to the commitment and efforts of all our staff. We are now being asked for advice by Trusts across the country.
   - Reference is made to the NHS Providers report - *Mission impossible? The task for NHS providers in 2017/18* **(Appendix A)**
2. *Operational Challenge:*
   - Comment on the NHSI and NHSE joint letter *"Action to get A&E performance back on track"* and its implications for the Trust and STP **(Appendix B)**
3. *Sustainability & Transformation Planning:*
   - Comment on the STP Emergency and Urgent Care Board (chaired by NNUH CEO) – update to meeting
   - Report on Corporate Services Costs Benchmarking **(Appendix C)**

Recommendation:

The Board is recommended to note the issues highlighted for information.

CHIEF EXECUTIVE'S REPORT TO TRUST BOARD – 31 MARCH 2017

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.

The issues highlighted below are all interrelated – concerning financial challenge, operational challenge and system change. Unspoken, but as a constant theme throughout, is our commitment and drive to maximizing the quality and safety of care and service that we can offer our patients – as detailed in our Integrated Performance Report.

1 FINANCIAL CHALLENGE & REGULATORY CONTEXT

This is the first public Board meeting since we have been released from Financial Special Measures. This is a significant mark of increased confidence in the Trust by the Regulator (NHSI) and reflects the huge efforts made by all our staff to improve the Trust's position.

It is worth noting a couple of aspects of the message from the Regulator in particular:

> *"I recognise the significant work that the Trust has undertaken to improve the financial position and I would like to take this opportunity to congratulate you and your team for the progress you have made".*
>
> *"I particularly want to mention the successful focus you placed on reducing pay spend particularly around high agency costs and usage. We will be looking to use this as an example of best practice for other Trusts".*

In fact a number of our senior team have been already been asked to present at NHS conferences concerning the approach we have taken to meet the financial challenge. We have also been contacted by a number of other Trusts around the country wanting to learn from our experience of FSM.

We remain on track to deliver our challenging savings target and to achieve our forecast deficit of £25m. With the further challenge we have set ourselves for next year, this marks the next step in addressing a number of longstanding issues and moving the Trust towards financial sustainability.

The title of the report issued by NHS Providers this month suggests however the size of the challenge ahead (*Mission impossible? The task for NHS providers in 2017/18).* Attached at **Appendix A** to this report is a copy of the press release issued by NHS Providers to accompany their report.

Commenting on their findings, the chief executive of NHS Providers, Chris Hopson, said:

> *"It is unprecedented for us to warn that the NHS will not be able to deliver on its commitments before the financial year has even started. But trusts are currently being asked to absorb a 5% plus cost and demand increase, recover the four A&E wait and 18 week surgery targets, improve care for cancer and mental health and balance next year's books financially. All on a 1.3% NHS England funding increase, down from this year's 3.6% increase. Taken together, this is mission impossible. The numbers don't add up."*

Whilst nothing will be achieved with a negative attitude, there is a need for realistic and accurate planning. In our region one particular aspect in which *"the numbers don't add up"* relates to the provision for patients waiting for treatment and the need to ensure that there is adequate capacity to meet demand.

2 OPERATIONAL CHALLENGE

The size of the operational challenge facing the NHS has been well-publicised. Nationally particular planning is now underway to maximise performance over the forthcoming Easter period. Attached at **Appendix B** to this report is a letter dated 9 March 2017 from both NHS England and NHS Improvement setting out their approach towards *"Action to get A&E performance back on track".* This has three elements:

i) Freeing up hospital capacity
ii) Managing A&E Demand
iii) Aligned national support and oversight

On (iii), it is explained that receipt of the 30% of STF funding that is performance-related will be linked to effective implementation of the actions at (i) and (ii), as well as achieving 90% A&E 4-hr performance before or in September, sustaining and improving this to 95% by March 2018.

Achievement of these requirements will require a system-wide response and increases the importance of the STP actions detailed below.

3 SUSTAINABILITY & TRANSFORMATION PLANNING

3.1 STP Emergency and Urgent Care Board

As previously discussed, we continue to work with partners in the STP, encouraging progress towards a system response to the challenges facing the NHS in our region. A potentially significant development is that we have been asked to establish an STP Emergency and Urgent Care Board chaired by NNUH CEO. The Board will be updated at its meeting.

3.2 Corporate Services Costs

As an element of the STP work, NHS organisations have agreed to look at the provision of support services to establish whether these can work better together – generating efficiencies that can improve services and concentrate resources on providing patient care. Our Director of Strategy, Simon Hackwell, is the SRO for this programme of work. It reports to the Norfolk Provider Partnership (NPP) and in turn feeds into the STP.

We have recently received information on benchmarked costs for support services in the Trust. These data show that our costs are amongst the lowest in the NHS and this is consistent with the earlier reports from the national 'Carter' work. A summary report from Mr Hackwell is attached at **Appendix C.**

4 RECOMMENDATION

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

NHS TRUSTS CAN'T DELIVER IN 2017/18 WITHOUT MORE REALISM, FLEXIBILITY AND SUPPORT

A detailed analysis by NHS Providers shows that what is currently being asked of NHS trusts in the coming financial year is well beyond reach. The report sets out how greater realism, flexibility and support are needed if trusts are to deliver in 2017/18.

The report, *Mission impossible? The task for NHS providers in 2017/18*, presents a detailed assessment of the demands that are being placed on NHS trusts through the NHS planning guidance. These are compared against next year's significantly lower funding increases, revealing a currently unbridgeable gap.

The report sets out, in detail, the challenges facing the NHS in 2017/18. These include:

- Absorb a projected 3.1% increase in overall demand from patients and 2.1% increase in costs including pay, buildings and laboratories;
- Recover key performance targets, such as for A & E and routine operations. The estimated extra cost of delivering these targets across the year is £2.4–3.1 billion;
- Deliver new commitments on cancer and mental health with an estimated cost of £150-£200 million;
- Trusts to collectively balance their books with an estimated financial performance improvement of £800-900 million required; and
- All of this is set against sharply reduced NHS England funding, with funding increases dropping from 3.6% this year to 1.3% in 2017/18.

The report sets out three ways on how the 2017/18 NHS trust task could be made more deliverable:

- NHS leaders setting more realistic performance trajectories against the key targets, as they have already started to do;
- Building on work already started, review whether more of the £5 billion currently spent on commissioning and the Department of Health and its arms length bodies can be redirected to front line care; and
- Providing more support to NHS trusts to enable them to improve performance and eliminate unwarranted variation more rapidly.

The report points out the patient impact in 2017/18 of continuing on the current performance trajectory:

- 1.8 million people in A & E will fall outside the target to deal with 95% of patients in four hours. That is half

a million more than this year, and an increase of nearly 40%
- On average 100,000 more patients than expected will wait longer than 18 weeks for routine surgery, 150% more than this year's figure of 40,000

The report points to the increasing patient safety risk over the winter period with record levels of demand leading to potentially unsafe bed occupancy levels and rising numbers of long ambulance handover times and 12 hour trolley waits. It also highlights the increasing burden on NHS staff of trying to deliver impossible targets without adequate funding.

Commenting on the findings, the chief executive of NHS Providers, Chris Hopson, said:

"The NHS is a can-do organisation which achieves extraordinary results for patients every day. NHS trusts are treating more patients than ever before and performance remains good by international standards. So when those trusts say that they can't deliver what's currently being asked for next year, it is time to sit up and listen.

"It is unprecedented for us to warn the NHS will not be able to deliver on its commitments before the financial year has even started. But trusts are currently being asked to absorb a 5% plus cost and demand increase, recover the four A&E wait and 18 week surgery targets, improve care for cancer and mental health and balance next year's books financially. All on a 1.3% funding NHS England funding increase, down from this year's 3.6% increase. Taken together, this is mission impossible. The numbers don't add up.

It is unprecedented for us to warn the NHS will not be able to deliver on its commitments before the financial year has even started.

"NHS trusts want to deliver NHS standards, achieve financial balance and improve performance. The standards on A&E and surgery were set for a good reason – they are a good proxy for the quality and access to care the NHS should provide. But trusts can only deliver if funding keeps pace with rapidly rising demand. In the absence of those funding increases, we need greater realism, flexibility and support from those leading the service.

"Trusts won't be able to recover the A&E and elective surgery targets across the whole year. Just stabilising the rapidly increasing performance decline would be an achievement in itself. Given that demand and cost increases will easily outstrip funding and efficiency increases, just reproducing this year's financial performance is a stretching target.

Given that demand and cost increases will easily outstrip funding and efficiency increases, just reproducing this year's financial performance is a stretching target.

"We also need to redirect money to front line care and provide more support to help providers reduce unwarranted variation and improve performance as quickly as possible.

"There is also a very clear and simple warning in our analysis. We have now reached the point where, on the resources available, NHS trusts can no longer deliver what the NHS constitution requires."

Related articles

All NHS Provider Trust Chief Executives
All CCG Accountable Officers
All CCG Clinical Leaders
Copy to Local Authority Chief Executives

Gateway Reference: 06600

9th March 2017

Dear colleague,

Action to get A&E performance back on track

We are writing to thank you and your staff for your work over what has been a highly pressurised winter, and - following the Chancellor's Budget statement yesterday - to let you know about the action now needed to turnaround A&E performance in 2017. Further detail will be provided in the NHS Delivery Plan being published in three weeks' time.

Throughout this winter, there have been three consistent themes relating to urgent and emergency care: difficulties in discharging inpatients when they are ready to go home; rising demand at A&E departments, with the fragmented nature of out-of-hospital services unable to offer patients adequate alternatives; and complex oversight arrangements between trusts, CCGs and councils.

To avoid a repeat next winter of this past winter, we need to make concrete changes on all three fronts.

Freeing up hospital bed capacity

First, we know that difficulties with discharging emergency inpatients has reduced the effective availability of beds in which to care for both emergency patients presenting in A&E, as well as patients needing planned surgery. It is therefore vital that, together with our partners in local government, we ensure that the extra £1 billion the Chancellor has made available for social care is in part used to free-up in the region of 2000-3000 acute hospital beds. We would ask that you immediately now engage with the senior leadership of your local adult social care departments to discuss how those patients stuck in hospital needing home care or care home places can access those services.

It is also, however, indisputable that there are places which have still not adopted best practice to enable appropriate flow, including better and more timely hand-offs between A&E clinicians and acute physicians, discharge to assess, 'trusted assessor' arrangements, streamlined continuing healthcare processes, and seven day discharge capabilities. You now need to ensure these happen everywhere, and well before October 2017.

Managing A&E demand

Some estimates suggest that between 1.5 and 3 million people who come to A&E each year could have their needs addressed in other parts of the urgent care system. They turn to A&E because they are unclear about the alternatives or are unable to access them.

You therefore now need to:

- Ensure every hospital implements a comprehensive front-door streaming model by October 2017, so that A&E departments are free to care for the most urgent patients. Yesterday's Budget has made available an extra £100 million of capital to be deployed in the next six months to support this. Proposals will need agreement with the Department of Health and we will be letting you know proposed allocations of this within the next six weeks.
- Strengthen support to your Care Homes so as to ensure that they have direct access to clinical advice, including where appropriate on-site assessment. We are making available £30 million to support universal roll-out of this model via 111, in order to reduce the risk of care home residents being admitted to hospital.
- Implement the recommendations of the Ambulance Response Programme by October 2017, freeing up capacity for the service to increase their use of Hear & Treat and See & Treat, thereby conveying patients to hospital only when this is clinically necessary.
- Proceed with the standardisation of Walk-In-Centres, Minor Injury Units and Urgent Care Centres, so that the current confusing array of options is replaced with a single type of centre which offers patients a consistent, high quality service.
- Roll out evening and weekend GP appointments, to 50% of the public by March 2018 and 100% by March 2019.
- Increase the number of 111 calls receiving clinical assessment by a third by March 2018, so that only patients who genuinely need to attend A&E, or use the ambulance service, are advised to do this.

Aligned national support and oversight

Given the national importance of improving NHS urgent and emergency care performance, we intend to simplify the focus of the 30% performance element of the Sustainability and Transformation Fund (STF) for 2017/18, so that it will focus on A&E rather than requiring providers to focus on multiple objectives. For individual trusts it will be linked to effective implementation of the actions set out above as well as achieving performance before or in September that is above 90%, sustaining this, and returning to 95% by March 2018.

In order to ensure complete alignment between NHS England and NHS Improvement in supporting and overseeing urgent implementation of the above actions, we have appointed Pauline Philip as the single national leader accountable to us jointly.

Furthermore, from 1st April we are nominating a single, named Regional Director drawn from NHSI and NHSE to support this implementation work and hold accountable both CCGs and trusts through their local STP's A&E Delivery Boards. Each RD will therefore act with the delegated authority of both NHSI and NHSE in respect of urgent and emergency care.

Thank you for your ongoing leadership on this critical part of what the NHS does for the people of this country.

Yours sincerely

Simon Stevens
CEO, NHS England

Jim Mackey
CEO, NHS Improvement

CEO Report (31.3.17) - Appendix C

NHS Corporate Services benchmarking

As part of the ongoing Cater work on improving NHS productivity, NHSI have recently conducted an exercise to benchmark the costs of trusts' corporate (back office) costs. We have recently received the benchmarking data. Extracted summary data is attached.

While this is important in terms of understanding the relative position of our services, it is also part of the requirement that all trusts should be working across their STP to consolidate these services to achieve efficiency gains.

NNUH position

The attached extract summarises the Trust's results. In relation to the total cost of each corporate service, in all cases NNUH scored lower than the national lower cost quartile. The cost for the finance service was the lowest across the NHS per £100m turnover and for the HR service the Trust has the second lowest cost.

Each corporate service is broken down into a number of components and these form part of the more detailed report sent through.

NPP & STP perspective

The Trust is leading the work across the five providers (3 hospitals plus acute and mental health trusts) in the STP to examine options for consolidating back office services. There are five workstreams:

- HR (led by Jeremy Over)
- IM&T (led by Ben Everitt)
- Payroll (led by Queen Elizabeth Hospital)
- Procurement (led by NCHC)
- Finance (led by NSFT). NNUH is not included in the finance workstream at present.

Simon Hackwell is the SRO for this programme of work. It reports to the Norfolk Provider Partnership and in turn feeds into the STP.

The Norfolk Provider Partnership's vision for consolidation of back office services is:

To enable greater system working and support our front line staff in delivering patient care, we will seek to share back office services wherever possible, providing this results in greater efficiency and value for money.

There are five key principles underpinning this vision:

1. To develop a programme of work around consolidation of services which seeks to generate cashable savings of at least 10% from current cost.

2. To prioritise work on those services which will have most impact and are comparatively more straightforward to consolidate.

3. To remain open-minded about the future operating model for our back office services e.g. lead provider, outsourced provider.

4. To accept that different providers have different starting positions and as a result some may gain more from consolidation than others.

5. To ensure that wherever possible we are transparent in communicating with staff. Our default position will be to share information unless individually or commercially sensitive.

Cases for change are being developed based around five options:

- Do nothing
- Hosted shared services
- Jointly managed service
- Joint venture with private sector
- Outsourced provider

These should be ready over the next few months and where appropriate the NPP will request preferred options are developed into formal business cases.

There are two important issues to consider in this work. First, given the relative low cost of NNUH corporate services the benefits from consolidation may not be significant to NNUH. Indeed in some areas it could be argued that additional investment is required to meet current and future demands. Second, and related to this, is the need to consider how any benefits might be distributed among partners. This will be tested out on a case by case basis.

As the work progresses, the Board will be kept informed.

NHS Corporate Services

FY 15/16 Benchmarking Report

February 2017

Guidance on using this report

This report provides an overview of the Key Performance Indicators (KPIs) collected from all trusts as part of the FY 15/16 national corporate services data collection. Driven by the Model Hospital and the operational productivity programme, this data represents the most comprehensive insight into corporate services spend the NHS has ever achieved. Corporate services functions included in the data are:

- Finance
- HR
- Payroll
- IM&T
- Procurement
- Governance & Risk
- Legal

There are more than 40 KPIs in the data set and this report provides detailed information on your trust's performance in each of these KPIs relative to other trusts - nationally, within your STP and to trusts in your Trust Type category.

The benchmarks within this report, based on returns from 230 of the current 236 NHS trusts, should be used as a focus for local discussions on the current and future practices in corporate services delivery in the NHS. The full explanation of our methodology can be found in Appendix A.

One of our main objectives is to help trusts identify efficiency opportunities in corporate services that deliver both value for money and a high quality service. The data in isolation is not an answer in itself. As part of your local discussions, benchmarks in this report should be used alongside the rich local knowledge of service delivery to help trusts identify where improvements can be made to deliver an increased quality of service with greater value for money.

Benchmarking review and local discussions

The data embedded within this report allows STPs and individual trusts to compare their performance in terms of the specific cost-based KPIs included (note that at this stage with the current dataset there is no assumption around quality).

Trusts are able to understand how they compare against other trusts within the same STP, as well as against the national median and lower cost quartile.

It is imperative that corporate services is on the agenda for STPs as early as possible. The data provided in the wider content of this report is of limited use unless it is used to drive discussions around potential improvements and shared understanding of existing approaches within and between corporate service functions. The process benefits from having wide discussion amongst function-based colleagues, for example, all HR directors discussing their approaches to Human Resources, and replicating for each function which the STP would consider to be 'in-scope'.

In terms of leadership and ownership, it is suggested that one overall SRO for the corporate services programme is identified within each STP, at Executive level, and that functional leads are identified to lead the discussion in their functions.

Trusts and STPs should attempt to understand why differences may exist between trusts, but also identify levels of unwarranted variation and begin outlining an approach to challenge and eliminate such variation by creating alternative solutions at scale.

Pathfinders approach

NHS Improvement has nominated four STP leads who will act as Pathfinders for the programme. The Pathfinders will be supported to help design the blueprints for high quality, good value for money corporate services in the NHS. The rationale behind this approach has been that there will be different ways to deliver successful corporate services solutions, however scale is essential and therefore pathfinders are helping to test the hypothesis that STP footprints provide a sensible basis for addressing the challenge.

Learning from our pathfinder approach to date, we envisage it to support other STPs in laying the foundations for their own corporate services programme, recognising the amount of complexity involved and the varying starting points.

The four lead Pathfinders are following a standard method to develop their future solutions, which is being refined through the work they are doing. This will be shared with other STPs, which will significantly reduce the cost and risk involved in future scale replication across the Corporate Services programme.

Understanding the Current Landscape - further discussion within your STP

In order to supplement the benchmarking data, a useful exercise undertaken by Pathfinders has been mapping out the delivery models currently employed at each trust for every function and sub-function. This has helped define locally what corporate service functions are in scope.

This landscape view enables trusts and STPs to understand the experience in the patch for operating in -house, shared services or outsourcing models and discuss shared experience and lessons learned.

Extending this exercise to include current systems and technology in place will allow STPs to take a view on where similar services are provided at varying levels of cost and embark upon their journey to design and implement sustainable solutions, whilst identifying significant savings opportunities.

Following the local discussions, this benchmarking report complemented by local knowledge should significantly strengthen awareness of a geographical approach to your STP's corporate services, existing strengths and weaknesses and the opportunities for positive, and potentially radical, change.

Trust Overview

Norfolk And Norwich University Hospitals NHS Foundation Trust

STP: Norfolk and Waveney

Trust Type: ACUTE - TEACHING

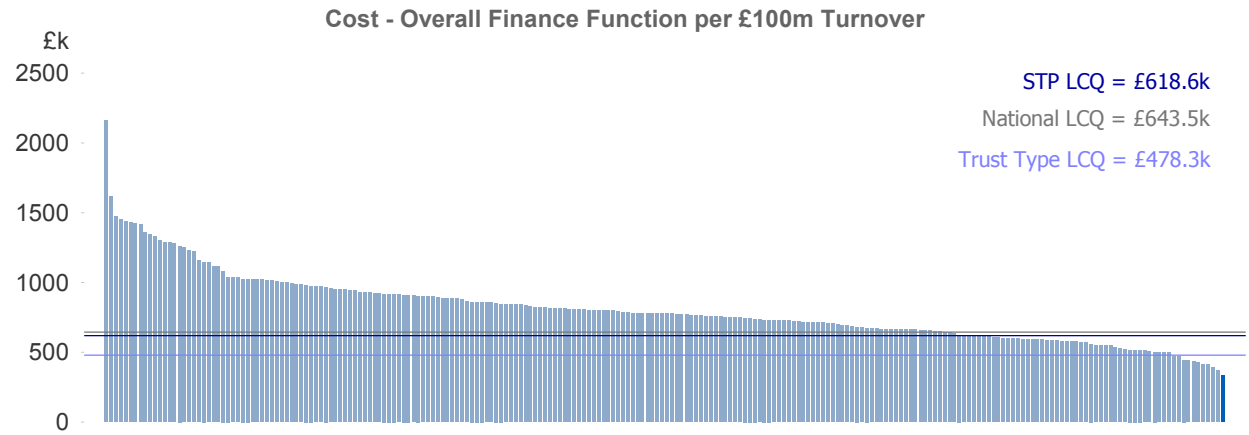
The overall cost of corporate services to the NHS in FY 15/16 was £3.2bn. However, there was significant variation in the cost of delivering corporate services between trusts.

Below you will find your trust's position against the rest of the country, your STP and your Trust Type for the overall cost of each corporate services function and up to five key indicators within each function. There is also a full table of all the KPIs in the current data collection and a table containing your absolute cost of each corporate services function.

Note: A blue highlighted bar indicates your trust position in the KPI graph. A blue number in the 'Value for Trust' column indicates a value above the National Lower Cost Quartile (LCQ), whereas a black number indicates a value below the National Lower Cost Quartile. Outliers and missing data are displayed as "n/a".

LCQ = Lower Cost Quartile

Finance



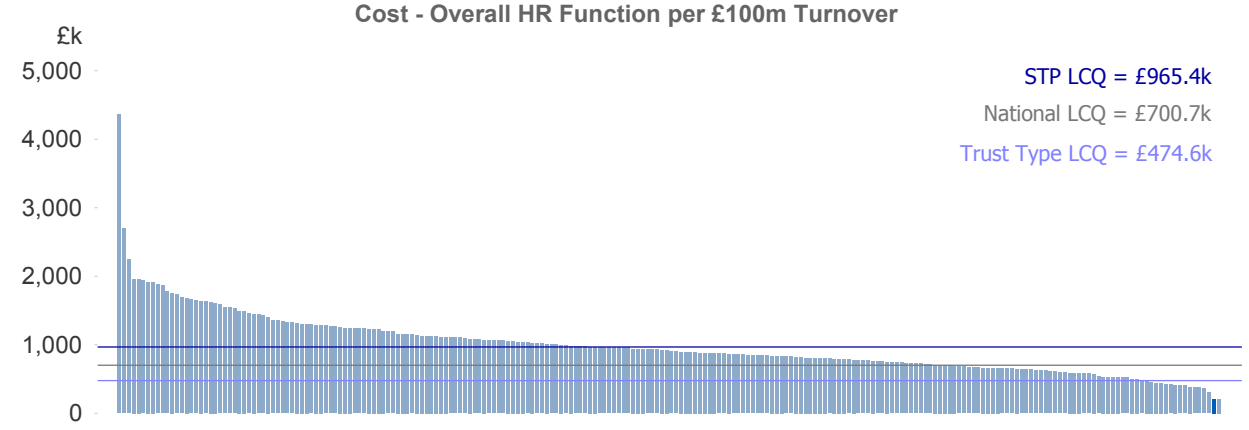
Key Finance Indicators	Value for Trust	National LCQ	STP LCQ	Trust Type LCQ
Cost - Overall Finance Function per £100m Turnover	£332.4k	£643.5k	£618.6k	£478.3k
Cost - Management Accounts per £100m Turnover	£84.5k	£232.6k	£233.1k	£192.3k
Cost - Financial Accounts per £100m Turnover	£34.2k	£48.0k	£75.9k	£34.2k
Cost - Accounts Payable per £100m Turnover	£32.2k	£51.2k	£54.9k	£42.8k
Processing Cost per Invoice (Accounts Payable)	£1.27	£2.16	£2.01	£1.91

Norfolk And Norwich University Hospitals NHS Foundation Trust

STP: Norfolk and Waveney

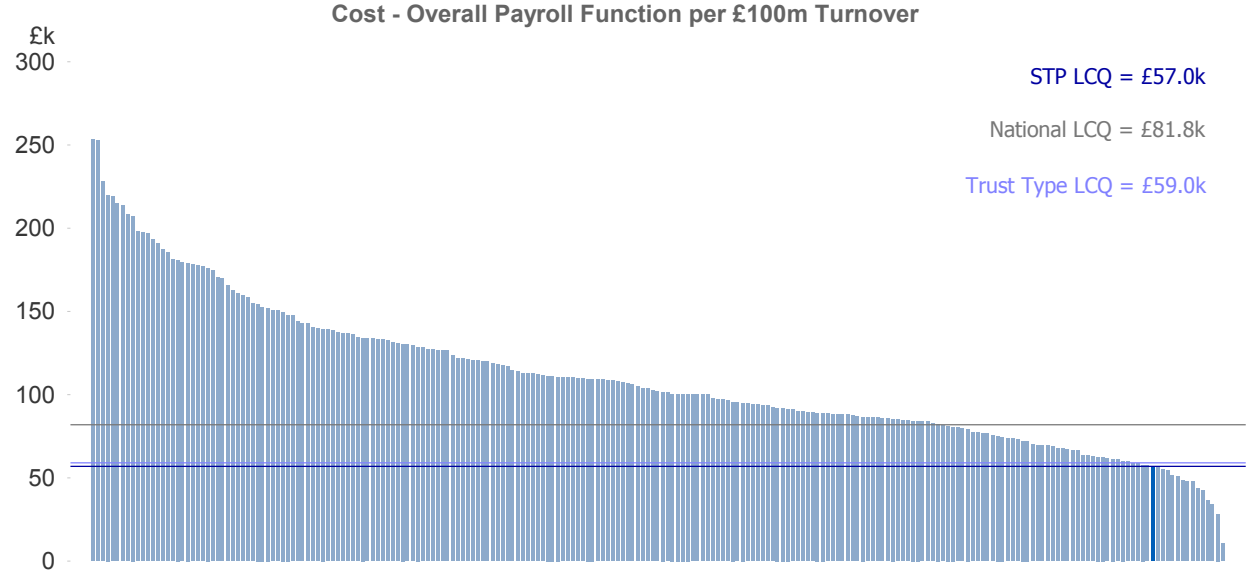
Trust Type: ACUTE - TEACHING

HR



Key HR Indicators	Value for Trust	National LCQ	STP LCQ	Trust Type LCQ
Cost - Overall HR Function per £100m Turnover	£210.4k	£700.7k	£965.4k	£474.6k
Cost - Occupational Health per £100m Turnover	£15.5k	£92.1k	£84.4k	£55.7k
Cost - Recruitment per £100m Turnover	£74.1k	£99.9k	£139.5k	£77.4k
Cost - HR Business Partners per £100m Turnover	£43.5k	£159.7k	£103.0k	£111.1k
Cost - Temporary Staffing Service per £100m Turnover	£37.8k	£37.3k	£83.3k	£31.9k

Payroll



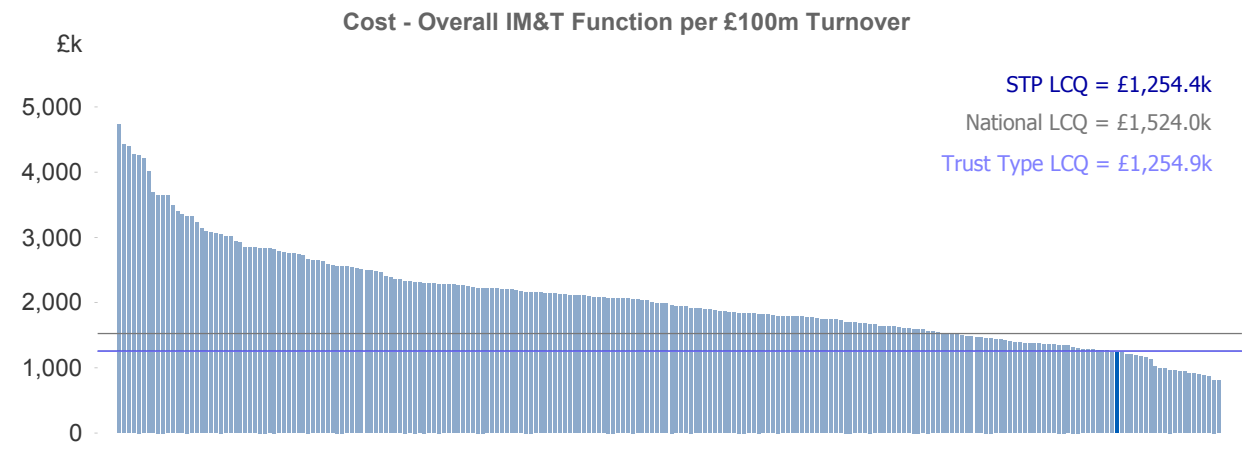
Key Payroll Indicators	Value for Trust	National LCQ	STP LCQ	Trust Type LCQ
Cost - Overall Payroll Function per £100m Turnover	£57.0k	£81.8k	£57.0k	£59.0k
Cost - Payroll Function per Payslip	£3.14	£3.40	£3.14	£2.94

Norfolk And Norwich University Hospitals NHS Foundation Trust

STP: Norfolk and Waveney

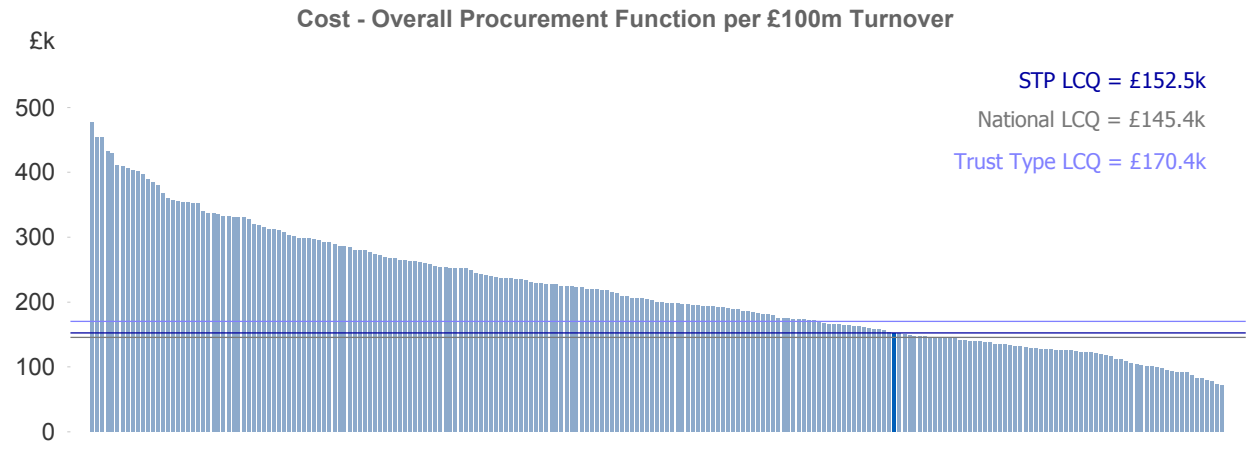
Trust Type: ACUTE - TEACHING

IM&T



Key IM&T Indicators	Value for Trust	National LCQ	STP LCQ	Trust Type LCQ
Cost - Overall IM&T Function per £100m Turnover	£1,238.1k	£1,524.0k	£1,254.4k	£1,254.9k
Cost - Core IT per £100m Turnover	£770.3k	£693.8k	£877.5k	£621.8k
Cost - Clinical Coding per £100m Turnover	£154.7k	£79.4k	£93.3k	£109.9k
Cost - Telecoms per £100m Turnover	£0.5k	£104.0k	£126.8k	£55.3k
Cost - Information Governance & FOI Management per £100m Turnover	£5.2k	£25.0k	£6.7k	£11.4k

