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

NHS
Norfolk and Norwich University Hospitals
NHS Foundation Trust

MEETING OF THE TRUST BOARD IN PUBLIC

FRIDAY 29 MARCH 2019

A meeting of the Trust Board in public will take place at 9.30am – 10.30am on Friday 29 March 2019 in the Boardroom of the Norfolk and Norwich University Hospital

The formal meeting will be preceded by clinical and departmental visits between 8.30am - 9.15am – schedule to follow

AGENDA

	Item	Lead	Purpose	Page No
	Reflections on the visits	All		
1	Apologies and Declarations of Interest			
2	Minutes of the Board meeting held in public on 25.01.19		Approval	**2**
3	Matters arising		Discussion	
4	Chief Executive's Report	CEO	Discussion	**12**
5	Reports from Board Committees: (i) Quality Programme Board (12.03.19)	MD	Information	**19**
6	Infection Prevention and Control Action Plan	NF	Discussion	**35**
7	Integrated Performance Report - Quality, Safety & Effectiveness - Caring & Patient Experience - Performance & Productivity - Workforce - Finance	Execs	Information	**43**
8	Feedback from Council of Governors	Chair	Information	**Verbal**
9	Any other business			

Date and Time of next Board meeting in public
The next Board meeting in public will be at 9.30am on Friday 31 May 2019 in Room UG55.B+C of the Quadram Institute, Norwich Research Park

Norfolk and Norwich University Hospitals NHS Foundation Trust

MINUTES OF TRUST BOARD MEETING IN PUBLIC

HELD ON 25 JANUARY 2019

Present:	Mr J Fry	- Chairman
	Mr C Cobb	- Acting Chief Operating Officer
	Mr M Davies	- Chief Executive
	Prof N Fontaine	- Chief Nurse
	Mr M Jeffries	- Non-Executive Director
	Mr J Hennessey	- Chief Finance Officer
	Dr G O'Sullivan	- Non-Executive Director
	Professor D Richardson	- Non-Executive Director
	Mrs A Robson	- Non-Executive Director
In attendance:	Ms F Devine	- Director of Communications
	Mr J P Garside	- Board Secretary
	Mr S Hackwell	- Director of Strategy
	Mr A Lundrigan	- Chief Information Officer
	Ms V Rant	- Assistant to Board Secretary
	Ms P Slinger	- NHSI Improvement Director
	Members of the public	

19/001 **APOLOGIES AND DECLARATIONS OF INTEREST**

Apologies were received from Professor Denton, Mr How and Mr Over. No conflicts of Interest were declared in relation to matters for consideration by the Board.

19/002 **MINUTES OF PREVIOUS MEETING HELD ON FRIDAY 30 NOVEMBER 2018**

The minutes of the meeting held on Friday 30 November 2018 were agreed as a true record and signed by the Chairman.

19/003 **MATTERS ARISING**

The Board reviewed the Action Points arising from its meeting held on 30 November 2018 as follows:

18/046 Carried forward. Mr How noted that around 20% of cancelled operations had been due to 'equipment failure/unavailability' (IPR Additional Slide 22b) and asked if these two issues could be reported separately to assist review of equipment failure in particular, given the constraints on our capital expenditure. Mr Parker explained that this is proving difficult to implement but should remain as an action until we find a solution. **Action: Mr Cobb**

18/046 Carried forward. Mr Lundrigan reported that the format of the IPR is being revised and a revised draft should be ready for review in January.
Action: Mr Lundrigan

18/046 Carried forward. With regard to the number of clinical and non-clinical patient moves, Mr Fry asked whether it would be possible to undertake some sample testing, to aid Board understanding and assurance. Mr Cobb thought that this would be possible – we can see the total number of moves and need to look beneath this. Dr O'Sullivan highlighted that it is important that this is established urgently.
Action: Mr Cobb/Professor Denton/Professor Fontaine

18/046 Carried forward. Mr Cobb suggested that review of the Internal Audit report concerning Theatre Productivity should be scheduled for February. **Action: Mr Cobb**

18/047 Mrs Devine has circulated a report providing an overview of accreditations or areas in which the Trust has been recognised for its services. Action closed.

18/053(a) With regard to the time for recognition and treatment of sepsis, Professor Fontaine explained that we are confident that clinicians are screening patients for sepsis and rapid treatment is being initiated. The manual processes of data collection are however cumbersome and this will be resolved when e-obs system is introduced. Action closed.

19/004 **REFLECTIONS ON DEVELOPMENT AND ASSURANCE VISITS**

Board members reflected on the visits they had undertaken immediately prior to the Board meeting, to a number of clinical and departmental environments across the hospital estate.

i) Edgefield Ward: Mr Garside reported that he had visited Edgefield Ward. The Ward appeared clean, tidy and well-ordered. He had spoken with Matron, Nurse Specialist, Receptionist, staff nurse, a newly recruited nurse graduating from UEA and the housekeeper. Each member of the team seemed happy, committed and positive about their work. The difficulties experienced on the ward in the past seem to have been resolved and the nurses reported that the medical staff are similarly positive about the ward and its services for patients.

ii) Pharmacy: Professor Richardson reported that he and Mr Hackwell had attended the Pharmacy Department. Professor Richardson reported that they had found a team of staff that were committed and included a number of UEA graduates.

Working conditions were challenging with overcrowding, small offices to accommodate a lot of people and a lack of work stations. There were technical challenges in respect of the robot which was not as reliable as it should be. Staff were asked about the mechanisms in place for escalation of issues that were not within their remit to resolve. It was apparent that there was a process in place and Mr Hackwell was already aware of the issues, indicating that the system is working. Professor Fontaine also noted that the issue with pharmacy transformation was raised by the Division at the recent Divisional Performance Review – indicating 'floor to Board' escalation of risks.

Staff were energetic, enthusiastic and committed in their roles but an increase in numbers has put a severe strain on physical space that they are working within. Mr Hackwell indicated that the Pharmacy Department will be introducing a 7 day service in February. Refurbishment of the department will be difficult as there are no spaces to which it can be easily decanted but we are working to find a solution so that this can be done.

Mr Garside suggested that it may be helpful for the Finance & Investments Committee to review the refurbishment plans for the Pharmacy.

Action: Mr Hackwell

Professor Richardson highlighted that there was a shortage of students graduating from pharmacy programmes across the UK. Recruitment and retention of UEA graduates has been strong but the limitations on available dispensing training space is a bottle neck for increasing the number of students. There may be opportunity to work together on a solution to increase space and

increase training facilities. Potential for development of a co-located dispensary space with UEA will be explored. **Action: Mr Hackwell**

Mr Lundrigan informed the Board that NHS Digital had visited our Pharmacy Department and had recognised the need to plan replacement of the robot. Enthusiasm of staff was noted and pharmacists working within the ward teams was a practice that had not been observed elsewhere.

iii) Radiology: Professor Fontaine reported that she and Mr Davies had visited the Radiology department, an area that had been criticised by the CQC at their last inspection. It was notable that they encountered a team that was proud of their work and focussed on governance. They were committed to quality improvement and have started projects based on quality improvement methodology, with a sense of commitment and energy.

Mr Davies commented that the team had responded to the CQC recommendations. They spoke positively about recent leadership training and plans for the future.

iv) Cringleford Ward: Dr O'Sullivan reported that she had visited Cringleford Ward with Mr Lundrigan. This ward is now focussed on orthopaedic patients having hip and knee joint surgery. The Ward Housekeeper has recently won an award. Staff were busy but the matron (Mr Danny Brewster) reported 100% rates of compliance with appraisal and 92% for mandatory training.

Dr O'Sullivan highlighted that the Electronic Discharge Letter compliance was 100% and these were completed by nursing staff/practitioners. This would seem to be a good precedent for other departments.

Mr Lundrigan reported that they had talked to staff about theatre systems and pre-assessment opportunities. Dr O'Sullivan reported there was good evidence of staff focus on quality improvement. Overall, Cringleford ward was perceived as being a happy, clean ward.

Professor Fontaine informed the Board that Sister Claire Brown was having a positive influence on the ward and staff were enthusiastic to come and work on the ward.

v) Buxton Ward: Mr Hennessey explained that he had visited Buxton Children's ward with Mrs Robson and Mr Cobb. Staff were proud and wanted to show-off their ward. There were clear issues regarding space and storage on the ward, but the staff were conscious of these and are looking at possible solutions. There had been discussion about budgets and there is a good relationship with the finance business partner – it was good to see that system is working.

Mrs Robson reported that staff were positive and complimentary about the Divisional Nurse and Chief Nurse. They know the channels for raising issues and are using them and feel they are being responded to. There was however an overwhelming feeling of clutter, particularly in the day unit, where there is also no sluice. Mr Cobb commented that staff recognise that the space is inadequate and are looking for actions to resolve issues.

Training, recruitment and the issues of student retention were discussed. Professor Fontaine reported that the level of student nurse training had been discussed with the Dean and we are working with the UEA to look at ways to increase the number of training spaces for paediatric nurses.

vi) AMU: Mr Jeffries reported that he had visited AMU with Mr Fry and met with Sister Kate Freeman. Patient flow and difficulties in identifying free beds in the hospital was a recognised issue.

The ward refurbishment has worked well and the working pods for doctors felt and looked right. The ward appeared calm and ordered but the drug fridge had not been checked every day, but had been checked recently, as had the resuscitation trolley. There were some issues with facilities management – waiting for notice boards to be remounted and walls painted.

19/005 **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.

(i) Winter Pressures

Mr Davies highlighted that the pressure of non-elective demand has been ramping up and our staff have been working extraordinarily hard to deal with new levels of activity on a daily basis. There has been a 10% increase in A&E attendances, a 15% increase in ambulance arrivals and we are admitting around 50% of these patients. It is difficult to determine how long this level of demand will continue.

One of the biggest operational challenges has been the number of ambulances arriving at A&E and the length of time that ambulances are waiting to handover patients. We perform better on some days than others but know this is something we must continue to improve. The number of ambulances on the road has increased and the number arriving at A&E has increased accordingly.

Mr Fry highlighted that our work to treat patients and send them home more rapidly has helped to lessen pressure but it is possible that some patients are being brought to hospital unnecessarily. Mr Davies agreed that this is something that should be reviewed with the Ambulance Trust but it may be an inevitable consequence following the increased number of ambulances that are now on the road. We continue to escalate delayed transfers of care to the Director at Social Services.

Mr Jeffries asked about the assumption of increased ambulance arrivals in the Winter Plan. Mr Cobb explained that that the assumption was 3-5% which is the historical norm, but the actual activity is way above that.

(ii) CQC

Mr Davies reminded the Board that there will be three parts to the CQC inspection process: service inspection; Use of Resources; and Well-led review. The first part of the inspection took place on 22 and 23 January.

(iii) Digital

The Board was informed that there is increasing optimism regarding the Digital Strategy following the Board's decision to support the Electronic Data Management System. The Executives are exploring opportunities to implement the electronic observation system. Mr Ed Prosser-Snelling (Consultant Obstetrician) has been appointed as Chief Clinical Information Officer to provide additional clinical leadership to improve our digital systems.

Mr Fry asked when the Board can expect to see the business case for e-obs. Mr Lundrigan explained that a briefing paper has been reviewed by the Management Board. We are talking to two market leading suppliers, about both hardware and software. Mr Davies commented that the clinical and operational advantages are well

understood – the issue is how we can make the finances work. This needs to form part of next year's financial plan. The aim will be to bring an E-obs OBC to the Board in March and it may be helpful for the F&IC to review first. **Action: Mr Lundrigan**

19/006 **QUALITY AND SAFETY IMPROVEMENT STRATEGY**

The Board received a report from Professor Fontaine and Barbara Hercliffe (Head of Patient Safety Improvement) concerning the Quality and Safety Improvement Strategy.

Professor Fontaine informed the Board that this was a first draft of the Quality and Safety Improvement Strategy which aims to set out our ambition and the journey we will take to achieve a rating of 'outstanding' within the next five years. The Strategy was presented and discussed at the Council of Governors meeting on 23 January 2019.

The Strategy will provide staff with a clear focus on quality of care and our ambition to develop a culture of learning and continuous improvement at all levels for patients. The Quality Improvement Programme will address the immediate concerns raised by the CQC inspection and will set the baseline for our longer term objectives and priorities. The Strategy sets out our five year ambition of quality improvement, setting out how we will improve and assure quality of services to outstanding.

We are exploring introduction of a Quality Improvement Faculty that will provide clinical teams with access to science and research innovations to bring about service improvements for patients. This is something that could also be extended across the STP.

Work is underway to develop quality improvement methodology and a number of staff have joined up to become Quality Improvement Science Trainers. We are also looking to introduce a support team in place to lead/support delivery of improvements. It is anticipated that statistical support may be needed and this is something that might be considered collaboratively with the UEA.

Work is underway to identify the Quality Priorities for 2019/20 and the indicators that will be tracked and measured under patient safety, clinical effectiveness; and patient experience.

We are planning to undertake a consultation on the Strategy with staff, service users and stakeholders. Governors have indicated that they would like to be included.

The Quality Improvement Strategy will undergo further development before it will be ready for review by the Council of Governors and Trust Board. Professor Fontaine will provide Mr Garside with an indication of when the Quality Improvement Strategy will be ready for the Board to review so that this can be added as an agenda item for a meeting in March or April. **Action: Professor Fontaine**

Dr O'Sullivan informed the Board that the Quality Improvement Strategy had been reviewed at the Quality and Safety Committee meeting on 16 January 2019.

Professor Fontaine highlighted the self-assessment template for the CQC Well-led domain (quality, innovation and sustainability) at Appendix 1 of the report. Mr Garside asked whether these were questions that are likely to be asked by the CQC about the Quality Improvement Strategy and this was confirmed.

19/007 **REPORTS FROM BOARD COMMITTEES**

(a) Quality Programme Board

The Board received a report from Mr Davies as Chair of the Quality Programme Board. Mr Davies reported that Dr O'Sullivan has joined the QPB and this is a very welcome and helpful increase in the NED representation on the membership. The QPB is working well, with good open discussions and good engagement from the divisions.

Mr Davies reported that there is a robust process for collecting the evidence of implementation of the Quality Improvement Plan. Mr Hennessey agreed – noting that he had attended the Evidence Committee and had been impressed by the thoroughness of the approach. Mr Davies reported that there had also been positive feedback from NHSI with regard to the approach to assessing the evidence of compliance with CQC recommendations.

Mr Fry reported that the QPB meetings are thorough, well organised and there is good engagement with a lot of people in the room. Mr Davies suggested that the QPB is now likely to remain as part of our governance structure, providing a monthly focus on quality with NED involvement.

(b) Quality and Safety Committee

The Board received a report from Dr O'Sullivan concerning the Quality and Safety Committee meeting held on 16 January 2019.

The Committee had started its meeting by attending one of the daily meetings in the Operations Centre, followed by a discussion with members of the Winter Team.

Committee members reported that they were impressed by how well people were working together, systematically reviewing the position across the hospital in a way that was inclusive and multi-professional.

Dr O'Sullivan reported that she had also attended the subsequent meeting which had focussed specifically on the safe-staffing tool and had seen how staff are allocated depending on operational pressures, patient needs and safety concerns. The structured and careful way this process was conducted was reassuring.

Dr Irvine (Consultant Anaesthetist) had attended the meeting to update in relation to our screening for and management of sepsis. An electronic observation system would help detection but in the meantime the focus is on education and training and awareness of staff.

Dr O'Sullivan reported that we have been reviewing how the Committee works. To enable oversight of safety, effectiveness and patient experience within each division, the Committee will be inviting divisional representatives to come to meetings on a rotational basis, starting with Surgery in February and following a standard format guided by Professor Fontaine and Professor Denton.

The Committee will also be using the BAF and High Risk Tracker to establish the areas of focus for its future meetings. At the next meeting the Committee will be reviewing a report from Mr Hackwell on equipment replacement and the process for managing associated risks to quality and safety arising from equipment failure.

19/008 **INTEGRATED PERFORMANCE REPORT**

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

(a) Quality, Safety and Effectiveness

Professor Fontaine reported that completion of Electronic Discharge Letters within 24 hours of discharge was 77% in December. A review has been undertaken with our

clinicians to determine what actions should be taken towards improvement and to reduce any safety risks for our patients. A new initiative has been introduced where Junior Doctors can opt in and be paid for completing EDLs. This approach has been successful at the JPUH.

Mr Fry asked if the Junior Doctors will have prior knowledge of the patients for whom they will be completing the EDLs. Mr Cobb confirmed that the doctors will be completing EDLs for patients within their service and reported that six doctors had signed up to do this for their wards so far.

Mr Cobb informed the Board that a second initiative is also being introduced to encourage criteria-led discharge. This will ensure that patients have structured plans in order to facilitate discharge. It is hoped that these two initiatives will work well together and assist in timely discharge of patients.

Mr Jeffries asked about the remuneration for completion of EDLs and asked how the quality of EDLs would be maintained. Mr Cobb confirmed that the Junior Doctors would be paid £10 per EDL and regular audits will be carried out to ensure quality is maintained.

Professor Fontaine reported that there had been a reduction in Duty of Candour compliance which was 80% in December against the 100% target. This had occurred in two areas where the teams had not met the time constraints and additional support has now been implemented to prevent recurrence.