Procurement



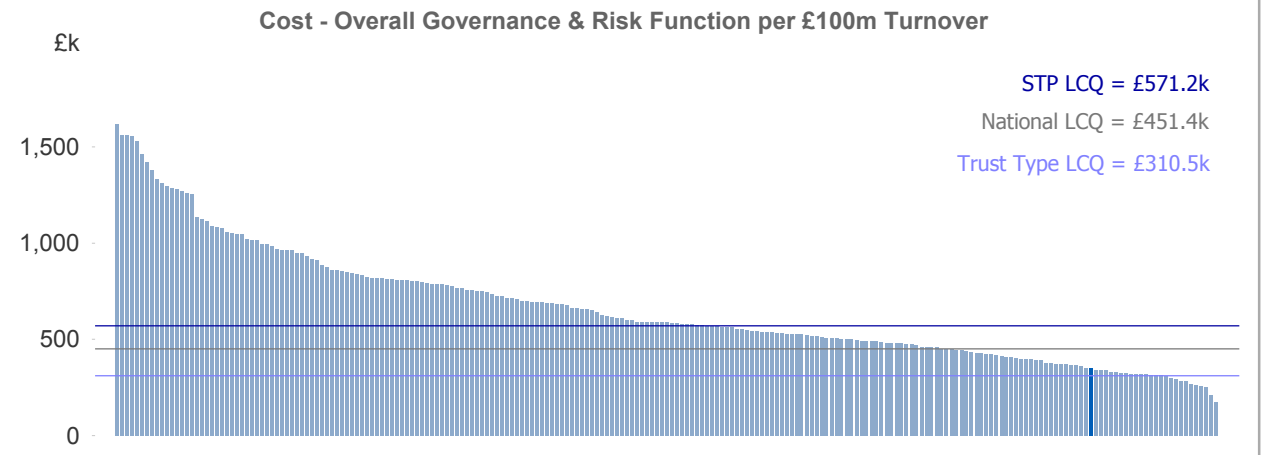
Key Procurement Indicators	Value for Trust	National LCQ	STP LCQ	Trust Type LCQ
Cost - Overall Procurement Function per £100m Turnover	£152.5k	£145.4k	£152.5k	£170.4k
Cost - Procurement Strategy/Leadership per £100m Turnover	£0.0k	£22.7k	£26.7k	£19.0k
Cost - Sourcing per £100m Turnover	£83.5k	£32.8k	£26.8k	£33.1k
Cost - Transactional Buying per £100m Turnover	£6.5k	£19.9k	£20.7k	£15.6k
Cost - Materials Management per £100m Turnover	£28.2k	£25.8k	£21.5k	£31.5k

Norfolk And Norwich University Hospitals NHS Foundation Trust

STP: Norfolk and Waveney

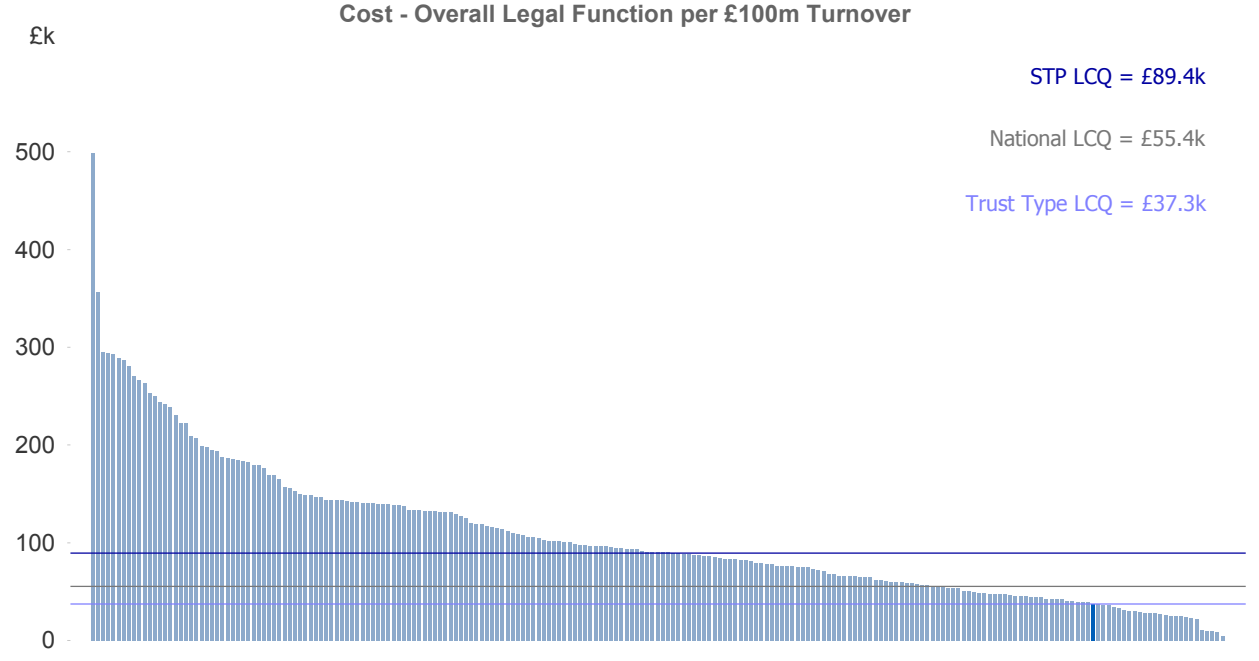
Trust Type: ACUTE - TEACHING

Governance & Risk



Key Governance & Risk Indicators	Value for Trust	National LCQ	STP LCQ	Trust Type LCQ
Cost - Overall Governance & Risk Function per £100m Turnover	£349.9k	£451.4k	£571.2k	£310.5k
Cost - Clinical Governance per £100m Turnover	£241.6k	£246.6k	£367.2k	£150.9k
Cost - Risk Management per £100m Turnover	£45.9k	£67.8k	£56.1k	£45.1k
Cost - Complaints Service per £100m Turnover	£33.7k	£42.1k	£33.7k	£25.4k
Cost - Admin Support to CEO & Directors per £100m Turnover	£28.6k	£55.6k	£64.5k	£31.7k

Legal



Key Legal Indicators	Value for Trust	National LCQ	STP LCQ	Trust Type LCQ
Cost - Overall Legal Function per £100m Turnover	£37.6k	£55.4k	£89.4k	£37.3k

Norfolk And Norwich University Hospitals NHS Foundation Trust

STP: Norfolk and Waveney

Trust Type: ACUTE - TEACHING

KPI Overview

		STP Footprint				Trust Type			National		
Department	**KPI**	Value for Trust	STP LCQ	KPIs above STP LCQ	KPI vs STP Max	Trust Type LCQ	KPIs above Trust Type LCQ	KPI vs Trust Type Max	National LCQ	KPIs above National LCQ	KPI vs National Max
Finance	Cost - Accounts Payable per £100m Turnover	£32.2k	£54.9k			£42.8k			£51.2k		
	Cost - Accounts Receivable per £100m Turnover	£25.1k	£18.7k	●		£19.0k	●		£19.6k	●	
	Cost - Capital Accounting per £100m Turnover	£14.2k	£20.5k			£10.9k	●		£12.2k	●	
	Cost - Costing/Service Line Reporting per £100m ...	£30.0k	£27.3k	●		£21.5k	●		£26.4k	●	
	Cost - External Audit per £100m Turnover	£17.4k	£32.4k			£11.0k	●		£21.9k		
	Cost - Finance Function as % of Turnover	0.33%	0.62%			0.48%			0.64%		
	Cost - Financial Accounts per £100m Turnover	£34.2k	£75.9k			£34.2k			£48.0k		
	Cost - Income/SLA Planning per £100m Turnover	£36.1k	£35.4k	●		£52.8k			£56.1k		
	Cost - Internal Audit & Counter Fraud per £100m ...	£11.7k	£47.1k			£20.3k			£33.9k		
	Cost - Management Accounts per £100m Turnover	£84.5k	£233.1k			£192.3k			£232.6k		
	Cost - Overall Finance Function per £100m Turnover	£332.4k	£618.6k			£478.3k			£643.5k		
	Cost - Service Improvement/PMO per £100m Tur...	£29.6k	£359.9k			£34.2k			£53.9k		
	Cost - Treasury Management per £100m Turnover	£35.6k	£25.5k	●		£20.1k	●		£24.4k	●	
	Processing Cost per Invoice (Accounts Payable)	£1.27	£2.01			£1.91			£2.16		
	Processing Cost per Invoice (Accounts Receivable)	£6.83	£6.16	●		£6.32	●		£6.75	●	
Gov & Risk	Cost - Admin Support to CEO & Directors per £10...	£28.6k	£64.5k			£31.7k			£55.6k		
	Cost - Clinical Governance per £100m Turnover	£241.6k	£367.2k			£150.9k	●		£246.6k		
	Cost - Complaints Service per £100m Turnover	£33.7k	£33.7k			£25.4k	●		£42.1k		
	Cost - Overall Governance & Risk Function per £...	£349.9k	£571.2k			£310.5k	●		£451.4k		
	Cost - Risk Management per £100m Turnover	£45.9k	£56.1k			£45.1k	●		£67.8k		
HR	Cost - Communications Team per £100m Turnover	£42.8k	£95.6k			£35.4k	●		£54.8k		
	Cost - HR Business Partners per £100m Turnover	£43.5k	£103.0k			£111.1k			£159.7k		
	Cost - Learning & Development per £100m Turnover	£25.6k	£196.6k			£67.7k			£144.8k		
	Cost - Occupational Health per £100m Turnover	£15.5k	£84.4k			£55.7k			£92.1k		
	Cost - Overall HR Function per £100m Turnover	£210.4k	£965.4k			£474.6k			£700.7k		
	Cost - Recruitment per £100m Turnover	£74.1k	£139.5k			£77.4k			£99.9k		
	Cost - Temporary Staffing Service per £100m Tur...	£37.8k	£83.3k			£31.9k	●		£37.3k	●	
	Cost - Workforce Analytics per £100m Turnover	£13.8k	£43.0k			£20.7k			£33.6k		
IM&T	Cost - Clinical Coding per £100m Turnover	£154.7k	£93.3k	●		£109.9k	●		£79.4k	●	
	Cost - Core IT per £100m Turnover	£770.3k	£877.5k			£621.8k	●		£693.8k	●	
	Cost - IM&T per device	£1,078.8	£933.5	●		£1,030.0	●		£820.1	●	
	Cost - Information Governance & FOI Management...	£5.2k	£6.7k			£11.4k			£25.0k		
	Cost - Information Services per £100m Turnover	£119.0k	£93.3k	●		£120.0k			£182.8k		
	Cost - Medical Records per £100m Turnover	£188.4k	£103.7k	●		£178.3k	●		£131.3k	●	
	Cost - Overall IM&T Function per £100m Turnover	£1,238.1k	£1,254.4k			£1,254.9k			£1,524.0k		
	Cost - Telecoms per £100m Turnover	£0.5k	£126.8k			£55.3k			£104.0k		
Legal	Cost - Overall Legal Function per £100m Turnover	£37.6k	£89.4k			£37.3k	●		£55.4k		
Payroll	Cost - Overall Payroll Function per £100m Turnover	£57.0k	£57.0k			£59.0k			£81.8k		
	Cost - Payroll Function per Payslip	£3.14	£3.14			£2.94	●		£3.40		
Procurement	Cost - Materials Management per £100m Turnover	£28.2k	£21.5k	●		£31.5k			£25.8k	●	
	Cost - Overall Procurement Function per £100m T...	£152.5k	£152.5k			£170.4k			£145.4k	●	
	Cost - Procurement Strategy/Leadership per £10...	£0.0k	£26.7k			£19.0k			£22.7k		
	Cost - Receipt & Distribution per £100m Turnover	£21.0k	£9.4k	●		£21.0k			£18.5k	●	
	Cost - Sourcing per £100m Turnover	£83.5k	£26.8k	●		£33.1k	●		£32.8k	●	
	Cost - Systems & Cataloguing per £100m Turnover	£13.3k	£13.3k			£7.4k	●		£11.3k	●	
	Cost - Transactional Buying per £100m Turnover	£6.5k	£20.7k			£15.6k			£19.9k		

● - KPI is above LCQ

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

Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

Integrated Performance Report

March 2017 (February data)

Format/Presentational Changes this month: None

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

Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

Core Slide 2

Quality and Safety Summary

Quality & Safety		Target	Oct 2015 to Sep 2016	2015/16	2016/17
Mortality	Core Slide 4				
1 SHMI*		N/A	1.090	1.056	N/A

Quality & Safety		Outturn 2015/16	Monthly Target	Feb-17	6 month trend	YTD 2015/16	YTD 2016/17
Mortality	Core Slide 4						
2 Deaths / 100 discharges		1.7	n/a	1.33		1.51	1.33
Incidents	Core Slide 5-6						
3 Serious Incidents		154	n/a	6		138	105
4 Incident Reporting		15499	n/a	1336		14062	14196
5 Zero insulin errors causing NPSA category moderate harm or above		3	0	0		3	1
6 Medication Errors		1431	n/a	75		1301	1158
7 Patient Falls causing moderate harm or above		42	n/a	2		40	32
8 Never Events		5	0	0		4	5
Pressure Ulcers	Core Slide 7						
9 Grade 2 hospital acquired pressure ulcers		151	n/a	12		136	144
10 Grade 3 hospital acquired pressure ulcers		58	n/a	6		51	46
11 Grade 4 hospital acquired pressure ulcers		3	0	0		3	3
Infection Control	Core Slide 8						
12 HAI C. difficile Cases (excluding non-trajectory and pending cases)		32	n/a	0		25	19
13 Zero Hospital Acquired MRSA bacteraemia		2	0	0		0	0
Other							
14 EDL to be completed within 24 hours in 95% of discharges		74.01%	95.00%	71.75%		74.40%	69.85%
15 Harm Free Care		91.18%	n/a	91.43%		91.35%	92.19%
16 Patients 'extremely likely' or 'likely' to recommend our service to friends and family		90.92%	100.00%	96.91%		90.36%	95.98%
17 Complaints		933	n/a	55		837	874

*SHMI data is updated quarterly by NHS Digital

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Core Slide 3

Quality Priorities – Patient Safety

	Quality Priorities - Patient Safety	Measure	Lead	Outturn 2015/16	Monthly Target	Feb-17	6 month trend	YTD 2015/16	YTD 2016/17
1	Reduction in medication errors	Zero insulin errors causing NPSA category moderate harm or above	Peter Chapman	3	0	0		3	1
2	Prompt recognition and treatment of sepsis	% of Sepsis patients screened	Peter	64.52%	90.00%	TBC		62.69%	
		% of Sepsis patients treated	Peter	49.79%	90.00%	TBC		45.66%	
3	Keeping patients safe from hospital acquired thrombosis	95% compliance with TRA assessment as evidenced on EPMA. (and audit of appropriate actions)	Peter Chapman	91.82%	95.00%	99.55%		91.32%	88.94%
4	Incident reporting and management	NNUH duty of candour compliance	Peter Chapman	100.00%	100.00%	100.00%		100.00%	100.00%
5	Incident reporting and management*	Remain within top quartile of acute trusts for incident reporting on NLRS	Peter Chapman	n/a	34/136	36/136		n/a	n/a

*The most recently published incident reporting rate for the Trust is 44.23 incidents per 1,000 bed days (for incidents reported to the NRLS between October 2015 and March 2016). When comparing this figure against 136 other Acute (non- specialist) organisations within our cluster, the median reporting rate for the cluster is 39.31 incidents per 1,000 bed days and the NNUH is ranked at 36th out of 136 and is currently sitting one place underneath the highest 25% of reporters.

Quality Priorities – Patient Experience

	Quality Priorities - Patient Experience	Measure	Lead	Outturn 2015/16	Monthly Target	Feb-17	6 month trend	YTD 2015/16	YTD 2016/17
1	Treat Patients with privacy and dignity	Patients 'extremely likely' or 'likely' to recommend our service to friends and family	Emma McKay	90.92%	100.00%	96.91%		90.36%	95.98%
2	Dementia Friendly/Mental Capacity/Learning Disability	2015/16 CQUIN criteria	Emma McKay		n/a	TBC			
3	Improved continuity of care and experience through reduced ward moves and reduced numbers of outliers	No more than 20 patients recorded as boarders. Monthly average	Richard Parker	523	20	65		458	500
4	Improved discharge processes	EDL to be completed within 24 hours in 95% of discharges	Richard Parker	74.01%	95.00%	71.75%		74.40%	69.85%

Quality Priorities – Clinical Effectiveness

	Quality Priorities - Clinical Effectiveness	Measure	Lead	Outturn 2015/16	Monthly Target	Feb-17	6 month trend	YTD 2015/16	YTD 2016/17
1	Acute Kidney Injury -Communication with GPs	EDL to contain evidence of required communication as judged by CQUIN criteria	Peter Chapman		n/a	TBC			
2	Keeping patients safe from infection	HAI C. difficile Cases (excluding non-trajectory and pending cases)	Emma McKay	32	n/a	0		25	19
3	Keeping patients safe from infection	Zero Hospital Acquired MRSA bacteraemia	Emma McKay	2	0	0		0	0
4	Improve quality of care through research	Year on year increase in patients recruited into research studies. Aim to recruit 5000 into research studies in 2016-17.	Peter Chapman	0	417	62		0	4216
5	Timely medical review of all patients	% of Patients with a Senior Review recorded by 12:00	Richard Parker		n/a	TBC			
6	Timely medical review of all patients	Average number of patients with LoS >14 days	Richard Parker	0	200	234		0	234

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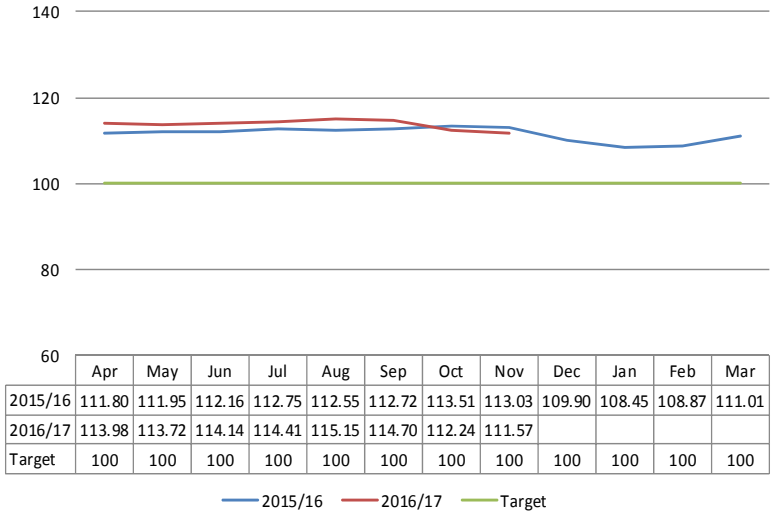
Core Slide 4

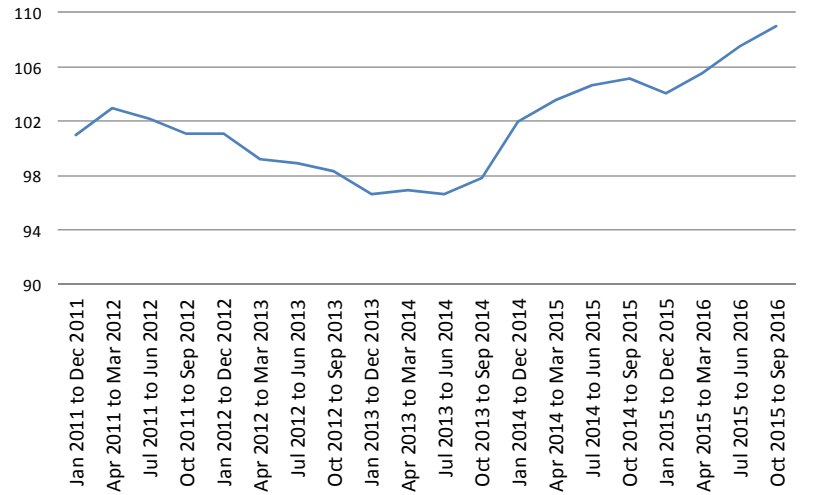
Quality & Safety (Mortality) – Lead Director Peter Chapman

HSMR



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	111.80	111.95	112.16	112.75	112.55	112.72	113.51	113.03	109.90	108.45	108.87	111.01
2016/17	113.98	113.72	114.14	114.41	115.15	114.70	112.24	111.57				
Target	100	100	100	100	100	100	100	100	100	100	100	100

SHMI

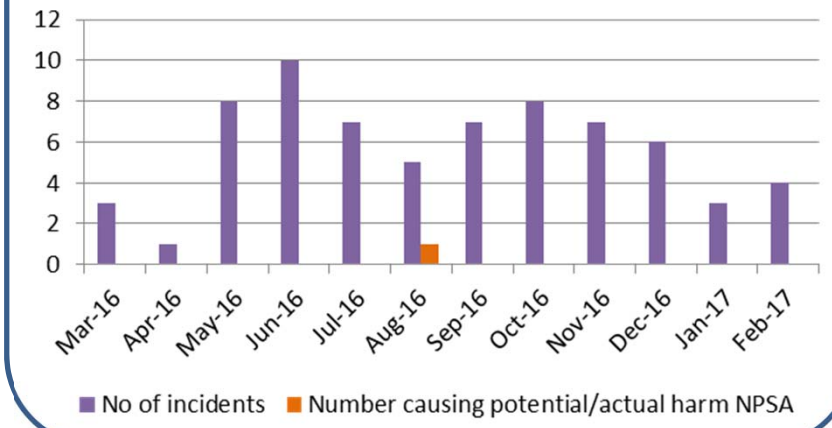


1. HSMR is the risk adjusted ratio of observed to expected in-hospital deaths within 56 clinical groups and is presented as the reported HSMR for each year prior to the month in question. For the year to Nov 2016 this was 112 – reduced for two successive months and than previous year but is still higher than expected.
2. SHMI is based upon HSCIC data and 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 is 109 to Nov 2016 and remains within the expected range though it continues on an upward trend.
3. Crude mortality within 30 days in December 2016 was 2..44%. This is slightly higher than the previous month (2.41%). This lower than Dec 2015 and on a downward trend since Jan 16 but with an expected seasonal increase since Aug 16.
4. HSMR basket monitoring – one group flagged with outlying mortality rising over last three months (deficiency and other anaemia). Sepsis mortality which triggered in Nov 16 now below average for Dec 16.
5. Continued marked drop in mortality from lobar pneumonia in Dec 16 following the previous 9 months of below average mortality.
6. Fractured neck of femur pathway MDT review group now formed with mortality review underway in this group. Themed learning will be disseminated through clinical governance leads.
7. Potentially Preventable Death review process is agreed and implemented and clinician training undertaken. NHS England commissioned RCP standardised mortality review agreed as format. Most recent themes – AKI management / EWS response / interface between ED and AMU. CQC report: “Learning, candour and accountability” reviewed and action plan/policy in progress.
8. Improving patient flow and >4hr waits in ED by improving processes of care through implementation of SAFER bundle considered to be vital in reducing overall HSMR and SHMI. Red to Green day now implemented on 5 “exemplar” wards.

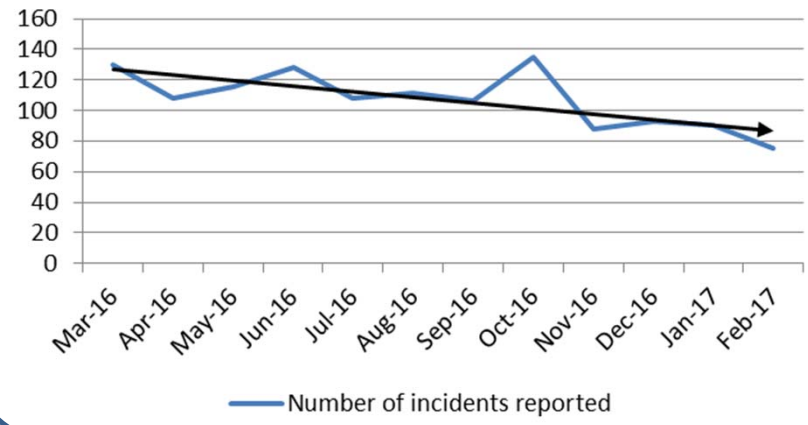
Core Slide 5

Quality & Safety (Incidents) – Lead Director Peter Chapman

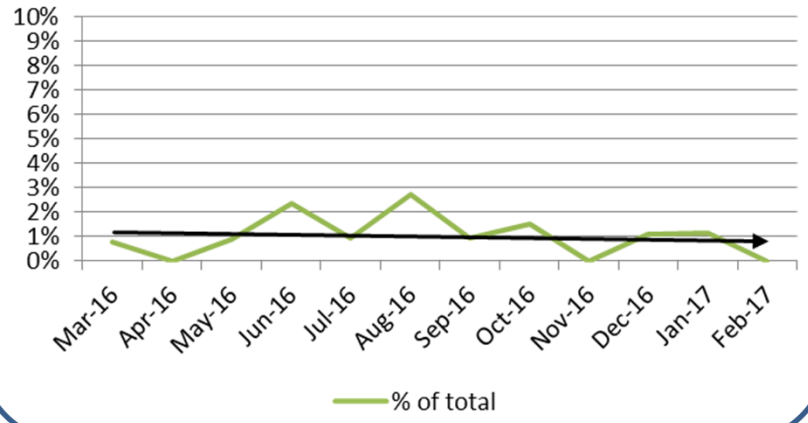
Insulin incidents past 12 months NPSA severity categories



Medication Incidents



Medication Incidents causing potential/actual harm



- We will focus on increasing reporting of medication errors whilst reducing those causing harm and in particular in relation to insulin. This has been agreed as part of our Local Quality Schedule and is an agreed Quality Priority for 2016-17.
- Total of 75 medication incidents reported and reviewed in February 2017. 14 not deemed to be true errors (IHI N/A – not deemed to be a medication incident).
- Of the remaining 61 no harm caused (IHI E or above)
- 4 Insulin related medication incidents were reported in February 2016 with no harm recorded
    - 2 prescribing errors
    - 1 incorrect dose
    - 1 beyond date
- One incident of potential or actual harm related to insulin in last 12 months (in August 2016).
- Medical division is reviewing targeted support for VRII across whole site aided by identification of at risk patients through EPMA

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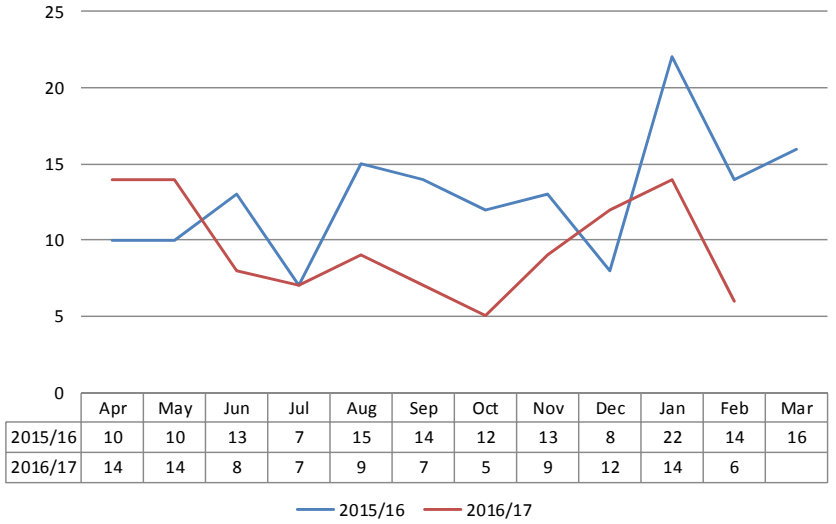
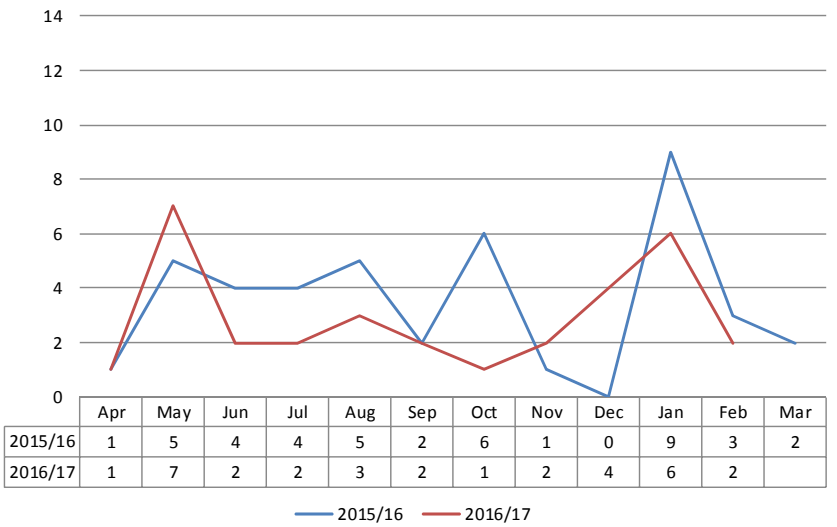
Core Slide 6 Quality & Safety (Incidents) – Lead Director Peter Chapman / Emma McKay

Serious Incidents



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	10	10	13	7	15	14	12	13	8	22	14	16
2016/17	14	14	8	7	9	7	5	9	12	14	6	

Patient Falls causing moderate harm or above



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	1	5	4	4	5	2	6	1	0	9	3	2
2016/17	1	7	2	2	3	2	1	2	4	6	2	

6 Serious Incidents were reported in February 2017
0 Never Events
Serious Incidents which were reported (includes Falls Pressure Ulcers).

- **2** Patient Falls resulting in moderate harm
- **2** Patient Grade 3 Hospital Acquired Pressure Ulcer (HAPU)
- **2** Other SI's
  - 1 Patient death – ED
  - 1 Multiple > 4 hour wait to be seen - ED

Compliance with the duty of candour has been confirmed and RCA investigations are in progress for all incidents.

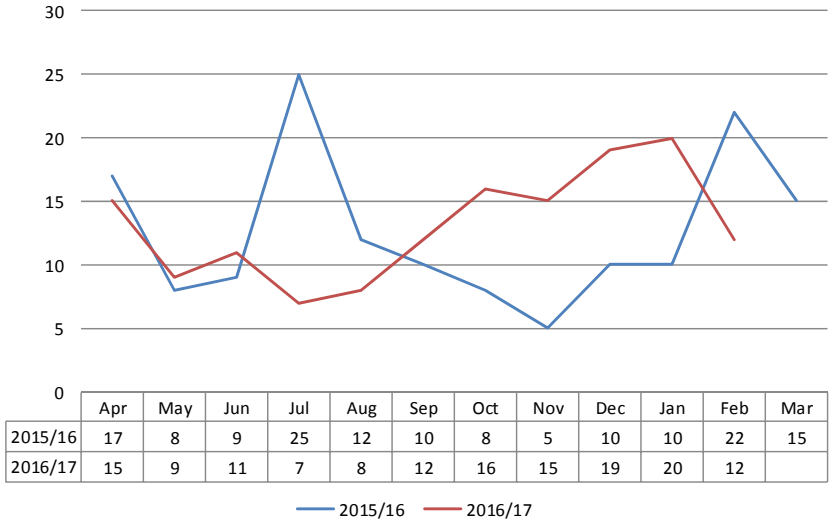
In February there were **229 inpatient falls** reported which is higher than the number reported in the previous month of 215 .

The number of patient **Falls resulting in Moderate harm (or above) and were** and reported as **SI's** has decreased this month to **2.**

Core Slide 7

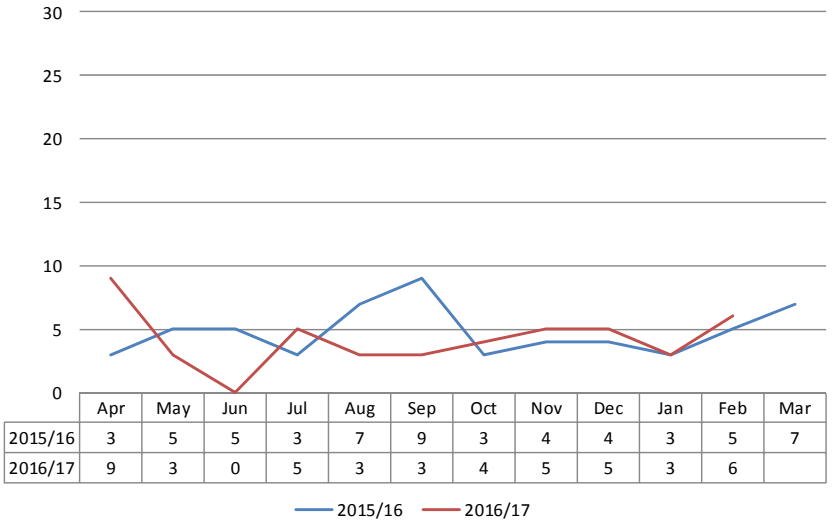
Quality & Safety (Pressure Ulcers) – Lead Director Emma McKay

Grade 2 hospital acquired pressure ulcers



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	17	8	9	25	12	10	8	5	10	10	22	15
2016/17	15	9	11	7	8	12	16	15	19	20	12	

Grade 3/4 hospital acquired pressure ulcers



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	3	5	5	3	7	9	3	4	4	3	5	7
2016/17	9	3	0	5	3	3	4	5	5	3	6	

The total number of **Grade 2** hospital acquired pressure ulcers reported in February was **12** which is significantly less than the **previous month (20)**. RCA investigations were undertaken and peer review found that **6** of these were **Avoidable** and **6** were **Unavoidable.**
6 patients developed a **Grade 3** hospital acquired pressure ulcer in February, RCA investigations found that **4** of these were **Avoidable. 2** were found to be **Unavoidable**.

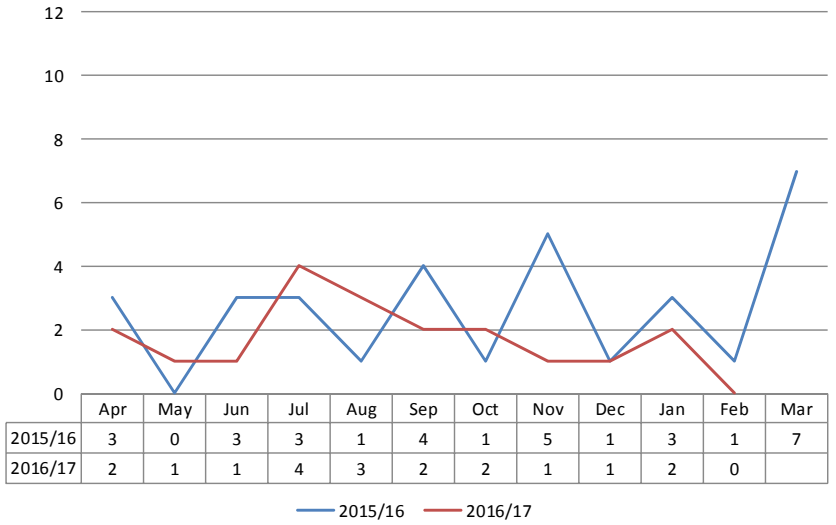
Learning from RCA investigations:

- Escalation to senior staff to ensure accurate grading of PU is identified.
- Staff to ensure consistent documentation regarding skin inspections.
- Staff to ensure TED stockings are removed daily for skin inspection and that this is recorded.
- Information pack has been developed with all relevant information leaflets e.g. pressure ulcer, falls. Staff to provide on admission to the patient and / or relatives.

Core Slide 8

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

HAI C. difficile Cases (excluding non-trajectory and pending cases)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	3	0	3	3	1	4	1	5	1	3	1	7
2016/17	2	1	1	4	3	2	2	1	1	2	0	

Issues
Following the monthly post infection review meeting the 4 pending cases of hospital acquired C. difficile from January were reviewed. Two cases were deemed non-trajectory and two cases trajectory.

The 2 cases of C. difficile identified as hospital acquired in February were deemed as non-trajectory .

Actions
Teams are reminded to be vigilant in isolating patients in a side room at onset of symptoms and the importance of documenting rationale if unable to isolate. Teams also reminded of the importance of daily bowel documentation.
Compliance with the Hand Hygiene policy & five moments of hand hygiene.

Following the post infection review [PIR] meeting with Trust and CCG's representatives each hospital acquired case of C. difficile is:-		
	Trajectory	deemed to have lapses in care
	Non-Trajectory	Deemed to have no lapses in care

	Pending cases are either awaiting the PIR meeting or the CCG's have requested further information

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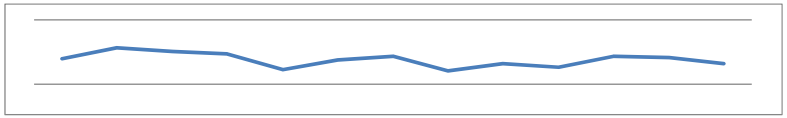
Core Slide 9

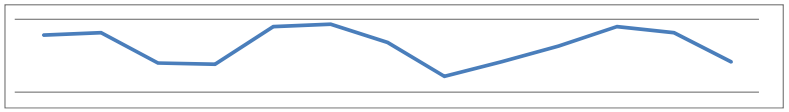
Safety Thermometer Dashboard – Lead Director Emma McKay

	All Acute		NNUH		Barts Health		Bright&Suss		Nott Univ		Royal Free		Royal Liver		Sheff Teach		Univ South Man		UCH	
Harm Free Care	93.79%		91.43%		93.46%		93.88%		95.38%		93.23%		93.19%		93.40%		91.96%		95.76%	
Pressure Ulcers - New	773	0.87%	6	0.64%	17	1.05%	3	0.34%	10	0.70%	0	0.00%	2	0.27%	28	1.79%	8	1.01%	6	0.85%
Falls with Harm	366	0.41%	2	0.21%	12	0.74%	2	0.23%	1	0.07%	0	0.00%	5	0.68%	5	0.32%	2	0.25%	1	0.14%
Catheters & NEW UTI's	281	0.32%	0	0.00%	3	0.19%	13	1.47%	1	0.07%	5	0.75%	5	0.27%	5	0.32%	1	0.13%	0	0.00%
New VTE's	532	0.60%	4	0.43%	11	0.68%	2	0.23%	12	0.84%	1	0.15%	14	1.91%	14	0.90%	8	1.01%	7	0.99%
New Harms	1915	2.16%	11	1.18%	43	2.65%	20	2.27%	24	1.68%	6	0.90%	51	3.13%	51	3.27%	19	2.39%	14	1.98%
No. Pt's in sample	86626		853		1,621		883		1,428		665		734		1,560		796		707	

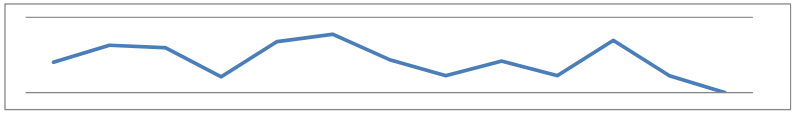
Pressure Ulcers - New



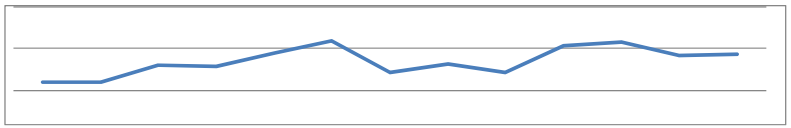
Falls with Harm



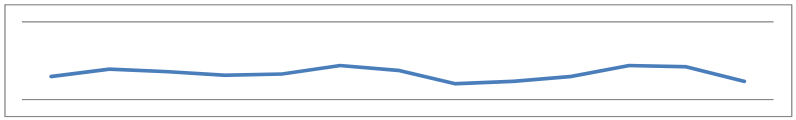
Catheters & New UTI's



New VTE's



ALL New Harms



The number of **New harms** reported at the Trust via the Safety Thermometer in February at **1.18 %** is lower than the national figure for All Acute New Harms which is **2.16%.**

In the comparison table above which lists the national figure (All Acute) and eight peer organisations the Trust continues to have a **low percentage** of reported harms for the following:

- Falls with harm **0.21% (0.41% All acute)**
- New Pressure Ulcers **0.64% (0.87% All acute)**
- New VTE's **0.43% (0.60% All acute)**

There were no reported harms associated with Catheters & New UTUI's at the Trust during February **(0.32% All Acute)**

The overall harm free care figure for the Trust of **91.43%** appears lower than the other peer Trusts this month. This is due to the number of Old pressure ulcer harms which is **7.72%.**

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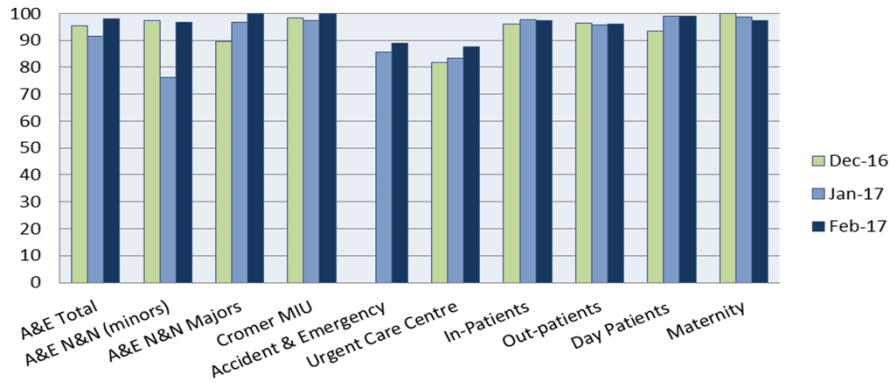
Core Slide 10

Maternity Safety Dashboard – Lead Director Peter Chapman

		Measure	Goal	Red	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Women Delivered	Number of women	Number of women	≤526	≥559	491	526	461	518	511	499	496	437	457	447	424		5267
Caesarean Sections	Total rate (elective & emergency)	Caesarean section births % of all deliveries	≤ 26.1%	>29.1%	26.7%	29.5%	28.4%	25.5%	29.0%	25.7%	27.0%	27.5%	25.8%	28.0%	26.2%		27.2%
Induction Rates		% of all deliveries	≤26.4%	≥29%	28.9%	29.5%	27.5%	31.5%	28.2%	34.7%	29.2%	33.9%	34.8%	31.5%	34.0%		31.2%
No. Black Alerts when women diverted		Number of occassions	0	≥1	0	1	2	2	1	0	1	0	0	1	1		9
Number of women diverted when on Black Alert		Number of women diverted			0	4	2	2	3	0	4	0	0	2	2		19
Midwife : Birth Ratio exc. band 3 MCA's		Ratio	≤1:29.5	>1:32	1:32.3	1:32.2	1:32.2	1:33	1:32	1:31	1:31	1:31	1:30	1:30	1:30		
Midwife : Birth Ratio inc. band 3 MCA's	Midwife : Birth Ratio inc. band 3 MCA's	Ratio	≤1:28	>1:30	1:30.6	1:30.6	1:30.6	1:31	1:30	1:29	1:30	1:29.7	1:28.5	1:28.5	1:28.5		
Unplanned NICU Admissions at Term >24hrs requiring ventilation	Unplanned NICU Admissions at Term >24hrs requiring ventilation	Number of babies			0	0	1	2	2	2	0	2	4	1	3		17
Number of SI's	Number of SI's	Number per month	0	≥1	0	0	1	0	2	0	1	0	0	1	0		5
3rd & 4th Degree Tears	3rd Degree Tears	% of all deliveries	<3.5%	>5%	2.44%	2.47%	1.74%	1.93%	1.96%	3.61%	3.63%	2.52%	1.75%	1.79%	3.07%		2.45%
All Stillbirth excluding TOP≥24wks & Severe Anomalies	excluding TOP≥24wks & Severe Anomalies	Number of babies			0	1	3	2	4	0	1	3	0	3	2		19

Comments Feb 17: Plan to separate IOLs in next Dashboard submission- request has been submitted. RAG ratings will be reviewed at end of financial yea. Black Alert due to acuity of patients and divert for 14hrs. No patients diverted.

Core Slide 11 — Caring and Patient Experience – Lead Director Emma McKay



Patient Feedback

- During February 2017, **2656** responses (later submissions outstanding) were received, (**3052** in Jan.). The overall Trust score was **97%**.
- The work in relation to improving sign-posting for patients to providing FFT feedback, as well as the text messaging service, are progressing to timescales.
- Of those patients who responded, **99%** were either satisfied or very satisfied with kindness and compassion shown.

#hellomynameis

- Of all staff (including Serco), **97.5%** (95.5% in Jan.) are reported to introduce themselves to our patients.

Patient Opinion

- **Twenty comments** were left on the Patient Opinion website in February of which **17** were to thank staff for their care. Of the others, **1** related to navigation around urgent care, **1** to in-patient care and **1** to out-patient time to be seen. All were fed back to the relevant clinical teams for action.

Patient Advice and Liaison Service (PALS)

- Including Patient Opinion, **287** PALS queries/contacts were received in February 2017. Of these, **49** were compliments and **88%** of queries requiring action were closed within 48 hours**.**
- The two highest subject matters, excluding General Queries (n.62) and compliments, were **Communication (n.50)** – a sustained increase from January and **Clinical Treatment (n.22):**

Communications		Clinical Treatment	
Communication with patients	4	Unhappy with outcome of consultation	6
Communication with relatives/carers/visitors	6	Questions/concerns regarding care/decisions	9
Delay in relaying information/test results	9	Unhappy with outcome of surgery/procedure	1
Difficulty communicating with department/ward	8	Unhappy with inpatient medical care	6
Request message to staff/department	3		
Request for information/contact details	3		
Communication with GP/Dentist	3		
Messages/calls not returned	3		
Inaccuracies in written communication	4		
Bereavement Services	4		
Communication regarding DNAR	3		
Total	**50**	**Total**	**22**

- The distribution of areas from which concerns originate is evenly spread. The one ward with a higher number of concerns in January, received only one concern in February.
- A process has recently been put in place whereby any communication concern in relation to DNACPR are reviewed by our Recognise and Respond committee.

Patient Experience Working Group

- A workshop style meeting has been held with the aim of identifying key improvement workstreams.
- The workshop was centred around analysis of the multiple sources of patient and carer feedback we receive and will aim to identify achievable workstreams that deliver demonstrable improvements.

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Core Slide 12

Caring and Patient Experience – Lead Director Emma McKay

Complaints

- **Fifty-five** complaints were received in February 2017 v **94** in Feb. '16.
- 'Values and behaviours' has not flagged in the top 5 issues this month.
- ED generates the highest number of complaints and analysis shows that we received **1** complaint for every **898** attendances. There is no particular pattern to these; no one clinician communicating poorly; or one single type of injury / illness that stands out.
- When errors occur the team take appropriate action to learn through "lessons of the week", induction programmes and education.

End of Life Care & Strategy

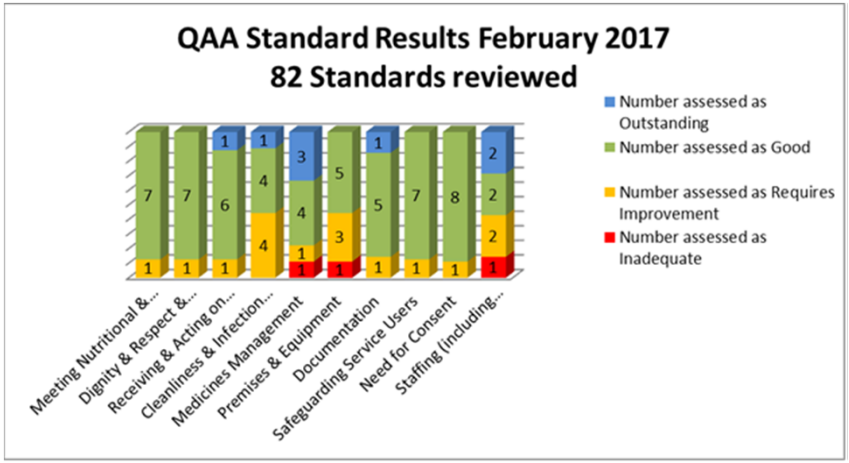
- The End of Life Strategy has been consulted upon and finalised.
- Audit of the pilot of an individualised care plan for patients at the end of life is planned.
- An alternative single use disposable infusion device with a continuous subcutaneous infusion is to be introduced for patients discharged home.
- We continue recruitment to fill agreed additional posts.

Patient Information Forum

- One hundred and eight patient information leaflets have been approved during the last quarter.
- The Forum has undertaken an audit of compliance with its associated guideline and compliance was generally good.

Quality Assurance Audits (QAAs)

- **Fifteen** QAAs (5 supported by external auditors) were undertaken during February 2017 (6 reports outstanding).
- **Eighty-two** fundamental standards have been reviewed during the QAAs reported on during January and February combined.
- Overall the percentage of 'Good' or 'Outstanding' standards remains high across the Trust at **88.6**
- In total, there were **3** out-of-hours audits to be undertaken and feedback has been received for **2** of these.
- **Six** of the **16** 'Requires Improvement' and the **3** 'Inadequate' ratings were identified for an escalation area. Immediate actions were taken and the area has since closed.



- Cleanliness & Infection, Prevention & Control 'Requires Improvement' ratings related to:
  - Trust – Clinell labels, cleaning logs and evidencing cleaning procedures
  - Cleaning logs and changing of 'Actichlor'
  - Serco – bathroom cleaning

- Premises & Equipment 'Requires Improvement' ratings related to:
  - No evidence of some checking processes
  - Equipment check frequencies including emergency equipment
  - Restricted environmental space

- The Divisional Nurse Director with responsibility for oversight of cleanliness and the Infection, Prevention and Control clinical lead are copied into each QAA where any areas for improvement are identified; as are our Serco colleagues.
- Checking of emergency equipment is a particular focus for matrons presently as a result of a revised Standard Operating Procedure and introduction of revised, standardised checklists for generic equipment.

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

Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

Core Slide 13

Nursing Dashboard – Lead Director Emma McKay

	Outturn 2015/16	Monthly Target	Feb-17	6 month trend	YTD 2015/16	YTD 2016/17
1 Same Sex Breach	0	0	0		0	16
Infection Prevention and Control						
2 C Diff cases (hospital acquired)	54	3	2		46	39
3 MRSA bacteraemias (hospital acquired)	2	0	0		0	0
4 Norovirus (confirmed cases)	133	1	21		121	219
5 Elective MRSA Screening Breaches	95.50%	95%	90.61%		95.48%	95.50%
6 Emergency MRSA Screening Breaches (Provisional)	98.51%	95%	91.00%		98.48%	96.63%
7 Hand Hygiene Compliance	98.12%	>98.00%	97.44%		98.10%	98.13%
8 Dress Code Compliance	99.13%	>98.00%	99.08%		99.10%	99.53%
9 Commode Audits	94.19%	>98.00%	93.06%		94.01%	93.99%
Health & Safety						
10 Needlestick Incidents	93	0	9		88	82
Incident Reporting						
11 Total Number of incidents in month	12638	N/A	1069		11528	10962
12 Incidents (reported in month) Finally Approved within 14 Days	7706	N/A	518		7143	6926
13 Incidents reported in month not closed within 14 Days	4502	0	551		3955	5128
Cleaning						
14 Cleaning Audit Results	96%	95%	95.8%		95.7%	95.8%
15 Cleaning Audit Results if Re-Audited	96%	95%	96.5%		96.3%	94.7%
Call Bell Waits						
16 Day Wandsworth Call Bell: Patient Call (total if not separated)	03 min 04 sec	02 min 30 sec	02 min 36 sec		03 min 04 sec	02 min 43 sec
17 Day Wandsworth Call Bell: Bathroom Call (total if not separated)	01 min 59 sec	02 min 00 sec	01 min 28 sec		01 min 58 sec	01 min 47 sec
18 Night Wandsworth Call Bell: Patient Call	01 min 56 sec	02 min 30 sec	01 min 37 sec		01 min 57 sec	01 min 37 sec
19 Night Wandsworth Call Bell: Bathroom Call	01 min 16 sec	02 min 00 sec	01 min 04 sec		01 min 16 sec	01 min 03 sec

Core Slide 14

Effectiveness - Lead Director Peter Chapman

RESEARCH & DEVELOPMENT

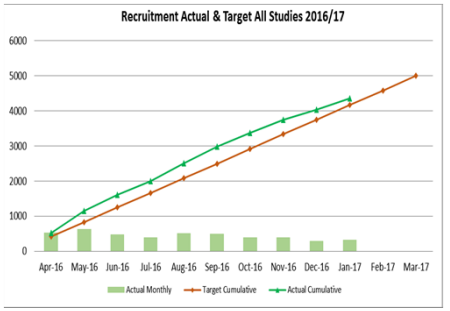
	April	May	June	July	Aug	Sep
No of Research Projects Active in the Trust	416	416	366	352	402	377
No of Studies Sponsored by NNUH & UEA	124	124	102	100	112	90
No of Studies Sponsored by NNUH	54	54	47	49	47	40
No of Studies Sponsored by UEA	70	70	55	51	65	50
No of Studies Approved	10	10	11	11	8	13
Median Days from Submission to Approval for All Studies (per month)	55.5	55.5	77.0	69.0	25.0	73.0
Median Days from Submission to Approval for All Studies (year to date)	36.0	36.0	46.0	51.0	51.0	48.0
Median Days from Submission to Approval for NIHR Studies (year to date)	37.0	37.0	47.0	54.0	51.0	57.0

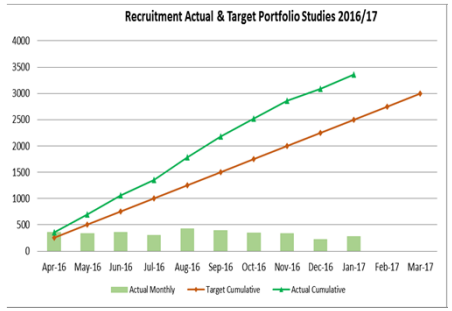
Table 1: Summary of number of research projects in the Trust & approval times

- Full implementation of HRA approval process commenced on 1st April 2016.
- Target time for approval of new studies is 40 days from site selection to confirmation from site of capacity and capability. Individual review of all studies not meeting target confirmed NNUH internal delays solely responsible in 1 case
- 15 new studies approved in Feb. 14 portfolio. 6 commercially sponsored.

New patient enrolment

Recruitment for 16/17	Number	Percent
Portfolio recruitment target	3000	
Total Recruitment	4335	
NIHR Portfolio	3362	78%
Non Portfolio	973	22%
Commercial Studies	303	7%
Non Commercial Studies	4032	93%



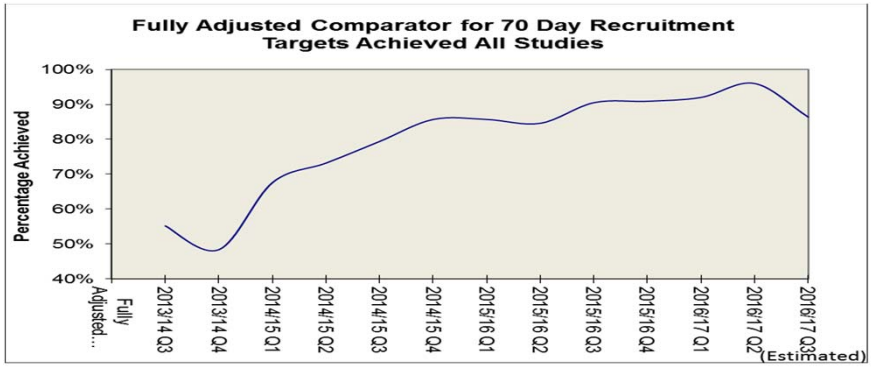


- CRN portfolio recruitment target (3000) for 2016-17 achieved
- All study quality priority recruitment target (5000) for 2016-17 on target

Initiation

Cumulative data is adjusted to reflect attributable to NNUH. Overall the achievement of this target is challenging for Trusts.

Cumulative data is adjusted to reflect delays attributable to NNUH. Overall the achievement of this target is challenging for all Trusts.



Core Slide 15 — Effectiveness - Lead Director Peter Chapman

R & D Performance Delivery
Performance in delivery looks at the number of studies which achieve their recruitment target by the agreed recruitment end date.

- Measure applied for all commercially sponsored clinical trials and is a valuable measure of the attractiveness of NNUH for commercial trials.
- 59% in 16/17 Q3 achieved final recruitment target. Reasons for non achievement reviewed and understood and mostly out of NNUH control

R&D Safety and compliance – Serious Adverse Events (SAEs)
19 new SAEs received in Feb including 4 follow-up reports
18 admissions to hospital and 1 death
17 not attributable to research activity
2 unlikely to be attributable to research activity

MHRA inspection report
MHRA 3 day inspection into dermatology trial (now closed) in December. Chief investigator has now left the Trust. Critical findings related to sponsor. 3 major and 5 other findings related to NNUH as host site and Corrective Action and Preventative Plan incorporating policies already written.

CLINICAL STANDARDS
Clinical Audit

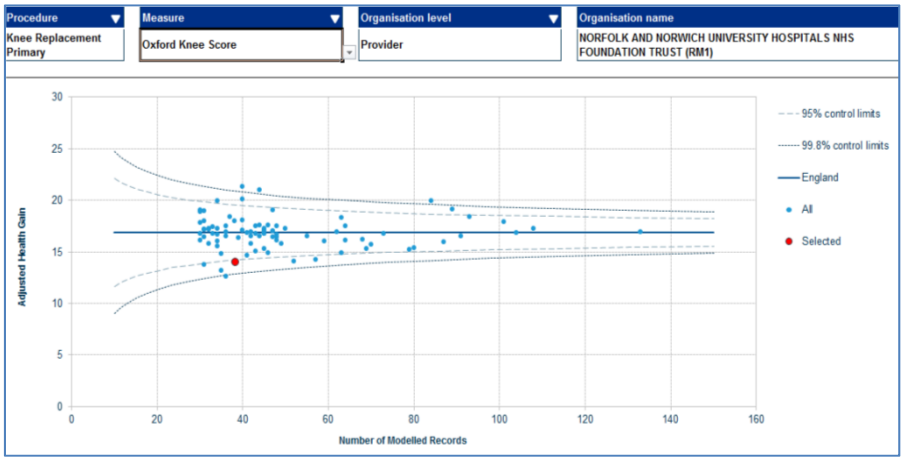
- Numbers of completed audits should rise following expected trajectory reporting by year end.
- Divisional governance leads to identify individual areas of concern in their divisions.

Published National Audits and Reports
Divisional review and actions plans as appropriate will be followed through divisional reporting to effectiveness for the following recently published national audits:

- National Pregnancy in Diabetes Audit Results
- National Prostate Cancer Audit Report
- Adult Critical Care Case Mix Programme annual quality report
- Myocardial Ischaemia National Audit programme annual report
- National Confidential Enquiries and Inquiries review. Current studies reviewed and revised process agreed through clinical audit for follow-up

TRAUMA COMMITTEE
All actions arising out of Regional Peer Review concerns completed or in progress.
Most recent TARN data:
73.5% data completeness and 96.1% data accreditation
0.41 additional survivors per 100 patients – a decrease from 0.9

RELATED OUTCOME MEASURES (PROMs)



Hip replacement, groin hernia, and varicose vein scores all within control limits. EQ-5D for knee replacement shows positive progress since Nov 16 but the Oxford knee score position has deteriorated though still within 95% control limit. (Ref. Chart) Actions taken continue – improved patient information, improved post-operative physiotherapy, helpline for discharge issues, increased involvement of nurse practitioners in pre-assessment clinic.

Core Slide 16

Performance – Monitor KPI's - Lead Director Richard Parker

Performance		Outturn 2015/16	Monthly Target	Feb-17	6 month trend	YTD 2015/16	YTD 2016/17
Cancer	Core Slide 18-20						
1 Cancer 62 day target for referral to treatment - GP Referral *		77.07%	85.00%	71.85%		76.65%	78.23%
2 Cancer 2 week wait - all cancers *		96.70%	93.00%	95.23%		96.50%	97.32%
4 Cancer 31 day target compliance		97.39%	96.00%	96.25%		97.44%	97.01%
5 Cancer 31 day target for subsequent treatments - Surgery *		91.58%	94.00%	95.05%		91.75%	92.26%
6 Cancer 31 day target for subsequent treatments - Anti Cancer Drugs *		99.26%	98.00%	100.00%		99.19%	99.93%
7 Cancer 31 day target for subsequent treatments - Radiotherapy *		97.76%	94.00%	97.62%		97.74%	97.73%
A&E	Core Slide 21						
9 A&E 4 hour target compliance		85.33%	95.00%	77.65%		85.88%	85.44%
10 Number of 30 minute handover breaches		4959	0	782		4093	5968
11 Number of 60 minute handover breaches		1606	0	309		1242	2137
12 Recording of Handover Times		94.72%	95.00%	90.82%		94.88%	92.44%
13 Number of patient handover times recorded		48581	n/a	3769		44499	44879
14 Arrival to Handover time (>15 minutes)		27.90%	n/a	38.99%		26.55%	30.55%
RTT	Core Slide 22						
15 18 week RTT target - Patients on an incomplete pathway		87.49%	92.00%	84.20%		87.65%	85.82%
16 Admitted Backlog		3039	n/a	3416		2868	3416
17 Incomplete Non Admitted Backlog		2285	n/a	2705		1887	2705
Stroke	Core Slide 23-24						
18 Percentage of patients with 90% of their length of stay on the stroke unit		80.26%	80.00%	65.69%		80.18%	82.29%
19 Patients with primary diagnosis of stroke admitted to a HASU within 4 hrs		74.08%	90.00%	58.00%		74.82%	78.22%
20 % of urgent Stroke patients with access to brain scan within 60 mins		86.27%	90.00%	90.24%		85.40%	83.45%
21 % Door to needle time of <= 60 minutes for eligible thrombolysis patients		79.22%	90.00%	90.00%		79.60%	82.68%
22 % of high risk TIA patients treated within 24 hour of first contact		91.84%	90.00%	80.00%		93.22%	86.12%
Patient Flow							
23 Diagnostics		95.93%	99.00%	99.70%		95.72%	98.31%
24 Cancelled Operations		1360	n/a	104		1227	1037
25 Number of 28 day breaches		267	0	12		199	203
26 Average Delayed Transfers of Care		552	n/a	28		497	483
27 28 Day Readmission Rates		6%	n/a	4.39%		5.68%	5.49%
28 Length of Stay (Elective)		3.09	n/a	3.17		3.31	3.17
29 Length of Stay (Non-Elective)		5.08	n/a	4.90		5.23	4.90
30 Average number of patients with LoS >14 days		0.00	200	234		0	234
*Please note these figures are provisional							

Core Slide 17

Performance - Lead Director Richard Parker

Performance – key issues

1. **Cancer** - 62-day GP referral performance remains a priority for recovery. Below standard performance in February reflects targeted backlog reduction. Work to set a trajectory for cancer recovery has been undertaken with system partners and the trajectory is for recovery in May 2017

2. **A&E** - ED transit time performance for February was below trajectory but broadly in line with peers. The revised System Wide plan is in place and continues to focus on performance stabilisation. Key issues were in line with national profile of significantly increased demand, heightened acuity of presentation and an increase in the number of 14-day 'stranded' patients

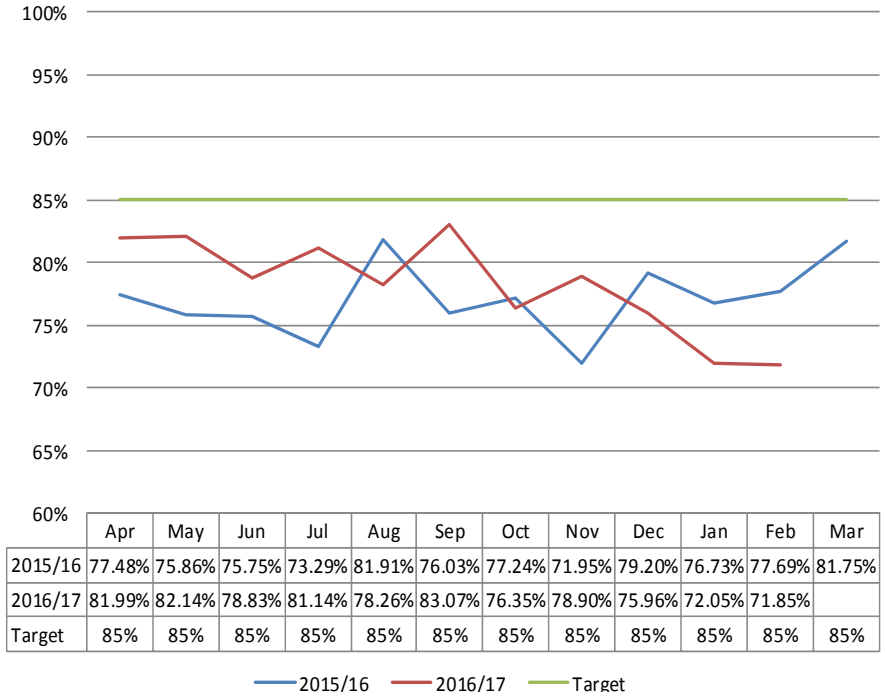
3. **RTT** – Significant partnership work has been completed to establish a recovery action plan with the CCG. Current recovery trajectories set a return to compliance by October 2018

4. **Stroke -** Progress had been made to recover key strands of stroke performance, specifically door to needle time and timely access to scanning. Access to dedicated stroke beds remains challenging and reflects the overall emergency care / bed capacity challenge in this early part of Winter. I SNNAP audit data for the period April 14 – November rates our Stroke performance as "recently" – Good, "2.5 year period" – Improving.