HSMR performance remains good and we remain in the best quartile for our performance.

Key issues relating to safety and effectiveness are:

- paper-based systems and need for E-Obs system;
- supply of medicines due to Brexit;
- ownership of Never Event actions – this now falls under the remit of the Divisions with onward reporting to the Clinical Safety and Effectiveness Board. The Department of Health research group will be working with us on behaviours and Never Events;
- capital equipment plans – capital expenditure being prioritised according to patient need and clinical risk;
- the number of Serious Incidents reported has increased by 50% over the last year. Most incidents are reported as low/no harm and this is an indication of good reporting practice. There are also more reported serious incidents that are de-escalated following review.

Mr Jeffries highlighted that there was no colour coding on the patient safety quality priorities table (Corse slide 2). Professor Fontaine confirmed that this would be reviewed and that national criteria would be added to assist oversight of sepsis performance where this is available. **Action: Professor Fontaine**

(b) Performance and Productivity

Mr Cobb informed the Board that good progress has been made in January to clear the backlog patients on the 62 day cancer pathway and performance is expected to recover to 85% in February. Urology has the highest number of waiting patients, primarily prostate patients. We are reviewing those patients who have been kept waiting and there has been no harm recorded for these patients. Performance in the two week wait pathway was affected by high numbers of referrals but is now recovering.

A&E 4 hour wait performance (including Walk-in Centre) was 82% in December 2018. Demand in the early part of December was in line with expectations but we saw a higher level of demand than anticipated in the latter part of the month. There was an increase in the number of major attendances but it has not been possible to identify any trends in the patients coming to A&E.

There has an increase in the number of ambulance handovers greater than 60 minutes. A trajectory for recovery has been agreed and we working to embed changes to eliminate extended handover waits by 31 March 2019. The Winter Plan was effective until Boxing Day at which point we were overwhelmed by emergency activity/demand.

Regarding RTT, the Board was reminded of the national focus to reduce the number of patients waiting over 52 weeks. Mr Cobb informed the Board that we are working towards zero patients waiting over 52 weeks by the end of March and the Interventional Radiology Team and Surgeons have agreed to work additional hours to achieve this. Mr Davies expressed thanks to the doctors, nurses, technicians and administrators for their commitment towards treating these longest-waiting patients. To do this many are working 6 days per week between now and end of March.

The SSNAP rating in December was B (80%) but performance is expected to recover to a rating of A in the New Year.

Dr O'Sullivan noted that the Emergency Department has been extremely busy and on alert status OPEL4, requiring elective work to stop and asked what impact this was expected to have on the RTT performance. Mr Cobb explained that when the hospital is at OPEL4 status, we do not cancel cancer patients and we do not stop the elective programme entirely – because we continue to admit cancer patients and patients of the highest priority wherever possible. We suspend other surgery, such as orthopaedics, where it is considered safe to do so. The plan to recover orthopaedic performance is reliant on the hospital returning to OPEL3 status.

Mr Davies highlighted that national criteria would require the hospital to close its doors to A&E patients if OPEL4 status was triggered. We consider that this would not be the safest action for our patients and we therefore maintain services for patients.

(c) Workforce

In Mr Over's absence, Mr Davies invited questions relating to the Workforce section of the IPR. Mrs Robson noted that whilst we seem to have good news relating to improved performance on appraisal and mandatory training, the figures on slide 32, 33 and 34 appears to be mislabelled. Mr Lundrigan said that he would look into this.

Action: Mr Lundrigan

(d) Finance

Mr Hennessey informed the Board that the deficit in the year to date is £46.7m which is £4.5m worse than the budget plan. Clinical income was £1.9m behind plan and pay costs were £1m worse than plan in December. The financial position in December was mitigated by £0.24m opening balance sheet review and £0.25m in year accruals resulting in a position that was £2.7m adverse to Plan.

Each of the Divisions fell behind plan in December. The increased non-elective activity has continued to impact on elective activity and the Surgery Division is £6.965m behind plan in the year to date with £6.2m of this variance being driven by clinical income. As non-elective activity increases the impact of the Marginal Rate Tariff grows.

Mr Hennessey reminded the Board that the CCG contractual requirements and marginal rate tariff are due to change in 2019. In the meantime, the Trust is negotiating the amount of income for 2018/19 for over performance in activity against the CCG contract. The Trust will be in a position to reforecast for 2018/19 at the end of the quarter and this is likely to be a deficit of £58.8m.

CIP performance in the year to date is £18.9m against the full-year plan of £30m. £28.5m cost improvement initiatives have been approved through Gateway 2 and £1.4m are being processed through Gateway 1. The Divisional Directors are being encouraged to identify schemes that will move us to our target.

Mr Jeffries asked if there were rigorous approval processes in place to maintain pay costs. It was confirmed that there are robust processes in place for new posts. We are also reviewing where there have been delays in recruitment to see what can be done to speed up processes to avoid temporary staffing costs.

19/009 **FEEDBACK FROM THE COUNCIL OF GOVERNORS**

Mr Fry informed the Board that the Council of Governors had met on 23 January in the Quadram Institute. Two new governors have joined the Council – Ms Jacqueline Hammond and Mr Matthew Roe. At its meeting the Council received a report from Mr Over concerning cultural development of our workforce and organisation. The Council also received a report from Mr Hackwell concerning Norfolk acute services and capacity covering the work undertaken by external consultants projecting a shortage of around 200 beds. The Quality Improvement Strategy was also discussed by the Council.

19/010 **ANY OTHER BUSINESS**

There was no other business.

19/011 **BOARD IN ITS CAPACITY AS CORPORATE TRUSTEE**

(a) Charitable Fund Expenditure Requests

In its capacity as Corporate Trustee the Board received a number of requests for expenditure of charitable funds, in excess of £10k. These were for:

- Refurbishment of control room for Linac 2;
- CCT Rheumatology Fellow extension of post until 31 December 2019;
- Enabling installation of a second CT scanner.

The proposed expenditure was confirmed to be consistent with the objects of the relevant charitable funds and in its capacity as Corporate Trustee, the Board **approved** expenditure of charitable funds as requested.

19/012 **DATE AND TIME OF NEXT MEETING**

The next meeting of the Trust Board in public will be at 9am on Friday 29 March 2019 in the Boardroom of the Norfolk and Norwich University Hospital.

Signed by the Chairman: …… Date: ……

Action Points Arising:

	Action
19/003	Carried forward. Mr How noted that around 20% of cancelled operations had been due to 'equipment failure/unavailability' (IPR Additional Slide 22b) and asked if these two issues could be reported separately to assist review of equipment failure in particular, given the constraints on our capital expenditure. Mr Parker explained that this is proving difficult to implement but should remain as an action until we find a solution. **Action: Mr Cobb**
19/003	Carried forward. Mr Lundrigan reported that the format of the IPR is being revised and a revised draft should be ready for review in January. **Action: Mr Lundrigan**
19/003	Carried forward. With regard to the number of clinical and non-clinical patient moves, Mr Fry asked whether it would be possible to undertake some sample testing, to aid Board understanding and assurance. Mr Cobb thought that this would be possible – we can see the total number of moves and need to look beneath this. Dr O'Sullivan highlighted that it is important that this is established urgently. **Action: Mr Cobb/Professor Denton/Professor Fontaine**
19/003	Carried forward. Mr Cobb suggested that review of the Internal Audit report concerning Theatre Productivity should be scheduled for February. **Action: Mr Cobb**
19/004(ii)	Mr Garside suggested that it may be helpful for the Finance & Investments Committee to review the refurbishment plans for the Pharmacy. **Action: Mr Hackwell**
19/004(ii)	Professor Richardson highlighted that there was a shortage of students graduating from pharmacy programmes across the UK. Recruitment and retention of UEA graduates has been strong but the limitations on available dispensing training space is a bottle neck for increasing the number of students. There may be opportunity to work together on a solution to increase space and increase training facilities. Potential for development of a co-located dispensary space with UEA will be explored. **Action: Mr Hackwell**
19/005(iii)	Mr Fry asked when the Board can expect to see the business case for e-obs. Mr Lundrigan explained that a briefing paper has been reviewed by the Management Board. We are talking to two market leading suppliers, about both hardware and software. Mr Davies commented that the clinical and operational advantages are well understood – the issue is how we can make the finances work. This needs to form part of next year's financial plan. The aim will be to bring an E-obs OBC to the Board in March and it may be helpful for the F&IC to review first. **Action: Mr Lundrigan**
19/006	The Quality Improvement Strategy will undergo further development before it will be ready for review by the Council of Governors and Trust Board. Professor Fontaine will provide Mr Garside with an indication of when the Quality Improvement Strategy will be ready for the Board to review so that this can be added as an agenda item for a meeting in March or April. **Action: Professor Fontaine**
19/008(a)	Mr Jeffries highlighted that there was no colour coding on the patient safety quality priorities table (Corse slide 2). Professor Fontaine confirmed that this would be reviewed and that national criteria would be added to assist oversight of sepsis performance where this is available. **Action: Professor Fontaine**
19/008(c)	In Mr Over's absence, Mr Davies invited questions relating to the Workforce section of the IPR. Mrs Robson noted that whilst we seem to have good news relating to improved performance on appraisal and mandatory training, the figures on slide 32, 33 and 34 appears to be mislabelled. Mr Lundrigan said that he would look into this. **Action: Mr Lundrigan**

REPORT TO THE TRUST BOARD (in public)

Date	**29 March 2019**
Title	**Chief Executive's Report**
Purpose	**To update the Board on matters relating to the Trust that are not covered elsewhere in the papers.**

The intention of this report is to briefly cover matters that are not addressed elsewhere in the papers.

In particular:

i) Improved position relating to ambulance handover
ii) Visit of Secretary of State for Health and Social Care
iii) Appointment of NNUH as Host of East of England Cancer Alliance Radiotherapy Network
iv) Business Leader Engagement
v) Interim Workforce Implementation Plan: Emerging priorities and actions

Recommendation:
The Board is recommended to **receive** this report for information.

CHIEF EXECUTIVE'S REPORT TO TRUST BOARD 29 March 2019 (Public)

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

1 FOCUS ON QUALITY AND SAFETY

1.1 Ambulance Handover

Board members will be aware of the difficulties that we have experienced with regard to accommodating the increased number of patients arriving at our Emergency Department by 999 Ambulance. This has resulted in some significant delays in ambulance handovers when the hospital has been full.

A great deal of work has been undertaken by teams across the hospital to help to improve the position and, at the time of writing, we have achieved a stretch of 15 consecutive days with no ambulance waiting over 60mins. This compares very favourably to other hospitals in the region and has been achieved even in a period when the hospital has been extremely busy, even to the point of utilising the renal dialysis unit as an inpatient escalation area.

The Board will be updated on the position at its meeting but is asked to note the very significant collective effort behind achieving this level of improved performance.

1.2 Oversight and Assurance Group (OAG)

The latest of the monthly OAG meetings was held on 21 March, involving a range of representatives from within and external to the Trust. The presentations this month related to the work that we are undertaking with regard to infection prevention and control and in the Emergency Department. They were excellent and were well received.

2 REGULATORY CONTEXT

2.1 NHS Access Standards

The NHS National Medical Director has released an interim report about the clinical led review of NHS Standards. The report proposes significant changes to access standards. Work is underway to establish the implications when the new rules come into effect and this will inform the Board's discussions on capacity planning.

A copy of the full report can be accessed via the following link:
https://www.england.nhs.uk/wp-content/uploads/2019/03/CRS-Interim-Report.pdf

2.2 Visit of Secretary of State for Health and Social Care – 28 February 2019

We were very pleased to welcome the Secretary of State for Health and Social Care, Rt Hon Mark Hancock MP, when he visited the Trust on 28 February 2019.

Whilst at the Trust the Secretary of State visited our new Endoscopy Unit (in the Quadram Institute) and the Weybourne chemotherapy unit. Our staff have been thanked for how well they had showcased their areas. The Secretary of State posted the following statement on Twitter after his visit:

"It was great to see the world-class endoscopy centre at Norwich today. Facilities like this, combined with collaboration between clinical staff and academics, are key to the Long Term Plan commitment to save 55,000 more lives a year through earlier cancer diagnosis.

The team at NNUH are working hard to improve the Trust's performance over all, and I am encouraged by what I saw today."

3 SYSTEM AND PARTNERSHIP WORKING

3.1 Radiotherapy Network

We were delighted to receive the **attached** letter confirming that NNUH has been selected to host the East of England Cancer Alliance Radiotherapy Operational Delivery Network. A central team, based at NNUH, comprising a Programme Manager and Clinical Lead, will work closely with the Chair of the ODN once they have been appointed to shape and lead the delivery of Radiotherapy treatment across a population of approximately six million people.

The key early objectives of the Network will be to co-ordinate actions to:

- Increase access to clinical trials and proven new treatments and techniques, taking advantage of new equipment;
- Develop and implement evidence-based standardised treatment protocols;
- Build a resilient workforce;
- Improve equipment utilisation;
- Improve access to sub-specialist expertise.

The Network covers the following specialist centres:

- Cambridge University Hospitals NHS Foundation Trust
- Colchester Hospital University NHS Foundation Trust
- Ipswich Hospital NHS Trust
- Norfolk and Norwich University Hospitals NHS Foundation Trust
- North West Anglia NHS Trust
- Southend University Hospital NHS Foundation Trust

Appointment to host this network is a significant achievement for the Trust and a further step toward our Strategic Objective to be a centre of excellence for complex and specialist medicine.

3.2 Business Leader Engagement

On 19 March, we held the inaugural event in what is now anticipated to be a programme of occasions in which local business and community leaders are invited to the hospital, to learn more about our organisation and the fantastic work that is done here by our staff. This was an event by invitation, informal and with a small group of four invitees who were taken on a 'behind the scenes' visit.

On this first occasion the attendees were Steve Davidson (Managing Director of Marsh - Norwich), Caroline Jarrold (Jarrolds-Community Affairs Director), Tim Robinson (Chief Operating Officer, Tech East) and Tim Bishop (Chief Executive, Forum Trust). The event was organised by the Hospital Charity Team but was not about asking for money but rather about building relationships. The evening involved an initial discussion including the Chief Executive and Medical Director, followed by a clinical tour accompanied by Dr Michael Irvine (Consultant in Anaesthesia and Intensive Care) and Mr Bhaskar Kumar (Oesophago-Gastric Surgeon).

The invitation was very well received and feedback has been very positive:

"*I enjoyed the visit very much - I was very impressed by the innovation, care and teamwork evident in what we saw. I came away concluding that the public and local businesses need to know more about the excellent contribution and value to the community of all that goes on the hospital. It was particularly encouraging to see the alignment, commitment and togetherness of the management team and I also thank the other colleagues in the operating theatre who gave up their own time to explain some facilities which they all clearly take great pride in being part of.*"

"*You asked for some feedback on the visit so here it is: … The team you had together were fantastic. Everyone answered questions directly, they were collaborating with each other and they seemed genuinely proud of the place and what they were doing. Lisa in theatre and her team were lovely and again the relationship between them and the consultants was just so different to what I've seen in the past. You and your team have a lot to be proud of. And that shone through during our visit*."

"*Thanks to you and the team for a really wonderful tour of the hospital this evening. An absolute eye opener – I left inspired and up-beat about Norwich, Norfolk and the East's current capability and potential.*"

There is real value in the hospital developing and strengthening links with other organisations in the local community. It is intended that we should continue this initiative in order to showcase the work of the hospital.

4 STAFF MATTERS

4.1 Interim NHS Workforce Implementation Plan: emerging priorities and actions

The Prime Minister and Secretary of State for Health and Social Care have tasked Dido Harding (Chair - NHS Improvement) and Julian Hartley (CEO - Leeds Hospitals) to develop an interim Workforce Implementation Plan, as part of the overall Implementation Plan for the NHS Long Term Plan (LTP). We understand that the Interim Plan will be published in early April and will include a 2019/20 action plan together with a more detailed vision of how our the NHS workforce is intended to transform over the next ten years. A full implementation plan will then follow within two months of the conclusion of the Comprehensive Spending Review.

The mission of this piece of work has been described as follows: *"To deliver 21st century care for our patients, we will need a transformed workforce – engaged, motivated and supported; with compassionate and inclusive leadership and working in positive cultures; with sufficient nursing staff and the right number of staff across all disciplines and all regions. We know that we don't simply need more of the same, but also a new skill mix which is more responsive to local patient and population needs. Finally, these actions will need to be delivered through a new workforce operating model where the right activities are done at the right level, whether this is employers, Integrated Care Systems (ICSs), regional or national bodies.*"

A consultation process to inform the 2019/2020 action plan took place earlier in March, which we participated in with Norfolk and Waveney STP colleagues. The People and Culture Committee had already agreed to focus its time at the next meeting in May on NNUH workforce redesign and transformation; the publication of the interim national workforce plan in April is therefore timely and highly relevant.

4.2 Junior Doctors feedback

Attached is an email with some really positive feedback from one of the specialist trainees in Respiratory Medicine, on behalf of the Junior Doctors Forum. There is a whole team of people supporting the work in making NNUH a good place to train as a junior doctor and it is heartening to that this is working and appreciated.

5 RECOMMENDATION

The Board is asked to:

- **note** the contents of this report for information.

Our ref: EoECA/RA/MD/210319

Midlands & East (East)
West Wing
Victoria House
Capital Park
Fulbourn
Cambridge
CB21 5XA

Mark Davies
CEO Norfolk and Norwich Foundation Trust

Via email only

Tel: 0113 8255058
Email: rory.harvey@bedfordhospital.nhs.uk
www.canceralliance.co.uk

21 March 2019

Dear Mark

Thank you for your expression of interest in being the host for the East of England Radiotherapy Operational Delivery Network.

The Cancer Alliance, in tandem with Specialised Commissioning, has given great consideration to the three expressions of interest that it received to host the Radiotherapy Operational Delivery Network.

All Trusts met the principal requirements to host the Network and the supporting information that you sent formed the basis of scoring each Trust against a set of criteria based on the NHS England Radiotherapy modernisation programme, which aims to:

- Increase access to clinical trials and proven new treatments and techniques, taking advantage of new equipment;
- Develop and implement evidence-based standardised treatment protocols;
- Build a resilient workforce;
- Improve equipment utilisation;
- Improve access to sub-specialist expertise.

The scoring was completed by Cancer Alliance leads and Specialised Commissioning. I am pleased to inform you that your trust scored highly and Specialised Commissioning, in partnership with the Alliance, is pleased to offer you the opportunity to host the Radiotherapy Operational Delivery Network.

We will be in contact shortly to discuss the next steps. In the first instance this will be agreed for one year, with a review of the agreed work programme by the Cancer Alliance and Specialised Commissioning.

Congratulations, we look forward to working with you on the important work of modernising the provision of radiotherapy services for patients in the East of England.

Yours sincerely

Rory Harvey

Chair of the East of England Cancer Alliance

Ruth Ashmore

Assistant Director of Specialised Commissioning (East of England)

Cc
Catherine O'Connell
Dr David Levy
Kim Fell

Subject: FW: Fatigue & Facilities Example: good news!

From: Martin, Thomas (NNUHFT) <THOMAS.MARTIN@nnuh.nhs.uk>
Sent: 22 March 2019 15:14
To: Guardian Of Safe Working Hours (NNUHFT Shared) <GuardianofSafeWorkingHours@nnuh.nhs.uk>; Ousseynou Ly <OLy@bma.org.uk>; Rowan Gossedge <rowan.gossedge@doctors.org.uk>
Cc: Susan Law <SLaw@bma.org.uk>; Sam Wakeford <SWakeford@bma.org.uk>; Denton, Erika (NNUHFT) <erika.denton@nnuh.nhs.uk>; Senver, Ece (NNUHFT) <Ece.Senver@nnuh.nhs.uk>; Fletcher, Simon (NNUHFT) <simon.fletcher@nnuh.nhs.uk>; Over, Jeremy (NNUHFT) <JEREMY.OVER@nnuh.nhs.uk>; Judd, Ashley (NNUHFT) <ASHLEY.JUDD@nnuh.nhs.uk>; Jewson, Esther (NNUHFT) <ESTHER.JEWSON@nnuh.nhs.uk>; Kavanagh, Caroline (NNUHFT) <CAROLINE.KAVANAGH@nnuh.nhs.uk>; Barker, Paul (NNUHFT) <paul.barker@nnuh.nhs.uk>; Easby, Deborah (NNUHFT) <deborah.easby@nnuh.nhs.uk>; Rowson, James (NNUHFT) <JAMES.ROWSON@nnuh.nhs.uk>
Subject: RE: Fatigue & Facilities Example

Dear all,

On behalf on the JDF committee and juniors in the hospital thank you so much for all of your hard work at making the NNUH the best hospital in the region, and the most responsive at listening to its junior doctors!

Echoing what everyone else has said, Dr Kavanagh has been instrumental to this achievement, and I have no doubt she probably knows price and size of every single recliner chair between here and Birmingham!

The NNUH is not perfect – yet – but I have no doubt with all of your help we will be a nationally recognised gold standard hospital for night shift working for junior doctors. Perhaps, going forward, some, or all of you would like to meet up and discuss not only how best to continue such outstanding work, but also how to promote all the work you have done… particularly as the NNUH is clearly one of the national leaders!

Finally, I would like to take this opportunity to invite you all to the next JDF meeting. This will be held in the doctors mess, at 12:30 on 12th April. As you will have seen in the email thread, the government has a pot of money specifically to improve the working lives of junior doctors in those trusts who have got on board with the fatigue and facilities charter. In practice, this is £75 000 per trust. It would be fantastic if all of you could be present during the discussions of how best to spend this money, which will be fairly top of the agenda.

Kind regards,

Tom

REPORT TO THE TRUST BOARD

Date	**29th March 2019**
Title	**Quality Programme Board update following 12th March meeting**
Author **Exec lead**	**Jane Robey, Head of Improvement** **Nancy Fontaine, Chief Nurse**
Purpose	**For Information**

1 Background/Context

The Quality Programme Board met on 12th March 2019.

The following documents are attached:

a) Agenda
b) Evidence Group Outcome Reports
c) Risk Register

2 Key Issues/Risks/Actions

Items of note considered at the meeting included:

	Issues considered	Outcomes/decisions/actions
1	Highlight reports	In February, of the Must do & Should do recommendations, we have : • 33 (44%) Blue • 12 (16%) Red • 16 (21%) Amber • 14 (19%) Green
2.	Change control	TW29.1 Complaints – the deadline was extended to 1st June 2019
3.	Outcome of the Evidence Group	The Evidence Group met: • on 27th February, to carry out a deep dive review of the evidence in respect of twenty seven recommendations related to the Section 29A warning notice dated 31st October 2017; • on 7th March, to review the evidence in respect of four recommendations, in addition to six recommendations brought back for review. Three of the four recommendations were approved as BLUE.
4.	Risk register	No new risks were added to the Risk Register; the register was not reviewed during the meeting.

3 Conclusions/Outcome/Next steps

The Quality Programme Board is scheduled to meet again at 9am on Tuesday 9th April 2019, at which meeting the Committee will review:

- Highlight reports from Trust-wide and functional areas for March.
- Recommendations assured as 'Complete and Evidenced' by the 28th March and 4th April Evidence Groups

Recommendation:

The Board is recommended to note the work of its Quality Programme Board.

QUALITY PROGRAMME BOARD AGENDA

Tuesday 12th March 2019 Boardroom 0900-12:00 Hours

	Item	Lead	Purpose	Format
1.	Apologies and declarations of interest	CEO		Verbal
2.	Review of actions, minutes and matters arising	Exec Directors and CODs	To note and discuss	Document
3.	OAG Deep Dives	CEO	Discussion	Verbal
4.	Changes in reporting processes	RRS and Pete Best	Discussion	Verbal
5.	Outcome of Evidence Groups held on 27th February and 7th March	Rosemary Raeburn Smith	Discussion	Documents
6.	Change Control – TW29.1	Rosemary Raeburn Smith	Discussion	Documents
7.	Highlight reports from Trust-wide and functional areas, focusing on: - Blue recommendations (complete and evidenced) - Red recommendations (Off track) - D.I 5.1 Radiology reporting times – status update - NHSi IP&C Recommendation Any successes or concerns that SROs wish to particularly highlight	Exec Directors and CODs	To note and discuss	Slide presentation
8.	AOB			

Date and Time of next meeting: Tuesday 9th April 2019, 09:00 hours, Boardroom

REPORT TO THE QUALITY PROGRAMME BOARD	
Date	**27th February 2019**
Title	**Outcome of Evidence Group**
Author & Lead	**Jane Robey** **Rosemary Raeburn Smith**
Purpose	**For Information**

1 Background/Context

The seventh QIP Evidence Group met on 27th February, to review the evidence in respect of twenty seven recommendations related to the Section 29A warning notice dated 31st October 2017.

The group reviewed the evidence for suitability, relevance, and completeness, using an appreciative enquiry approach, assessing the quality of the evidence supplied by the SRO and action leads and the current level of assurance for each recommendation.

2 Outcome

Eight of the twenty seven recommendations had already been signed off as BLUE (complete and evidenced) at previous Evidence Group meetings. One further recommendation was signed off as BLLUE in this meeting. The group provided guidance as to the additional evidence required to turn the other recommendations BLUE, and offered suggestions how this could be achieved. These recommendations will be brought back to future meetings, when the supplementary evidence will be reviewed.

3 Conclusions/Outcome/Next steps

The Evidence Group is scheduled to meet again at 8.30am on 7th March 2019, at which meeting the Committee is due to consider:

- New potential blue recommendations
- Bring back actions from previous evidence groups

Another Deep Dive review into the Section 29a recommendations will be scheduled for week commencing 18th March 2019 – date and time to be agreed.

Recommendation:

The Quality Programme Board is asked to note the work of its Evidence Group.

1. Apologies and declarations of interest

Alice Richardson (AR); Sara Shorten (SS); Karen Kemp (KK)

2. Introductions

Persons in attendance

The following people attended the meeting:

- Nancy Fontaine (NF), Chief Nurse NNUH (Chair)
- Abbe Swain (AS), Improvement Manager, NNUH
- Aiden Rice (AR), Senior Site Matron, NNUH
- Andree Glaysher (AG), Governance Lead Medicine, NNUH
- Anthony McDonnell (AM), Deputy Emergency Theatres team leader, NNUH
- Caroline Kavanagh (CK), Chief of Service, Winter Directorate, NNUH
- Claire Nash (CN), Improvement Manager, NNUH
- Claire Sewell, CQC
- Cursty Pepper, Winter Room Director, NNUH
- Ed Aldus (EA), Deputy Divisional Operations Manager, Emergency Directorate, NNUH
- Erika Denton (ED), Medical Director, NNUH
- Fiona Allinson (FA), Head of Hospital Inspections, CQC
- Gemma Lawrence (GLa), Mental Health Matron, NNUH
- Gemma Lynch (GLy), Governance Compliance Manager, NNUH
- Hugo Vasconcelos (HV), ED Staff Nurse, NNUH
- Ian Butlin (IB), Medicine Division Risk & Governance Facilitator, NNUH
- Jane Robey (JR), Head of Improvement Team, NNUH
- Jon Green (JG), Director of System Transformation, NNUH
- Katie Smith (KS), Improvement Support Officer, NNUH
- Lisa Reed (LR), Quality & Patient Safety Manager, NN/SN CCG
- Maggie Pacheco (MP), ED Matron, NNUH
- Nye Harries (NH), Associate Director NHS Improvement
- Oliver Mason (OM), ED Staff Nurse, NNUH
- Rachel Cocker (RC), Winter Room Nurse Director, NNUH
- Rosemary Raeburn-Smith (RRS), Programme Director - Quality Improvement Plan, NNUH
- Ruthanne Middleton (RM), Deputy DoD (Medicine), NNUH
- Stacy Hartshorn (SH), Improvement Manager, NNUH

3. Actions for Review and potential sign Off

Outcome of evidence reviews

Ref.	Recommendation	Outcome of Review
Blue Recommendations		
U1.1 and U8.1	The Trust must ensure that the premises for urgent and emergency services protect patients from potential harm and used for the intended purpose. This includes all areas of the service for both children & adults.	Status: Remains Blue No Outstanding actions

U 3.1	The trust must action its plans to expand the children's and adults emergency department, including the provision of a high dependency unit for children outside of the resuscitation department	Status: Remains Blue No Outstanding actions
TW 2.1	The trust must review the knowledge, competency and skills of staff in relation to the Mental Capacity Act and Deprivation of Liberty safeguards	Status: Remains Blue No Outstanding actions
U10.1	The trust must ensure that there is a medical lead appointed for the service.	Status: Remains Blue No Outstanding actions
U12.1	The trust should ensure that regular and minuted mortality and morbidity meetings take place for urgent and emergency services.	Status: Remains Blue No Outstanding actions
U22.1	The trust should ensure that all relevant information is gathered and reviewed during incident investigations, including input from all relevant staff, external stakeholders and specialist providers.	Status: Remains Blue No Outstanding actions
TW 13.1	The trust must ensure that there are effective systems and processes in place to ensure assessing the risk of, and preventing, detecting and controlling the spread of infections, including those that are healthcare associated	Status: Remains Blue There is a separate Trust-wide IP&C action plan following recommendations from NHSi. Progress will be reported to OAG and QPB; IP&C will also be included within the March Evidence Group deep dive. The Rapid improvement plan re IP&C will be completed and sent to NHSi on 27.2.19. **New Action - NF:** Send a copy of the report to NH
Actions for consideration to become blue		
U13.1	The trust should ensure that a safety thermometer is implemented for children's and adult urgent and emergency services.	OUTCOME: BLUE; return in 1 month with evidence of dissemination of learning via CQRM and IPR. **New Action – SH:** Add the CAU evidence to the repository. **New Action - AR/MP:** Evidence dissemination of learning via Newsletter and the ED noticeboard

U7.1	The trust must ensure audio and visual separation between adults and children being assessed and waiting within the emergency department and minor injuries unit	OUTCOME: NOT BLUE. Review again once the following actions are complete and the evidence is available: **New Action – SH**: Add the final, approved version of the SOP to the repository once it's been through due diligence (e.g. Children's Board and Clinical Safety and Effectiveness Sub Board), signed off and uploaded to Trust Docs. **New Action – MP:** Write down the process for dissemination of learning to team via CG meetings, Newsletter etc. **New Action – SH:** Add audit data to the repository.
U14.1	The trust should ensure that sepsis training is available to all staff providing urgent and emergency care.	OUTCOME: NOT BLUE; return for further review once we hit the target of 90%, and have sufficient supporting evidence. **New Action - MP:** Embed into training for new starters and transferees into the department **New Action - SH**: Put the plan in the repository **New Action - SH:** Bring update back to the March evidence group.
U15.1	The trust must ensure there are effective governance processes in place to ensure timely and appropriate capacity and risk assessments for mental health patients are undertaken	OUTCOME: NOT BLUE **New Action - MP**: Introduce an observational audit; include Band 7s, NHSE and CCGs as participants. **New Action - SH**: Add the Enhanced Observation and Support Policy to the evidence repository **New Action - MP:** Ensure sign off of documentation by MH Ops Group and MH Board
Red Recommendations		
U16.1	The trust must review and monitor the use of the Clinical Decisions Unit for patients who present with mental health requirements, to ensure that patients are protected from potential harm	OUTCOME: NOT BLUE **New Action - EA:** Liaise with IT (Lily Hemmings) to put a process in place that allows reporting of patients in CDU, and agree a timeline (agree the timeline by 28th February). **New Action - EA:** Put on the agenda for the U&EC Board. **New Action - SH:** Add final SOP to evidence repository

Amber and Green Recommendations		
U4.1 & U4.2	The trust must review its nursing and medical staffing numbers for the urgent and emergency services and plan staffing acuity accordingly	OUTCOME: NOT BLUE **New Action- AR/MP:** Review rosters, workforce and recruitment strategy and bring updated staffing figures back to next meeting
U9.1	The trust must improve its performance times in relation to national time of arrival to receiving treatment (which is no more than one hour), four-hour target and monthly median total time in A&E.	OUTCOME: Not fully discussed; to be picked up by U&EC Board
U2.1	The trust must ensure that there is a system in place, which is adequately resourced, to ensure that patients are assessed, treated and managed in a time frame to suit their individual needs. (The trust should review its use of the Rapid Assessment and Treatment (RAT) system and ensure this is embedded into practice.)	OUTCOME: Not fully discussed; to be picked up by U&EC Board
U5.1 U6.1 U17.1	Ensure that there is one registered children's nurse at all times within the children's emergency department and take necessary action to increase the number of registered children's nurses employed. Ensure a good skill mix within the children's ED nursing workforce. The trust should continue to monitor and actively recruit to ensure that there is an adequate number of nursing and medical staff with the appropriate skill mix to care for patients in urgent and emergency services. Nursing vacancies have been filled, to enable the new MH treatment rooms to open appropriately to meet need	OUTCOME: Not fully discussed To bring back to next deep dive for fuller discussion
U11.1	The trust must ensure that there is a local audit programme in place for the service, that action plans are in place and necessary improvements are made to practice following audit.	OUTCOME: Not fully discussed To bring back to next deep dive for fuller discussion
U18.1	The trust must ensure that effective governance and quality assurance processes are in place to measure service improvement. Including escalation of concerns and monitoring of actions arising from meetings, local audits, recommendations from regulators and external reviews.	OUTCOME: Not fully discussed To bring back to next deep dive for fuller discussion
U19.1	The trust must ensure that effective processes are in place, and monitored, to ensure clinical policies and guidelines are regularly reviewed and updated in line with national guidance.	OUTCOME: Not fully discussed To bring back to next deep dive for fuller discussion

U20.1	The trust must improve staff understanding of isolation procedures and ensure that compliance is regularly monitored	OUTCOME: Not discussed To bring back to next deep dive for fuller discussion
U21.1	The trust should ensure that the emergency department strategy is regularly reviewed.	OUTCOME: Not discussed To bring back to next deep dive for fuller discussion
U23.1	The trust should ensure that information is gathered to monitor whether areas within the urgent and emergency service are being utilised as intended	OUTCOME: Not discussed To bring back to next deep dive for fuller discussion
U24.1	The trust should review the level of scrutiny and oversight that the mental health board provides	OUTCOME: Not discussed To bring back to next deep dive for fuller discussion
TW 19.1	The trust must ensure that the healthcare records for patients' subject to restraint are complete and in line with the trust's policy and procedure	OUTCOME: Not discussed To bring back to next deep dive for fuller discussion

New Actions

Ref.	Action	Owner
TW13.1	Send a copy of the report to NH	NF
U13.1	Add the CAU evidence to the repository.	SH
	Evidence dissemination of learning via Newsletter and the ED noticeboard	AR/MP
U7.1	Add the final, approved version of the SOP to the repository once it's been through due diligence (e.g. Children's Board and Clinical Safety and Effectiveness Sub Board), signed off and uploaded to Trust Docs.	SH
	Write down the process for dissemination of learning to team via CG meetings, Newsletter etc.	MP
	Add audit data to the repository.	SH
U14.1	Embed into training for new starters and transferees into the department	MP
	Put the plan in the repository	SH
	Bring update back to the March evidence group.	SH
U15.1	Introduce an observational audit; include Band 7s, NHSE and CCGs as participants.	MP
	Add the Enhanced Observation and Support Policy to the evidence repository	SH
	Ensure sign off of documentation by MH Ops Group and MH Board	MP
U16.1	Liaise with IT (Lily Hemmings) to put a process in place that allows reporting of patients in CDU, and agree a timeline (agree the timeline by 28th February).	EA
	Put on the agenda for the U&EC Board.	EA
	Add final SOP to evidence repository	SH
U4.1 & U4.2	Review rosters, workforce and recruitment strategy and bring updated staffing figures back to next meeting	AR/MP
	Schedule next Deep Dive into Section 29a for week commencing 18th March and issue invitations	RRS

4. AOB
5. Date and Time of Future Meetings Thursday 7th March 08:30 - 10:00 Board room

REPORT TO THE QUALITY PROGRAMME BOARD	
Date	**7th March 2019**
Title	**Outcome of Evidence Group**
Author & Lead	**Jess Woodhouse** **Rosemary Raeburn Smith**
Purpose	**For Information**

1 Background/Context

The QIP Evidence Group met on 7th March, to review the evidence in respect of four recommendations, in addition to six recommendations brought back for review. The Agenda and Evidence Reports presented at the meeting are attached.