Core Slide 18

Performance (Cancer) - Lead Director Richard Parker

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	77.48%	75.86%	75.75%	73.29%	81.91%	76.03%	77.24%	71.95%	79.20%	76.73%	77.69%	81.75%
2016/17	81.99%	82.14%	78.83%	81.14%	78.26%	83.07%	76.35%	78.90%	75.96%	72.05%	71.85%	
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

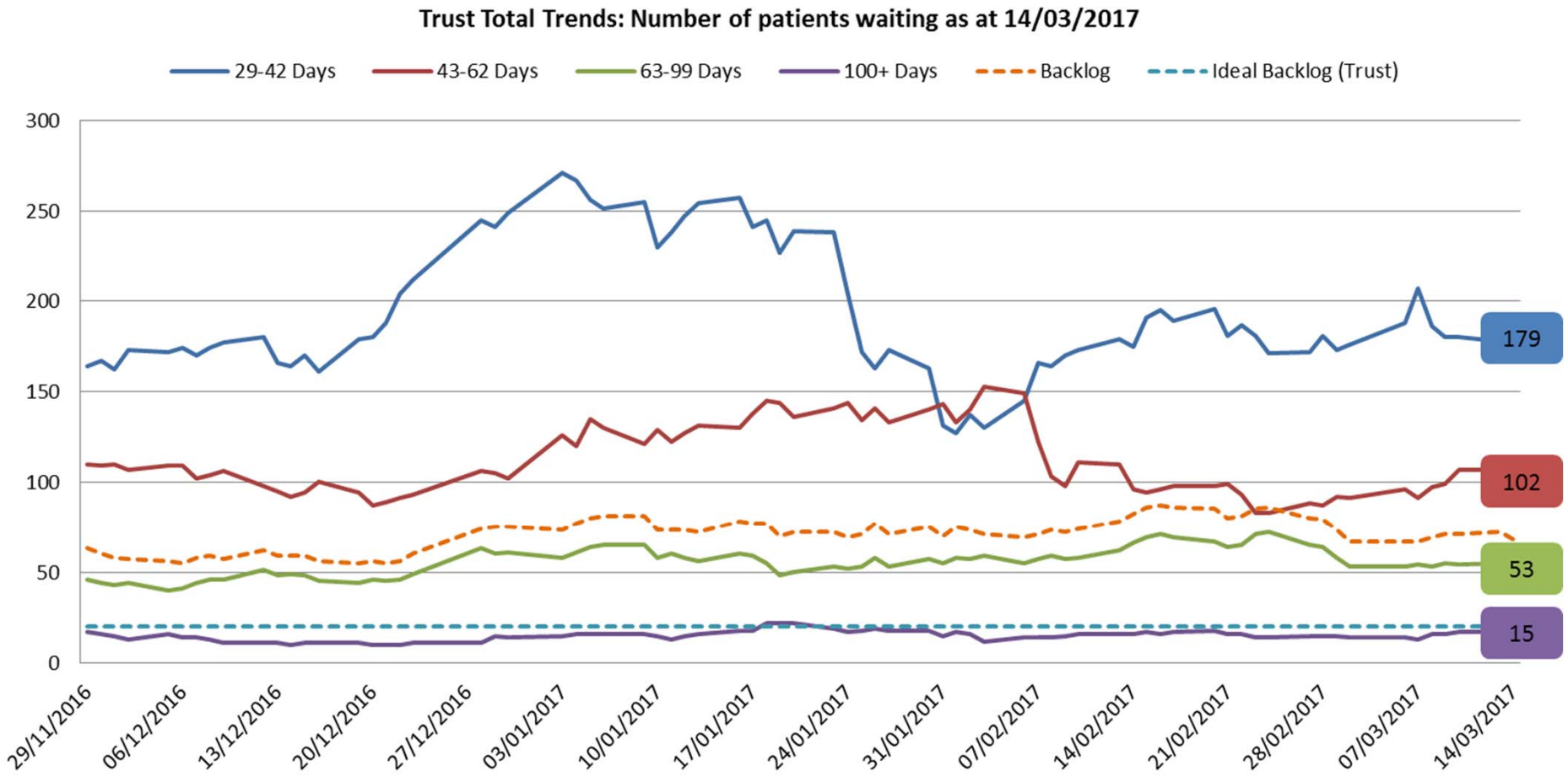
Issues

- On going sub-85% performance reflects backlog clearance to achieve recovery trajectory of **May 2017**
- Delays in the urology pathway and surgical capacity for both diagnostics and treatment remain the main issue to resolve
- Gynae-oncology capacity constraints are a significant but improving issue
- Performance 'drop' reflects treatment of backlog patients,

Actions

- Increased capacity for outpatients and diagnostics to implement a revised urology pathway is now in place. Work ongoing for radiology and surgical capacity. Successful trial of three session day for robot cases has taken place and is being embedded in April
- 4th Gynae Consultant has commenced, clinic timetables under review
- Cancer RAP signed off by CCG's with fortnightly reporting in place- all actions predict recovery in **May 2017**

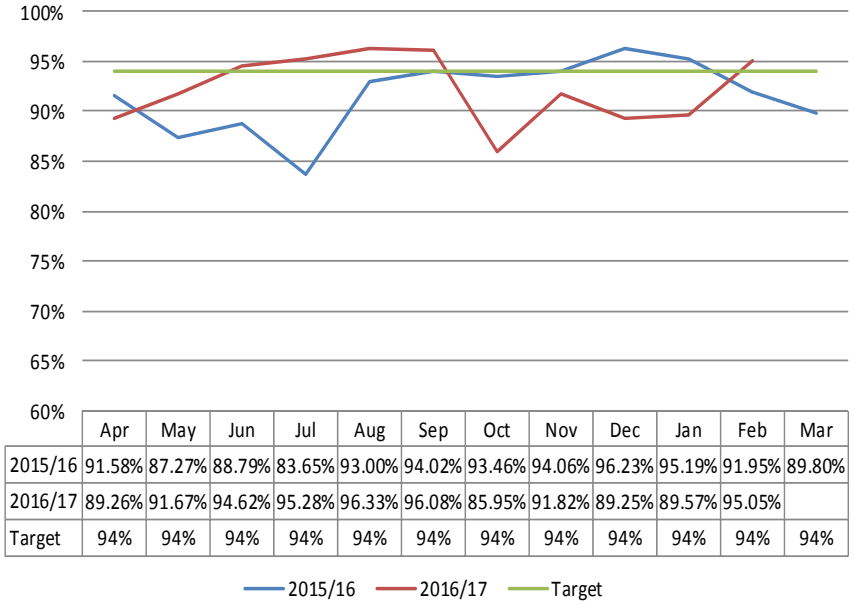
Core Slide 19 Performance (Cancer) - Lead Director Richard Parker



Core Slide 20

Performance (Cancer) – Lead Director Richard Parker

Cancer 31 day target for subsequent treatments - Surgery *



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	91.58%	87.27%	88.79%	83.65%	93.00%	94.02%	93.46%	94.06%	96.23%	95.19%	91.95%	89.80%
2016/17	89.26%	91.67%	94.62%	95.28%	96.33%	96.08%	85.95%	91.82%	89.25%	89.57%	95.05%	
Target	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%

Issues

- This target is always challenging due to small number of breaches. Achieved in February as predicted.
- New processes in place in Skin/plastics to ensure early escalation of issues
- **Unusual increase in number of complex Urology patients in March places target at risk**

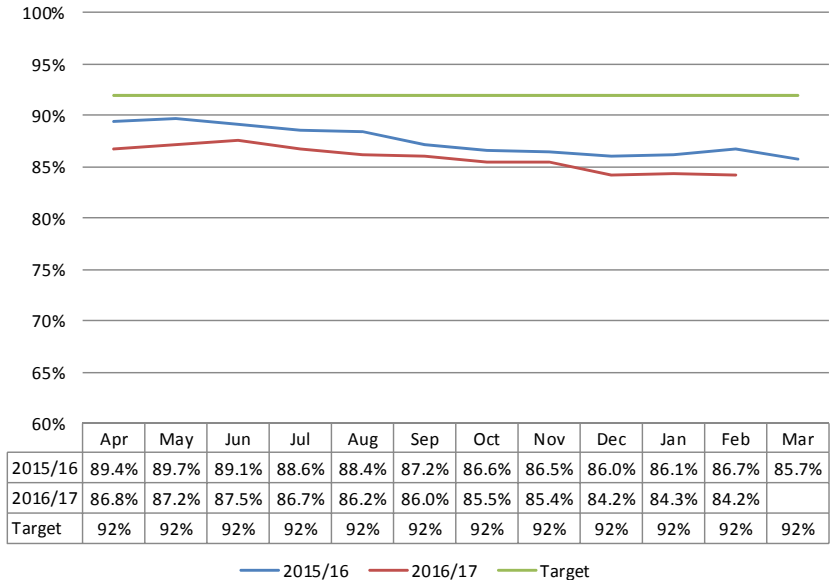
Actions

- Source additional theatre capacity for urology to manage increased demand

Core Slide 21

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

18 week RTT target - Patients on an incomplete pathway

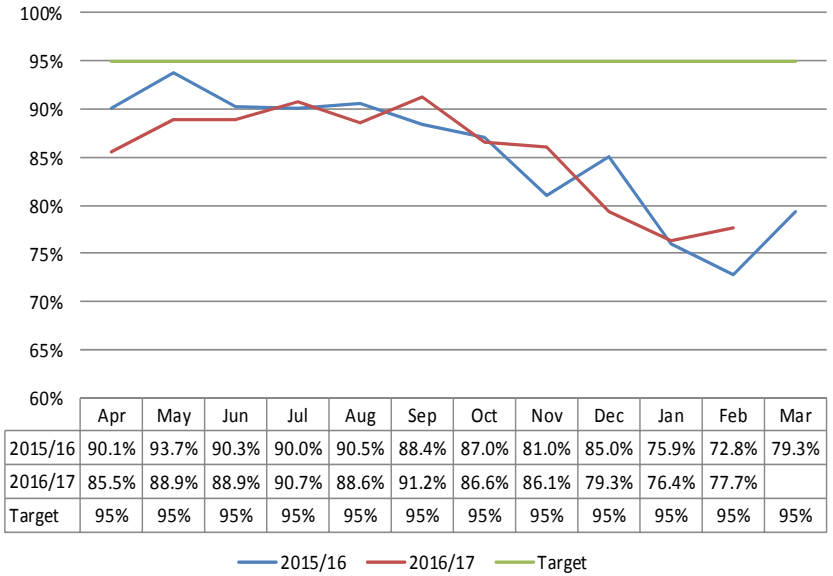


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	89.4%	89.7%	89.1%	88.6%	88.4%	87.2%	86.6%	86.5%	86.0%	86.1%	86.7%	85.7%
2016/17	86.8%	87.2%	87.5%	86.7%	86.2%	86.0%	85.5%	85.4%	84.2%	84.3%	84.2%	
Target	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%	92%

Issues
- Capacity concerns remain across most surgical specialities and cardiology
- External review undertaken by IST. Supportive of both modelling, actions to date and need for an increase in substantive capacity

Actions
- Compliance action plan in place & recovery currently set for October 2018;
- Exploring options to increase outpatient and theatre capacity with three session days and additional weekend working

A&E 4 hour target compliance



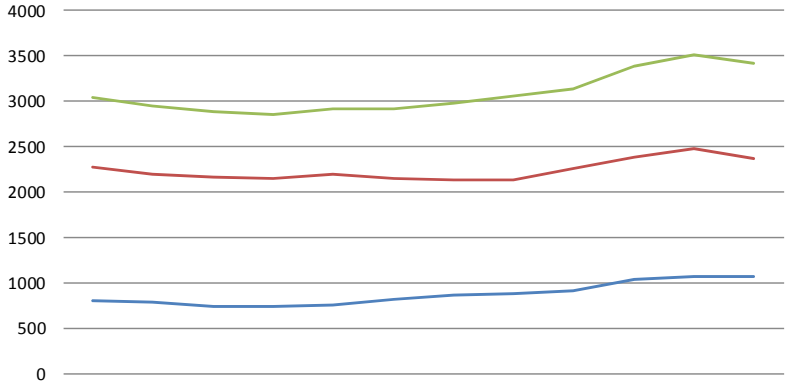
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	90.1%	93.7%	90.3%	90.0%	90.5%	88.4%	87.0%	81.0%	85.0%	75.9%	72.8%	79.3%
2016/17	85.5%	88.9%	88.9%	90.7%	88.6%	91.2%	86.6%	86.1%	79.3%	76.4%	77.7%	
Target	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%	95%

Issues
- Bed availability & demand issues main reasons for failure.
- ED Attendances 3.2% decrease on 2016
- ED command and control function requires improvement

Actions
- Continue to focus on System Recovery Plan and red-green day actions
- Preparing an ED Strategy workshop and revised future leadership model & ECIP supported ED “Superweek” in April 17.

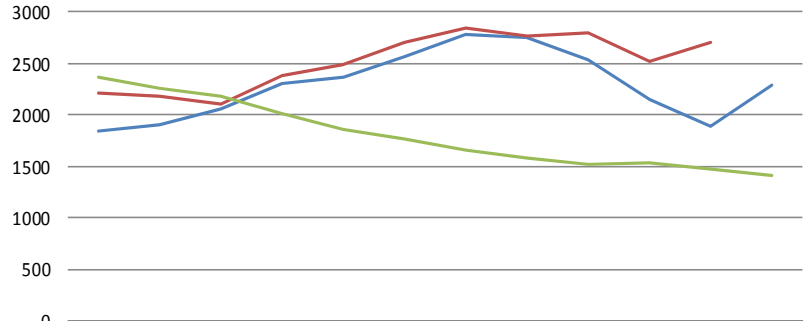
Core Slide 22 — Performance (RTT) – Lead Director Richard Parker

Admitted Backlog



	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Admitted IP Backlog	795	780	741	735	750	813	861	880	912	1036	1067	1072
Admitted DC Backlog	2267	2192	2167	2139	2194	2144	2130	2138	2260	2378	2467	2368
Admitted Backlog	3039	2940	2887	2843	2912	2915	2976	3060	3133	3386	3504	3416

Incomplete Non Admitted Backlog



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	1840	1903	2051	2305	2363	2568	2782	2752	2540	2153	1887	2285
2016/17	2214	2176	2106	2376	2482	2705	2850	2762	2790	2517	2705	
Target	2360	2262	2182	2008	1854	1766	1658	1581	1515	1529	1469	1413

Issues
- Capacity concerns remain across most surgical specialities
- Insourcing for General Surgery is having a positive impact

Actions
- Develop speciality specific plans to increase capacity
- Develop plan to replace high cost insourcing work with internal solution in General Surgery
- Exploring insourcing for ENT
- Significant programme underway to extend weekday & weekend working hours

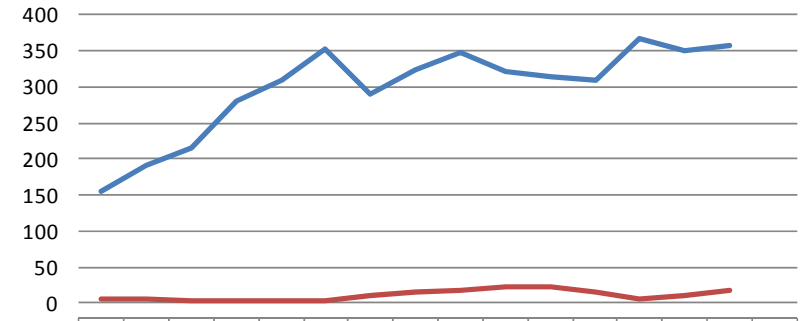
Issues
- Capacity issues across a wide range of services as reported elsewhere

Actions
- Additional OP capacity across all specialities in progress
- Targeted validation of waiting lists in place

Additional Slide 22a

Performance (RTT) – Lead Director Richard Parker

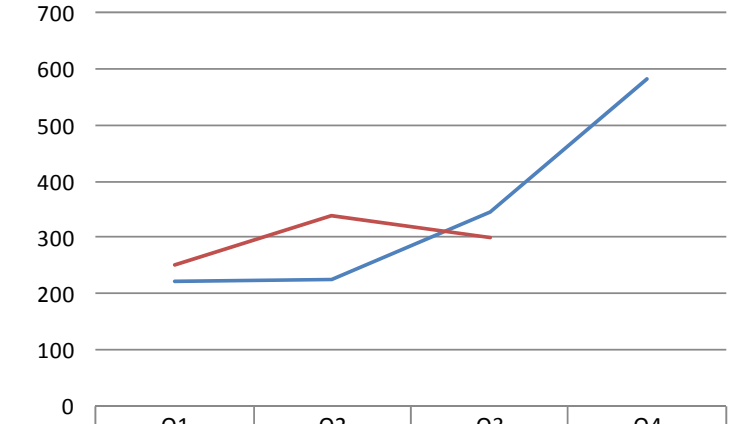
Long Waiters - Over 40 and 52 weeks



	Dec 15	Jan 16	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	Mar 17
40+ Weeks	156	190	215	279	308	352	289	324	348	321	313	309	367	351	358	
52+ Weeks	6	7	4	4	4	4	10	15	19	23	22	15	6	10	19	

40+ Weeks 52+ Weeks

Cancelled Operations



	Q1	Q2	Q3	Q4
2015/16	220	225	345	581
2016/17	251	337	300	

2015/16 2016/17

Comments

- Proactive management of long-wait patients commended by the elective IST
- Significant reduction in 52-week risk patients through additional IRU weekend working
- Significant reduction in General Surgery 52-week risks anticipated through insourcing actions
- ENT remains the most significant area of challenge – system wide ENT meeting not attended by neighbouring Trusts, reallocating lists internally and exploring insourcing

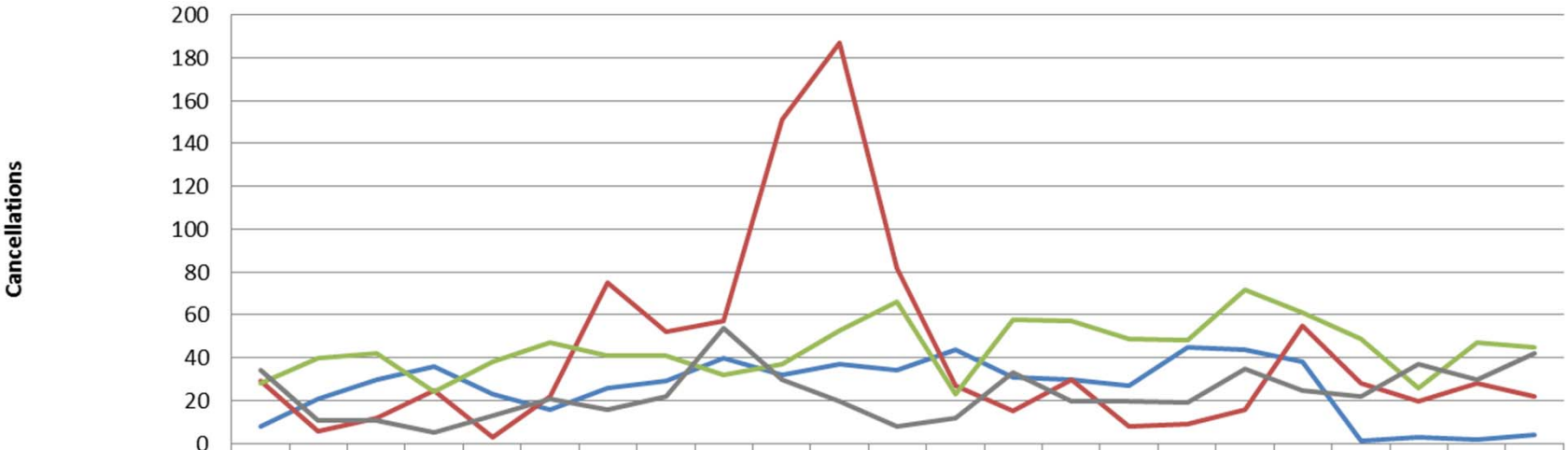
Comments

- Increased usage of DPU, with flexible bed booking and extended opening hours has prevented the increased winter bed cancellations normally seen.

Additional Slide 22b

Performance (RTT) – Lead Director Richard Parker

Cancelled Operations - Reasons



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
	2015									2016												2017	
Admin Reasons	8	21	30	36	23	16	26	29	40	32	37	34	44	31	30	27	45	44	38	1	3	2	4
Bed Shortage	29	6	12	25	3	22	75	52	57	151	187	82	27	15	30	8	9	16	55	28	20	28	22
No OP Time	28	40	42	24	38	47	41	41	32	37	53	66	23	58	57	49	48	72	61	49	26	47	45
Other	34	11	11	5	13	21	16	22	54	30	20	8	12	33	20	20	19	35	25	22	37	30	42

Reasons for cancellations (01 April 2015 to date)

- Lack of Theatre Time – 35.30%
- Bed Shortages – 32.95%
- Administrative Reasons – 16.59%
- Other – 15.15%

Comments

Increased usage of DPU, with flexible bed booking and extended opening hours has prevented the increased winter bed cancellations normally seen.

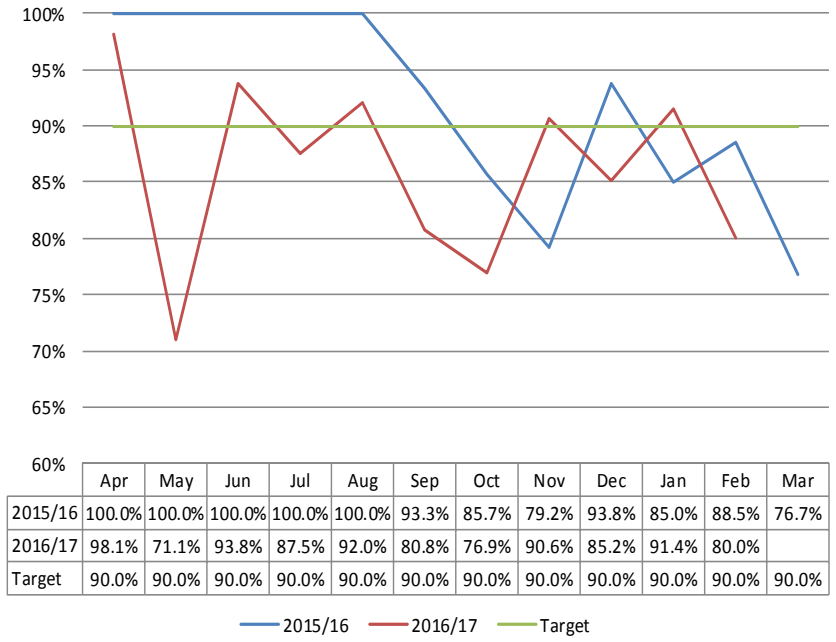
Our Vision
To provide every patient with the care we want for those we love the most

Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

Core Slide 23

Performance (Stroke) – Lead Director Richard Parker

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

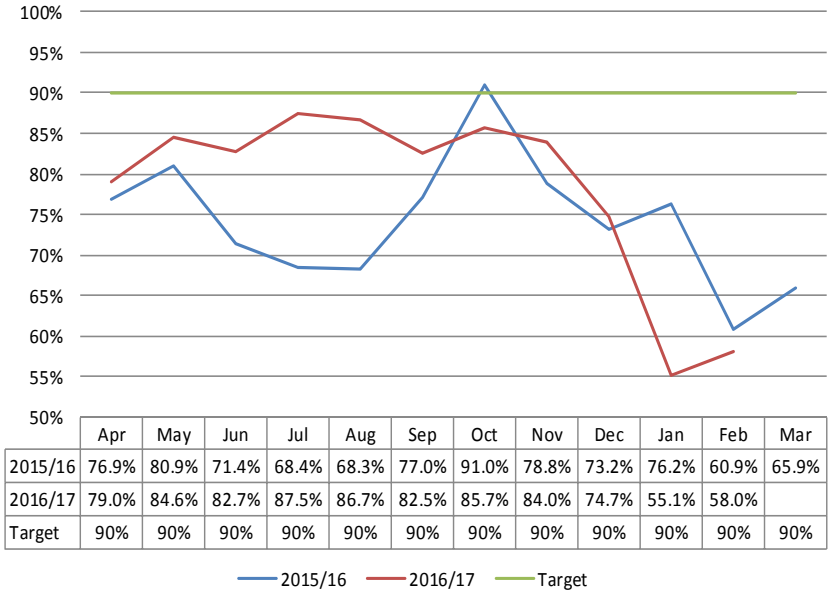


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	100.0%	100.0%	100.0%	100.0%	100.0%	93.3%	85.7%	79.2%	93.8%	85.0%	88.5%	76.7%
2016/17	98.1%	71.1%	93.8%	87.5%	92.0%	80.8%	76.9%	90.6%	85.2%	91.4%	80.0%	
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%

Issues

- **5 Breaches** –due to lack of Doppler availability

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	76.9%	80.9%	71.4%	68.4%	68.3%	77.0%	91.0%	78.8%	73.2%	76.2%	60.9%	65.9%
2016/17	79.0%	84.6%	82.7%	87.5%	86.7%	82.5%	85.7%	84.0%	74.7%	55.1%	58.0%	
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

Issues
30 breaches-

- 27 x No beds available on Heydon Ward
- 1 x stroke team busy with multiple patients in A&E
- 1 x Not diagnosed as stroke by stroke team
- 1 x Patient referred to Neurology by AMU, patient never seen by stroke team

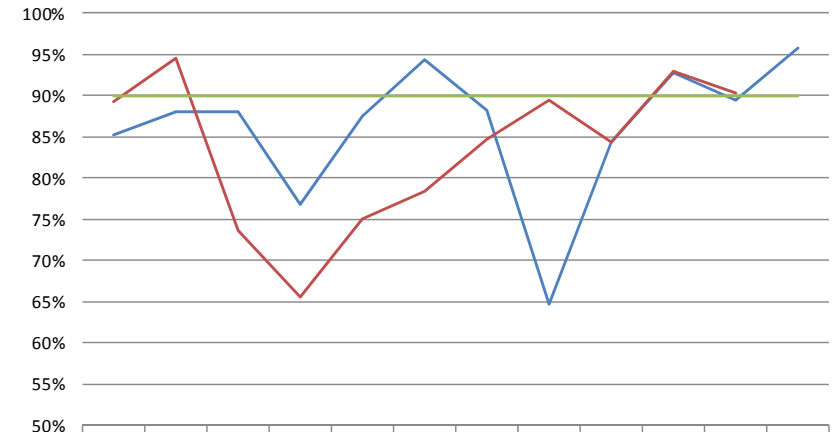
Actions

- Ensure ring-fenced Stroke bed is protected to ensure admission pathway is maintained.
- Red-to-Green launched in Stroke to help bed flow / occupancy

Core Slide 24

Performance (Stroke) – Lead Director Richard Parker

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	85.2%	88.1%	88.1%	76.7%	87.5%	94.3%	88.2%	64.7%	84.4%	92.7%	89.5%	95.8%
2016/17	89.3%	94.4%	73.7%	65.5%	75.0%	78.3%	84.6%	89.5%	84.4%	93.0%	90.2%	
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

Issues
Performance standard achieved
4 Breaches –

- 1 x CT Perfusion scan not available in time, required as unknown onset time
- 1 x Stroke team busy with 2 thrombolysis patients
- 1 x Patient referred to Neurology by AMU, patient never seen by stroke team
- 1x CT busy with another patient

Actions

- Continue to communicate with ED & Radiology

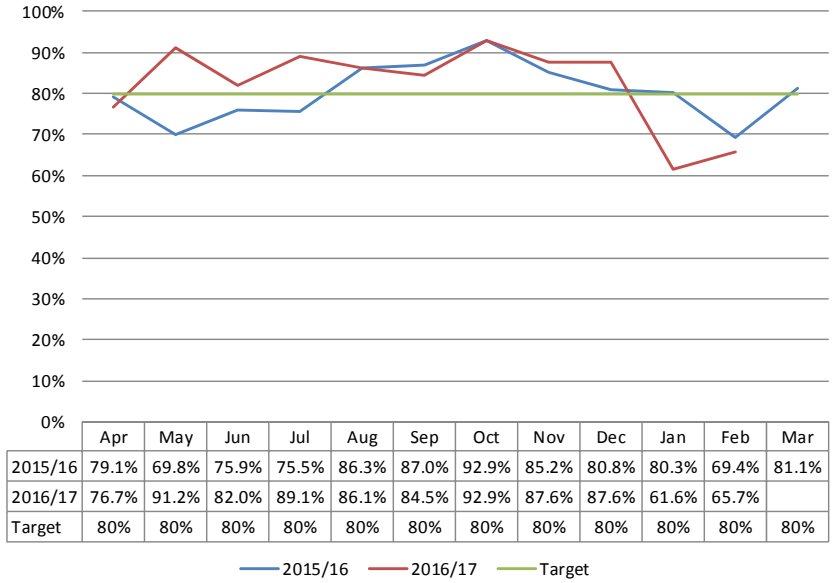
Our Vision
To provide every patient with the care we want for those we love the most

Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

Additional Slide 24a

Performance (Stroke) – Lead Director Richard Parker

Percentage of patients with 90% of their length of stay on the stroke unit



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	79.1%	69.8%	75.9%	75.5%	86.3%	87.0%	92.9%	85.2%	80.8%	80.3%	69.4%	81.1%
2016/17	76.7%	91.2%	82.0%	89.1%	86.1%	84.5%	92.9%	87.6%	87.6%	61.6%	65.7%	
Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%

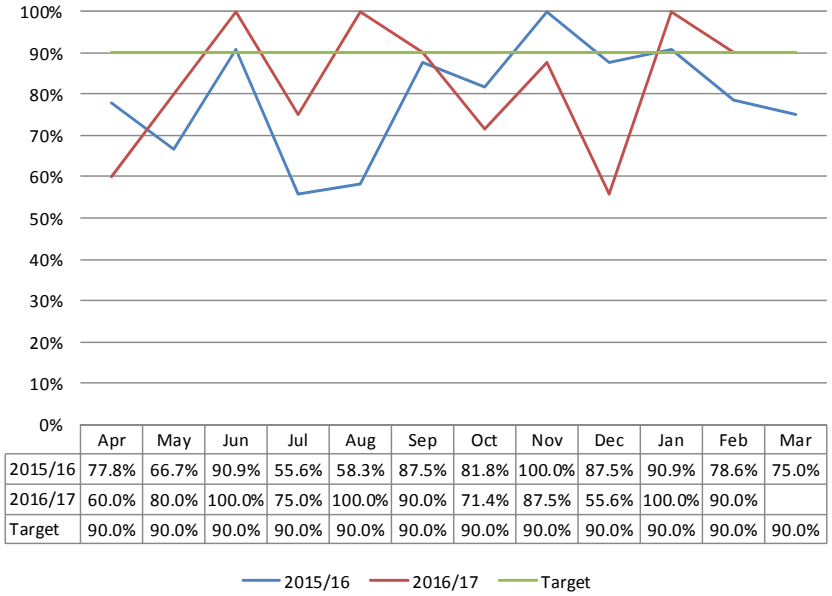
30 breaches-

- 27 x No beds available on Heydon Ward
- 1 x Stroke team busy with multiple patients in A&E
- 1 x Not diagnosed as stroke by stroke team
- 1 x Patient referred to Neurology by AMU, patient never seen by stroke team

Actions

- Prioritise direct admission for stroke and no step downs

% Door to needle time of <= 60 minutes for eligible thrombolysis patients



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	77.8%	66.7%	90.9%	55.6%	58.3%	87.5%	81.8%	100.0%	87.5%	90.9%	78.6%	75.0%
2016/17	60.0%	80.0%	100.0%	75.0%	100.0%	90.0%	71.4%	87.5%	55.6%	100.0%	90.0%	
Target	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%	90.0%

1 Breach – CT Perfusion scan not available in time, required as unknown onset time

Actions

- Clinical Team to continue to look at breaches to improve performance

Core Slide 25 Performance (Patient Flow) – Lead Director Richard Parker

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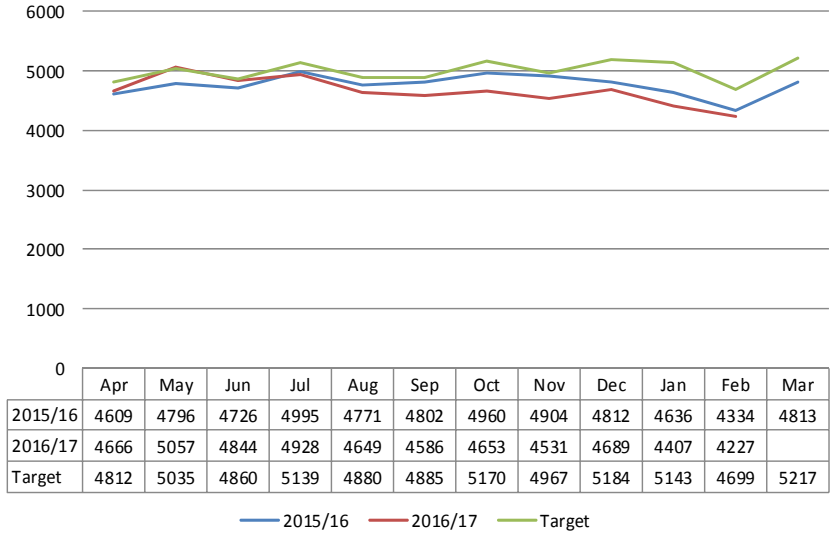
Core Slide 26 Performance (Productivity) Summary – Lead Director Richard Parker

Productivity		Outturn 2015/16	Monthly Target	Feb-17	6 month trend	YTD 2015/16	YTD 2016/17
A&E Activity (attendances)		120062	11534	9228		109414	115817
Emergency Admissions	Core Slide 27	57158	n/a	4227		52345	51237
Outpatient Activity (consultant led & non-consultant led)	Core Slide 27	692747	n/a	57029		632224	658857
Elective Activity - Elective inpatient spells	Core Slide 28	14038	n/a	999		12913	12565
Elective Activity - Day case spells	Core Slide 28	80385	n/a	6831		73363	77956
Theatre Utilisation		75.67%	85.00%	77.00%		75.64%	77.91%

Core Slide 27

Performance (Productivity) – Lead Director Richard Parker

Emergency Admissions



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	4609	4796	4726	4995	4771	4802	4960	4904	4812	4636	4334	4813
2016/17	4666	5057	4844	4928	4649	4586	4653	4531	4689	4407	4227	
Target	4812	5035	4860	5139	4880	4885	5170	4967	5184	5143	4699	5217

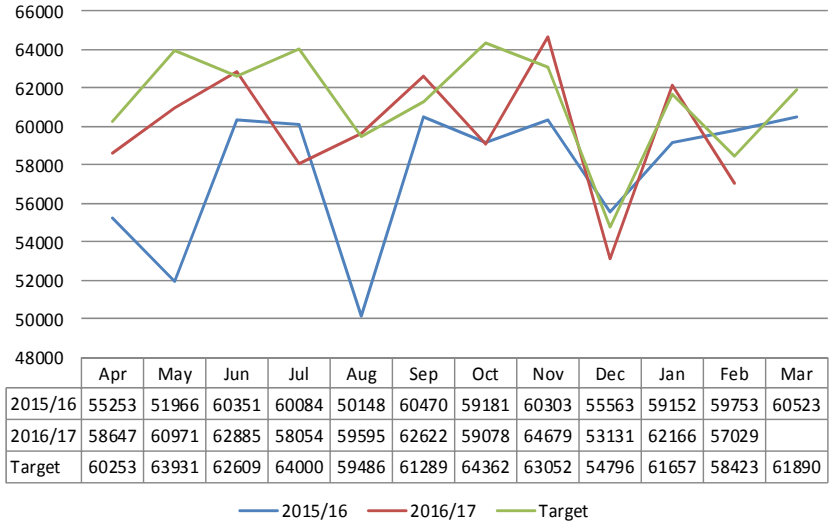
Issues

- 3.3% decrease in ED attendances.
- Number of emergency admissions reduced by 2.4% on February 2016.
- Conversion rate of ED attendance to admission was 25.3%: an increase of 0.5% on February 2016

Actions

Continue to focus on Ambulatory Emergency Care and introduce extended short stay pathways and revised medical bed model.