The group reviewed the evidence for suitability, relevance, and completeness, using an appreciative enquiry approach, assessing the quality of the evidence supplied by the SRO and action leads and the current level of assurance for each recommendation.

2 Outcome

Three of the four recommendations were signed off as BLUE (complete and evidenced). All were assigned dates to be brought back for review with additional evidence to ensure practice is being embedded. These recommendations will be brought back to future meetings, when the supplementary evidence will be reviewed. The group provided guidance as to the additional evidence required for the remaining recommendation and offered suggestions how this could be achieved. This recommendation will be brought back to a future meeting, when the supplementary evidence will be reviewed.

3 Conclusions/Outcome/Next steps

The Evidence Group is scheduled to meet again at 9.00am on Thursday 28th March 2019, at which meeting the Committee is due to conduct a 'deep dive' review into the recommendations that sit under the Executive responsibility of the Chief Nurse.

Recommendation:

The Quality Programme Board is asked to note the work of its Evidence Group.

1. Apologies and declarations of interest

Apologues received from Erika Denton, Andree Glaysher, Joel Fiddy, Caroline Kavanagh and Rosemary Raeburn-Smith.

2. Introductions

Persons in attendance

The following people attended the meeting:

- Nancy Fontaine (NF), Chief Nurse, NNUH
- Jane Robey (JR), Head of Improvement Team, NNUH
- Stacy Hartshorn (SH), Improvement Manager, NNUH
- Abbe Swain (AS), Improvement Manager, NNUH
- Jess Woodhouse (JW), Improvement Manager, NNUH
- Oliver Loveless (OL), Improvement Officer, NNUH
- Lisa Read (LR), Clinical Quality & Patient Safety Manager, North and South Norfolk Clinical Commissioning Groups
- Nye Harries (NH), Associate Director NHS Improvement
- Gemma Lawrence (GLa), Mental Health Matron, NNUH
- Sarah Morter (SM), Senior Nurse, Infection Prevention & Control, NNUH
- Jon Green (JG), Director of System Transformation, NNUH

2. Minutes and actions from previous meeting 17/01/2019

The minutes of the meeting of 17/01/2019 were confirmed for accuracy.

Open actions were reviewed as follows. Updates in red below.

Ref.	Action	Owner
TW6.1 & 6.2	• The group requested that the checklist for opening escalation areas and some completed examples should be added to the evidence repository. • The group requested evidence that staff feel the new processes are safe and that staff feel supported. The Group asked Aiden Rice to review this. • The group requested evidence on the number of whistle blows for safety within escalation, as they would expect this number to decrease. • To change wording from mothballed to vacant. • New action: Replace the escalation policy with final version • To be discussed in the Section 29A deep dive.	SH AR via SH SH SH SH
TW 14.1	• New action: Training records must be made available centrally rather than at departmental levels. • JW has received final list from Debbie Laws of which staff members require which training. To pass to ESR team for upload. • JW highlighted low compliance figures for the Emergency Department. NF requested a breakdown of the figures by profession.	JW
TW 25.1	• New action: Need to include an example of an area audit to ensure they have all their assets on eQuip • JW to liaise with Mark Bowpitt regarding creating a small sub-group to progress this.	JW

TW 36.1	• New action: Communication to staff of AbleAssist App • NH to take funding issue back to NHSi. • NH has queried regarding funding however it was a negative response as this is considered core funding and not improvement work. • NF & NH to go through list and identify spending for the last £30K. • LR & NF to discuss funding from underachievement of CQUIN	NF / NH LR / NF
TW 31.1	• New action: FIT testing training needs to be prioritised in ED, Hethel, Mulbarton and Mattishall (now Gunthorpe). • JW to share the league table with the membership of Evidence Group. • Close - complete	JW
U23.1	• Explore adding data field to triage section in Symphony to alert that patient is high risk and unsuitable for CDU. • Add details of new SOP in ED Newsletter. • To be discussed in the Section 29A deep dive.	CG CG
AOB	• Prepare Rapid Tranquilisation SOP • GLa advised that a meeting is being held on 12th March with Pharmacy and medical representation to work on a policy. Two deputy matrons have been recruited and are due to start on 15th April.	GLa
U12.1	• Amend minutes to include year and job titles. • Use standard pro-forma for future M&M meeting minutes. • Ensure clear action log in place. • Ensure sustainable admin support to meetings. • To be discussed in the Section 29A deep dive.	SH MP MP MP

3. Recommendations Brought Back for Review

Ref.	Recommendation	Outcome of Review
DI 2.1	The trust must ensure that specialist personal protective equipment, such as the integrity of lead aprons, is checked on a regular basis.	JW advised that no issues, concerns or changes had been raised SRO or delivery lead ahead of the review. For review again in 3 months.
DI 4.1	The trust must ensure that the environment, equipment storage, medicines management and infection control procedures are appropriate in the interventional radiology unit.	JW advised that no issues, concerns or changes had been raised SRO or delivery lead ahead of the review. For review again in 3 months.
TW 25.1	The trust must ensure that equipment is maintained and fit for use	JW advised that further assurance is being sought from Medical Devices Committee that local audits are taking place. **New Action:** NF to ask Simon Hackwell for an update regarding the 5 year rolling Capital Replacement Programme including the process and governance arrangements.

TW 27.1	The trust should ensure that the management of referrals into the organisation reflects national guidance in order that the backlog of patients on an 18-week pathway are seen.	JW advised that no issues, concerns or changes had been raised by the SRO or delivery lead ahead of the review. For review again in 2 months. **New Action:** NF requested that an up to date copy of the RAP is provided.
TW 28.1	The trust should ensure that effective processes are in place for correct handling and disposal of clinical waste, including sharps bins, and that storage of chemicals is secure in line with the Control of Substances Hazardous to Health (COSSH) guidelines.	JW advised that no issues, concerns or changes had been raised by the SRO or delivery lead ahead of the review. For review again in 3 months. JG queried whether any sharps bin issues had been raised in the recent IP&C inspection. SM advised that this is included within the IPC Perfect Ward audit.
TW 24.1	The trust must ensure that medicines and contrast media are stored securely and in line with national guidance	JR advised that the evidence has been updated. NF asked for the percentage figures for fridge and resus trolley checks. **New Action:** JR to obtain figures for NF ahead of next OAG meeting.

4. Recommendations for Review and Potential Sign Off

Outcome of evidence reviews

Ref.	Recommendation	Outcome of Review
TW 3.1	The Trust must ensure that staff annual appraisal completion improves	NF requested additional information ahead of QPB to include hotspots, monthly improvement trajectory and future projections. Agreed to turn 'Blue' with monthly review and to revert to Red if performance slips.
TW 16.1	The trust must ensure that patient venous thromboembolism (VTE) risk assessments are completed.	**New Action:** JR to obtain the Thrombosis and Thromboprophelaxis Committee minutes in the Evidence Repository. Agreed to turn 'Blue' with review in 3 months
TW 23.1	The trust must ensure that incidents are reported and investigated in a timely way by trained investigators	**New Action:** NF to follow up with Karen Kemp regarding non-clinical incidents and time taken to complete RCAs. Agreed to turn 'Blue' with review in 3 months.

TW 30.1	The trust should ensure morbidity and mortality meeting minutes include sufficient detail of background information, discussions and those in attendance.	**New Action:** JR to speak to ED to discuss the possibility of an exploratory review into this subject. **New Action:** NH to share structured deep dive approach with NF. Not agreed as 'Blue' due to insufficient assurance.

5. Recommendations for discussion not for sign off

Ref.	Recommendation	Outcome of Review
	None identified.	

Open Actions

Ref.	Action	Owner
TW 14.1	• JW to request breakdown of the Emergency Department compliance figures by profession.	JW
TW 25.1	• Need to include an example of an area audit to ensure they have all their assets on eQuip • JW to liaise with Mark Bowpitt regarding creating a small sub-group to progress this. • NF to ask Simon Hackwell for an update regarding the 5 year rolling Capital Replacement Programme including the process and governance arrangements.	JW / NF
TW 36.1	• NF & NH to go through list of potential improvement activities and identify spending for the last £30K of NHSi funding. • LR & NF to discuss funding from underachievement of CQUIN	NF / NH LR / NF
AOB	• Prepare Rapid Tranquilisation SOP	GLa
TW 27.1	• Request an up to date copy of the amended RTT RAP	JW
TW 24.1	• Obtain percentage figures for fridge and resus trolley checks for NF ahead of next OAG meeting	JR
TW 16.1	• JR to obtain the Thrombosis and Thromboprophelaxis Committee minutes in the Evidence Repository.	JR
TW 23.1	• NF to follow up with Karen Kemp regarding non-clinical incidents and time taken to complete RCAs	NF
TW 30.1	• JR to speak to ED to discuss the possibility of an exploratory review into this subject • NH to share structured deep dive approach with NF	JR / NH
DI 5.1	• Add to the agenda for QPB on 12th March	JR

4. AOB

- JW escalated DI 5.1 (Radiology reporting standards) to the group as progress on developing and agreeing standards has stalled. NF requested that this be added to the QPB agenda.
- JW advised that an IT cloud solution has been enabled to allow external sharing of Evidence Group and QPB papers

5. Date and Time of Future Meetings

Thursday 28th March 2019, 09:00 to 10:00. This meeting will focus on a deep dive for the recommendations under the Executive responsibility of the Chief Nurse.

QIP Risk and Issues Log

								Unmitigated				Mitigated		
Risk No.	Risk	Project	Raised By	Date Raised	Owned By	Description	Status	Consequence (1-5)	Likelihood (1-5)	Score (1-25)	Measures currently in place to manage the risk	Consequence	Likelihood	RR score
1	If there is insufficient executive capacity to drive improvement our improvement will not gain the necessary traction	Overall	CEO	07/08/2018	CEO	The Trust's strategic and operational agenda is challenging; therefore it is possible that executive directors and chiefs of division will find it difficult to release time to drive the improvements required to meet the CQC recommendations	Open	5	3	15	Discussion to be held at QIP Board about capacity and resources required to deliver, and consideration of the Trust's short and medium term priorities	5	2	10
2	If pressures within the hospital place competing priorities on staff it could lead to staff finding it difficult to engage with the quality improvement plan	Overall	CEO	07/08/2018	CEO	Staff are feeling under pressure and therefore may feel a little change fatigue and be concerned that their efforts may not make any difference	Open	4	4	16	Staff engagement plan needs to be developed	4	2	8
3	If there is insufficient capacity within individual roles within divisions, services and functions to undertake additional activity to drive the QIP, improvement may not proceed at pace	Overall	CEO	07/08/2018	CEO	Individual staff across the Trust will be required to undertake activity to drive forward the improvement work; it is likely that those staff do not have current capacity within their role	Open	4	4	16	Executive leads will need to consider the capacity required within the workforce to deliver the plan.	4	3	12
4	If the Trust's financial position remains challenged and the QIP requires more resources (recurrent and non recurrent) than the Trust has currently allocated, this will either add to the Trust's CIP or starve the QIP of needed resource	Overall	CEO	07/08/2018	CEO	It is possible that in order to provide the capacity and/or expertise required to deliver the plan the Trust will need to buy in additional people ; it is also possible that the sustainable solution to some of the quality challenges requires significant recurrent additional investment	Open	5	4	20	Significant financial involvement in the development of the plan and its delivery to ensure that costs in excess of provision can be mitigated	5	3	15
5	If the Trust's focus on quality and the operational challenges reduces the focus and attention on the systems of financial control and delivery of the CIP, this could lead to a worsening financial position	Overall	CEO	07/08/2018	CEO	The Trust's financial position is challenging and requires considerable attention to ensure the Trust delivers the financial plan. With the addition of significant quality pressures to address, there's a danger that the good work that has been achieved with finance starts to slip through lack of capacity to maintain the current level of focus	Open	5	4	20	The trust will need to consider the capacity it requires to deliver both financial and quality improvement	5	3	15

QIP Risk and Issues Log

								Unmitigated				Mitigated		
Risk No.	Risk	Project	Raised By	Date Raised	Owned By	Description	Status	Consequence (1-5)	Likelihood (1-5)	Score (1-25)	Measures currently in place to manage the risk	Consequence	Likelihood	RR score
6	If the wrong actions and metrics have been selected the desired outcomes may not be achieved.	Overall	Head of Improvement	04/09/2018	Head of Improvement	The 60 'must do' and 22 'should do' recommendations are underpinned by supporting actions. Completion of these actions by the deadline could lead to false assurance that the aims of the recommendation have been addressed when, in reality, further work is required to ensure that the necessary changes have been embedded and could be articulated by staff.	Open	5	4	20	The Improvement Team is working with action owners and teams to amend actions and metrics to ensure that they are SMART and outcome focused. The revised actions/metrics should then provide greater assurance that the necessary changes will be properly embedded, fully understood by staff, and could be articulated by all members of the front line teams.	5	2	10
7	If action owners do not send their updates to Information Services in good time, or if the data source is inaccurate, incomplete or poor quality, IS will not be able to provide robust management reports, and monitoring of progress will be compromised	Overall	Chief Nurse	09/10/2018	Pete Best	Good quality, timely, relevant data is necessary to enable monitoring of progress towards achieving the recommendations. If this is not forthcoming, remedial action may be delayed and key milestones may be missed.	Open	4	4	16	Information Services is working with the Improvement Team to identify data providers for each of the agreed metrics. IS have a data collection proforma and a tried-and-tested process for requesting timely updates (which works well for the IPR). This process includes escalation triggers and named escalation routes if data submission dates are missed.	4	2	8
8	If the reporting interface is changed from slide pack format to live dashboard format in January, just prior to the CQC inspection, this could confuse members of the QPB and reduce confidence in the assurance process	Overall	Rosemary Raeburn-Smith	15/11/2018	Nancy Fontaine	Clear, understood, and familiar reporting processes are essential for gaining assurance. Changing the reporting interface in the immediate run-up to the CQC inspection has the potential to cause confusion and erode confidence among members of the QPB, especially if reporting & data/comment collection timescales result in the reported data being disseminated too close to the January QPB to enable members to thoroughly review the information in advance of the meeting.	Open	3	4	12	If the data collection template is ready in time, the Improvement Team will attempt to parallel run the two reporting interfaces for the December Board, by producing a full Slide Pack (original reporting interface) and also contributing fully to the live dashboard (new reporting interface). An agenda item on the December QPB will clearly outline the new reporting process that members can expect in January.	3	3	9

REPORT TO TRUST BOARD

Date	**29 March 2019**
Title	**Infection Prevention and Control [IP&C], NHS Improvement Inspection on 11/02/19**
Author	**Sarah Morter, Senior Nurse for IP&C** **Professor Nancy Fontaine, DIPC and Chief Nurse**
Purpose	**For information and approval on post NHSI inspection IP&C Recovery Plan**
Relevant Strategic Objective & BAF reference	**SO 1 – High Quality Health & Care services** **BAF reference: 1.1**

1. Background/Context

NHSI infection prevention and control [IP&C] inspection on 11/02/19 by Dr Debra Adams, Senior Infection Prevention and Control Advisor (Midlands and East), accompanied by Glynis Bennett: Lead IP Nurse at West Hertfordshire NHS Trust and Judy Ames: Lead IP Nurse North Norfolk CCG.

The inspection was to follow up on the CQC visit undertaken in November 2018 (report released in January 2019). The CQC report identified: The trust **must** improve staff understanding of isolation procedures and ensure that compliance is regularly monitored. The CQC assessment automatically triggers the risk as AMBER on the NHSI IP internal risk assessment matrix.

Further to the CQC review, NHSI undertook a quality visit alongside the CCG on the 7th January 2019 where again significant IP concerns were identified in the ED.

During the inspection on 11/02/19 a number of IP&C issues were highlighted and the report stated *there appeared to be a lack of awareness by the ward staff and Matrons regarding their roles and responsibilities towards IP and a lack of response to the previous findings from the CQC and NHSI quality team.* This resulted in the Trust being escalated to RED on the NHSI internal IP escalation matrix.

2. Risks and actions

The Trust must ensure patient safety through the provision of good Infection Prevention & Control (IP&C) and cleaning systems & standards.

A rapid recovery programme has been commenced with Divisional and Trust wide IP&C Recovery Plans in place. This will be monitored as part of the QIP Programme.

3. Next steps

- NHSI require an action plan to be developed and discussed with the Trust Board for approval of the plan going forward.
- Trust & Divisional Action Plans in place and being monitored by Quality Programme Board & Hospital Management Board.
- Evidence Group Deep Dive for Infection Control Plans 25th April 2019.
- NHSi Colleagues visiting to offer support.
- Dr Debra Adams will undertake a series of Matrons master class sessions which consists of taking matrons around a clinical area to enable them to see a ward from an IP&C perspective rather than just focusing on an audit form.
- Dr Debra Adams will arrange a follow up visit in July to review progress.

Recommendations: The Board is recommended to **note and approve** the proposed IP&C action plan.

NHSi IP&C
RECOMMENDATIONS AND ACTIONS

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: MARCH QPB

Exec SRO:	Delivery Lead:	Completion date per NHSI plan	Target OUTCOME delivery date	Confidence of achieving target by OUTCOME delivery date		% Evidence in repository
				Mar	Feb	
Nancy Fontaine	Sarah Morter	30th June 2019	31st May 2019	G	N/A	

Recommendation:	IP&CR TW1.1: The Trust must ensure patient safety through the provision of good Infection Prevention & Control (IP&C) and cleaning systems & standards.
We will have achieved GOOD when:	• Divisional and Trustwide IP&C Recovery Plans are in place and monitored as part of the QIP programme • There is compliance with the IP&C relevant audit schedules defined the Standard Operating Procedure for the Quality Audits Framework • There is evidence of attainment of IP&C Perfect Ward audit standards at the defined level of compliance • Good standards of IP&C and cleaning are evidenced in monthly executive-led inspections • IP&C feedback is included as an agenda item for discussion in Specialist Practitioner Forum and Clinical Leader meetings • There is an escalation process for low compliance with IP&C audits and standards, within Divisions and trust wide • Standardised IP&C/cleaning/environmental accountabilities are defined for Band 8a/7/6 nurses and housekeepers • There is a Trustwide communications programme, refreshing knowledge of IP&C, PPE and cleanliness • Procured sharps bins are appropriate to IP&C and Divisional requirements • There is a training programme and audit for the use of procured sharps bins

Page 2 of 6	
We will have achieved GOOD when: (continued)	• SERCO cleaning schedules are up to date and present information in a clear and readable format • SERCO processes have been reviewed to ensure cleaning standards are monitored and escalated appropriately • There is a robust process for cleaners to escalate any concerns • There is a defined process for the timely cleaning of any clinical areas that are inaccessible during scheduled cleaning hours • The revised Dress Code and Uniform policy is published and communicated to staff • There is 98% compliance with Hand Hygiene quality standards • There is nursing representation and participation in monthly C4C audits • There is 90% compliance with the Trust element of the C4C audits • The IP&C Link Person role is reviewed • Clinical areas attend the Quarterly IP&C Link Person meetings at the defined frequency of compliance • New matrons spend a day with the IP&C team as part of their induction • There is 90% compliance with IP&C mandatory training
Exec Summary:	• **Current position: the number of audits carried out during February has increased and the percentage compliance has either stayed the same or increased. For example, For Hand Hygiene (HH) & Dress Code (DC) 97 audits were carried out with 780 staff audited HH 97% and DC 98%. Commodes remained the same at 89%. Bed Pan audits showed an increase in compliance from 91% to 97%.** • A rapid recovery programme has been commenced with a Trust wide IP&C Recovery Action Plan in place and Divisional plans are being developed and signed off to address the areas of concern. This will be monitored as part of the QIP programme • Twice weekly meetings taking place to review progress • Deep dive presentation to take place at March Oversight and Assurance Group and April Evidence Group • Senior IP&C Advisor (Midlands and East) will undertake a series of Matrons master class sessions commencing in April. This consists of taking matrons around a clinical area to enable them to see a ward from an IP&C perspective rather than just focusing on an audit form • Senior IP&C Advisor (Midlands and East) will arrange a follow up visit in July 2019 time to review progress

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: MARCH QPB

Recommendation:	IP&CR TW1.1: The Trust must ensure patient safety with the provision of good Infection Prevention & Control (IP&C) and cleaning systems & standards.

Open Actions (Page 3 of 6)	Progress Update and Next Steps	Action RAG
IP&CR TW1.1.1 Establish draft Trustwide and Divisional Rapid IP&C Recovery (IP&CR) action plans and working group	Target action completion date: 25 February 2019 Action plans integrated into QIP programme/governance. Initial working group meeting 13.02.19 and scheduled twice weekly.	G
IPC&R TW1.1.2 Agree a Standard Operating Procedure for the Quality Audits Framework, that includes the schedule for ward and matron IP&C audits and escalation processes	Target action completion date: 01 March 2019 Standard Operating Procedure for the Quality Audits Framework has been developed and discussed at the IP&C working group meetings.	G
IPC&R TW1.1.3 Establish and monitor compliance with IP&C quality audit schedules via the S-Drive spreadsheet	Target action completion date: 01 April 2019 Spreadsheet is being developed further following feedback.	G
IP&CR TW1.1.4 Implement a programme of monthly Executive-led inspections (Chief Nurse, DCN, External IP&C Lead and DNDs) and set up a process for monitoring IP&C standards assessed during inspections	Target action completion date: 15 March 2019	G
IP&CR TW1.1.5 Include IP&C feedback as an agenda item for discussion in Specialist Practitioner Forum and Clinical Leader meetings	Target action completion date: 28 February 2019	G
IP&CR TW 1.1.6 Agree standardised cleaning, environmental and IP&C accountabilities for Band 8a/7/6 nurses and housekeepers	Target action completion date: 15 April 2019 Document drafted and reviewed in weekly meeting, feedback being incorporated ready for review and sign off.	G

Highlight Report to: MARCH QPB

Recommendation:	IP&CR TW1.1: The Trust must ensure patient safety with the provision of good Infection Prevention & Control (IP&C) and cleaning systems & standards.

Open Actions (Page 4 of 6)	Progress Update and Next Steps	Action RAG
IP&CR TW1.1.7 Deliver a Communications programme, including Clean Hands Campaign and correct use of PPE	Target action completion date: 30 April 2019 Meeting has taken place with Communications Team. Plan in development.	G
IP&CR TW1.1.8 Review the procurement and usage of sharps bins	Target action completion date: 11 March 2019	G
IP&CR TW1.1.9 Obtain training data from Health & Safety to establish levels of training for new sharps bins across clinical areas	Target action completion date: 11 March 2019	G
IP&CR TW1.1.10 Develop an audit schedule to monitor compliance with the safe use of sharps bins	Target action completion date: 31 March 2019	G
IP&CR TW1.1.11 Review and revise SERCO cleaning schedules	Target action completion date: 15 March 2019	G
IP&CR TW1.1.12 Carry out meetings with SERCO regarding communal areas and cleaning hours, schedules and processes including areas that are inaccessible during scheduled cleaning hours	Target action completion date: 15 March 2019	G
IP&CR TW1.1.13 Review escalation structures and process for cleaners to raise concerns	Target action completion date: 15 March 2019	G

Highlight Report to: MARCH QPB

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Recommendation:	IP&CR TW1.1: The Trust must ensure patient safety with the provision of good Infection Prevention & Control (IP&C) and cleaning systems & standards.

Open Actions (Page 5 of 6)	Progress Update and Next Steps	Action RAG
IP&CR TW1.1.14 Sign off, publish and communicate the revised Dress Code and Uniform policy to ensure infection prevention and control standards	Target action completion date: 01 April 2019	G
IP&CR TW1.1.15 Achieve required compliance with hand hygiene quality standards via IPR	Target action completion date: 31 March 2019	G
IP&CR TW1.1.16 Review clinical lead / nursing representation, participation and sign off of C4C audits via HICC	Target action completion date: 31 March 2019	G
IP&CR TW1.1.17 Undertake a review of compliance with the Trust elements of C4C audits via HICC	Target action completion date: 31 March 2019	G
IP&CR TW1.1.18 Review the IP&C Link Person role	Target action completion date: 28 March 2019 Role being reviewed.	G
IP&CR TW1.1.19 Set standard and review clinical area attendance at the quarterly IP&C Link Person meetings via Divisional HICC Report	Target action completion date: 01 April 2019	G
IP&CR TW1.1.20 Include shadowing with IP&C team as part of induction programme for new Matrons / Ward sisters / Head of profession s (DND led)	Target action completion date: 01 April 2019	G

Domain
Safe

Overall RAG Rating			
Overdue or not on track	At risk of delivery	On Track	Complete & evidenced

Highlight Report to: MARCH QPB

Recommendation:	IP&CR TW1.1: The Trust must ensure patient safety with the provision of good Infection Prevention & Control (IP&C) and cleaning systems & standards.

Open Actions (Page 6 of 6)	Progress Update and Next Steps	Action RAG
IP&CR TW1.1.21 Undertake a review of compliance with IP&C Mandatory Training via Divisional HICC Reports	Target action completion date: 31 March 2019	G
IP&CR TW1.1.22 Establish process, undertake and prepare a sharing the learning on sharps management e.g. safety mode	Target action completion date: 31 March 2019	G
IPR&C TW1.1.23 Obtain training data from H&S to establish levels of training for new sharps bins across clinical areas	Target action completion date: 15 March 2019	G
IPR&C TW.1.24 Agree process for monitoring infection control practice within areas in collaboration with IPC and the Water Safety committee	Target completion date: 29 March 2019	G

Risks/Issues	Mitigating Actions	Escalation & Decisions for QPB

Integrated Performance Report

March 2019 (February 2019 data)

Changes

Core Slide 15 – Renamed Corporate risk Register (formerly High Risk Tracker)

Core Slide 1 Quality and Safety Summary - Lead Directors Nancy Fontaine / Erika Denton

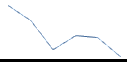
Quality & Safety		Target	October 2017 to September 2018	Oct 2016 to Sep 2017
Mortality	Core Slide 3			
1 SHMI*		N/A	107.48	106.62

Quality & Safety		Outturn 2017/18	Monthly Target	Feb-19	6 month trend	YTD 2017/18	YTD 2018/19
Mortality	Core Slide 3-4						
1 HSMR**			100	94.6			
2 Crude Mortality Rate***		5.07	n/a	4.72		5.07	3.92
Incidents	Core Slide 5-7						
3 Serious Incidents		138	n/a	17		113	165
4 Incident Reporting		17171	n/a	30		15621	17546
5 Insulin errors causing NPSA category moderate harm or above		1	0	0		1	1
6 Medication Errors		1204	n/a	140		1110	1396
7 Patient Falls causing moderate harm or above		33	n/a	5		31	26
8 Never Events****		7	0	1		5	5
Pressure Ulcers	Core Slide 8						
9 Grade 2 hospital acquired pressure ulcers		217	n/a	20		198	210
10 Grade 3 hospital acquired pressure ulcers		56	n/a	0		51	45
11 Grade 4 hospital acquired pressure ulcers		2	0	0		2	0
Infection Control	Core Slide 9						
12 HAI C. difficile Cases (excluding non-trajectory and pending cases)		11	0	0		11	10
13 Hospital Acquired MRSA bacteraemia		0	0	0		0	1
14 CPE screens taken		554	n/a	24		523	551
15 CPE positive screens		4	n/a	2		4	4
16 CPE screens of patients positive from other hospitals		0	n/a	0		0	1
17 E.coli trust apportioned		57	n/a	4		53	52
18 E. Coli community apportioned		311	n/a	24		288	271
19 Klebsiella trust apportioned		21	n/a	1		19	13
20 Klebsiella community apportioned		64	n/a	4		61	50
21 Pseudomonas trust apportioned		11	n/a	1		9	15
22 Pseudomonas community apportioned		32	n/a	0		30	26
Other							
23 EDL to be completed within 24 hours in 95% of discharges		76.72%	95.00%	77.71%		76.83%	77.04%
24 Harm Free Care		90.95%	n/a	96.00%		91.28%	89.22%
25 Patients 'extremely likely' or 'likely' to recommend our service to friends and family		96.73%	100.00%	95.44%		96.79%	96.27%
26 Complaints		890	n/a	89		798	962

* SHMI data is updated quarterly by NHS Digital
** HSMR data is the latest available and reported three months in arrears
*** Crude Mortality Rate is reported one month in arrears, in order to include deaths within 30 days of discharge from hospital
****Please note that (8)Never events are also included in the total for (3)Serious Incidents

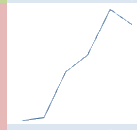
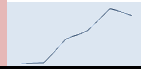
Core Slide 2

Quality Priorities – Patient Safety

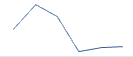
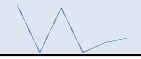
	Quality Priorities - Patient Safety	Measure	Lead	Outturn 2017/18	Monthly Target	Feb-19	6 month trend	YTD 2017/18	YTD 2018/19
1	Reduction in medication errors	Insulin errors causing NPSA category moderate harm or above	Erika Denton	1	0	0		1	1
2	Prompt recognition and treatment of sepsis*	% of Sepsis patients screened	Erika Denton	86.17%	90.00%	82.00%		86.18%	81.44%
		% of Sepsis patients treated	Erika Denton	92.61%	90.00%	96.00%		92.70%	92.38%
3	Keeping patients safe from hospital acquired thrombosis	95% compliance with TRA assessment as evidenced on EPMA. (and audit of appropriate actions)	Erika Denton	98.93%	95.00%	98.90%		98.94%	98.89%
4	Incident reporting and management	NNUH duty of candour compliance	Erika Denton	99.48%	100.00%	72.00%		99.43%	86.34%

*Reported in arrears – current value is for December 2018

Quality Priorities – Patient Experience

	Quality Priorities - Patient Experience	Measure	Lead	Outturn 2017/18	Monthly Target	Feb-19	6 month trend	YTD 2017/18	YTD 2018/19
1	Treat Patients with privacy and dignity	Patients 'extremely likely' or 'likely' to recommend our service to friends and family	Nancy Fontaine	96.73%	100.00%	95.44%		96.79%	96.27%
2	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	Chris Cobb	42.65	20.00	52.00		42.65	29.96
3	Improved discharge processes	EDL to be completed within 24 hours in 95% of discharges	Chris Cobb	76.72%	95.00%	77.71%		76.83%	77.04%

Quality Priorities – Clinical Effectiveness

	Quality Priorities - Clinical Effectiveness	Measure	Lead	Outturn 2017/18	Monthly Target	Feb-19	6 month trend	YTD 2017/18	YTD 2018/19
1	Keeping patients safe from infection	HAI C. difficile Cases (excluding non-trajectory and pending cases)	Nancy Fontaine	11	0	0		11	10
2	Keeping patients safe from infection	Hospital Acquired MRSA bacteraemia	Nancy Fontaine	0	0	0		0	1
3	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.	Erika Denton	3500	417	198		3302	4352
4	Timely medical review of all patients	Average number of patients with LoS >14 days	Chris Cobb	196.6	200	180		196.6	184.3

Core Slide 3

Mortality Dashboard - Inpatient Monitoring

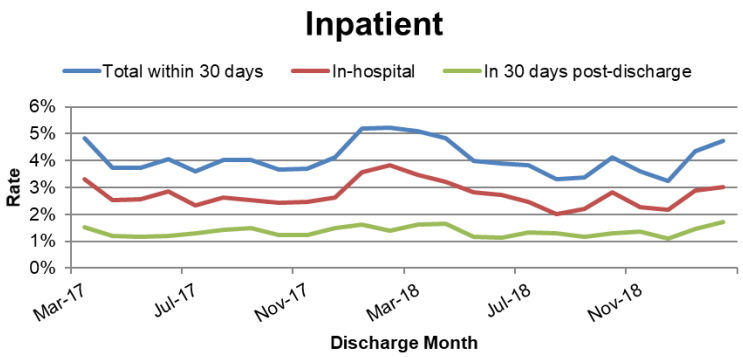
Crude Mortality	
Month	Rate
Sep-18	3.38%
Oct-18	4.12%
Nov-18	3.60%
Dec-18	3.26%
Jan-19	4.33%
Feb-19	4.72%