Outpatient Activity (consultant led & non-consultant led)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	55253	51966	60351	60084	50148	60470	59181	60303	55563	59152	59753	60523
2016/17	58647	60971	62885	58054	59595	62622	59078	64679	53131	62166	57029	
Target	60253	63931	62609	64000	59486	61289	64362	63052	54796	61657	58423	61890

Issues

- Activity graphs do not reflect 15/16 vs 16/17 working day / leap year effect
- **Average OPD 2,845 per day in 2016 vs 2851 in 2017**

Actions

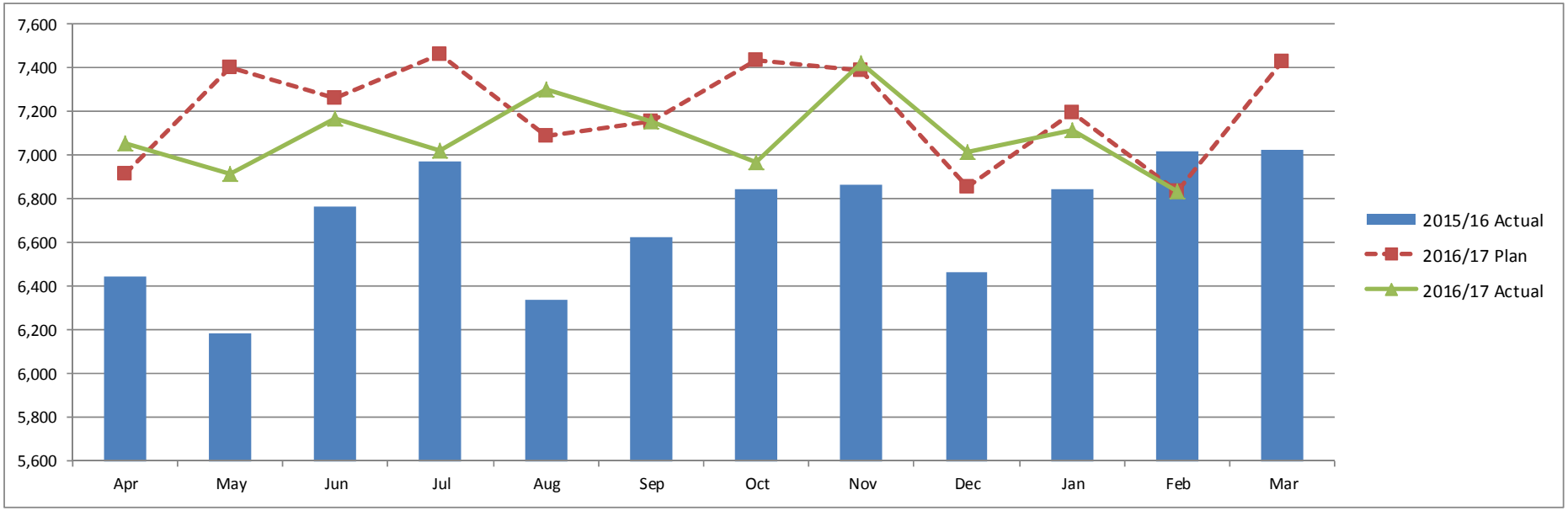
- Improved OPD utilisation tool in development
- Targeted actions to decrease DNA rates and re-allocate poorly utilized clinics
- 3-session day working programme being rolled out for OPD

Core Slide 28

Performance (Productivity) – Lead Director Richard Parker

Activity
2015/16 vs 2016/17 YTD
Daycase (excluding Lucentis, including reclassified RDAs from October onwards)

Activity	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Full Year
2015/16 Actual	6,447	6,183	6,764	6,970	6,338	6,627	6,841	6,862	6,465	6,847	7,019	7,022	**73,363**	**80,385**
2016/17 Plan	6,917	7,401	7,259	7,461	7,091	7,152	7,435	7,386	6,853	7,192	6,836	7,425	**78,983**	**86,408**
2016/17 Actual	7,052	6,914	7,169	7,022	7,299	7,154	6,970	7,419	7,013	7,113	6,831		**77,956**	**77,956**
Variance to 2015/16	605	731	405	52	961	527	129	557	548	266	(188)		**4,593**	**4,593**
Variance to 2015/16 %	9.4%	11.8%	6.0%	0.7%	15.2%	8.0%	1.9%	8.1%	8.5%	3.9%	-2.7%		**6.26%**	
Variance to Plan	135	(487)	(90)	(439)	208	2	(465)	33	160	(79)	(5)		**(1,027)**	**(1,027)**
Variance to Plan %	2.0%	-6.6%	-1.2%	-5.9%	2.9%	0.0%	-6.3%	0.4%	2.3%	-1.1%	-0.1%		**-1.30%**	



Issues

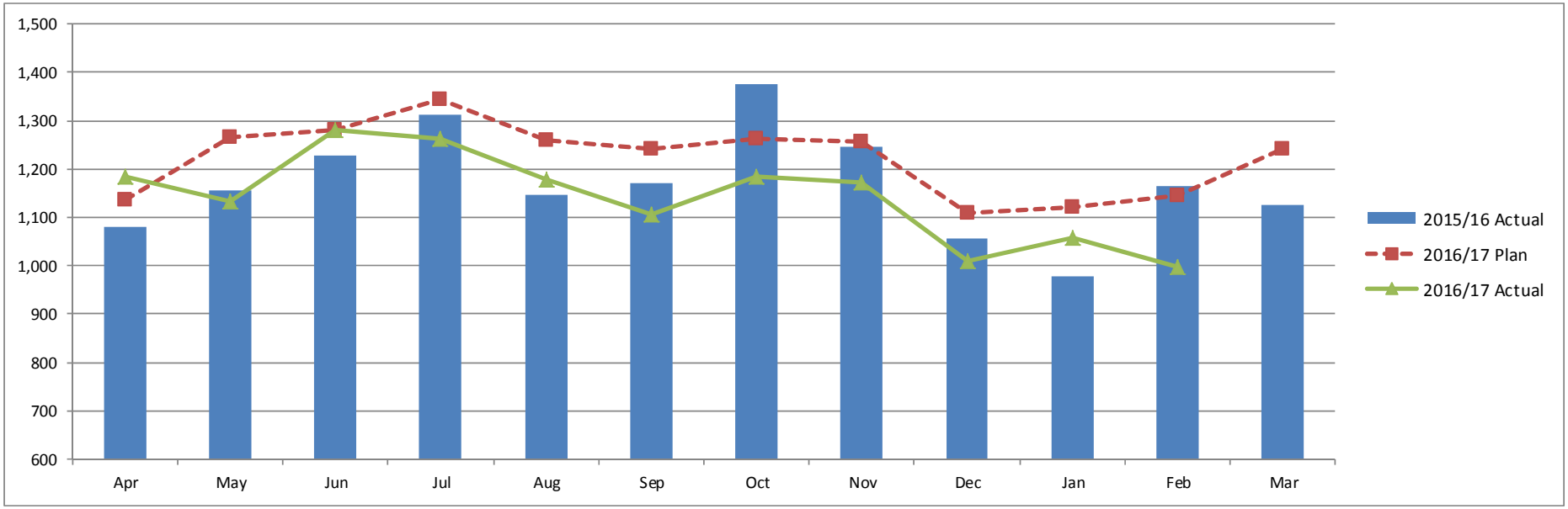
- Activity graphs do not reflect 15/16 vs 16/17 working day / leap year effect
- **Average Day-case rate 334 per day in Feb 2016 vs 342 in Feb 2017**
- Day-case activity slightly behind 16/1q7 plan but 3.8% ahead of 15/16 actual
- Continued ring-fencing of DPU for surgical activity is expected to enable plan-or-better performance in March

Additional Slide 28a

Performance (Productivity) – Lead Director Richard Parker

Activity
2015/16 vs 2016/17 YTD
Elective Inpatient

Activity	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Full Year
2015/16 Actual	1,080	1,157	1,228	1,312	1,146	1,170	1,376	1,246	1,057	977	1,164	1,125	**12,913**	**14,038**
2016/17 Plan	1,136	1,266	1,282	1,343	1,260	1,241	1,264	1,257	1,110	1,121	1,146	1,241	**13,424**	**14,666**
2016/17 Actual	1,184	1,134	1,280	1,263	1,177	1,107	1,184	1,171	1,009	1,057	999		**12,565**	**12,565**
Variance to 2015/16	104	(23)	52	(49)	31	(63)	(192)	(75)	(48)	80	(165)		**(348)**	**(348)**
Variance to 2015/16 %	9.6%	-2.0%	4.2%	-3.7%	2.7%	-5.4%	-14.0%	-6.0%	-4.5%	8.2%	-14.2%		**-2.69%**	
Variance to Plan	48	(132)	(2)	(80)	(83)	(134)	(80)	(86)	(101)	(64)	(147)		**(859)**	**(859)**
Variance to Plan %	4.3%	-10.4%	-0.1%	-5.9%	-6.6%	-10.8%	-6.3%	-6.8%	-9.1%	-5.7%	-12.8%		**-6.66%**	



Issues

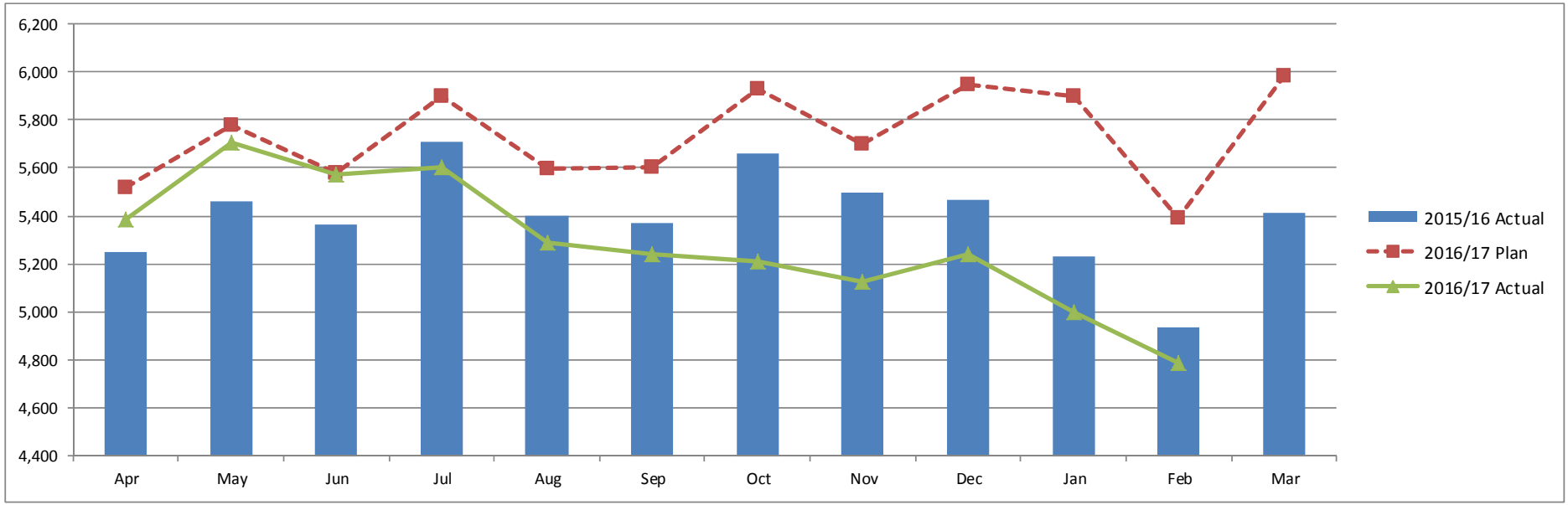
- Activity graphs do not reflect 15/16 vs 16/17 working day / leap year effect but still show a decrease on 2016 – predominantly due to 1) a shift to day-case work / clearance & 2) complexity of case mix (income 4% under plan (£120k) vs 12.8% activity under-performance)
- **Average electives 55 per day in Feb 2016 vs 50 per day in Feb 2017**

Additional Slide 28b

Performance (Productivity) – Lead Director Richard Parker

Activity
2015/16 vs 2016/17 YTD
Non Elective (excluding impact of marginal rate)

Activity	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Full Year
2015/16 Actual	5,248	5,459	5,365	5,708	5,402	5,373	5,661	5,498	5,467	5,229	4,933	5,412	**59,343**	**64,755**
2016/17 Plan	5,521	5,776	5,576	5,896	5,599	5,605	5,931	5,698	5,947	5,900	5,392	5,985	**62,841**	**68,826**
2016/17 Actual	5,385	5,703	5,572	5,602	5,289	5,240	5,212	5,128	5,240	4,998	4,788		**58,157**	**58,157**
Variance to 2015/16	137	244	207	(106)	(113)	(133)	(449)	(370)	(227)	(231)	(145)		**(1,186)**	
Variance to 2015/16 %	2.6%	4.5%	3.9%	-1.9%	-2.1%	-2.5%	-7.9%	-6.7%	-4.2%	-4.4%	-2.9%		**-2.00%**	
Variance to Plan	(136)	(73)	(4)	(294)	(310)	(365)	(719)	(570)	(707)	(902)	(604)		**(4,684)**	**(4,684)**
Variance to Plan %	-2.5%	-1.3%	-0.1%	-5.0%	-5.5%	-6.5%	-12.1%	-10.0%	-11.9%	-15.3%	-11.2%		**-7.45%**	



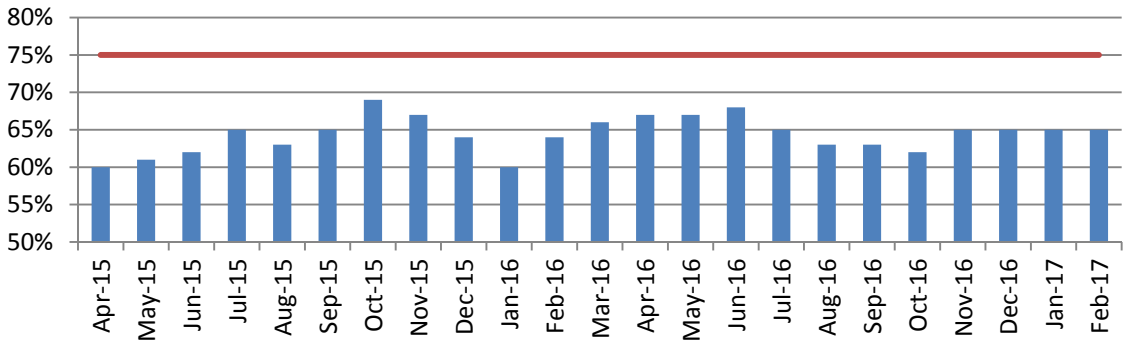
Issues

- Further reductions in non-elective activity reflect work undertaken to convert admissions to Ambulatory Emergency Care (AEC) attendances
- This reduction is emergency admissions has enabled both the reduction in cancellations and increase in day-case activity

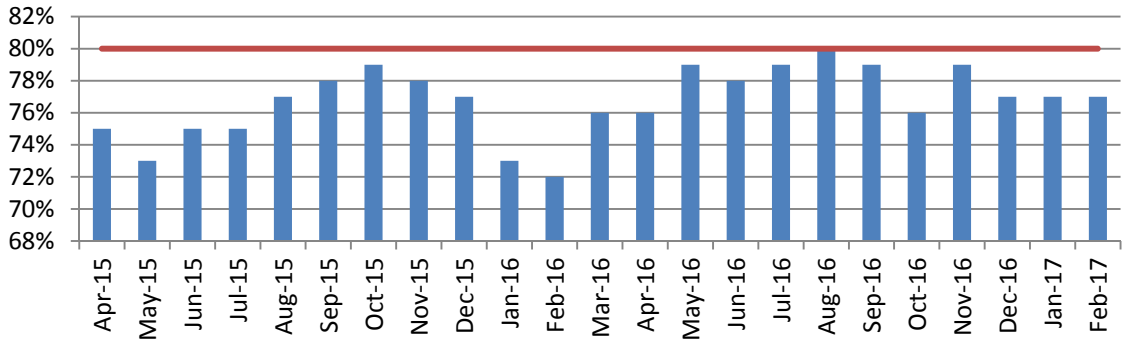
Additional Slide 28c

Theatre Utilisation – Lead Director Richard Parker

DPU Utilisation



Main Theatre Utilisation



Comment

- Theatre Utilisation improvement (against previous year) reflects reduced cancellations
- Internal utilisation improvement programme running plus NNUH have been selected for the Four-Eye / NHSI sponsored programme to further help in this area.
- Next steps local are:

- Working day / team restructure
- 6-3-2 Challenge to allocate unused theatres earlier (& so improve booking efficiency)
- Excellence Together programme targeting T&O, Gen Surg & Gynae

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Core Slide 29

Workforce Summary – Lead Director Jeremy Over

Workforce		Outturn 2015/16	Monthly Target	Feb-17	6 month trend	YTD 2015/16	YTD 2016/17
Payroll							
1 Budgeted WTE*		6819	n/a	7194		6811	7194
2 Actual WTE*		6266	n/a	6484		6278	6484
3 Vacancy maximum (%)		8.12%	10.00%	9.86%		7.82%	9.86%
Pay Spend							
4 Pay spend - % employed (%)*		85.80%	n/a	90.46%		86.10%	87.29%
5 Pay spend - % bank (%)*		2.34%	n/a	2.94%		2.32%	2.80%
6 Pay spend - % agency (%)*		5.42%	n/a	2.48%		5.37%	4.11%
7 Pay Spend - % Medical Locum (%)*		4.06%	n/a	2.43%		3.82%	3.92%
Staffing Numbers	Core Slide 37						
8 % of registered nurse day hours filled as planned		93.31%	0.00%	92.17%		93.33%	93.40%
9 % of unregistered care staff day hours filled as planned		105.22%	0.00%	120.53%		104.94%	115.41%
10 % of registered nurse night hours filled as planned		90.91%	0.00%	92.58%		91.04%	93.44%
11 % of unregistered care staff night hours filled as planned		113.76%	0.00%	132.21%		113.50%	128.24%
12 RGN % Actual to planned		92.27%	0.00%	92.35%		92.34%	93.42%
13 HCA % Actual to planned		108.67%	0.00%	125.41%		108.40%	120.64%
Other							
14 Non-Medical Appraisals completed	Core Slide 33	57.97%	80.00%	62.11%		57.87%	60.90%
15 Staff Turnover rate	Core Slide 34	10.63%	10.00%	10.85%		10.65%	10.70%
16 Mandatory Training	Core Slide 34	76.43%	90.00%	77.09%		76.87%	75.54%
17 Sickness levels**	Core Slide 35	4.28%	3.50%	4.49%		4.24%	4.17%
Staff Survey							
18 Staff FFT – recommendation of NNUH as a place to receive care	Core Slide 36	TBC	n/a	TBC		TBC	TBC
19 Staff FFT – recommendation of NNUH as a place to work	Core Slide 36	TBC	n/a	TBC		TBC	TBC
* Please note these figures are provisional							
** Reported one month in arrears							

Core Slide 30

Workforce – Lead Director Emma McKay

Nurse Staffing ('Red Flags')

The common themes across all red flags are level of vacancies, impact of sickness absence and inability to provide specials due to patient acuity.

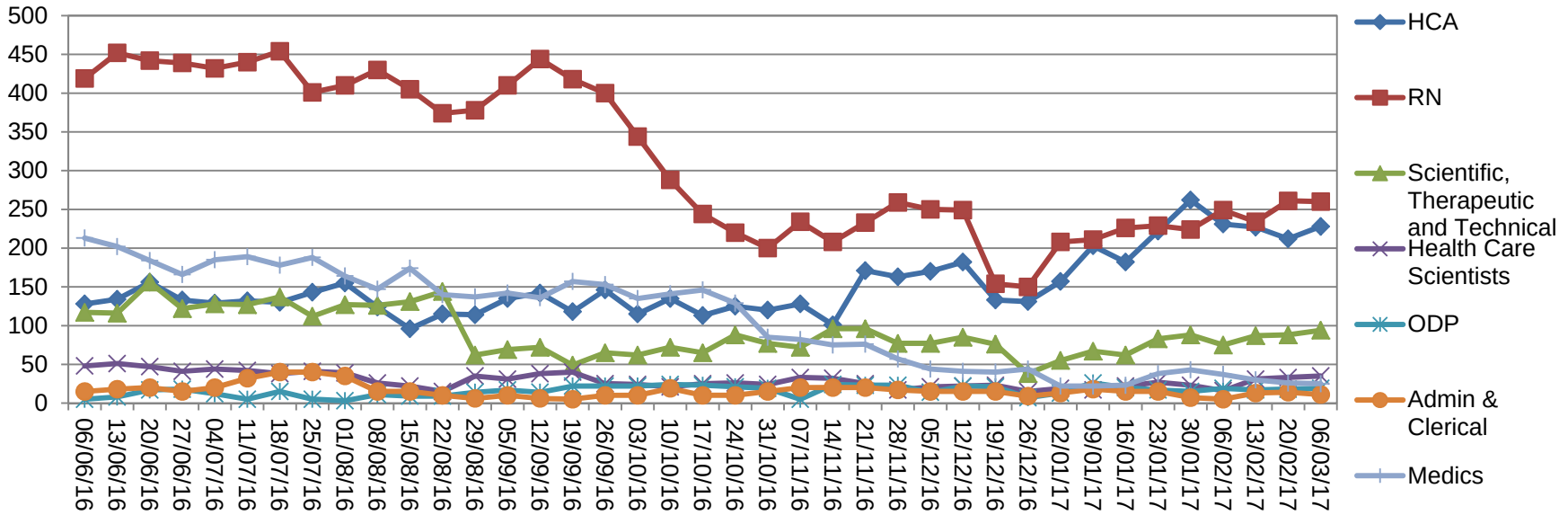
The following actions are being taken:

- Recruitment: influx of newly-qualified staff between September and January equating to circa 120 new joiners.
- Engagement with the international recruitment market for registered nurses continues.
- Daily evaluation of staffing allocations by the operations centre with flexible deployment of staff to address specific vacant shifts
- Growth of the NNUH staff bank to increase fill rate of vacant shifts with our own staff, supported by financial incentives, which have been further tailored from January.

	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	
Medicine	357	374	219	256	295	409	331	534	352	495	656	482	
Surgery	727	531	487	591	591	748	478	511	305	452	601	340	
Women and Children	102	77	82	75	49	110	99	61	83	83	147	115	
Maternity	373	245	62	510	510	123	362	189	315	297	294	398	

Core Slide 31 — Workforce - Lead Director Jeremy Over

Agency and Locum Shifts Booked



Issues

- Demand for agency staff has remained broadly stable in February.
- The reduction in demand and impact of agency price cap compliance since October has led to significantly reduced agency expenditure.
- In turn, this has contributed to the favourable position in terms of total pay expenditure versus plan (£290k favourable; 1.1% compared to plan).
- Overall volumes of booked shifts are around 50% lower than the peak seen in June 2016.
- Controls continue to be effective and responsive to situations where temporary workers are absolutely required based on clinical need.
- The Finance section of the IPR details the expenditure for the month.

Actions

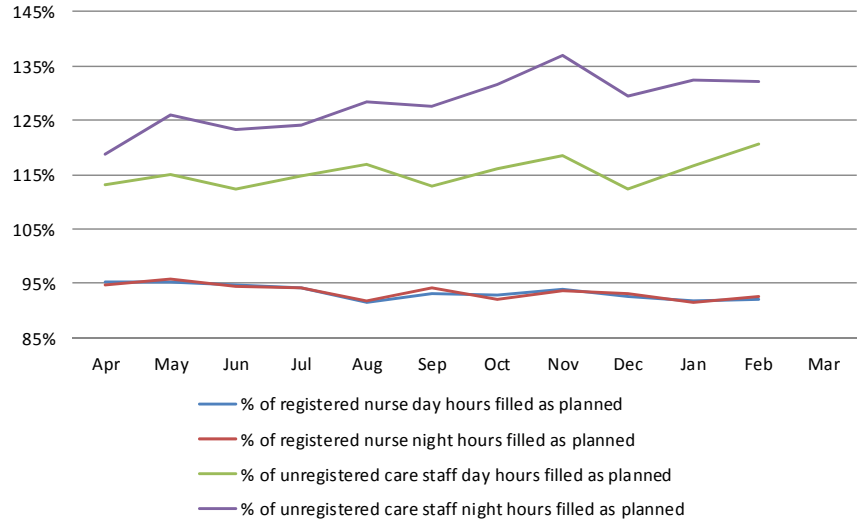
NNUH has an overarching work programme addressing expenditure on 'Premium Pay' activity, with:

- Weekly price cap compliance is now at 79% (compared to c.0% in September
- Break glass arrangements only for exceptional safety grounds (with executive level sign off).
- Pre-authorisation checklist and daily scrutiny by Medical Director for all locum requests has been very effective.
- Recruitment Oversight Group is in operation and applies controls and assists with speedy recruitment.
- Bank incentives are embedding.
- NHSI and EoE Procurement Hub are encouraging other Trusts to learn from our approach.

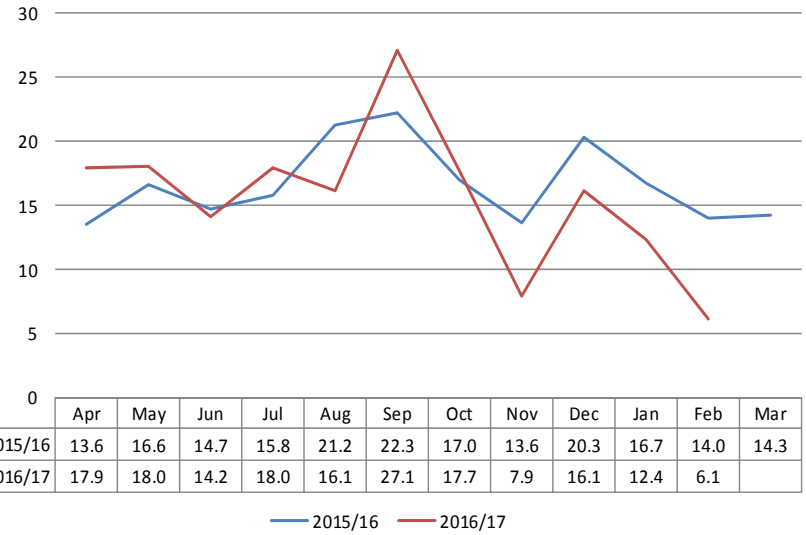
Core Slide 32

Workforce - Lead Director Jeremy Over

Ward Nursing fill-rate Analysis



Turnover - Registered Nursing and Midwives



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	13.6	16.6	14.7	15.8	21.2	22.3	17.0	13.6	20.3	16.7	14.0	14.3
2016/17	17.9	18.0	14.2	18.0	16.1	27.1	17.7	7.9	16.1	12.4	6.1	

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 Premium Pay activity in respect of the scrutiny on agency usage and agency rates is being closely monitored by senior Nurses, Managers and HR through the Workforce CIP meeting and Workforce Sub Board.
- Core Slide 37 confirms growth in substantive workforce

Issues

- The number of Registered Nurses and Midwives leavers in February (6.1 WTE) is the lowest number of leavers recorded in the past two years. This shows a decrease from January (13.0 WTE) and a significant reduction from the peak in September 2016 (27.1 WTE).

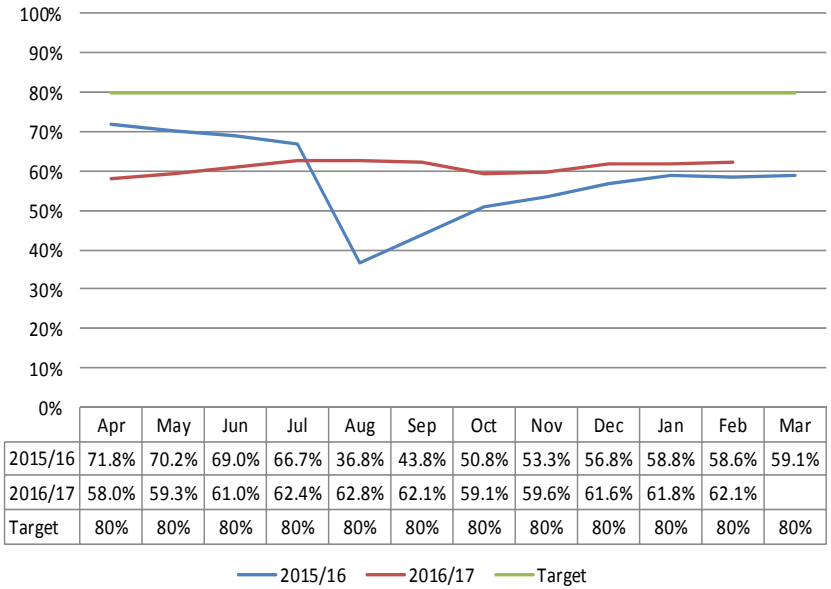
Actions

- Senior nurses are encouraging wards managers to retain experienced and valued staff.
- The Staff Experience Working Group has a sub-group which is reviewing/ exploring retention issues.

Core Slide 33

Workforce - Lead Director Jeremy Over

Non-Medical Appraisals completed



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	71.8%	70.2%	69.0%	66.7%	36.8%	43.8%	50.8%	53.3%	56.8%	58.8%	58.6%	59.1%
2016/17	58.0%	59.3%	61.0%	62.4%	62.8%	62.1%	59.1%	59.6%	61.6%	61.8%	62.1%	
Target	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%	80%

Non-Medical Appraisal Completion	Eligible for Appraisal	Current Appraisal	Completion %
Trust	5590	3472	62.1%
by Division			
Medicine	1673	878	52.5%
Surgery	1550	1026	66.2%
Women & Children	584	437	74.8%
Clinical Support Services	1221	825	67.6%
Corporate	562	306	54.4%
Nursing & Education	143	73	51.0%
Research & Development	98	56	57.1%
Resources	144	63	43.8%
Strategy & Planning	48	36	75.0%
Workforce	103	73	70.9%
by Staff Group			
Add. Prof. Scientific and Technical	317	210	66.2%
Additional Clinical Services	1110	715	64.4%
Administrative and Clerical	1414	784	55.4%
Allied Health Professionals	411	266	64.7%
Estates and Ancillary	144	61	42.4%
Healthcare Scientists	214	147	68.7%
Nursing and Midwifery Registered	1980	1289	65.1%

Issues

- In the last 12 months, 3,472 appraisals have been undertaken within timescales.
- This equates to 62.1% of all staff having had an appraisal within the preceding year.
- The NHS Staff Survey results for 2016 suggests that 83% of our staff have responded that they have been appraised in the last 12 months (up from 77% in 2015). Also, the survey reports an increase in the quality of appraisals from 2015 to 2016 (the 'rating' increasing from 2.84 to 2.91 of a scale of 1-5). These figures will include medical appraisal, compliance with which is at 96%.

Actions

- Appraisal rates are discussed with divisions at monthly performance committee meetings.
- The CEO and Executive Directors continue to stress the importance of the appraisal experience.
- The importance of appraisal is a feature PRIDE Values in Action plans and our PRIDE values and behaviours are included within appraisal conversations.