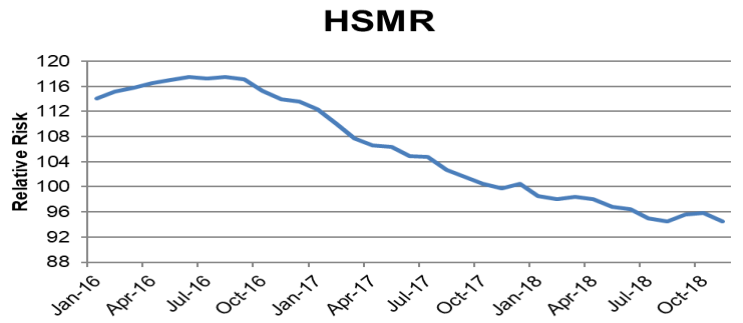
(Crude Mortality is reported one month in arrears)

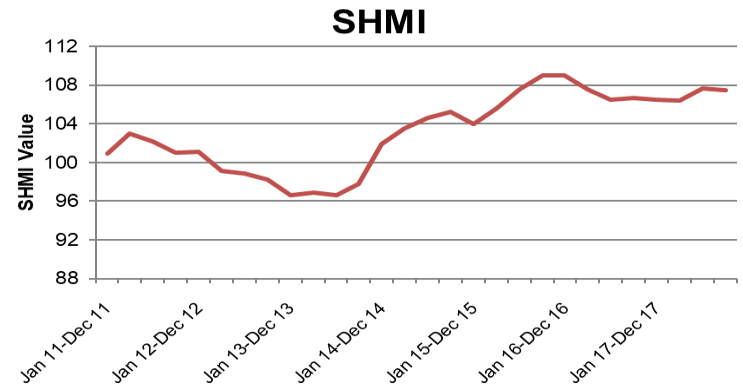
HSMR	
Sep-18	95.58
Oct-18	95.78
Nov-18	94.55

(HSMR and SHMI reported on Slide 2 are the latest available data)

SHMI	
Oct 17-Sep 18	107.48



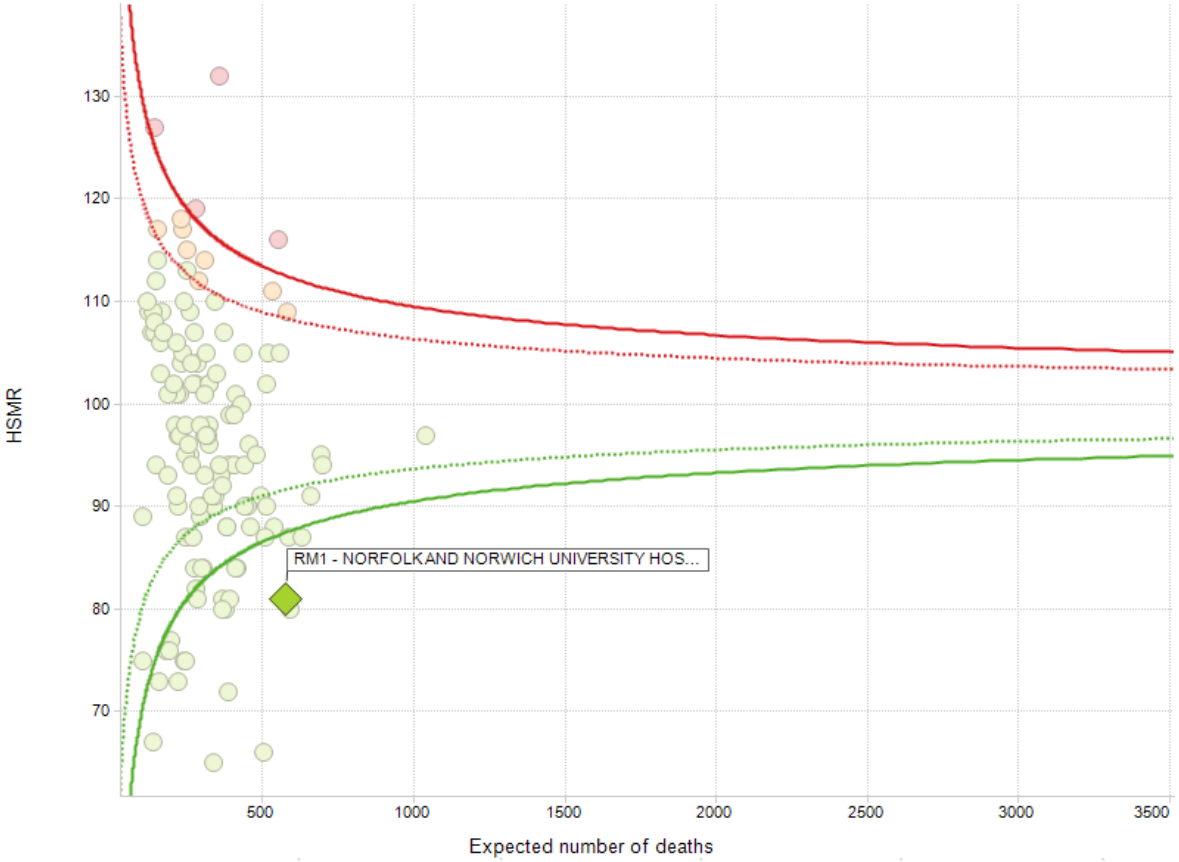




	2018/19			
	Q1	Q2	Q3	Q4
Total deaths excluding ED	875	806	838	681
Total deaths for ED	0	0	0	0
Number of in-hospital deaths	602	526	547	473
Number of deaths within 30 days of discharge	273	280	291	208
Number of reviews completed	403	409	319	135
Number of deaths on review considered potentially preventable	4	2	3	1
Percentage of deaths considered as potentially preventable	0.99%	0.49%	0.94%	0.74%
Numbers of deaths considered under SI process	6	4	8	6
Maternity deaths reviewed	0	0	0	0
Deaths in Learning disability reviewed (LeDeR)	4	2	1	0
Paediatric deaths reviewed	0	0	0	0
Mental Health deaths reviewed	0	0	0	0
Themes identified from mortality reviews and investigations				
Actions taken				

Core Slide 4 HED - HSMR Overview – September 2018 to November 2018

Please note that the funnel plot is only valid when the overall HSMR score is around 100.



Trust Name: RM1 - NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST
Trust Group: Login Trust
Alert level: Green
HSMR: 81
HSMR 95% CI: (74.20,89.10)
Number of discharges: 17979.00
Expected number of deaths: 574.99
Number of deaths: 468.00

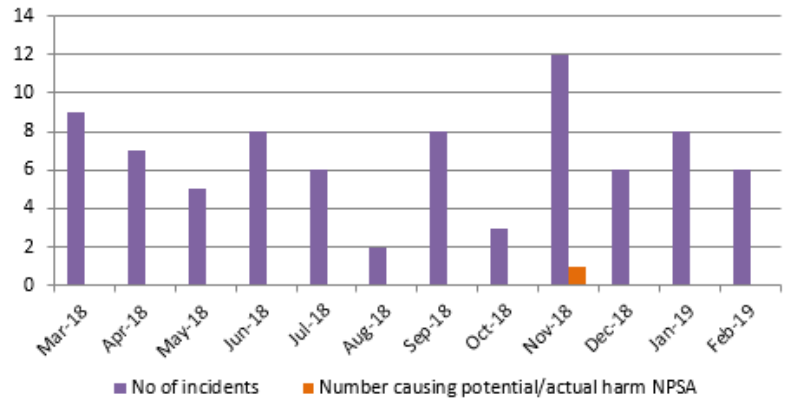
Core Slide 5 Safety and effectiveness - Lead Directors Nancy Fontaine / Erika Denton

Key Issues

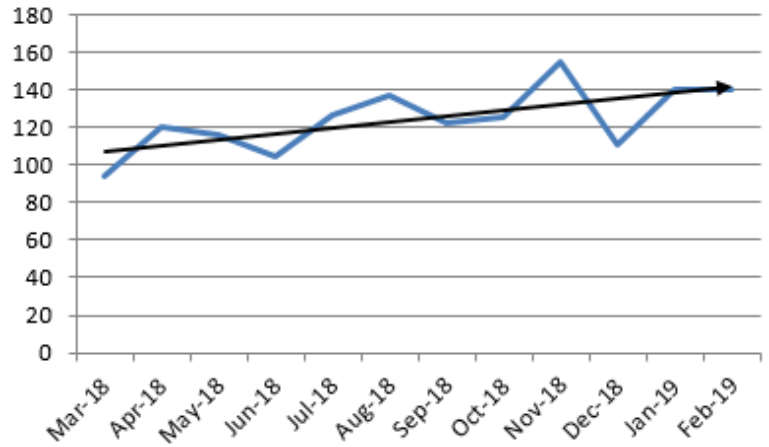
- Pharmacy and CSS have detailed plans to mitigate against the risks from production unit mould contamination. A total shutdown of the unit will be required in next 6-12 months to undertake required remedial work and plans are in place to relocate services for this to be done
- Following our NHI IP&C red rating there is now a detailed action plan covering all areas of the trust. This was presented at the March OAG.
- Duty of candour compliance continues to be below target. Face to face training is being delivered to staff since and the e-learning package is awaited.
- Supply of medicines – concerns surrounding supply and stockpiling because of Brexit remain

Core Slide 6 Quality & Safety (Incidents) – Lead Directors Nancy Fontaine / Erika Denton

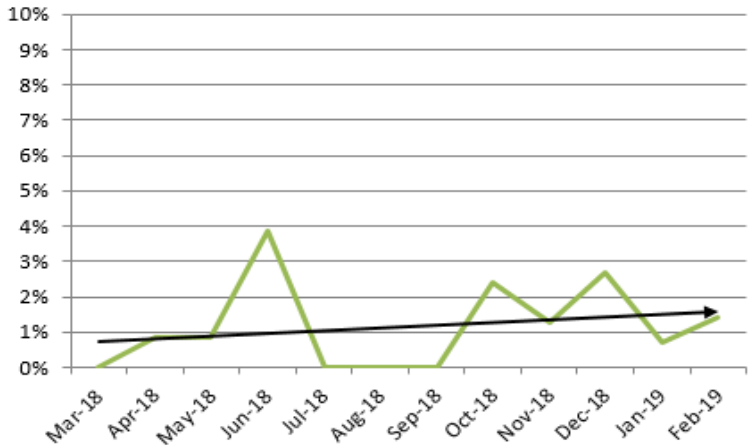
Insulin incidents past 12 months NPSA severity categories



Medication Incidents



Medication Incidents causing potential/actual harm

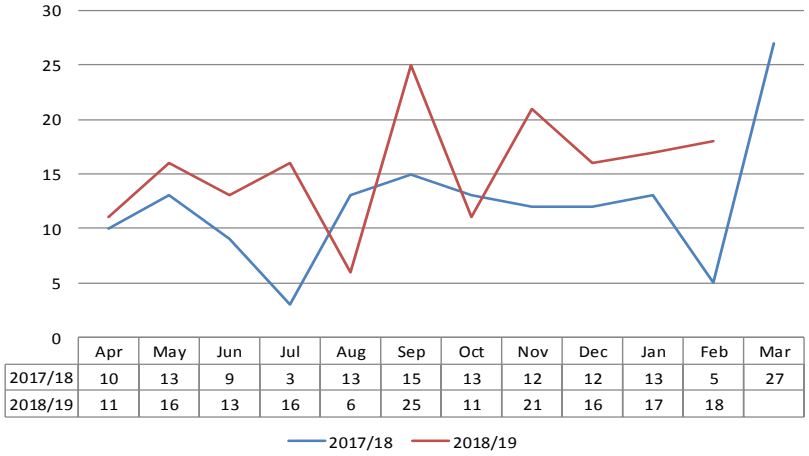


- 2 medication incidents were associated with death of the patient. These have been reported as SIs and to the coroner and subsequent investigations are awaited.
- Continuing upwards trend in the number of medication incidents reported. This is a sign of an improving safety culture.

Core Slide 7

Quality & Safety (Incidents) – Lead Directors Nancy Fontaine / Erika Denton

Serious Incidents and Never Events (reported onto STEIS)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	10	13	9	3	13	15	13	12	12	13	5	27
2018/19	11	16	13	16	6	25	11	21	16	17	18	

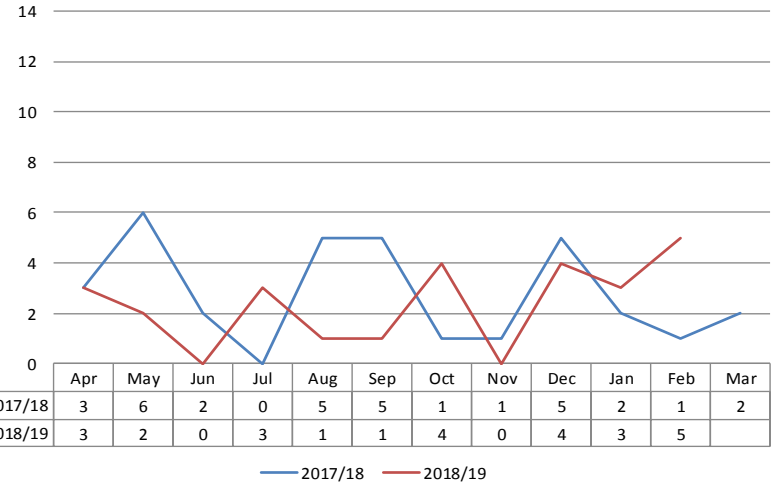
Individual SI's (incidents reported onto STEIS which impact patients directly)
1 NEVER EVENT – wrong side hip aspiration
1 patients with Cat 4 PU
1 Adult Safeguarding (W&C)
1 Delayed diagnosis Choroidal Melanoma
1 Patient fall
2 Sub-optimal care
2 IP&C (Norovirus ward closures)
2 Medication Incidents (insulin OD & paracetamol OD)
2 Treatment Delay incidents
1 Human Tissue Loss
1 IG incident (cardiology admin)

Organisational SI's (incidents reported onto STEIS that may indirectly affect patient safety)
2 12hr breach for MH bed incidents
1 SI report for December over 60 minute ambulance delays

Duty of Candour
Compliance with the Duty of Candour is 77% and has breached in 5/22 cases as follows:

ED, Docking, Edgefield, Respiratory Investigation Unit, CAU.

Patient Falls causing moderate harm or above (reported onto DATIX)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	3	6	2	0	5	5	1	1	5	2	1	2
2018/19	3	2	0	3	1	1	4	0	4	3	5	

There is 1 fall reported as a Serious Incident in February 2019. The Root Cause Analysis report will be presented at the Trust Essential Care Scrutiny Panel.
In February 2019 there were 185 patient falls reported (53%) of these falls did not cause any harm to patients however (43%) of patients who fell did suffer minor harm (abrasions, bruising etc). A further 1 (2%) patient sustained either a fracture or head injury that has caused either moderate or long term severe harm.

Falls per Occupied Bed Day (OBD)

The data for January (February data not yet available) indicates that the NNUH inpatient falls rate was **8.33 falls** per 1000 patient bed days. This is an increase in reporting of patient falls in the organisation.

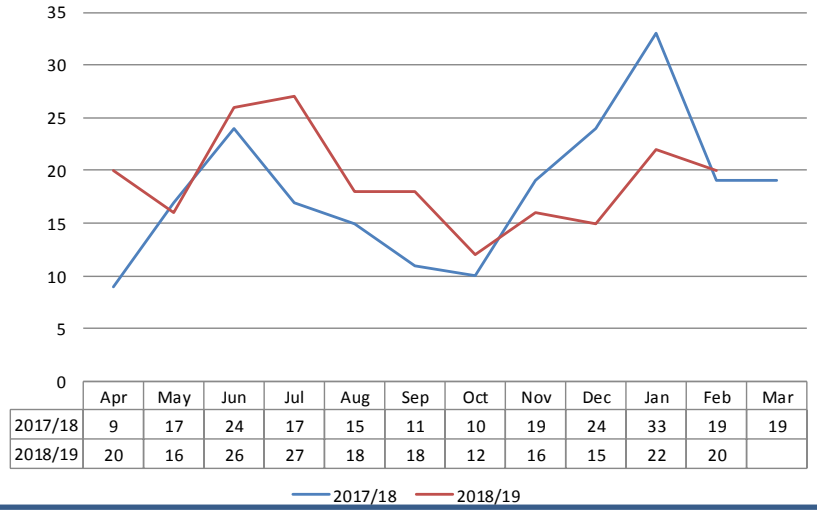
For falls that resulted in moderate harm or greater, the Trust's rate for December 2018 is **0.148** falls per 1000 patient bed days. This is a decrease of fallls of moderate harm of greater.

The Essential Care Scrutiny Panel continue to review all falls RCA's to identify and share learning to improve this patient safety outcome measure.