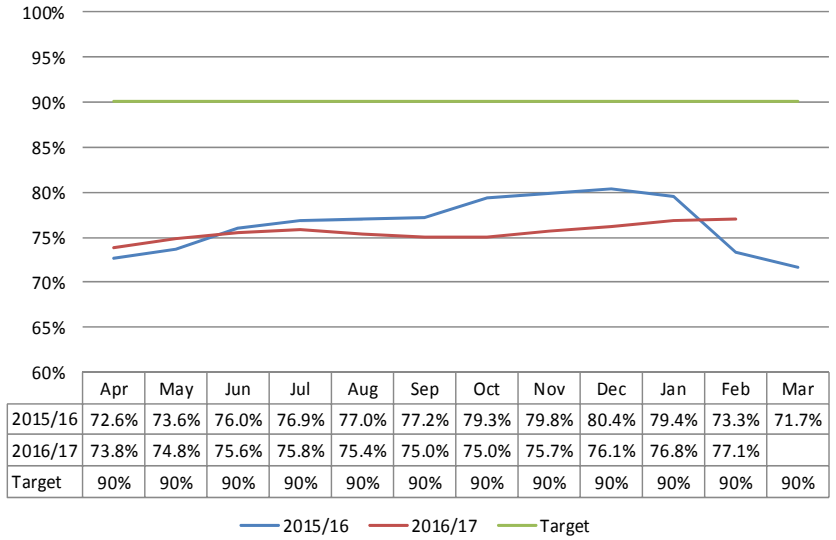
Our Vision
To provide every patient with the care we want for those we love the most

Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

Core Slide 34

Workforce - Lead Director Jeremy Over

Mandatory Training

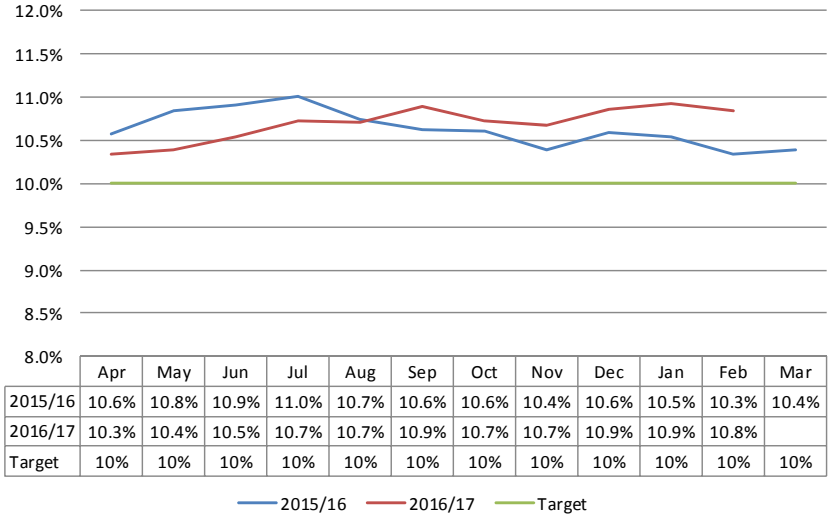


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	72.6%	73.6%	76.0%	76.9%	77.0%	77.2%	79.3%	79.8%	80.4%	79.4%	73.3%	71.7%
2016/17	73.8%	74.8%	75.6%	75.8%	75.4%	75.0%	75.0%	75.7%	76.1%	76.8%	77.1%	
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

Issues
- The overall compliance rate has risen to 77.1%.
- This is the highest rate in since January 2016 and is the 5th consecutive month-on-month increase.

Actions
- Divisional level mandatory training rates are discussed at executive performance committee.
- The Head of OD & Learning is leading on a project to address the capacity and system constraints that need to be overcome in order to enable greater take-up of mandatory training.
- A review of core mandatory training has been presented to the Workforce Sub Board which provides clarity for essential requirements and new learning requests.

Staff Turnover rate



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	10.6%	10.8%	10.9%	11.0%	10.7%	10.6%	10.6%	10.4%	10.6%	10.5%	10.3%	10.4%
2016/17	10.3%	10.4%	10.5%	10.7%	10.7%	10.9%	10.7%	10.7%	10.9%	10.9%	10.8%	
Target	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%	10%

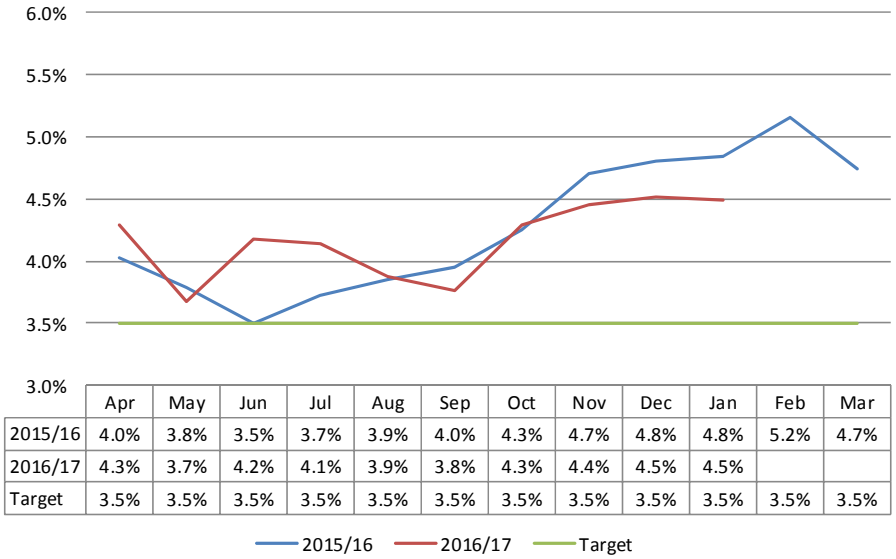
Issues
- The 12-monthly turnover rate remains consistent at 10.8%.
- The actual numbers of leavers in February was 26.8 (WTE) and the monthly turnover rate 0.5%.
- This is the lowest monthly turnover rate in two years.

Actions
- The newly-formed Staff Experience Working Group has established a working group to focus on turnover.
- Retention is a feature in discussions with senior nurses as part of overall approach to resourcing.
- Of the known reasons for leaving, approximately two-thirds continue to be for retirement or promotion/relocation-related reasons.

Core Slide 35

Workforce - Lead Director Jeremy Over

Sickness levels**



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	4.0%	3.8%	3.5%	3.7%	3.9%	4.0%	4.3%	4.7%	4.8%	4.8%	5.2%	4.7%
2016/17	4.3%	3.7%	4.2%	4.1%	3.9%	3.8%	4.3%	4.4%	4.5%	4.5%		
Target	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%

** Reported one month in arrears

Issues

- The sickness figure for January is 4.49%.
- Promisingly, for the past six months (from August 2016), the monthly sickness figure has been either at, or less than, the corresponding months in 2015/16.
- Expectations are that sickness levels will be lower Q4 than the corresponding period 12 months ago.
- 'Medium-term' (8-28 days) sickness accounts for just 15-20% of all absences, which suggests that it is a forerunner to longer-term absences.
- For data accuracy and reliability purposes, sickness figures are reported one-month in arrears.

Actions

- Sickness is discussed in detail at divisional Performance Committees.
- HRBPs continue to work with divisional management teams to support appropriate interventions and reinforcing the 'Know Your Staff' message, underpinned by trust, relationships, engagement and empowerment.
- The critical message remains the need for supportive interventions within the first week of absence, in order to minimise absences becoming 'certified'. This is because evidence suggests that, where staff are off sick for more than one week, they are likely to be absent longer term (between 1-3 months).

Core Slide 36

Workforce - Lead Director Jeremy Over

Friends and Family Scores

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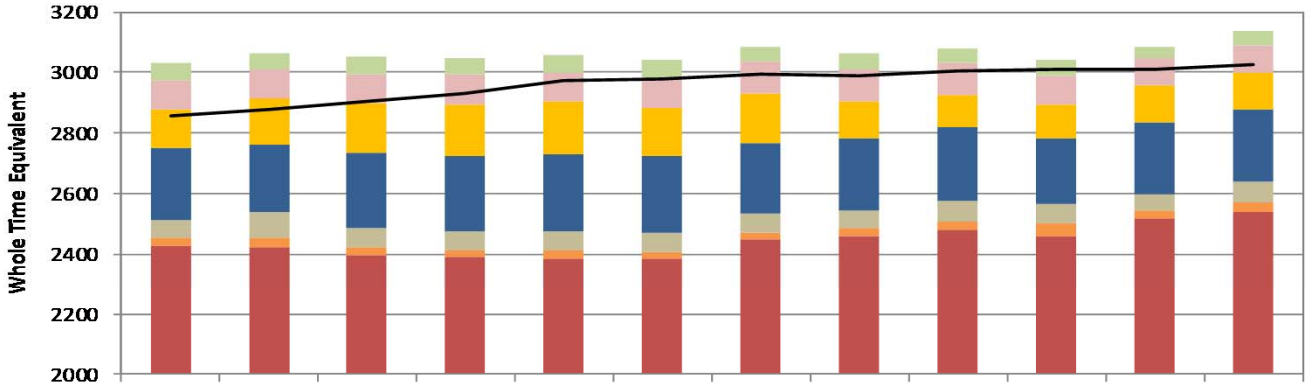
Core Slide 37

Workforce - Lead Director Jeremy Over

Registered & Unregistered Nursing Workforce Metrics (all areas)



	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Establishment	2857.9	2876.1	2906.6	2930.7	2972.1	2980.8	2992.9	2991.4	3003.3	3010.2	3010.8	3028.6
Resourcing - surplus(+) gap(-)	+175.6	+185.2	+147.8	+118.4	+86.8	+62.9	+93.0	+69.9	+76.1	+33.3	+73.5	+109.5
SIP - Long Term Sick*1	61.6	52.0	59.0	56.2	57.4	64.8	51.8	53.5	49.4	53.7	38.8	48.8
SIP - Maternity & Other*2	93.9	92.6	98.0	97.4	96.8	94.6	104.7	105.9	104.0	96.3	87.8	87.4
Agency*3	124.7	153.3	161.7	173.2	175.0	162.1	161.4	120.0	104.9	112.1	120.0	124.1
Bank*3	241.5	222.5	249.1	244.3	254.3	253.9	236.7	238.1	247.5	214.8	242.9	239.1
Overtime*3	55.7	87.4	65.0	64.0	64.2	63.9	61.5	59.3	64.4	62.7	50.7	66.4
Excess Hours*3	28.5	28.6	24.0	20.6	23.8	19.6	21.7	24.5	27.2	41.9	24.5	32.9
'Attending' Staff in Post *4	2427.7	2425.0	2397.5	2393.6	2387.5	2385.0	2448.1	2460.1	2482.1	2462.0	2519.5	2539.6
Staff in Post (SIP)	2583.1	2569.5	2554.6	2547.2	2541.7	2544.3	2604.6	2619.5	2635.4	2612.0	2646.2	2675.8
'Vacancy' level interpretations												
Establishment less SIP	274.7	306.6	352.0	383.6	430.5	436.5	388.3	371.9	367.9	398.2	364.7	352.9
Establishment less attending SIP	430.2	451.1	509.1	537.2	584.6	595.9	544.8	531.3	521.2	548.2	491.3	489.0

*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 13/3/2017, Staff in post from ESR 14/3/2017, Bank & Agency from e-Roster 3/3/2017, OT & excess hours from Finance 7/3/2017

- This analysis reflects nursing workforce data incorporating equivalent figures for employed, bank, agency, overtime and excess hours.
- This data also reflects the impact of the Premium Pay activities in reducing agency volume
- The actual numbers of staff in post is at its highest ever level, reflecting growth in the workforce.
- Despite vacancies, temporary resources are supplementing the workforce.

Additional Slide 37a – Workforce – supplementary briefing

National Staff Survey

- The 2016 national staff survey was undertaken during October-November. The survey period closed at the beginning of December.
- Results have been published and will be presented to the Board at its meeting on 31 March.
- The sharing of results internally continues with good coverage thus far through CEO Viewpoint and the associated all-staff briefing, Management Board, our four divisions, and with staff representatives.
- The NNUH response rate was 46% with over 3,000 responses.
- The executive and divisions have agreed to bring detailed conclusions and actions together at management board on 11 April.

Workplace Health & Well-being Business Plan

- NNUH has a large and well-respected occupational health service provision which is marketed externally to NHS, other public sector bodies and private sector employers.
- Commercial income this year is on plan to achieve £1m, which ensures that the service provided to the 8,000 staff and volunteers at NNUH is funded at virtually nil cost to us.
- Further growth of this service will move us into net profit, with the potential to fund additional services for NNUH staff
- A business plan has been developed and agreed to take forward this work in 2017/18.

Mandatory Training review

- As part of our ongoing programme of assurance and delivery in terms of core skills, the Head of Learning & OD has led an overarching review of our mandatory training requirements and provision with the aim of simplifying and streamlining the framework
- Training leads have agreed proposed changes to certain training strands which will be presented to management board in April for approval

IR35 changes and associated NHSI requirements

- The NNUH Workforce Team has led a review of our compliance with IR35 changes which are active from April and relate to the use of off-payroll workers in the public sector
- In recent years NNUH has used a minimal number of management interims and the changes are not deemed to pose a significant risk for us
- NHSI has required that Trusts seek approval of all off-payroll interims prior to engagement, regardless of whether they are deemed in or out of scope for IR35
- Within correspondence addressing IR35 issues, the Chief Executive of NHSI has also set the principle that staff employed substantively within the NHS should not be working elsewhere via an agency, rather this work should be contracted and remunerated through staff banks.

Weekly Pay

- The NNUH workforce team has been working with our payroll supplier to implement a weekly payment cycle for our bank workers. This will go live from April. It is anticipated that this will further improve the attractiveness of bank work within our hospital.

CORE SLIDE 38

Finance Summary – Lead Director - James Norman

	Full Year Plan 16/17	Feb-17 Actual	YTD Actual	YTD Plan	Variance from YTD Plan
Total income excluding interest	£565,288k	£45,278k	£515,020k	£516,527k	(£1,507k)
Total Pay Costs	£319,866k	£26,007k	£291,962k	£293,630k	£1,668k
Other Operating Expenditure (excluding drugs)	£155,745k	£12,552k	£143,877k	£143,070k	(£807k)
EBITDA	£18,408k	£1,000k	£14,139k	£14,515k	(£376k)
CIP Savings Achieved 'Overall'	£24,897k	£3,475k	£21,875k	£21,820k	£55k
Pay CIP Savings Achieved	£11,957k	£1,661k	£10,877k	£10,519k	£358k
Non-Pay CIP Savings Achieved	£6,053k	£976k	£5,124k	£5,335k	(£211k)
Revenue CIP Savings Achieved	£4,598k	£557k	£3,464k	£3,825k	(£361k)
Closing Cash balance	£1,778k	£2,232k	£2,232k	£994k	£1,238k
Capital expenditure	£21,517k	£23k	£11,133k	£17,167k	(£6,034k)
Non-Elective Activity - marginal rate - Financial Impact	£7,756k	£645k	£7,046k	£7,081k	£35k
Emergency readmissions penalties: Following Elective & Non Elective	£2,125k	£87k	£1,696k	£1,941k	£245k
Use of Resources Metric (UoR)	4		3	3	
Deficit for the year	(£25,032k)	(£2,613k)	(£25,220k)	(£25,222k)	£2k
Forecast - Full Year	(£25,032k)				

M11 YTD & Discreet

- Clinical income is cumulatively £7.1m (1.8%) behind plan, mainly due to non-electives, outpatients and cost & volume activity being lower than plan.
- Other income is favourable to plan which in part offsets non recurrent costs over plan, with the remainder being the result of a balance sheet prudence review.
- Operating expenditure – Pay costs were underspent in month (£289k) which reflects the continued impact of tightened controls over premium pay. Cumulatively, Pay is underspent by £1,668k. Clinical Supplies were underspent in month (£183k) & remain underspent in the YTD (£346k). Non-Clinical Supplies were overspent in month (£66k), the YTD overspend is £1,276k.
- The M11 Pay underspend of £289k compares to underspends in the previous three months - M8 (£399k under), M9 (£258k under), M10 (£234k under).
- The CIP plan of £21.8m to date has been met with an overachievement overall of £55k.

Risks

- CCG challenge risks remain – at @ £0.5m full year.
- CQUIN under-delivery is being provided for to cover an updated 'most likely' risk of £1.26m full year. This has been provided in full at M11.
- Penalties – an update will be provided at the meeting. No provision for any unexpected charges has been made in the I&E nor in the cash flow.

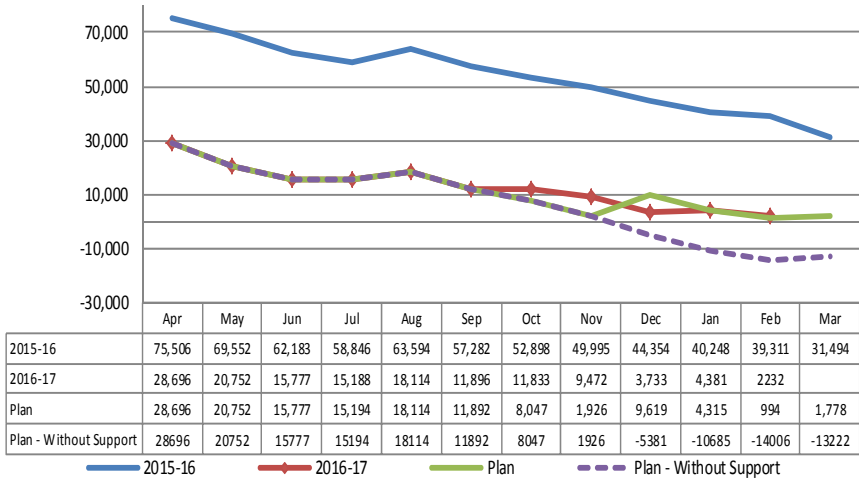
Cash

- Cash at end M11 was £2.2m – being better than plan. The original plan assumed receipt of £15m working capital in September which has not been required as a result of the work performed on cash management. The improvement results from a reduction in supplier payment runs and negotiated improvements on timing of cash inflows from CCGs.
- We have submitted the details required to secure £16m of funds for mid-March 2017. This will crystallise a saving of £1.2m in interest charges as we have now exited FSM

CORE SLIDE 39

Lead director – James Norman

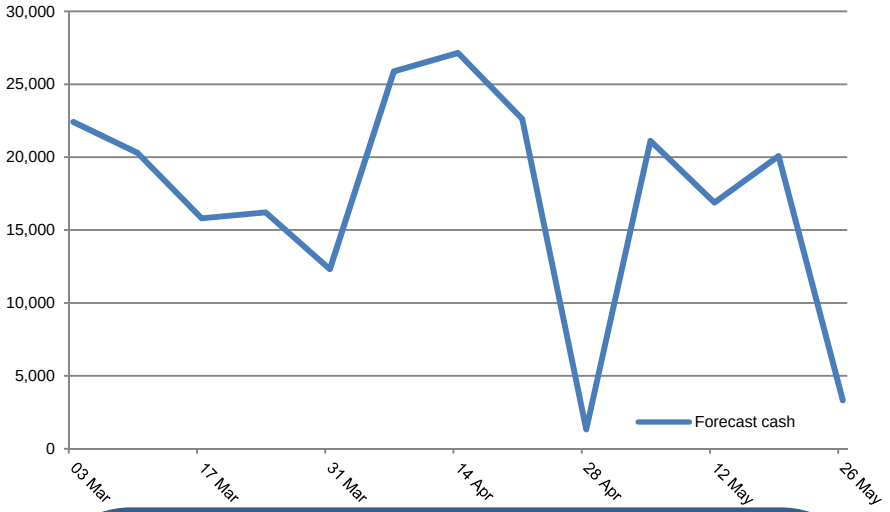
Closing Cash balance



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015-16	75,506	69,552	62,183	58,846	63,594	57,282	52,898	49,995	44,354	40,248	39,311	31,494
2016-17	28,696	20,752	15,777	15,188	18,114	11,896	11,833	9,472	3,733	4,381	2232	
Plan	28,696	20,752	15,777	15,194	18,114	11,892	8,047	1,926	9,619	4,315	994	1,778
Plan - Without Support	28696	20752	15777	15194	18114	11892	8047	1926	-5381	-10685	-14006	-13222

- Closing cash at the end of M11 was £2.2m - better than forecast plan.
- The forecast is updated on a weekly basis. The required working capital draw down has moved out to the week ending 24th March from end February.
- This was again facilitated by earlier receipt of CCG payments for activity, cost controls and close supplier payment management.
- Cash will be required in March 2017 and a draw down of £16m has been requested.
- NHSI have confirmed that the applicable interest rate for us is now 3.5%. Our cash management has successfully avoided incurring rates of 6% on any draw downs.
- The rolling 13 week cash flow forecast is Appendix 4 to the financial appendices.

Rolling week cash flow forecast

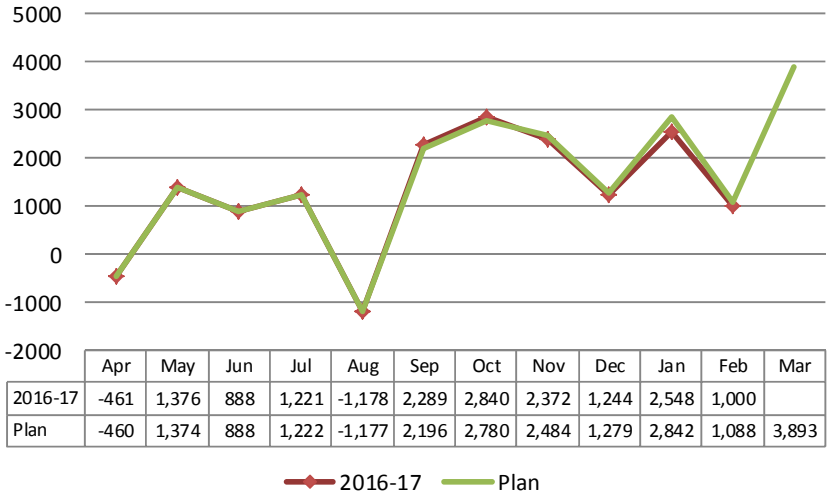


- Pattern of income and expenditure demonstrates pinch point weeks within a monthly 'period'.
- We have reduced the number of pay runs to one per week and agreed earlier receipt date for our clinical income from CCGs.
- A formal agreement for a working capital facility is in place with the DH for a maximum of £21.233m.
- **Risks include**; ***(i) timing*** - clinical income over-performance being withheld by CCGs pending queries, other NHS bodies implementing similar strategies & delaying payment to the NNUH and ***(ii) amount*** – penalties, CQUINs and Commissioner QIPPs.

CORE SLIDE 40

Lead director – James Norman

EBITDA



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016-17	-461	1,376	888	1,221	-1,178	2,289	2,840	2,372	1,244	2,548	1,000	
Plan	-460	1,374	888	1,222	-1,177	2,196	2,780	2,484	1,279	2,842	1,088	3,893

- At the end of M11, EBITDA is £376k behind plan. This reflects a net of items, key being Clinical Income at £7.1m less than plan mostly mitigated by Other Income being £6.4m better than plan.
- Clinical income movement in month was £1.35m behind plan.

- Focus on forward review of planned activity to inform actions to improve clinical income & productivity.
- We are continuing our work with the divisions to create a culture of sustainable cost containment.

CIP Performance

- The CIPs are assessed monthly on a scheme by scheme basis.
- Planned CIP savings for February were £3.386m. Savings reported for the month totalled £3.475m, a favourable variance of £0.90m.
- Planned CIP savings for the YTD were £21.8m. Savings reported YTD total £21.9m, a favourable variance of £0.055m.
- Plan CIP for the remaining month is £3.1m, if this is achieved we will deliver total savings for the year of £24.9m against a plan of £24.6m.

CIP update

- NHSI have been provided with details of all the CIPs which have been profiled by month into the forecast. These total £24.614m.
- After a review of the CIP plans at the end of Q3, we have a revised plan total of £24.897m for 16/17.
- Savings will be generated in the following areas:

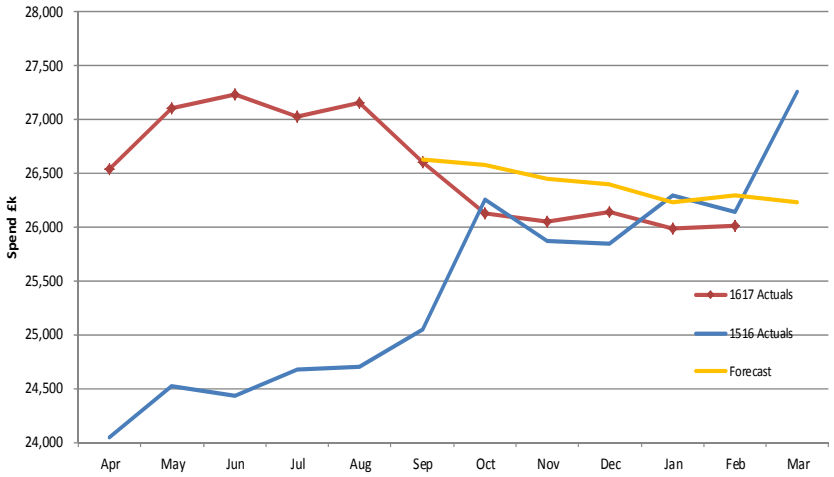
Revenue	£4,599k
Pay	£11,957k
Drugs	£666k
Clinical supplies	£1,413k
Non-clinical supplies	£3,706k
PFI operating expenses	£267k
Other non-opex	£2,289k
Total	**£24,897k**

- A weekly governance process is in place to review and challenge progress.

CORE SLIDE 41

Lead director – James Norman

Pay – Plan & Actual

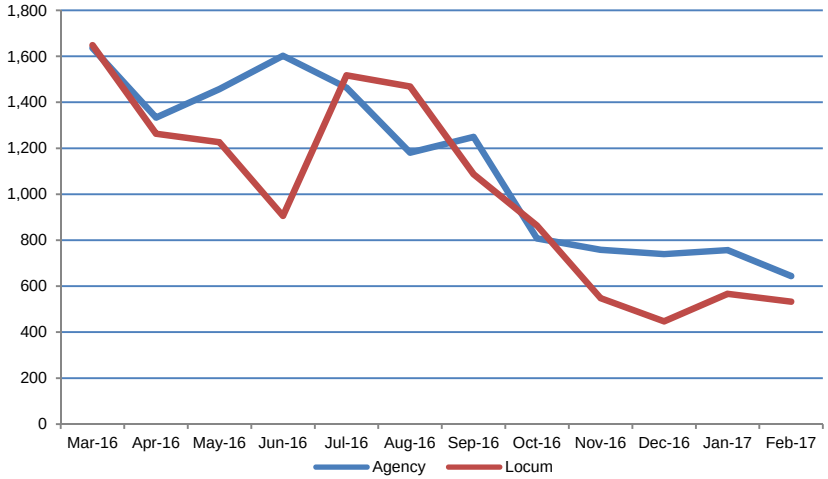


- In February, Pay was under-spent by £289k (1.1%).
- Cumulative Pay expenditure is £292m against a forecast of £293.6m, a favorable variance of £1.7m (0.6%).
- Pay CIP plan for the month was £1,576k, reported savings were £1,661k.

Planned Actions

- Workforce team focusing on premium cost reduction in particular controls over associated spend..
- Focus on recruitment to vacant posts to limit reliance on locums, agency & other premium payroll costs
- Active planning for every locum post to displace and focus on reducing locum agency rates. Nationally the view is there is further to go on Locum costs, with plans to 'correct' the market in train.
- Further development of weekly reports showing shifts booked, allowing more real time scrutiny.

Pay – Locums & Agency (actual) rolling 12 months



- Agency spend in M11 was £644k. The average monthly cost of all agency year to date is £1.1m. Thus M11 is £456k better than monthly average for year to date.
- Agency spend average for previous three months is £741k. Thus M11 is better by £97k than the previous three months average.
- Locum spend in M11 was £532k. The average monthly cost of all locums year to date is £947k. Thus M11 is £415k better than monthly average for the year to date.
- Locum spend average for previous three months is £500k. Thus M11 is worse by £32k than the previous three months average.

- New staffing framework is complete with a list of preferred suppliers at price cap levels.
- 'Break glass' arrangements are possible in exceptional circumstances.
- New RN bank incentives commenced in October.
- Work actively in progress on addressing medical locum agency rates.

CORE SLIDE 42

Lead director – James Norman

Key Risks to Financial Plan

- Capacity risk - failure to deliver planned clinical activity has significant financial consequences. The plan assumes 3% more activity than 2015/16 outturn plus additional to meet targets. The 3% contributes £6.1m to our net position.
- CQUIN risk – c.£9m of clinical income is dependent upon ownership of and tight focus on delivery of the CQUIN measures.
- CCG savings plans risk of £10m. We have assumed that we can mitigate this in full. This is dependent on delivery of a number of projects which require ownership and management.

Securing support funding

- Our going concern assessment is predicated upon receipt of support / distressed funding from the Department of Health.
- The updated cash flow forecast plan assumes £21.2m of revenue support for 2016/17, which has now been formally secured in an agreement 7 March 2017. We have successfully limited our draw against this to £16m for the year, which will reduce interest charges.

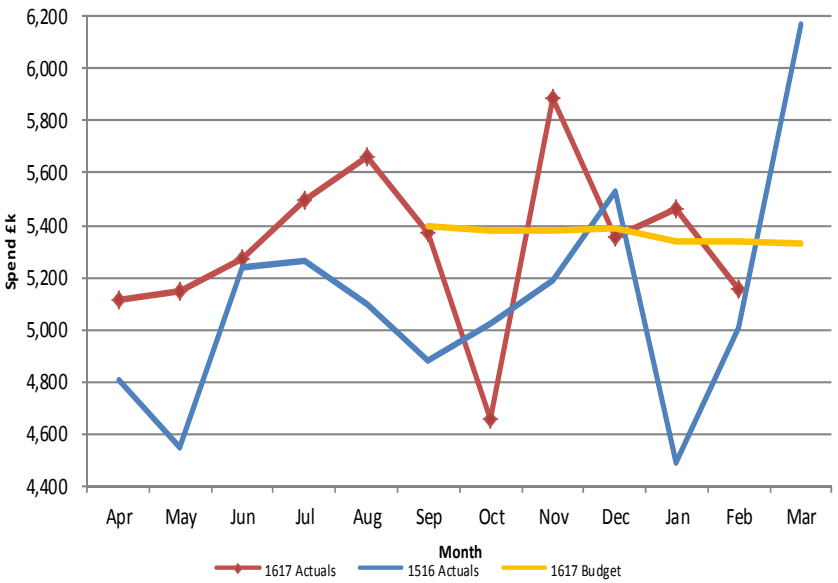
Key Risks to Financial Plan

Risk	Comment/concern
Cash	Cash is reducing as envisaged. This is being actively managed. We have secured an interim revenue support facility of £21.23m, of which £16m will be drawn in March. The agreed interest rate is 3.5% on this 'draw' until it is repaid.
Capacity	Month 11 income is £1.35m behind plan. Cumulatively it is £7.1m behind, after reflecting £1.89m of penalty and CQUIN risk. It is imperative that clinical income is managed back on track in order to deliver the £25m forecast outturn deficit plan agreed with NHSI.
Penalty	Uncertainty exists over the application of penalties, particularly re RTT. Provision has been made for certain penalties – in the sum of £557k cumulatively to M11.
CIP	The CIP plans have been scheduled by individual scheme and are reported on monthly. We are cumulatively overall on plan but there are schemes not delivering and others over delivering. Confidence is growing over delivery of the planned £24.9m in 2016/17.
CQUIN	Evaluation of Q1 is full delivery. The updated assessment of the most likely outturn is a loss of income of £1.2m – this is fully provided at M11. Work continues to ensure that the loss is minimised. Current best case and worst case estimates are losses of £344k and £4.9m respectively.
CCG Challenges	A number of unsettled and unprovided-for challenges remain in the order of £0.5m.

CORE SLIDE 43

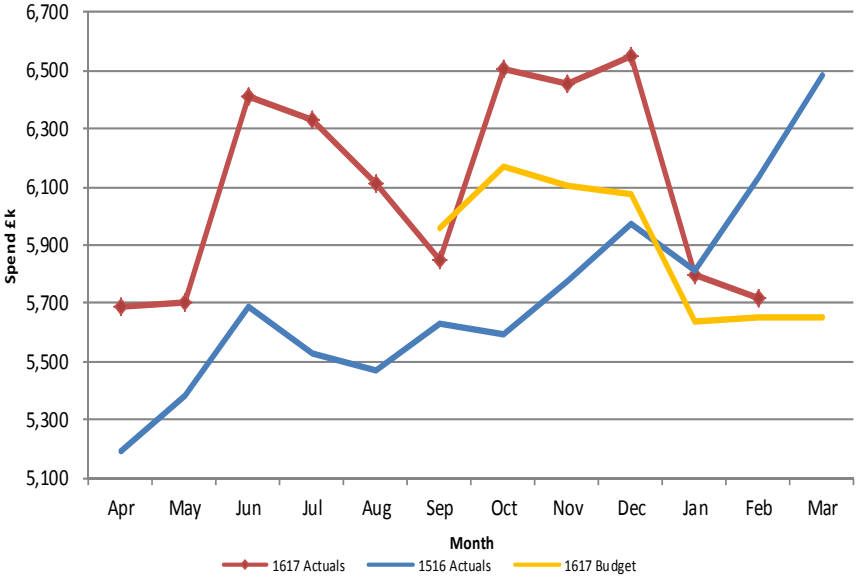
Lead director – James Norman

Clinical Supplies



- M11 was £183k (3.4%) underspent against the plan for the month. Cumulatively, £346k (0.6%) underspent.
- Expenditure in M11 was £5,158k. Average cost in M1-10 has been £5,342k.
- Clinical supplies CIP plan for the month was £337k, reported savings were £359k, a favorable variance of £22k.

Non-Clinical Supplies

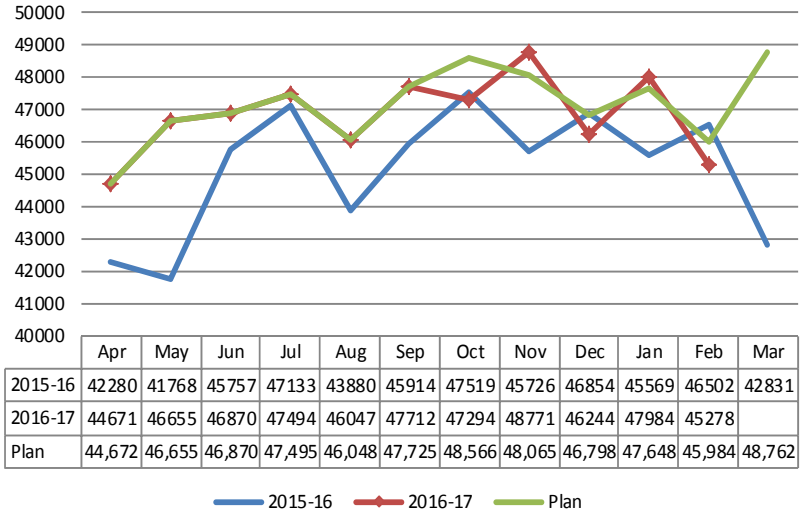


- M11 was £66k (1.2%) overspent against the plan for the month. Cumulatively, £1,276k (1.9%) overspent.
- Some progress can be seen in the Divisions leading on cost containment.
- Non-Clinical supplies CIP reported savings were £456k, which is in line with plan.

CORE SLIDE 44

Lead director – James Norman

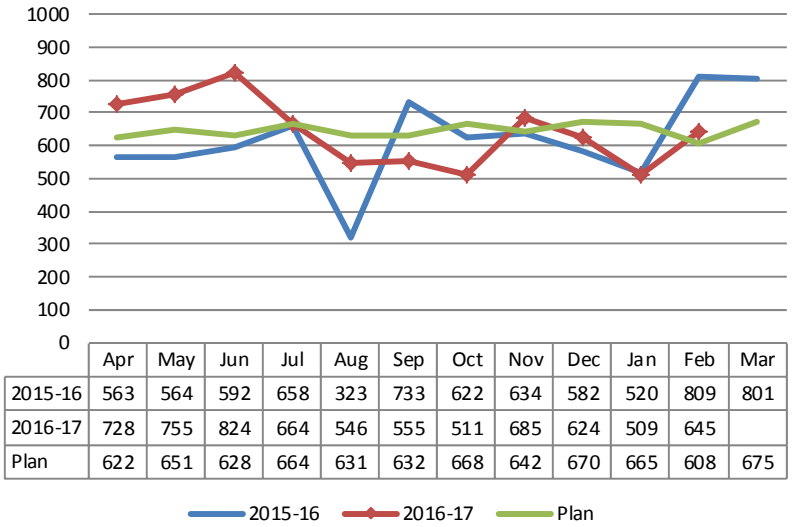
Total income excluding interest



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015-16	42280	41768	45757	47133	43880	45914	47519	45726	46854	45569	46502	42831
2016-17	44671	46655	46870	47494	46047	47712	47294	48771	46244	47984	45278	
Plan	44,672	46,655	46,870	47,495	46,048	47,725	48,566	48,065	46,798	47,648	45,984	48,762

- Total income YTD is £515m, £1.5m behind forecast. Excluding non-tariff drugs, which are largely offset by drug costs, it is £0.9m behind plan.
- Clinical income in M11 is £1.349m behind plan.
- Penalty costs and CQUIN risks have been reflected as a reduction to clinical income. Cumulative total at M11 is £1.89m.
- The ongoing CQUIN and residual CCG QIPP risk needs to continue to be actively managed to minimise income loss.
- Our 'most likely' CQUIN risk is assessed as £1.26m, consistent with our provision. A significant improvement. Work remains focused on improving the delivery of schemes to minimise this further.
- We need to actively manage these remaining risks to achieve the best outcome and certainty for our financial and cash position.

Non-Elective Activity - marginal rate - Financial Impact



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015-16	563	564	592	658	323	733	622	634	582	520	809	801
2016-17	728	755	824	664	546	555	511	685	624	509	645	
Plan	622	651	628	664	631	632	668	642	670	665	608	675

- The reduction in income relating to the marginal rate associated with the volume of non-elective admissions is £7,046k to date. This is £36k better than plan.
- The reduction in income relating to readmissions within 30 days is £1,696k to date. This is £245k better than plan.

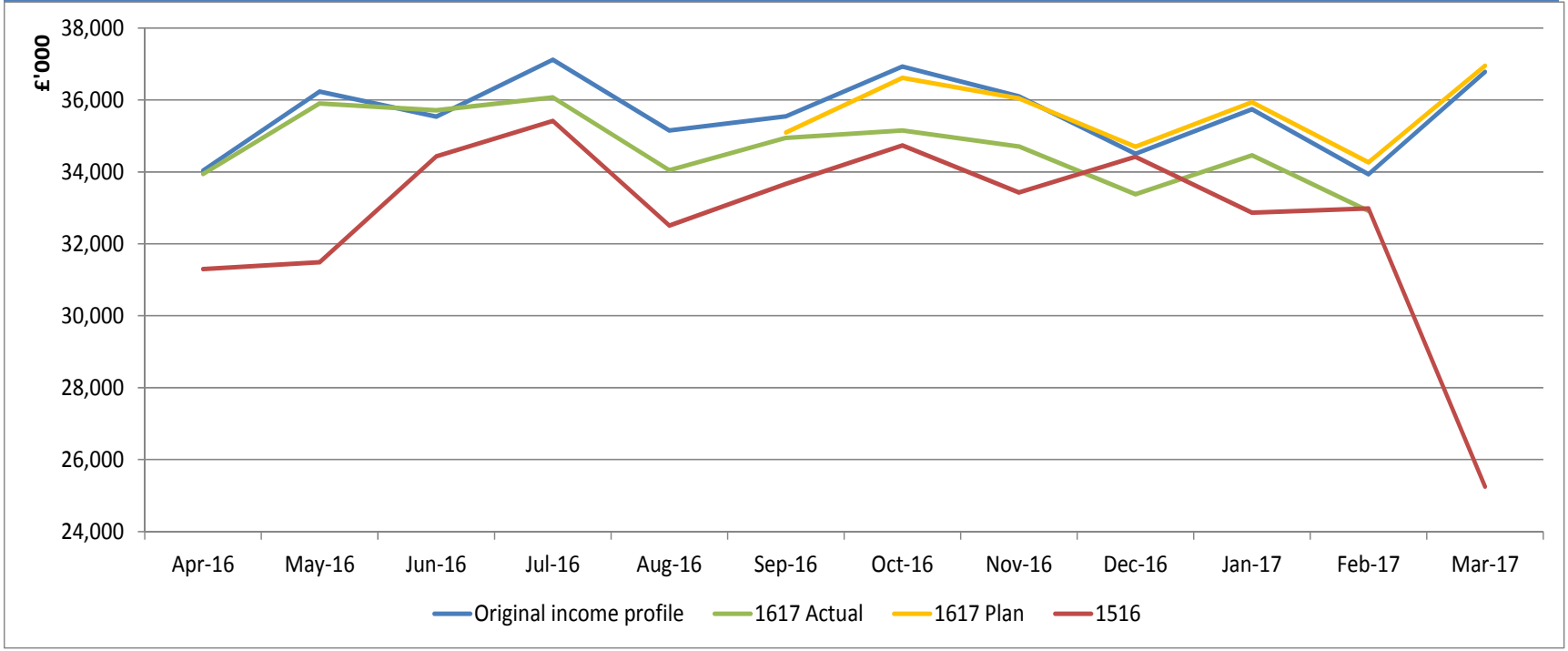
Actions

- Review readmissions to identify patterns, etc. for remedial action.

CORE SLIDE 45

Lead director – James Norman

Clinical Income



- Clinical income plan for the year is £425.3m. This includes assumed CIPs of £1.71m, with £0.405m assumed in M12.
- At M11 the CIP plan for clinical income was £1.3m of which £0.8m has been reported as achieved.
- The key schemes underperforming are 3 session day - £0.18m and Stroke BPT - £0.1m.
- The key schemes at risk for the remaining month are: Theatre productivity - £0.1m, the three session day - £0.1m, and Relocation of the Cardiac Radial Lounge of £0.1m. These represent an ongoing risk to our full year plan.
- We are £7.1m behind the clinical income plan at M11. February income is £1.35m (3.9%) lower than plan.
- The clinical income forecast profile reflects actual and working days.
- CQUIN risk of £1.2m has been provided cumulatively. This is consistent with the updated full year assessment of most likely risk.
- Penalty cost of £557k has been provided cumulatively. Uncertainty remains over penalties for RTT risk in particular.
- Commissioner QIPP / challenges risk has been updated following agreement – remaining risk is @ £0.5m.

Norfolk and Norwich University Hospitals NHS Foundation Trust **Appendix 1**

Income Statement Compared to Forecast Profile

11 month position to 28 February 2017

	Forecast Plan £'000	YT Jan-16 Actual £'000	Year to date Actual £'000	Year to date Forecast Plan £'000	Year to date Variance £'000	Forecast to 31st March 2017 Forecast Forecast £'000	Forecast to 31st March 2017 Forecast Plan £'000	Forecast to 31st March 2017 Forecast Variance £'000
INCOME								
NHS clinical income								
Clinical Income	425,288	367,242	381,229	388,339	(7,110)	418,178	425,288	(7,110)
NT Drugs	60,897	49,756	55,142	55,765	(623)	60,274	60,897	(623)
Total NHS clinical income	**486,185**	**416,998**	**436,371**	**444,104**	**(7,733)**	**478,452**	**486,185**	**(7,733)**
Non NHS clinical income								
Private patients	1,741	1,837	1,536	1,581	(45)	1,696	1,741	(45)
Other - RTA	1,239	1,174	926	1,129	(203)	1,036	1,239	(203)
Total Non NHS clinical income	**2,980**	**3,011**	**2,462**	**2,710**	**(248)**	**2,732**	**2,980**	**(248)**
Other Income								
R&D	22,589	20,672	20,397	20,689	(292)	22,297	22,589	(292)
Education & Training	20,046	17,900	18,680	18,341	339	20,385	20,046	339
Other non patient care income	33,488	40,321	37,110	30,683	6,427	39,915	33,488	6,427
Total other Income	**76,123**	**78,893**	**76,187**	**69,713**	**6,474**	**82,597**	**76,123**	**6,474**
TOTAL OPERATING INCOME	**565,288**	**498,902**	**515,020**	**516,527**	**(1,507)**	**563,781**	**565,288**	**(1,507)**
EXPENDITURE								
Employee benefit expenses	(319,866)	(277,828)	(291,962)	(293,630)	1,668	(318,198)	(319,866)	1,668
Drugs	(71,269)	(59,504)	(65,042)	(65,312)	270	(70,999)	(71,269)	270
Clinical supplies	(64,252)	(55,070)	(58,578)	(58,924)	346	(63,906)	(64,252)	346
Non clinical supplies	(71,472)	(62,119)	(67,101)	(65,825)	(1,276)	(72,748)	(71,472)	(1,276)
PFI operating expenses	(20,021)	(18,556)	(18,198)	(18,321)	123	(19,898)	(20,021)	123
TOTAL OPERATING EXPENSES	**(546,880)**	**(473,077)**	**(500,881)**	**(502,012)**	**1,131**	**(545,749)**	**(546,880)**	**1,131**
Profit/(loss) from operations	**18,408**	**25,825**	**14,139**	**14,515**	**(376)**	**18,032**	**18,408**	**(376)**
Non-operating income								
Interest	58	223	57	55	2	60	58	2
Profit/(loss) on asset disposals	86	(2)	45	78	(33)	53	86	(33)
Total non-operating income	**144**	**221**	**102**	**133**	**(31)**	**113**	**144**	**(31)**
Non-operating expenses								
Interest on PFI and Finance leases	(17,623)	(16,408)	(16,159)	(16,159)		(17,623)	(17,623)	
Interest on Non Commercial Borrowing	(300)			(217)	217	(83)	(300)	217
Depreciation	(12,378)	(12,563)	(11,120)	(11,342)	222	(12,156)	(12,378)	222
PDC	(2,352)	(1,965)	(2,155)	(2,155)		(2,352)	(2,352)	
Other - Contingent Rent	(10,931)	(9,105)	(10,027)	(9,997)	(30)	(10,963)	(10,931)	(32)
Total non operating expenses	**(43,584)**	**(40,041)**	**(39,461)**	**(39,870)**	**409**	**(43,177)**	**(43,584)**	**407**
(Deficit) after tax from continuing operations	**(25,032)**	**(13,995)**	**(25,220)**	**(25,222)**	**2**	**(25,032)**	**(25,032)**	
Memo:								
Donated Asset Additions	35	492	136	32	104	136	35	101
(Deficit) after tax and Donated Asset Additions	**(24,997)**	**(13,503)**	**(25,084)**	**(25,190)**	**106**	**(24,896)**	**(24,997)**	**101**

Norfolk and Norwich University Hospitals NHS Foundation Trust **Appendix 2**

Statement of Position

Position as at 28 February 2017

	2016/17 £'000 Actual Year to Date	2016/17 £'000 Forecast Plan Year to Date	2016/17 £'000 Forecast Plan Full Year	2015/16 £'000 Audited Actual Full Year
Assets				
Assets, Non-Current				
Property, Plant and Equipment, Net	74,509	79,934	83,888	73,912
PFI: Property, Plant and Equipment, Net	209,651	209,507	208,979	209,798
NHS Trade Receivables, Non-Current				
Non NHS Trade Receivables, Non-Current	2,274	2,524	2,514	2,629
Prepayments, Non-Current	61,661	61,701	62,251	61,241
Assets, Non-Current, Total	**348,094**	**353,666**	**357,632**	**347,580**
Assets, Current				
Inventories	8,325	8,434	8,434	8,434
NHS Trade Receivables, Current	11,508	25,359	25,758	13,929
Non NHS Trade Receivables, Current	3,371	5,110	5,110	5,110
PDC Receivables, Current				232
Accrued Income	7,522	4,138	3,415	3,415
Prepayments, Current, non-PFI related	3,217	3,959	3,023	3,023
Cash	2,232	994	1,778	31,494
Assets, Current, Total	**36,175**	**47,994**	**47,518**	**65,637**
ASSETS, TOTAL	**384,270**	**401,660**	**405,150**	**413,217**
Liabilities				
Liabilities, Current				
Deferred Income, Current	(12,453)	(15,898)	(15,415)	(21,784)
Provisions, Current	(291)	(161)	(202)	(862)
Current Tax Payables	(6,524)	(6,300)	(6,300)	(5,594)
Trade Creditors, Current	(17,377)	(16,281)	(15,368)	(15,846)
Other Creditors, Current	(4,248)	(5,854)	(5,854)	(5,854)
Capital Creditors, Current	(292)	(471)	(1,835)	(1,835)
Accruals, Current	(37,026)	(30,398)	(29,848)	(27,384)
Loans, non-commercial, Current (DH, ITFF, NLF, etc.)		(21,000)	(25,000)	
Finance Leases, Current	(13)	(13)	(168)	(162)
PFI leases, Current	(277)	(277)	(2,972)	(3,360)
Liabilities, Current, Total	**(78,501)**	**(96,653)**	**(102,962)**	**(82,681)**
NET CURRENT (LIABILITIES) ASSETS	**(42,326)**	**(48,659)**	**(55,444)**	**(17,044)**
Liabilities, Non-Current				
Deferred Income, Non-Current	(7,237)	(7,237)	(7,228)	(7,333)
Provisions, Non-Current	(2,823)	(2,609)	(2,748)	(2,852)
Finance Leases, Non-current	(777)	(335)	(167)	(335)
PFI leases, Non-Current	(199,077)	(199,076)	(196,102)	(199,076)
Liabilities, Non-Current, Total	**(209,914)**	**(209,257)**	**(206,245)**	**(209,596)**
TOTAL ASSETS EMPLOYED	**95,855**	**95,750**	**95,943**	**120,940**
Taxpayers' and Others' Equity				
Taxpayers Equity				
Public dividend capital	25,105	25,105	25,105	25,105
Retained Earnings (Accumulated Losses)	6,084	5,979	6,259	30,214
Revaluation Reserve	64,666	64,666	64,579	65,621
TAXPAYERS EQUITY, TOTAL	**95,855**	**95,750**	**95,943**	**120,940**
TOTAL ASSETS EMPLOYED	**95,855**	**95,750**	**95,943**	**120,940**

Norfolk and Norwich University Hospitals NHS Foundation Trus **Appendix 3**

Cash Flow Statement

Position as at 28 February 2017

	£'000	2016/17 £'000	£'000	2016/17 £'000 Forecast	2015/16 £'000 Audited
	Actual Year to Date	Forecast Plan Year to Date	Variance Year to Date	Plan Full Year	Actual Full Year
(Deficit) after tax including donated assets	**(25,084)**	**(25,190)**	**106**	**(24,997)**	**(21,930)**
Non-cash flows in operating surplus					
Finance income/charges	26,129	26,099	30	28,796	27,611
Depreciation and amortisation, total	11,120	11,342	(222)	12,378	13,843
Less: Gain on disposal of property plant and equipment	(45)	(78)	33	(86)	63
PDC dividend expense	2,155	2,155		2,352	1,869
Non-cash flows in operating surplus, Total	**39,359**	**39,518**	**(159)**	**43,440**	**43,386**
Operating Cash flows before movements in working capital	**14,275**	**14,328**	**(53)**	**18,443**	**21,456**
Increase/(Decrease) in working capital					
Decrease in inventories	109		109		(190)
Decrease in NHS Trade Receivables	2,421	(11,430)	13,851	(11,829)	(6,615)
Decrease in Non NHS Trade Receivables	1,739		1,739		(943)
(Increase) in accrued income	(4,107)	(723)	(3,384)		(471)
(Increase) in prepayments	(194)	(821)	627		(956)
(Increase)/decrease in Other assets		(1,149)	1,149	(7)	
(Decrease) in Deferred Income (excluding Donated Assets)	(9,427)	(5,982)	(3,445)	(6,474)	(8,217)
(Decrease) in provisions	(600)	(944)	344	(764)	(1,141)
Increase in tax payable	930	706	224	706	154
Increase in Trade Creditors	575	(478)	1,053	(478)	(878)
(Decrease) in Other Creditors	(1,606)		(1,606)		1,008
Increase in accruals	9,642	3,014	6,628	2,464	933
(Decrease) in other Other Financial liabilities	(1)		(1)		(180)
(Decrease) in working capital, Total	**(519)**	**(17,807)**	**17,288**	**(16,382)**	**(17,496)**
Net cash (outflow)/inflow from operating activities	**13,756**	**(3,479)**	**17,235**	**2,061**	**3,960**
Net cash flow from investing activities					
Property, plant and equipment - non-maintenance expenditure	(11,133)	(17,167)	6,034	(21,517)	(8,710)
Proceeds on disposal of property, plant and equipment	53	85	(32)	94	10
(Decrease) in Capital Creditors	(1,547)		(1,547)		976
Other cash flows from investing activities	(420)	(522)	102	(1,010)	(6,254)
Net cash (outflow) from investing activities, Total	**(13,047)**	**(17,604)**	**4,557**	**(22,433)**	**(13,978)**
Net cash (outflow)/inflow before financing	**708**	**(21,083)**	**21,791**	**(20,372)**	**(10,018)**
Net cash flow from financing activities					
PDC Dividends paid	(966)	(966)		(2,142)	(1,954)
Interest element of finance lease rental payments - *Other*	(25)	(25)		(27)	(18)
Interest element of finance lease rental payments - *On-balance sheet PFI*	(16,134)	(16,133)	(1)	(17,594)	(17,878)
Interest element of finance loans		(225)	225	(300)	
Capital element of finance lease rental payments - *Other*	(149)	(149)		(162)	(172)
Capital element of finance lease rental payments - *On-balance sheet PFI*	(3,082)	(3,083)	1	(3,362)	(3,541)
Interest received on cash and cash equivalents	57	57		59	231
Movement in Other grants/Capital received					15
(Increase)/decrease in non-current receivables	355	105	250	115	637
Distressed funding required - Revenue cash requirement		15,000	(15,000)	15,000	
Distressed funding required -Capital cash requirement		6,000	(6,000)	10,000	
Other cash flows from financing activities	(10,027)	(9,998)	(29)	(10,931)	(9,946)
Net cash (outflow) from financing activities, Total	**(29,971)**	**(9,417)**	**(20,554)**	**(9,344)**	**(32,626)**
Net (decrease)/increase in cash and cash equivalents	**(29,262)**	**(30,500)**	**1,238**	**(29,716)**	**(42,644)**
Opening cash and cash equivalents	31,494	31,494		31,494	74,138
Closing cash and cash equivalents	**2,232**	**994**	**1,238**	**1,778**	**31,494**

Norfolk and Norwich University Hospitals NHS Foundation Trust
CURRENT WEEK - SUMMARY
Consolidated short term cash forecast

		Mar-17				Apr-17				May-17				Jun-17				
	£'000	Actual	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast	Forecast
RAG	Week ended	10 Mar	17 Mar	24 Mar	31 Mar	07 Apr	14 Apr	21 Apr	28 Apr	05 May	12 May	19 May	26 May	02 Jun	09 Jun	16 Jun	23 Jun	30 Jun
	Balance B/F	**22,416**	**20,294**	**31,808**	**16,216**	**12,315**	**25,890**	**27,149**	**22,623**	**1,324**	**21,125**	**16,878**	**20,080**	**3,319**	**(6,164)**	**13,702**	**25,964**	**(1,731)**
	Clinical Income (inflow)																	
G	Clinical Income	1,634	7,176			22,350	4,173	6,402		22,350		10,575			22,350	10,575		
A	Drugs	(70)	2,874	892		1,325	1,648	2,496		1,325		4,144			1,325	4,144		
A	Over/Under performance	400										800				950		
	Other income (inflow)																	
G	Health Education	1,616	169				100	1,600				1,700				1,700		
A	NHS	312	220	1,736		190	280	290	1,514	190	190	190	640	590	190	190	190	950
A	NON NHS	502	250	250	275	235	365	235	235	235	235	365	235	235	235	365	235	235
A	R&D		1,932					1,690				1,690				250	1,690	
G	VAT			1,519					1,676				1,676					1,676
		4,394	**12,621**	**4,397**	**275**	**24,100**	**6,566**	**12,713**	**3,425**	**24,100**	**425**	**19,464**	**2,551**	**825**	**24,100**	**18,174**	**2,115**	**2,861**
	Payroll (outflow)																	
G	Salaries	544	350	14,650	300	350	350	350	14,950	350	350	350	14,950	350	350	350	14,950	350
G	Superannuation		4,139					4,250				4,250					4,250	
G	Inland Revenue		6,480					6,700				6,835					6,835	
	Non-pay (outflow)																	
R	NON NHS	3,369	2,291	2,060	2,259	2,690	1,900	1,900	1,900	2,170	1,900	1,900	1,900	2,170	1,900	1,900	1,900	1,900
A	NHS	121	616	740		300	581	600	740	300	300	494	740	300	300	494	300	740
A	Pharmacy	2,240	1,400	1,400	1,400	1,400	1,400	1,400	1,400	1,400	1,400	1,400	1,400	1,400	1,400	1,400	1,400	1,400
G	Litigation							861				861				861		
A	R&D	242	658	977			1,076	572			642	91	242	213	109	732		277
G	Shawbrook							541										
G	Octagon					5,754			5,700					5,700				5,700
		6,516	**15,934**	**19,827**	**3,959**	**10,494**	**5,307**	**17,174**	**24,690**	**4,220**	**4,592**	**16,181**	**19,232**	**10,133**	**4,059**	**5,737**	**29,635**	**10,367**
	Cash from operations	**(2,122)**	**(3,313)**	**(15,430)**	**(3,684)**	**13,606**	**1,259**	**(4,461)**	**(21,265)**	**19,880**	**(4,167)**	**3,283**	**(16,681)**	**(9,308)**	**20,041**	**12,437**	**(27,520)**	**(7,506)**
	Finance and capital																	
G	PDC		1,152															
A	Capital programme		20	162	217	32		64	34	80	80	80	80	175	175	175	175	176
G	Interest paid/received																	
		0	**1,172**	**162**	**217**	**32**	**0**	**64**	**34**	**80**	**80**	**80**	**80**	**175**	**175**	**175**	**175**	**176**
	Net Inflow / (Outflow)	**(2,122)**	**(4,486)**	**(15,592)**	**(3,901)**	**13,574**	**1,259**	**(4,525)**	**(21,299)**	**19,800**	**(4,247)**	**3,203**	**(16,761)**	**(9,483)**	**19,866**	**12,262**	**(27,695)**	**(7,682)**
	Forecast Balance C/F - excluding WCF	**20,294**	**15,808**	**16,216**	**12,315**	**25,890**	**27,149**	**22,623**	**1,324**	**21,125**	**16,878**	**20,080**	**3,319**	**(6,164)**	**13,702**	**25,964**	**(1,731)**	**(9,413)**
	Working Capital facility drawdown (inflow)		16,000															
	Working Capital facility repayment (outflow)																	
	Forecast Balance C/F	**20,294**	**31,808**	**16,216**	**12,315**	**25,890**	**27,149**	**22,623**	**1,324**	**21,125**	**16,878**	**20,080**	**3,319**	**(6,164)**	**13,702**	**25,964**	**(1,731)**	**(9,413)**

Norfolk and Norwich University Hospitals NHS Foundation Trust

Appendix 5

2016/17 Capital Programme

2016/17 Annual Plan

The Annual Plan submitted to NHSI for 2016/17 required a 5 year capital plan - detailed below is the first 3 years of that plan. There are 3 items which will require separate funding which has yet to be secured. However, they are included - consistent with the Annual Plan. They are identifiable by a *.

2017/19 Annual Plan - Submitted December 2016

We have completed the 2 year operating Annual Plan for 2017/19 as requested by NHSI. As part of that a 5 year capital plan was required which will supercede the existing annual plan for those years below. The key items are ACAD £51m, EPR £29.4m, ED development £17.5m & CAU £10m.

		3 Year Planned Future Spend			2016/17 Annual Plan								
					Q1	Q2	Q3	Q4					
	3 Year Plan Total £'000	2016/17 £'000	2017/18 £'000	2018/19 £'000	£'000	£'000	£'000	M10 £'000	M11 £'000	M12 £'000	Total 2016/17 £'000	Actual Spend YTD 2016/17 £'000	Variance to Plan (over) / under £'000
Annual Plan Projects													
Mattishall Ward Fit Out	2,765	70	2,695	-	70	-	-	-	-	-	**70**	1,676	(1,606)
Weybourne Oncology Day Unit	985	985	-	-	292	439	254	-	-	-	**985**	678	307
Quadram Institute (formerly Institute of Food, Health and Gut) [1]	3,300	-	1,800	1,500	-	-	-	-	-	-	**-**	-	-
Monitoring Equipment	833	833	-	-	833	-	-	-	-	-	**833**	630	204
Pathology / EPA	720	720	-	-	180	180	180	60	60	60	**720**	82	578
E-Prescribing	334	334	-	-	84	84	84	28	28	26	**334**	99	209
Children's A&E Unit *	10,000	-	10,000	-	-	-	-	-	-	-	**-**	-	-
Ambulatory Care and Diagnostic Centre (ACAD) *	35,000	-	35,000	-	-	-	-	-	-	-	**-**	-	-
Total Annual Plan	**53,937**	**2,942**	**49,495**	**1,500**	**1,459**	**703**	**518**	**88**	**88**	**86**	**2,942**	**3,164**	**(308)**
Capital - Business as usual													
Med & Surg	3,964	1,938	264	1,762	483	483	483	161	161	167	**1,938**	1,991	(220)
IT	1,532	543	120	869	135	135	135	45	45	48	**543**	78	417
Estates	1,565	577	119	869	144	144	144	48	48	49	**577**	110	418
Total - Trust Funded Capital Through Performance Against Plan	**60,998**	**6,000**	**49,998**	**5,000**	**2,221**	**1,465**	**1,280**	**342**	**342**	**350**	**6,000**	**5,344**	**306**
Other Items													
IRU & Cardiology Capacity *	10,000	10,000	-	-	-	-	-	3,000	3,000	4,000	**10,000**	-	6,000
Donated Assets	-	-	-	-	-	-	-	-	-	-	**-**	136	(136)
Lifecycle Maintenance Capitalisation	5,517	5,517	-	-	-	5,517	-	-	-	-	**5,517**	5,517	-
Capitalisation of Capital Project Staff Salaries	-	-	-	-	-	-	-	-	-	-	**-**	136	(136)
TOTAL CAPITAL	**76,515**	**21,517**	**49,998**	**5,000**	**2,221**	**6,982**	**1,280**	**3,342**	**3,342**	**4,350**	**21,517**	**11,133**	**6,034**

[1] Contractually committed amount of £8.6m in total - no funding yet secured

Capital Commitments	**£'000**	**£'000**
Total Capital for 2016/17		21,517
Less: Centrally Funded Capital & LCM Capitalisation		(15,517)
Total Trust Funded Capital		**6,000**
Committed Spend from end of 2015/16 - orders placed	2,419	
Capital Committee & Chair Approvals Year to 6/17 Annual Plan	4,734	
Total Committed and Spent		(7,153)
Adjustment for acceleration of Mattishall Ward Fit Out from 2017/18		1,844
Trust Funded Capital - Uncommitted / (Overcommitted)		**691**

Breakdown of Committed and Spent Capital:	**£'000**
Purchases made and invoices received	5,344
Chair & Committee approvals awaiting order and orders placed not received	1,810
	7,153

Application of Single Oversight Framework to current NNUH Performance

Use of Resource (UoR) Metrics - Applicable from 1st October 2016

The five themes of the Single Oversight Framework - *Extract from NHSI Document*
In carrying out their role NHSI will work across five themes:

1 Quality of care (safe, effective, caring, responsive): we will use CQC's most recent assessments of whether a provider's care is safe, effective, caring and responsive, in combination with in-year information where available. We will also include delivery of the four priority standards for 7-day hospital services.

2 Finance and use of resources: we will oversee a provider's financial efficiency and progress in meeting its financial control total, reflecting the approach taken in *Strengthening financial performance and accountability* . We are co-developing this approach with CQC.

3 Operational performance: we will support providers in improving and sustaining performance against NHS Constitution standards and other, including A&E waiting times, referral to treatment times, cancer treatment times, ambulance response times, and access to mental health services. These NHS Constitution standards may relate to one or more facets of quality (ie safe, effective, caring and/or responsive).

4 Strategic change: working with system partners we will consider how well providers are delivering the strategic changes set out in the *NHS 5 year Forward View* , with a particular focus on their contribution to sustainability and transformation plans (STPs), new care models, and, where relevant, implementation of devolution.

5 Leadership and improvement capability (well-led): building on the joint CQC and NHS Improvement well-led framework, we will develop a shared system view with CQC of what good governance and leadership look like, including organisations' ability to learn and improve.

This appendix provides the detail for segment 2.