Core Slide 8

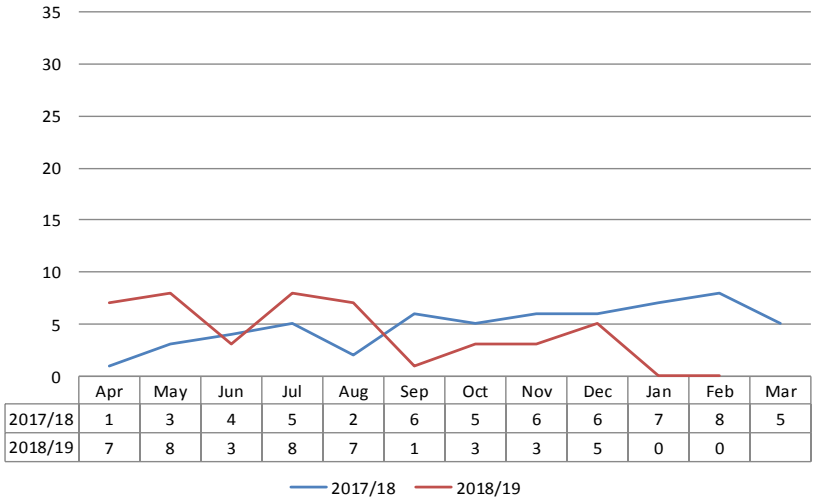
Quality & Safety (Pressure Ulcers) – Lead Director Nancy Fontaine

Grade 2 hospital acquired pressure ulcers



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	9	17	24	17	15	11	10	19	24	33	19	19
2018/19	20	16	26	27	18	18	12	16	15	22	20	

Grade 3/4 hospital acquired pressure ulcers



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	1	3	4	5	2	6	5	6	6	7	8	5
2018/19	7	8	3	8	7	1	3	3	5	0	0	

Category 2 PU

- A total of 20 patients developed a Grade 2 HAPU whilst in our care in January 2018.

Category 3 & 4 HAPU

- No patients developed a Grade 3 hospital acquired pressure ulcer whilst in our care in February 2019. This is the second consecutive month since June 2016 that the Trust has a nil return for this. However, one patient developed a Category 4 pressure ulcer in our care.

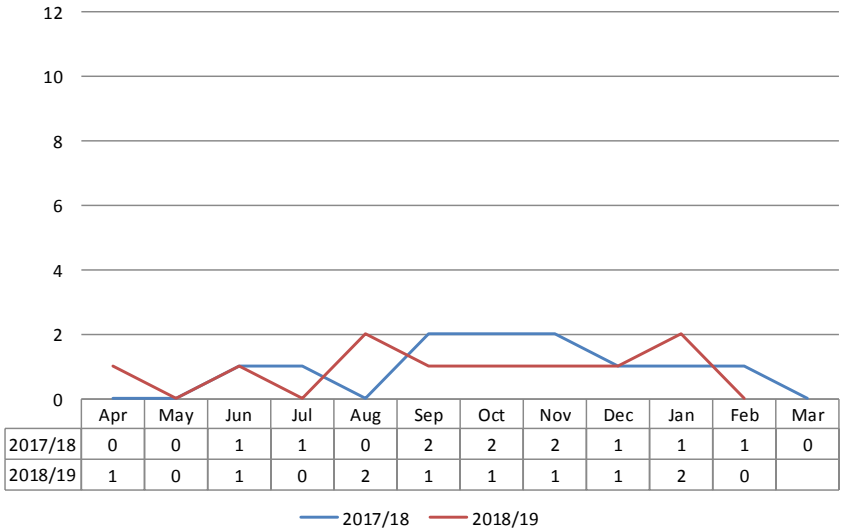
Learning from recently completed RCA's

The learning from the RCA's is reviewed by the TVN's: highlighted actions/concerns/achievements following RCA include the following

- Denton ward has now reached 200 days pressure ulcer free.
- Education to areas is being concentrated on by the delivery of informal training sessions by TVN team, ward safety huddles and ward education boards.
- Hethel are scoping new oxygen face masks for improved protection for vulnerable areas (noses, ears)
- Ongoing concerns with implementation of pressure relieving equipment in a timely fashion – but there have been some problems with access to dynamic mattresses especially at weekends. This is being looked at by a Trust committee.
- Accuracy of documentation is still a problem in some areas.

Core Slide 9 Quality & Safety (Infection Control) – Lead Director Nancy Fontaine

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	0	0	1	1	0	2	2	2	1	1	1	0
2018/19	1	0	1	0	2	1	1	1	1	2	0	

MRSA Hospital Attributable Bacteraemia 2018/19 Objective zero
- Year to date 1

MSSA Hospital Attributable Bacteraemia 2018/19 No objective
- Year to date 10

Gram Negative Hospital Attributable Bacteraemia 2018/19 (YTD)
- E. coli 52
  Pseudomonas aeruginosa 15
- Klebsiella sp. 13

MRSA Supportive measures on Denton Ward.
Earsham and Elsing closed due to Norovirus
New attribution for C. difficile from 01/04/19 ,will increase overall hospital attributable cases during the year.
NHSI IP&C inspection rated NNUHFT red. Rapid recovery programme in place
Increased Influenza cases – 134 within January 2019

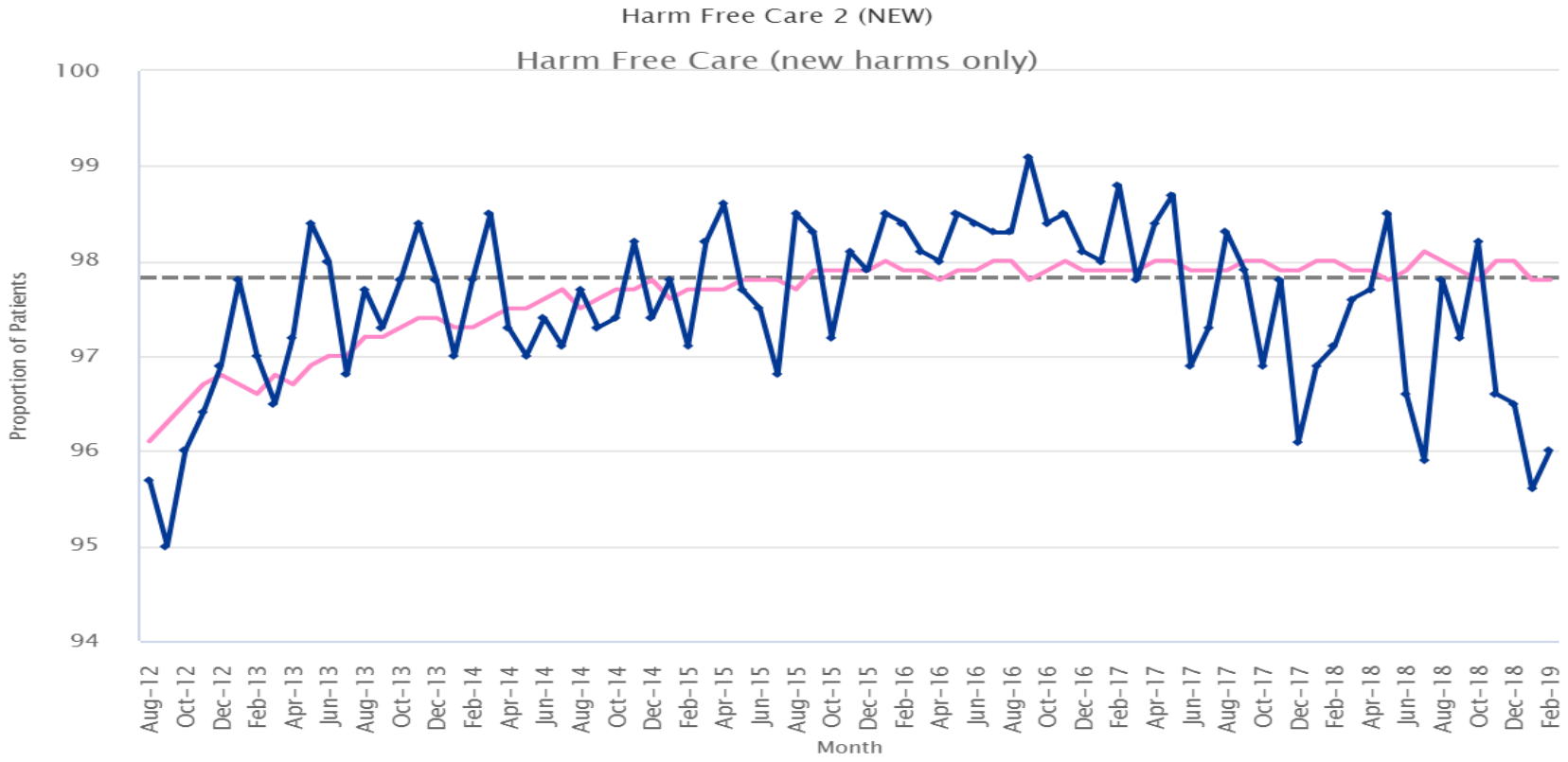
Following the post infection review [PIR] meeting with Trust and CCG's representatives each hospital acquired case of C. difficile is:-	
Trajectory	deemed to have lapses in care
Non-Trajectory	Deemed to have no lapses in care

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

C. difficile Summary Table		Non-Trajectory	Trajectory	Pending	Total
Quarter	4	0	0	2	2
	3	1	3	0	4
	2	8	3	0	11
	1	6	2	0	8
Year to date 18/19		15	8	2	25
Previous year 2017/18 Total		*24*	*11*	*0*	*35*

Core Slide 10

Safety Thermometer – Lead Director Nancy Fontaine



The Patient Safety Thermometer (PST) Data published on the national website contains information that relates to all data collection up to end February 2019. The graph has been taken from the website and demonstrates NNUH NHSFT Harm Free Care (All new harms) of 96% for February 2019 against a national average reported of 97.8%.
It should be noted that from January 2019, Children and Maternity Services will report into specialty specific Safety Thermometers and their data submissions will no longer be included in the classic submission. Therefore caution should be applied when benchmarking against data prior to January 2019.

Core Slide 11

Maternity Safety Dashboard – Lead Director Nancy Fontaine

		NNUH Maternity 2018/19	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Total
Activity	Mothers Delivered	Mothers delivered	438	479	460	475	470	475	486	419	427	442	382	4953
	Babies Delivered	Total Births	443	488	466	479	479	482	496	426	431	451	388	5029
		Live Births	439	483	463	478	477	479	494	425	430	451	387	5006
		Stillbirths	4	4	3	1	1	3	2	1	1	0	1	21
		Adjusted Stillbirths Total SB less TOP ≥24wks & SB with severe anomalies	*4*	*0*	*3*	*1*	*0*	*3*	*1*	*0*	*0*	*0*	*0*	*16*
	Early NND	NNUH born alive & die ≤ 7days	0	1	0	0	1	0	1	0	2	1	1	7
	Bookings	Total number of Bookings	489	520	496	491	458	476	528	505	460	568	457	5448
		% Bookings ≤12+6 Weeks	93.0%	92.1%	90.7%	92.7%	91.5%	93.5%	90.3%	91.9%	93.0%	91.4%	89.1%	91.7%
	Inductions of labour	% Total IOLs	37.0%	35.3%	36.7%	35.2%	30.6%	30.7%	31.5%	39.1%	33.7%	33.7%	33.8%	34.2%
	Normal Vaginal Deliveries	% Total Cephalic & Other Cephalic & Breech	61.4%	65.8%	60.7%	57.7%	59.4%	62.3%	61.1%	60.4%	57.8%	56.1%	59.2%	60.2%
	Instrumental Deliveries	% Total Ventouse / Forceps	9.8%	10.0%	12.0%	11.4%	11.7%	10.9%	10.1%	10.7%	12.6%	11.5%	8.4%	10.9%
		% Forceps	7.5%	6.3%	8.3%	8.2%	7.2%	7.8%	6.0%	7.9%	10.1%	9.3%	6.3%	7.7%
		% Ventouse	2.3%	3.8%	3.7%	3.2%	4.5%	3.2%	4.1%	2.9%	2.6%	2.3%	2.1%	3.2%
	Caesarean Sections	% Total CS (Elective & Emergency)	29.2%	26.5%	28.5%	31.8%	30.9%	27.6%	30.9%	30.5%	29.5%	32.8%	31.9%	30.0%
		% Emergency (CS1, CS2, CS3)	16.9%	12.3%	15.9%	17.1%	13.2%	14.9%	18.1%	16.7%	14.8%	16.7%	17.5%	15.8%
		% Elective (CS4)	12.3%	14.2%	12.6%	14.7%	17.7%	12.6%	12.8%	13.8%	14.8%	16.1%	14.4%	14.2%
		% Robson 1: Primip single cephalic ≥37 wks spont. onset	1.6%	2.5%	2.4%	1.5%	2.3%	3.2%	4.1%	3.1%	1.9%	2.5%	3.4%	2.6%
		% Robson 2: Primip single cephalic ≥ 37 wks IOL / ELCS	9.8%	8.8%	12.4%	14.7%	10.6%	9.7%	11.9%	12.6%	11.5%	13.6%	14.1%	11.8%
		% Robson 5: Multip Prev CS, single cephalic ≥37 wks	8.0%	5.0%	5.7%	5.9%	5.1%	5.3%	3.9%	6.2%	4.7%	5.2%	3.7%	5.3%
Place of	MLBU Births	MLBU Births	18.9%	18.4%	16.7%	18.1%	17.4%	18.7%	16.9%	20.0%	15.9%	15.8%	15.4%	17.5%
	Homebirths	Home births (Planned & Unplanned & Intransit)	2.1%	2.5%	2.0%	1.7%	1.7%	0.8%	3.1%	1.7%	3.3%	0.9%	3.1%	2.1%
Professionals	Care in Labour	Number BBA's (No MW or Obstetrician in attendance)	5	8	3	2	2	0	11	4	6	1	6	48
		% 1:1 Care in Labour	91.9%	92.2%	92.5%	93.1%	93.8%	91.6%	88.4%	93.4%	89.3%	93.0%	90.8%	91.8%
	Lead professional	% MW Led at birth	41.6%	39.9%	34.8%	38.5%	34.0%	26.7%	27.0%	22.7%	24.1%	20.4%	19.1%	30.2%
		% Cons Led at birth	58.7%	60.3%	65.2%	61.5%	66.2%	73.3%	73.0%	77.6%	75.9%	80.1%	81.2%	70.0%
	Cons Hrs	Wkly dedicated Cons hrs on Labour ward	60	60	60	60	60	60	98	98	98	98	98	60
	MW Hrs	Midwife : Birth Ratio excl. band 3 MCA	1:30	1:30	1:30	1:30	1:30	1:30	1:30	1:29	1:28	1:28	1:28	1:30
		Midwife : Birth Ratio inc. band 3 MCA's	1:28	1:28	1:28	1:28	1:28	1:28	1:28	1:28	1:27	1:27	1:27	1:28
Wellbeing	Smoking status	% Mothers smoking at Booking *(delivered within month)*	10.5%	11.5%	12.8%	11.4%	10.0%	12.0%	9.9%	12.4%	12.2%	12.2%	13.4%	11.6%
		% Mothers smoking at Delivery	10.7%	10.6%	10.2%	9.9%	8.7%	9.5%	8.6%	11.2%	10.8%	10.4%	13.1%	10.3%
	Breastfeeding	% Initiation: Breast milk < 48hrs	83.1%	80.4%	79.3%	78.5%	79.1%	78.3%	80.0%	79.5%	86.2%	82.8%	74.9%	80.2%
		% Exclusive BF @ transfer to community	62.3%	63.7%	62.2%	61.3%	64.0%	64.0%	63.2%	61.1%	64.9%	63.1%	53.4%	62.2%
		% Breast + Mixed feeding @ transfer to community	72.6%	71.6%	70.9%	69.5%	72.3%	72.8%	70.6%	69.7%	74.9%	71.3%	62.8%	70.9%
Risk Management	Maternal	% 3rd & 4th degree tears (per vaginal births)	2.2%	3.9%	4.2%	3.7%	4.2%	2.6%	1.7%	2.7%	2.0%	2.3%	4.3%	3.1%
		% PPH ≥1500mls	3.7%	2.9%	3.3%	3.8%	2.3%	5.1%	3.3%	4.1%	3.7%	3.6%	3.1%	3.5%
		Number Unplanned Admission To Critical Care Complex	0	0	0	0	1	1	0	0	0	0	1	3
		Number Emerg readmissions ≤30 days of delivery	6	10	4	12	4	6	5	8	4	9	6	74
		Number Maternal Death	0	0	0	0	0	0	0	0	0	0	0	0
	Neonatal	Number of Hypoxic Encephalopathy (Grades 2 & 3)	0	0	0	0	0	0	0	2	1	0	1	4
		Number Unplanned NICU ≥37wk Admissions (E3)	19	19	13	19	27	23	19	21	20	22	17	219
		Number Apgar score <7 @5, ≥37wk	3	7	5	0	8	2	4	6	11	4	3	53
	Serious Incidents	Number Number of SI's	0	0	0	1	1	2	0	1	1	0	1	7
	Closures & Diverts	Number Unit closures	0	0	0	0	0	1	0	0	0	0	0	1
		Number Mothers transferred out of unit	2	0	0	0	3	5	2	0	2	0	0	14
HoM Comments:		Highest percentage of SATOD since April. Working group with robust action plan aiming to reduce rate												