UoR Metrics

Area	Weighting	Metric	Definition	Score 1	2	3	4[1]
Financial sustainability	0.2	Capital service capacity	Degree to which the provider's generated income covers its financial obligations	>2.5x	1.75-2.5x	1.25-1.75x	< 1.25x
	0.2	Liquidity (days)	Days of operating costs held in cash or cash-equivalent forms, including wholly committed lines of credit available for drawdown	>0	(7)-0	(14)-(7)	<(14)
Financial efficiency	0.2	I&E margin	I&E surplus or deficit / total revenue	>1%	1-0%	0-(1)%	≤(1)%
Financial controls	0.2	Distance from financial plan	Year-to-date actual I&E surplus/deficit in comparison to Year-to-date plan I&E surplus/ deficit	≥0%	(1)-0%	(2)-(1)%	≤(2)%
	0.2	Agency spend	Distance from provider's cap	≤0%	0%-25%	25-50%	>50%

Overall Single Oversight Framework Scoring Across 5 Themes (including UoR)

Segment	Description
1	**Providers with maximum autonomy** – no potential support needs identified across our five themes – lowest level of oversight and expectation that provider will support providers in other segments
2	**Providers offered targeted support** – potential support needed in one or more of the five themes, but not in breach of licence (or equivalent for NHS trusts) and/or formal action is not needed
3	**Providers receiving mandated support for significant concerns** – the provider is in actual/suspected breach of the licence (or equivalent for NHS trusts)
4	**Special measures** – the provider is in actual/suspected breach of its licence (or equivalent for NHS trusts) with very serious/complex issues that mean that they are in special measures

Current Performance to 28 February 2017

Capital Service Capacity Metric

Profit / Loss from Operations	(Appendix 1)	14,139
Interest Receivable	(Appendix 1)	57
Total		**14,196**
Non-Operating Costs	(Appendix 1)	39,461
Less: Depreciation	(Appendix 1)	(11,120)
Add: Capital Elements of Lease Payments	(Appendix 3)	3,231
Total		**31,572**

Revenue generated covers commitments 0.45 times

Liquidity Metric

Net Current Assets	(Appendix 2)	(42,326)
Less: Inventories	(Appendix 2)	(8,325)
Total		**(50,651)**
Total Operating Expenses	(Appendix 1)	500,881
Annualised (x 12/11)		**546,416**

-33.4 Days worth of expenses held as cash equivalents

I&E Margin Metric

Surplus/(Deficit)	(Appendix 1)	(25,220)
Donated Asset Depreciation		627
(Gains)/losses on Asset Disposal	(Appendix 1)	(45)
Total		**(24,638)**
Operating Income	(Appendix 1)	515,156
Donated Additions	(Appendix 1)	(136)
Total		**515,020**

Actual I&E Margin is -4.78%

Difference from Financial Plan

Surplus/(Deficit)	(Appendix 1)	(25,222)
Donated Asset Depreciation		840
(Gains)/losses on Asset Disposal	(Appendix 1)	(78)
Total		**(24,460)**
Operating Income	(Appendix 1)	516,559
Donated Additions	(Appendix 1)	(32)
Total		**516,527**

Planned I&E Margin is -4.74%

I&E Margin Variance is -0.05%

Agency Spend Metric

Agency Spend YTD	(20,635)
Agency Ceiling YTD	(17,991)

Agency Spend is 14.69% above ceiling

Summary - Score is 3

Current Capital service capacity of 0.45 gives a score of 4 for this metric.
Current Liquidity of -33.4 days gives a score of 4 for this metric.
Current I&E Margin of -4.78% gives a score of 4 for this metric.
Current Variance in I&E Margin of -0.05% gives a score of 2 for this metric.
Agency Spend of 14.69% gives a score of 2 for this metric.

The overall score for UoR is 3, resulting in segment 'Use of Resources' being categorised as:
'Provider receiving mandated support for significant concerns'

Norfolk and Norwich University Hospitals NHS Foundation Trust **Appendix 7**

Income Statement Comparison - for the Month of February 2017

	For the month			Variances Fav / (Adv)			
	Actual	Forecast Plan	Prior year	To Forecast Plan		To prior year	
	£'000	£'000	£'000	£'000	%	£'000	%
INCOME							
NHS clinical income							
Clinical Income	32,916	34,265	32,984	(1,349)	(4%)	(68)	(0%)
NT Drugs	4,817	5,131	5,083	(314)	(6%)	(266)	(5%)
Total NHS clinical income	**37,733**	**39,396**	**38,067**	**(1,663)**	**(4%)**	**(334)**	**(1%)**
Non NHS clinical income							
Private patients	131	159	145	(28)	(18%)	(14)	(10%)
Other - RTA	141	111	129	30	27%	12	9%
Total Non NHS clinical income	**272**	**270**	**274**	**2**	**1%**	**(2)**	**(1%)**
Other Income							
R&D	1,780	1,899	1,954	(119)	(6%)	(174)	(9%)
Education & Training	1,734	1,706	1,648	28	2%	86	5%
Other non patient care income	3,759	2,713	4,559	1,046	39%	(800)	(18%)
Total other Income	**7,273**	**6,318**	**8,161**	**955**	**15%**	**(888)**	**(11%)**
TOTAL OPERATING INCOME	**45,278**	**45,984**	**46,502**	**(706)**	**(2%)**	**(1,224)**	**(3%)**
EXPENDITURE							
Employee benefit expenses	(26,007)	(26,296)	(26,142)	289	1%	135	1%
Drugs	(5,719)	(5,958)	(5,893)	239	4%	174	3%
Clinical supplies	(5,158)	(5,341)	(5,003)	183	3%	(155)	(3%)
Non clinical supplies	(5,714)	(5,648)	(6,135)	(66)	(1%)	421	7%
PFI operating expenses	(1,680)	(1,653)	(1,709)	(27)	(2%)	29	2%
TOTAL OPERATING EXPENSES	**(44,278)**	**(44,896)**	**(44,882)**	**618**	**1%**	**604**	**1%**
Profit/(loss) from operations	**1,000**	**1,088**	**1,620**	**(88)**	**(8%)**	**(620)**	**(38%)**
Non-operating income							
Interest	3	3	15		0%	(12)	(80%)
Profit/(loss) on asset disposals		8	(7)	(8)	100%	7	(100%)
Total non-operating income	**3**	**11**	**8**	**(8)**	**(73%)**	**(5)**	**(63%)**
Non-operating expenses							
Interest on PFI and Finance leases	(1,464)	(1,464)	(1,486)		0%	22	(1%)
Interest on Non Commercial Borrowing		(83)		83	100%		
Depreciation	(1,017)	(1,036)	(1,149)	19	2%	132	(11%)
PDC	(197)	(196)	(135)	(1)	(1%)	(62)	46%
Other - Contingent Rent	(938)	(933)	(841)	(5)	(1%)	(97)	12%
Total non operating expenses	**(3,616)**	**(3,712)**	**(3,611)**	**96**	**3%**	**(5)**	0%
Surplus (deficit) before tax	**(2,613)**	**(2,613)**	**(1,983)**	**(0)**	**0%**	**(630)**	**32%**
Profit / (loss) from discontinued operations, net of tax							
Surplus (deficit) after tax from continuing operations	**(2,613)**	**(2,613)**	**(1,983)**	**(0)**	**(0%)**	**(630)**	**(32%)**
Memo:							
Donated Asset Additions		3	11	(3)	(100%)	(11)	(100%)
Surplus (deficit) after tax and Donated Asset Additions	**(2,613)**	**(2,610)**	**(1,972)**	**(3)**	**(0%)**	**(641)**	**(33%)**

Notes:

Calendar Days	28	28	29
Working Days	20	20	21

Norfolk and Norwich University Hospitals NHS Foundation Trust **Appendix 8**

Income Statement Comparison - 11 month position to 28 February 2017

	Year to Date			Variances Fav / (Adv)			
	Actual	Forecast Plan	Prior year	To Forecast Plan		To prior year	
	£'000	£'000	£'000	£'000	%	£'000	%
INCOME							
NHS clinical income							
Clinical Income	381,229	388,339	367,242	(7,110)	(2%)	13,987	4%
NT Drugs	55,142	55,765	49,756	(623)	(1%)	5,386	11%
Total NHS clinical income	**436,371**	**444,104**	**416,998**	**(7,733)**	**(2%)**	**19,373**	**5%**
Non NHS clinical income							
Private patients	1,536	1,581	1,837	(45)	(3%)	(301)	(16%)
Other - RTA	926	1,129	1,174	(203)	(18%)	(248)	(21%)
Total Non NHS clinical income	**2,462**	**2,710**	**3,011**	**(248)**	**(9%)**	**(549)**	**(18%)**
Other Income							
R&D	20,397	20,689	20,672	(292)	(1%)	(275)	(1%)
Education & Training	18,680	18,341	17,900	339	2%	780	4%
Other non patient care income	37,110	30,683	40,321	6,427	21%	(3,211)	(8%)
Total other Income	**76,187**	**69,713**	**78,893**	**6,474**	**9%**	**(2,706)**	**(3%)**
TOTAL OPERATING INCOME	**515,020**	**516,527**	**498,902**	**(1,507)**	**(0%)**	**16,118**	**3%**
EXPENDITURE							
Employee benefit expenses	(291,962)	(293,630)	(277,828)	1,668	1%	(14,134)	(5%)
Drugs	(65,042)	(65,312)	(59,504)	270	0%	(5,538)	(9%)
Clinical supplies	(58,578)	(58,924)	(55,070)	346	1%	(3,508)	(6%)
Non clinical supplies	(67,101)	(65,825)	(62,119)	(1,276)	(2%)	(4,982)	(8%)
PFI operating expenses	(18,198)	(18,321)	(18,556)	123	1%	358	2%
TOTAL OPERATING EXPENSES	**(500,881)**	**(502,012)**	**(473,077)**	**1,131**	**0%**	**(27,804)**	**(6%)**
Profit/(loss) from operations	**14,139**	**14,515**	**25,825**	**(376)**	**(3%)**	**(11,686)**	**(45%)**
Non-operating income							
Interest	57	55	223	2	4%	(166)	(74%)
Profit/(loss) on asset disposals	45	78	(2)	(33)	42%	47	(2350%)
Total non-operating income	**102**	**133**	**221**	**(31)**	**(23%)**	**(119)**	**(54%)**
Non-operating expenses							
Interest on PFI and Finance leases	(16,159)	(16,159)	(16,408)		0%	249	2%
Interest on Non Commercial Borrowing		(217)		217			
Depreciation	(11,120)	(11,342)	(12,563)	222	2%	1,443	11%
PDC	(2,155)	(2,155)	(1,965)		0%	(190)	(10%)
Other - Contingent Rent	(10,027)	(9,997)	(9,105)	(30)	(0%)	(922)	(10%)
Total non operating expenses	**(39,461)**	**(39,870)**	**(40,041)**	**409**	**1%**	**580**	**1%**
Surplus (deficit) after tax from continuing operations	**(25,220)**	**(25,222)**	**(13,995)**	**2**	**0%**	**(11,225)**	**(80%)**
Memo:							
Donated Asset Additions	136	32	492	104	325%	(356)	(72%)
Surplus (deficit) after tax and Donated Asset Additions	**(25,084)**	**(25,190)**	**(13,503)**	**106**	**0%**	**(11,581)**	**(86%)**

Notes:

Calendar Days to Date	334	334	335
Working Days to Date	232	232	231

Penalty Position as at 28 February 2017

Appendix 9

Contract Tracker - Commissioning Information

GROSS TOTAL (BEFORE REINVESTMENT)

Operational Standards

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb (Estimate)	Mar	YTD
18 Weeks	£765,300	£709,320	£645,804	£724,104	£766,092	£782,988	£855,648	£817,092	£970,944	£945,708	£945,708		£8,928,708
Diagnostic Waiting Times	£10,400	£16,600	£17,000	£31,800	£33,600	£27,600	£18,200	£0	£0	£0	£0		£155,200
A&E Waits	£113,640	£81,240	£78,120	£60,240	£87,120	£49,200	£110,400	£108,480	£187,200	£175,440	£166,080		£1,217,160
Cancer Waits - 2 Week Wait			£0			£0			£0				£0
Cancer Waits - 31 Days			£7,000			£0			£10,000				£17,000
Cancer Waits - 62 Days			£22,000			£22,000			£36,500				£80,500
Mixed Sex Accomodation Breaches	£0	£1,000	£0	£0	£0	£0	£0	£750	£1,000	£0	£500		£3,250
Cancelled Operations	£114,166	£38,370	£33,315	£49,306	£14,992	£32,439	£57,818	£45,529	£43,324	£61,314	£35,209		£525,782
Total	**£1,003,506**	**£846,530**	**£803,239**	**£865,450**	**£901,804**	**£914,227**	**£1,042,066**	**£971,851**	**£1,248,968**	**£1,182,462**	**£1,147,497**	**£0**	**£10,927,600**

Quality Requirements

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
MRSA	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0		£0
C Difficile													£0
52 Week Waiters	£0	£15,000	£45,000	£70,000	£95,000	£115,000	£80,000	£60,000	£30,000	£50,000	£50,000		£610,000
Ambulance Handovers - more than 30 minutes	£102,400	£69,400	£69,800	£59,200	£79,800	£85,200	£120,400	£105,000	£183,400	£162,600	£162,600		£1,199,800
Ambulance Handovers - more than 60 minutes	£188,000	£102,000	£106,000	£66,000	£135,000	£117,000	£219,000	£175,000	£361,000	£359,000	£359,000		£2,187,000
A&E Trolley Waits	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0		£0
Multiple Urgent Cancelled Operations	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0		£0
Duty of Candour													£0
NHS Number - OP/APC Datasets (SUS)	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0		£0
NHS Number - A&E Datasets (SUS)	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0		£0
Total	**£290,400**	**£186,400**	**£220,800**	**£195,200**	**£309,800**	**£317,200**	**£419,400**	**£340,000**	**£574,400**	**£571,600**	**£571,600**	**£0**	**£3,996,800**

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Other - Never Events	£2,807	£1,774	£0	£0	£0	£0	£3,000	£4,000	£0	£0	£0		£11,581
Other - GC9													£0

Grand Total	**£1,296,713**	**£1,034,704**	**£1,024,039**	**£1,060,650**	**£1,211,604**	**£1,231,427**	**£1,464,466**	**£1,315,851**	**£1,823,368**	**£1,754,062**	**£1,719,097**	**£0**	**£14,935,981**

NET PENALTY (AFTER REINVESTMENT AGREEMENT)

Operational Standards

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
18 Weeks													£0
Diagnostic Waiting Times													£0
A&E Waits													£0
Cancer Waits - 2 Week Wait			£0			£0			£0				£0
Cancer Waits - 31 Days			£7,000			£0			£10,000				£17,000
Cancer Waits - 62 Days													£0
Mixed Sex Accomodation Breaches	£0	£1,000	£0	£0	£0	£0	£0	£750	£1,000	£0	£500		£3,250
Cancelled Operations	£114,166	£38,370	£33,315	£49,306	£14,992	£32,439	£57,818	£45,529	£43,324	£61,314	£35,209		£525,782
Total	**£114,166**	**£39,370**	**£40,315**	**£49,306**	**£14,992**	**£32,439**	**£57,818**	**£46,279**	**£54,324**	**£61,314**	**£35,709**	**£0**	**£546,032**

Quality Requirements

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
MRSA	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0		£0
C Difficile	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0		£0
52 Week Waiters													£0
Ambulance Handovers - more than 30 minutes													£0
Ambulance Handovers - more than 60 minutes													£0
A&E Trolley Waits													£0
Multiple Urgent Cancelled Operations	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0		£0
Duty of Candour	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0		£0
NHS Number - OP/APC Datasets (SUS)	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0		£0
NHS Number - A&E Datasets (SUS)	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0		£0
Total	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**	**£0**

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Other - Never Events	£2,807	£1,774	£0	£0	£0	£0	£3,000	£4,000	£0	£0			£11,581
Other - GC9	£0	£0	£0	£0	£0	£0	£0	£0	£0	£0			£0

Grand Total	**£116,973**	**£41,144**	**£40,315**	**£49,306**	**£14,992**	**£32,439**	**£60,818**	**£50,279**	**£54,324**	**£61,314**	**£35,709**	**£0**	**£557,613**

	Covered by Decision Trees
	Provisional Figures

Source: Commissioning x5865

Norfolk and Norwich University Hospitals NHS Foundation Trust **Appendix 10**

Pay variance Month 11 2016/17

Staff group	Actual-YTD £	Budget-YTD £	Variance-YTD £	WLI, NAG, locums, bank & agency £	Vacancy/ Other £	Total	Budget WTE	Actual WTE
Consultant	51,095,641	58,840,572	-7,744,932	0	-7,744,932	-7,744,932	448	407
Locum consultant	3,325,948	16,500	3,309,448	3,309,448	0	3,309,448	0	1
WLI Consultants	4,789,961	0	4,789,961	4,789,961	0	4,789,961	0	0
NAG	1,033,525	0	1,033,525	1,033,525	0	1,033,525		
	60,245,075	58,857,072	1,388,003	9,132,935	-7,744,932	1,388,003	448	408
Other medical staff	30,745,300	35,641,435	-4,896,135	0	-4,896,135	-4,896,135	623	546
Locum other medical staff	7,099,544	15,620	7,083,924	7,083,924	0	7,083,924	0	0
WLI other medical staff	1,255,027	0	1,255,027	1,255,027	0	1,255,027	0	0
	39,099,871	35,657,055	3,442,816	8,338,951	-4,896,135	3,442,816	623	546
Registered nurses	68,239,968	80,578,665	-12,338,697	0	-12,338,697	-12,338,697	2,105	1,840
Nurse bank - Registered	1,666,960	25,758	1,641,202	1,641,202	0	1,641,202		
Agency nurse	9,184,749	0	9,184,749	9,184,749	0	9,184,749		
	79,091,677	80,604,423	-1,512,746	10,825,951	-12,338,697	-1,512,746	2,105	1,840
Unqualified nurses	16,190,283	19,098,201	-2,907,918	0	-2,907,918	-2,907,918	853	740
Nurse bank - Unregistered	5,071,501	168,392	4,903,109	4,903,109	0	4,903,109		
	21,261,784	19,266,593	1,995,192	4,903,109	-2,907,918	1,995,192	853	740
Midwives	8,525,004	9,226,625	-701,621	0	-701,621	-701,621	218	218
A&C **	30,919,966	34,962,929	-4,042,963	0	-4,042,963	-4,042,963	1,396	1,335
A&C bank	1,152,377	42,442	1,109,935	1,109,935	0	1,109,935		
	32,072,342	35,005,370	-2,933,028	1,109,935	-4,042,963	-2,933,028	1,396	1,335
AHP	17,348,280	21,655,981	-4,307,702	0	-4,307,702	-4,307,702	598	526
AHP Bank	20,207	0	20,207	20,207	0	20,207		
AHP Agency	1,813,716	137,500	1,676,216	1,676,216	0	1,676,216		
	19,182,204	21,793,481	-2,611,278	1,696,424	-4,307,702	-2,611,278	598	526
Other non-medical *	31,646,564	34,733,572	-3,087,008	0	-3,087,008	-3,087,008	953	872
Other non-medical Agency	994,700	8,617	986,083	986,083	0	986,083		
	32,641,264	34,742,189	-2,100,925	986,083	-3,087,008	-2,100,925	953	872
Sub Total	**292,119,222**	**295,152,808**	**-3,033,587**	**36,993,388**	**-40,026,975**	**-3,033,587**	**7,194**	**6,484**
Reserve Allocation	0	1,210,335	-1,210,335	0	-1,210,335	-1,210,335		
Slippage QIPP achieved	0	0	0	0	0	0		
QIPP in Divisions	0	-5,624,450	5,624,450	0	5,624,450	5,624,450		
Subtotal	**292,119,222**	**290,722,345**	**1,396,876**	**36,993,388**	**-35,596,511**	**1,396,876**	**7,194**	**6,484**
Reserves	-157,109	2,907,813	-3,064,922	0	-3,064,922	-3,064,922		
Non-Recurrent Pay Slippage QIPP less achieved to date	0	0	0	0	0	0		
Grand Total	**291,962,112**	**293,630,158**	**-1,668,046**	**36,993,388**	**-38,661,434**	**-1,668,046**	**7,194**	**6,484**

Reserves Detail

3% Activity Qipp	64,948	3% Activity Qipp
Contingency	(450,318)	Contingency
Mths 1-6 Adjust Plan To Actual	374,182	Adjust 1-12 To Plan
Cardiology 7 Day Working	(66,232)	Cardiology 7 Day Working
Additional Safer Staffing	(82,327)	Additional Safer Staffing
Staffing Reserve	(725,350)	Staffing Reserve
Cquin Delivery	(76,072)	Cquin Delivery
Business Planning Css 16/17	(70,768)	Business Planning Css 16/17
Ct Business Case	(124,855)	Ct Business Case
Critical Care	(105,775)	Critical Care
Other	(1,802,354)	Other
Total	(3,064,922)	

Norfolk and Norwich University Hospitals NHS Foundation Trust **Appendix 11**

Clinical Supplies Variance Month 11 2016/17

	16/17				Prior Year			
Cost name	**Actual YTD 16/17 £**	**Budget YTD 16/17 £**	**Variance YTD 16/17 £**	**Comments - 16/17 YTD**	**Actual YTD 15/16 £**	**Variance to PY £**	**Variance to PY (%)**	**Comments - 16/17 YTD vs prior year comparison**
Med & Surg equipment	25,698,167	26,185,196	-487,029	Overspends: T&O £198k, Radiology £169k, Surgical Support £165k Underspends: Cardiology £611k, Reserves £394k	25,268,119	430,048	2%	Increase on PY: Radiology £511k, Opthalmology £155k Decrease on PY: Surgival Support £153k, Reserves £297k
Prostheses	5,339,104	5,663,361	-324,256	Underspend: Theatres £291k	5,151,606	187,498	4%	Increase on PY: Surgical Support £157k
Service maintenance & usage contracts	9,548,329	9,441,832	106,497	Overspent: Lab Med £66k, Gastro £20k	8,632,582	915,747	11%	Increase on PY: Lab Med £571k, Urology £105k, Surgical Support £86k
Blood products	2,936,594	2,978,283	-41,689	Underspend: Oncology £17k, Obs & Gynae £15k	2,973,259	-36,665	-1%	Increase on PY: OPM £43k, Oncology £41k Decrease on PY: Lab Med £105k ,
Lab consumables	3,511,484	3,515,706	-4,221	Underspends: Cell Path £52k Overspend: Lab Med £27k	3,141,559	369,926	12%	Increase on PY: Lab Med 440k
Spec. Path Test	1,520,961	1,285,818	235,143	Overspends: Lab Med £130k, Oncology £55k. OPM £17k	1,215,984	304,977	25%	Increase on PY: Lab Med £199k, OPM £38k. General Surgery £23k
Respironics - pass through	1,574,743	1,505,612	69,131	Respiratory, pass-through payment, will be offset by increased income	1,360,337	214,406	16%	Respiratory, pass-through payment, will be offset by increased income
Stents	1,988,163	2,021,761	-33,598	Overspends: Radiology £38k Underspends: Cariology £82k	1,874,915	113,247	6%	Increase on PY: Cardiology £98k, Gastro £28k
Dressings	1,297,618	1,449,161	-151,544	Underspends: Surgical Support £64k, Plastics £29k	1,300,162	-2,544	0%	Increase on PY: Plastic Surgery £24k Decrease on PY: Dermatology £13k, Surgical Support £7k
Surgical Foot/Appliance	1,126,169	1,218,572	-92,403	Underspends: T&O £41k, Endocrinology £40k	1,026,024	100,145	10%	Increase on PY: T&O £106k
Surgical Instruments	1,081,084	1,176,750	-95,666	Underspends: Surgical Support £144k	439,771	641,313	146%	Increase on PY: Surgical Support £524k, Lab Med £48k
Other clinical supplies	2,955,209	2,638,785	316,424	Overspend: Reveal Devices £174k, X-Ray Equipment £78k, Patient applinances £81k	2,685,698	269,511	10%	Increase on PY: Reveal Devices £193k, Branemarks £71k, X-Ray Equipment £61k
Clinical Supplies CIP	0	-368,571	368,571					
Sub total	**58,577,625**	**58,712,265**	**-134,640**		55,070,015	3,507,610	6%	
Reserves*	0	211,974	-211,974		0	0		
Grand Total	**58,577,625**	**58,924,239**	**-346,614**		55,070,015	3,507,610	6%	

* Reserves

R & D Reserve	(130,142)
Cardiology 7 Day Working	(66,232)
Other	(15,600)
Total Reserves variance	(211,974)

Norfolk and Norwich University Hospitals NHS Foundation Trust **Appendix 12**

Non-Clinical Supplies Variance Month 11 2016/17

	16/17				Prior Year			
Cost name	**Actual YTD 16/17 £**	**Budget YTD 16/17 £**	**Variance YTD 16/17 £**	**Comments - 16/17 YTD**	**Actual YTD 15/16 £**	**Variance to PY £**	**Variance to PY (%)**	**Comments - 16/17 YTD vs prior year comparison**
Services Received Externally	5,524,245	5,534,607	-10,362		0	5,524,245	0%	Prior year, this code was not used only, Premises Services Received Externally. Increase on prior year: £1,726k Gastro - Medinet & 18 week support, £1,454k Radiology due to InHealth van usage to deliver CT & MRI activity, £1,113k Surgical Support - Vanguard, £380k ENT - Medinet, £341k General Surgery - BMI Healthcare and 18 week support (with effect from Feb 17) & £207k Ophthalmology -
Premises Services Received Externally	7,614,807	7,530,792	84,015		9,466,285	-1,851,478	-20%	(£664k) Emergency - UCC, medical and a proportion of the nursing staff now provided in-house, (£534k) Radiology - InHealth & (£485k) Gastro - 18 week support - now coded to Services Received Externally, (£201k) Henderson Ward & (£197k) Neurology - cessation of Medinet usage £539k Services - Serco/ Procurement function
CNST Contribution (insurance)	7,640,325	7,640,325	0		6,529,986	1,110,339	17%	Increase in 1617 CNST contributions
Stroke - Pass Through Payments	3,726,142	3,715,030	11,112		3,799,514	-73,372	-2%	
Rates	2,555,462	2,598,363	-42,900		2,581,121	-25,658	-1%	
Consultancy	4,327,093	4,019,788	307,305	£231k PWC Transformation team and external consultants, £52k PMO & £35k Lab Med	2,536,504	1,790,590	71%	Prior year £2,099k incurred for Transformation Project (Newton costs). £4,051k incurred current year for the PWC transformation team and external consultants
Electricity	1,923,515	2,055,594	-132,079		1,959,178	-35,662	-2%	
Rent	1,601,908	1,724,213	-122,305	(£92k) Henderson Ward closure & (£26k) Audiology	1,659,182	-57,274	-3%	(£92k) Henderson ward closure & £43k Cotman Centre
Comp.H/W-Maint	1,674,132	1,543,915	130,217	£141k IT - increase in expenditure	1,685,434	-11,302	-1%	
ISS Transport	1,082,709	1,099,442	-16,732		1,092,983	-10,273	-1%	
Printing & Stationery	1,138,152	1,124,783	13,370		1,069,809	68,343	6%	
Travel & Subsistence	1,399,802	1,233,742	166,060	£26k T&O, £22k Paediatrics, £18k Radiology, £14k Public Health Trainees (income-backed), £14k Dermatology, £13k Vascular Surgery, £12k Ophthalmology, £10k General Surgery & £10k Community Midwives	1,078,584	321,217	30%	£76k Anaesthetics, £33k Services, £31k T&O, £27k Ophthalmology, £23k Paediatrics, £21k Radiology, £20k Obs & Gynae, £19k General Surgery, £16k Lab Med & £13k Dermatology
Gas	840,022	842,894	-2,872		916,791	-76,769	-8%	
Computer equipment and materials	717,813	728,346	-10,532		840,026	-122,213	-15%	
Postage	644,791	586,790	58,001		615,034	29,757	5%	
Training	437,013	438,970	-1,956		716,720	-279,707	-39%	(£109k) NANIME - will be offset by income underachievement, as income funded
Operating leases	609,466	609,466	0		587,592	21,875	4%	
Professional fees	518,346	80,647	437,699	£131k Armed Forces Programme, funded by Education and Training income & £22k NANIMF	573,757	-55,411	-10%	
Other non-clinical supplies	7,056,061	7,038,600	17,461		7,070,043	-13,982	0%	
Sub-Total	51,031,806	50,146,305	885,501		44,778,541	6,253,265	14%	
Specialty CIP - Non Clinical Supplies	0	-488,543	488,543		0	0	0%	
Sub-Total	0	-488,543	488,543		0	0	0%	
Research & Development								
Clrn Payments - Pass Through Payments	15,730,081	16,900,492	-1,170,411	NNUH hosts the Clinical Research Network for the East of England (previously the Trust hosted the CLRN for just Norfolk and Suffolk). Expenditure is a pass through cost matched to income	16,722,777	-992,697	-6%	
R&D (Non CLRN)	903,532	-210,340	1,113,872	Research Capability Funding programme slippage (£428k). Other programme slippage (£264k). R&D reserve £1,806k. Expenditure is a pass through cost matched to income	826,274	77,258	9%	
Clinical Trials	-56,293	0	-56,293		-47,840	-8,453	18%	
Sub-Total	67,609,126	66,347,914	1,261,212		62,279,753	5,329,374	9%	
Reserves	-508,526	-522,982	14,456		-160,942	-347,584	216%	
Grand Total	**67,100,600**	**65,824,932**	**1,275,668**		**62,118,811**	**4,981,789**	**8%**	

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

Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

High Risk Tracker - Lead Director Emma McKay

This high risk tracker highlights all current risks on the Risk Register that have a Residual Risk Rating of 15+. Each risk is summarised below together with its current score and trend data (3-month and 6-month). A direction of travel over the last 3 months is also displayed. The final column details the anticipated date for the reduction or resolution of the risk. (Updated 10/03/2017)

Ref	Risk Name	Current RR			RRR Score			Date Risk added	Executive Lead	Date of Last review	Latest Status report	Anticipated Date for reduction or resolution
		C	L	R	1mth ago	2mth ago	3mth ago					
RR.012	Failure to achieve key local and national operational performance targets	4	4	16	<>	<>	<>	13/10/2015	R.Parker	10/03/2017	IST review complete. System escalation (NHSI and NHSE) in February 2017. Trajectory to achieve by October 2018	Oct-18
RR.018 & RR.734	Failure to ensure sufficient numbers of staff are in place to deliver the services.	4	4	16	<>	<>	<>	03/04/2014 (RR0018) 15/11/2016 (RR.734)	J. Over (RR.018) Emma McKay (RR.734)	10/03/2017	Level of nursing vacancies remains static. Initiatives continue to address the risks: - progressing staffing acuity review in March 2017. 5 wards are piloting SafeCare (acuity tool that works alongside E-Roster) - Denton, Gateley, Holt, Knapton, Kimberley . - continue to implement "break Glass2 for agency backfill - weekly pay introduced for bank staff to assist with "Grow the Bank" initiative - escalation ward closed to support refurbishment programme, which reduces need to redeploy staff from other areas.	Apr-17
RR 359	Outpatient capacity Ophthalmology	4	4	16	<>	<>	<>	29/04/2015	R.Parker	09/03/2017	Newmedica service further expanded but not yet providing 5 day a week service as per contract. The extra activity is assisting with glaucoma follow ups, and backlog has slightly reduced.Follow up backlogs in other subspecialties have not been addressed due to increases in new referrals and waiting list size, resulting in a need to refocus extra clinics from follow up to new. Two vacancies in junior doctor team limiting ability to backfill clinics, resulting in more WLI.	Apr-17
RR 384	Chemotherapy demand & capacity	4	4	16	<>	<>	<>	26/06/2013	R.Parker	09/03/2017	WDU remains on target for reopening on 27th March 2017. Risk will be mitigated once WDU is operational.	Apr-17
RR 476 RR 605 RR 393	IRU capacity incorporating RR 605.Renal fistula waits for IRU RR. 393 Vascular waits for IRU	4	4	16	<>	<>	<>	03/06/2014	R.Parker	09/03/2017	Interventional Radiology developement is at the final stages of the outline business case. Intention for htis to be an additional floor on the East Block, likely to be achieved through a 'managed equipment contract'. Business case is going to the Trust Board in May 2017.	Jun-18
RR 510	Deferral of annual refurbishment programme - Pharmacy production	3	5	15	<>	<>	<>	06/11/2014	R.Parker	10/03/2017	Options appraisal and business continuity plan awaiting finalisation before being submitted for Divisional review	Apr-17
RR 538	Waiting times for pacemaker implantation - Cardiology	5	3	15	<>	<>	<>	03/06/2015	R.Parker	10/03/2017	250 patients waiting upto 19 weeks currently. Plans from April 2017 to introduce a 3 wave day through cath labs and formalise weekend working capacity. The ability to deliver this plan would be compromised by use of Radial Lounge for escalation/stepdown.	May-17
RR 635	Capacity for O&G Ultrasound	3	5	15	<>	<>	<>	12/12/2015	P. Chapman	10/03/2017	Audit results are under review by Obstetric Service Director and once signed off, business case will be submitted for Divisional review and approval.	Mar-17
RR.735	Increase risk of cybercrime and cyber attacks involving the use of Ransomware in the NHS which have the potential to cause the IT infrastructure unusable and patient data inaccesible.	5	3	15	<>	<>	New	07/12/2016	R. Parker	10/03/2017	Funding secured to purchase InterceptX software, which works on the basis of scanning for "behaviours" rather than known threats. Software tested and being rolled out to Trust workstations - currently 2000 of 5000 workstations have this installed. Business case in development by IT for additional staffing resources to support future Network and IT security developments.	May-17
The following risks will be removed from the HRT as following review in March there has been a reduction of the residual score as displayed to under 15+.												
RR 511	Deferral of annual refurbishment programme - Wards	3	1	3	<>	<>	<>	06/11/2014	R.Parker	09/03/2017	Refurbishment programme has commenced and is no longer deferred, therefore risk as stated has been mitigated	Feb-17
RR 604	Inpatient diabetes insulin errors	4	3	12	<>	<>	<>	06/11/2015	P.Chapman	09/03/2017	Increased hours and uplift of staffing to provide leadership to DISN team. Additional training for VRII is in place. Working towards a solution with EPMA.	Apr-17