Core Slide 12

Quality and Safety Dashboard – Lead Director Nancy Fontaine

		Outrun 2017/18	Monthly Target	Feb-19	6 Month Trend	YTD 2017/18*	YTD 2018/19
Caring and Patient Experience							
1	Same Sex Breach	47	0	0		41	27
Infection Prevention and Control							
2	C Diff cases (hospital acquired)	35	N/A	0		34	25
3	MRSA bacteraemias (hospital acquired)	0	0	0		0	1
4	Norovirus (confirmed cases)	88	N/A	32		64	129
5	Elective MRSA Screening compliance	93.7%	>=95.0%	97.5%		93.8%	95.9%
6	Emergency MRSA Screening compliance	96.4%	>=95.0%	95.7%		96.6%	96.1%
7	Hand Hygiene Compliance	94.7%	>98.0%	98.3%		94.8%	96.9%
8	Dress Code Compliance	98.1%	>98.0%	99.0%		98.1%	98.8%
9	Commode Audits	95.6%	>98.0%	87.1%		95.9%	93.5%
Health & Safety							
10	Needlestick Incidents	111	N/A	12		105	85
Incident Reporting							
11	Total Number of Datix Incidents in month	12116	N/A	1234		11011	12387
12	Datix Incidents (reported in month) Finally Approved	5911	N/A	396		5452	6221
13	Number of Datix Incidents reported in month not closed	6205	0	838		5559	6799
Cleaning							
14	Cleaning Audit Results	96.1%	>=95.0%	96.0%		96.1%	96.2%
15	Cleaning Audit Results if Re-Audited	96.3%	>=95.0%	97.0%		96.4%	96.7%
Call Bell Waits							
16	Day Call Bell: Patient Call	02 min 07 sec	02 min 30 sec	02 min 37 sec		02 min 06 sec	02 min 09 sec
17	Day Call Bell: Bathroom Call	01 min 23 sec	02 min 00 sec	01 min 31 sec		01 min 22 sec	01 min 25 sec
18	Night Call Bell: Patient Call	01 min 20 sec	02 min 30 sec	01 min 39 sec		01 min 19 sec	01 min 20 sec
19	Night Call Bell: Bathroom Call	01 min 02 sec	02 min 00 sec	00 min 57 sec		01 min 02 sec	00 min 54 sec
Staffing							
20	Number of red flags for the month	12164	N/A	440		11502	5423

**YTD 2017/18 refers to the YTD figure at this point last year*

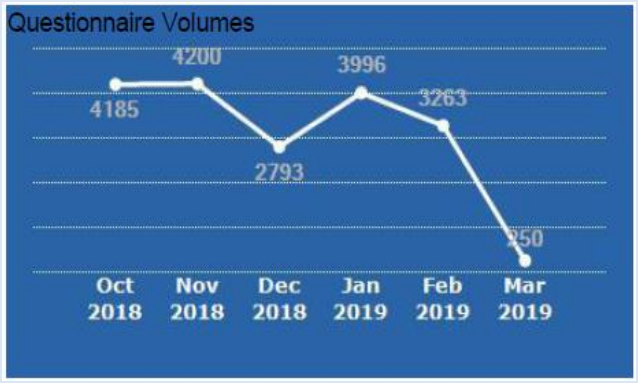
Core Slide 13 Caring and Patient Experience – Lead Director Nancy Fontaine

PALS
211 enquiries were received in February 2019.

41 compliments were received in January. All compliments received in PALS or via the Care Opinion Website are now recorded on Meridian

Area of Concern
Issues regarding communication remain the single biggest area of concern (15) although there was a decrease from the previous month (23). Results of the annual PALS survey results were shared with the sub-board where 64 callers were asked to feedback on using the PALS team – 95% felt it was a professional service and 91% were happy with the way their query was dealt with

FFT
Overall Trust-wide performance is 95% in January 2019



Housekeeping for Caring and Patient Experience
The sub board were asked to note the following information:
Attendance for 2018/2019
Reports Received in line with reporting schedule

Discharge Report
The group discussed OOH discharges as discussions had taken place previously about if they were all clinically viable. Further analysis reassured the group that this was the case.

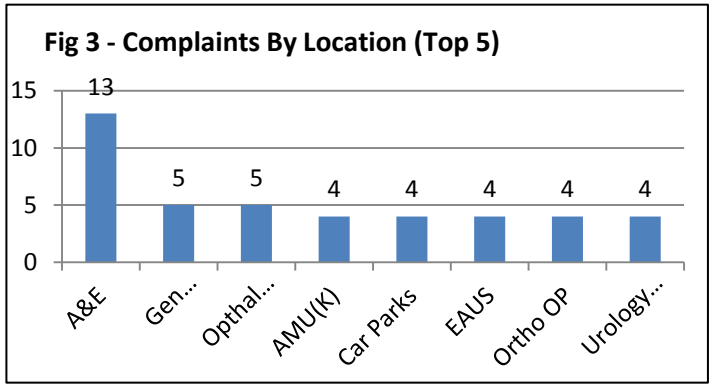
Ward Transfers
In depth look at the number of ward transfers experienced by some patients during their stay. To improve patient flow need to be looking more closely at step- down processes.

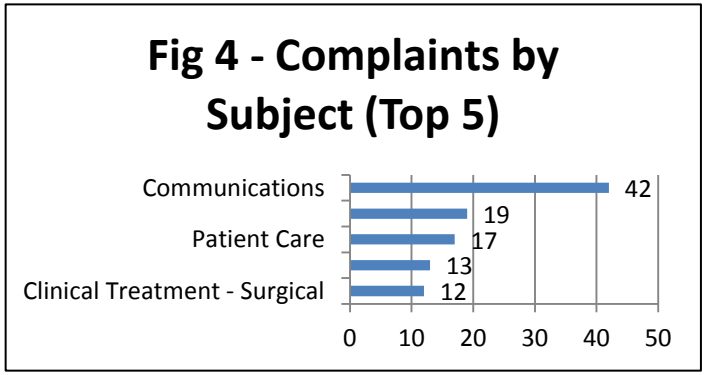
Deep Dive Analysis of Complex Complaints
It had previously been agreed that each of the Divisions would present complex cases to share any learning and identify where improvements could be made. The first case discussed was a paediatric case which will also be shared with Clinical Leaders and at Senior Practitioners Forum.

Policy for Management for National Survey Results
CSG has been disbanded so the policy showing the reviewed and updated to reflect current governance structure.

Core Slide 14 Caring and Patient Experience – Lead Director Nancy Fontaine

Complaints Summary
98 complaints were received in January 2019 compared with 96 for January 2018





EOL and SPCT
- Essential Training for all staff in EOL care to be approved and commenced
- ICP continues to be embedded Trust wide

Butterfly Coordinator
Emma Taylor introduced herself to the Group who will come under the Volunteers but work primarily with the SPCT.
A team of specially trained volunteers will offer to sit with patients when they are at EOL and have no visitors or to provide cover for family members to allow them a break.
Awareness session will take place on 10th April. It is hoped the service will be available for June.

PIF
Report providing an updated list of amended leaflets was shared as part of the papers.

Bereavement Suite
Work on the Bereavement Suite for NICU and Delivery will commence on March 25th

Core Slide 15 Corporate Risk Register (page 1 of 3) Lead Director Nancy Fontaine

Corporate Risk Register 15+ Risks **Date of Update** **05/03/2019**

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 direction of travel over the last 3 months. The final column details the anticipated date for the reduction or resolution of the risk.

Ref	Risk Name	Current Risk score			3 month risk trend			Date Risk added	Executive Lead	Date of Last review	Latest Status report
		Cons.	Freq.	Risk Score	1mth ago	2mth ago	3mth ago				
619	CQC Rating	4	5	20	20	20	20	02/10/2018	Chief Nurse	05/03/2019	QIP in place and being actively monitored via Quality Programme Board and Oversight and Assurance Group. Unannounced inspection took place Jan 22nd and 23rd. Use of resources review took place mid Feb and well led inspection last week Feb. All data requests following inspection have been submitted. Awaiting draft report for factual accuracy.
572	Financial sustainabilty	4	5	20	20	20	20	13/10/2015	CFO	10/01/2019	Risk of financial penalties both from 16/17 not resolved and 18/19 penalties due to the Trust not accepting its control total still not resolved. 55 million deficit dependant on additional allocation of budget
623	Non delivery of financial plan 2018/19	4	5	20	20	20	16	31/10/2018	CFO	10/01/2019	It is highly likely that we will not deliver the plan without recognition of increased activity by commissioners. Q3 forecast out turn not on track. Risk score raised to 20
624	Medium term financial strategy	4	5	20	20	20	20	31/10/2018	CFO	10/01/2019	Work on medium term financial strategy continues. PWC assisting to work up the plan. Will be completed by Q4. No change to score
571	Failure to achieve key local and national operational performance targets	4	5	20	20	20	16	13/10/2015	COO	10/01/2019	New RATS facility and Discharge suite opened in late December. Need to review impact. Cancer deep dive presented at Board in November. Risk increased to 20
610	Ageing IT infrastructure	5	4	20	20	20	20	02/08/2018	CIO	09/01/2019	Trust digital strategy agreed. Additional funding approved by board and next year investment increasing for end user devices
611	Ageing Sterile Services Equipment	4	5	20	20	20	16	14/08/2018	Director of Strategy	28/12/2018	New replacement equipment ordered. Risk remains the same until equipment arrives and is commissioned.
524	GIOTTO detector failure	4	5	20	20	20	10	07/07/2017	Director of Strategy	24/01/2019	Purchased new equipment. Waiting for costing for room adaptions. Risk remains until works complete and equipment installed.
642	Impact of no deal Brexit on pharmacy stock holding / stock availability.	5	4	20	20	20	New	22/11/2018	Medical Director	17/01/2019	No change, awaiting Brexit decision. Unable to stockpile any medications. DoH and Chief Pharmaceutical Officer are strictly monitoring this and no exceptions are allowed.
646	Ultrasound drop probe	4	5	20	20	20	New	14/12/2018	Director of Strategy	14/12/2018	Broken robot ultrasound drop probe in urology theatres this will prevent the treatment of some patients on the cancer pathway. Rep/Company aware and have quoted for replacement.Supplier has offered a loan device as soon as they receive a purchase order number.Dept planning to purchase a replacement robotic ultrasound drop probe from either BK Medical or Hitachi (quote being sought from second supplier)
651	Non compliance with Network and Information Systems Regulations 2019	4	5	20	20	20	New	28/12/2018	CIO	28/12/2018	Inability to comply with the UK's NIS Regulations as a defined operator of essential services, due to a lack of people, technology, training, appropriate processes and pockets of shadow IT as identified by the NIS Gap Analysis report submitted to Trust Board. Business case submitted.
677	Ageing defibrillators	4	5	20	20	New	New	03/01/2019	Director of Strategy	03/01/2019	The hospital has over 80 defibrillators which are at the end of their lives as spare parts will not be available after December 2018. We get at least 60 arrest calls per month. Replacement equipment required.
562	Mould spores (Penicillium Chrysogenum) found in pharmacy preparative services	5	4	20	12	9	9	21/12/2017	Director of Strategy	27/02/2019	Issue has been discussed at HMB and with NHSi at the trust performance review meeting. Also external audit has again highlighted the issue as significant. Scoring increased to 20 as the issue could cause significant patient harm, have an adverse impact on Trust reputation and cause significant service disruption.

Core Slide 15a Corporate Risk Register (page 2 of 3) Lead Director Nancy Fontaine

Ref	Risk Name	Current Risk score			3 month risk trend			Date Risk added	Executive Lead	Date of Last review	Latest Status report
		Cons.	Freq.	Risk Score	1mth ago	2mth ago	3mth ago				
717 (supercedes 325)	Ambulance Handover Delays	4	5	20	New	New	New	19/02/2019	COO	19/02/2019	RAT's assessment area opened which has increased the number of cubicles from 4 to 8, doubling previous capacity. Also created a dedicated space for patients who don't need cubicle and can wait for their assessment in a sitting waiting area. SOP developed to provide framework for improving safety of those patients with delayed handover by ensuring identification, escalation and management of unwell patients Regular escalation of delays by EDFC to site team, and use of the new aylsham suite has a positive reduction in the scale of the problem by improving flow out of ED to create space for handover
604	Sustainability of Cardiology catheterisation laboratory services due to equipment failure	4	4	16	16	16	16	03/05/2018	COO	07/02/2019	Contract scheduled to be signed at the end of February, and due to come into place in April. This should lead to new equipment being in place by the end of the year . Score remains the same
576	Nuclear Medicine - loss/disruption of service and regulatory compliance due to equipment failure, design of facilites and access to medical physics resource.	4	4	16	16	16	16	18/01/2018	Director of Strategy	28/12/2018	Business case progressing.Ageing and failing equipment. Nuclear Medicine visited by F&I sub board. SRO changed from COO to Director of Strategy
387	IRU capacity	4	4	16	16	16	16	03/06/2014	COO	24/01/2019	Once Quadram opens in Q3 this will create some capacity in Cath lab to help manage the waiting list until new IRU building work is completed.
363	Opthalmology capacity for follow up appointments	4	4	16	16	16	16	20/03/2013	COO	28/12/2018	HII action plan being worked through. Processes have been improved which will assist with prospective management of the waiting list. However the backlog of patients is still being worked through and a failsafe office needs to be appointed. Until these have occurred no change to score.
404	Cardiology pacing waiting lists	4	4	16	16	16	16	10/11/2017	COO	07/02/2019	Quadram now open which should stop the Radial Lounge being inappropriately moved and therefore cancellations should be reduced. Need to review impact. The procedure room refurb has been signed off and should be available for more complex cases in August 2019. If the cath lab recovery area can be used as a recovery area again turnaround times will improve and increase efficiency through increased flow. Unable to utilise the Endoscopy space.
654	IM&T staffing	4	4	16	16	16	16	28/12/2018	CIO	28/12/2018	IM&T department are unable to meet the demands for its services across the organisation. The current requests from the divisions and organisation as a whole outweighs the number of resources available. This is now having an impact on key projects being requested and hindering their ability to deliver. Department are utilising contract/agency staff to maintain 'business as usual' but this additional capacity doesn't help support these new initiatives and projects
655	Inappropriate use of POCT equipment	4	4	16	16	16	New	28/12/2018	Medical Director	17/01/2019	Inappropriate use of POCT equipment could lead to harm to patients. Need to follow MHRA guidance on POCT testing, as defined in Management and use of IVD point of care test devices. POCT committee with appropriate clinical input from outside of pathology. Lines of accountability for POCT management need to be clear. Assessment of the service by an external accreditation body is required e.g. ISO 22870:2016. Clear, comprehensive record keeping and documentation of POCT; Competency, reagents, results. Transfer of POCT results to Web ICE

Core Slide 15b Corporate Risk Register (page 3 of 3) Lead Director Nancy Fontaine

Ref	Risk Name	Current Risk score			3 month risk trend			Date Risk added	Executive Lead	Date of Last review	Latest Status report
		Cons.	Freq.	Risk Score	1mth ago	2mth ago	3mth ago				
678	Ageing Cobra counting equipment - Nuclear Medicine	4	4	16	16	16	New	03/01/2019	Director of Strategy	03/01/2019	Risk of service failure in Nuclear Medicine for undertaking Glomerular Filtration Rate investigation. The Packard Cobra II Auto-gamma counting equipment and Epson dot matrix printer LQ-590 are more than 20 years old. The Cobra fails to count every sample leading to necessity of repeat counting.The Cobra needs to be supported by a dot matrix printer which is also old and fails on occasions. Replacement equipment required. Cost of equipment approx. £40k. Prioritisation work being undertaken for all imaging failing equipment
697	Aesculap dental drilling/sawing system out of use	4	4	16	16	New	New	30/01/2019	Director of Strategy	30/01/2019	Aesculap dental drilling/sawing system is unable to be used following overheating whilst being used by different Consultant Surgeons. Less robust drills from outpatients are being usedwhich is impacting the ability to undertake extractions via Minor Oral Surgery. The more complex work is still able to continue as we are 'trialling' potential replacement kit. Business case for replacement equipment being pursued.
703	Lack of aneasthetic capacity in CT	4	4	16	New	New	New	19/02/2019	Medical Director	19/02/2019	Increased demand has resulted in a lack of general anaesthetic capacity, due to the unavailability of substantially funded anaesthetic and support posts. This has resulted in a number of potentially curative oncology CT interventional procedures being delayed. Requests for ad-hoc sessional availability made but this is limited. Business case to be written for increased anaesthetist, ODP and recovery nurse hours to ensure increased capacity on a timetabled basis
568	Non -compliance with mandatory training	3	5	15	15	15	15	02/09/2015	HRD	28/12/2018	Progress is showing - current overall % is above 85% for the first time, however the target is 90% so score remains unchanged.
625	Equipment replacement programme	5	3	15	15	15	15	31/10/2018	Director of Strategy	16/01/2019	Division will be asked to submit their urgent equipment requirements for 19/20 and this will follow the same governance process as previously used. A project has been commenced to establish a 5yr rolling programme of equipment replacement although this is unlikely to be completed until spring 2019.
632	IRU on call rota - nursing shortage	5	3	15	15	15	15	22/11/2018	Chief Nurse	24/01/2019	Currently 8 nurses short for on call service due to vacancies, new /untrained staff, sickness and restrictions to practice adversely impacting on patient treatment through delay a lack of Interventional On call service. Recently recruited 4 nurses but still require training. SOP to be approved by HMB regarding use of staff in other Divisions. Staff from other Divisions already supporting IRU
671	Medisa Camera - poor quality images	3	5	15	15	15	New	02/01/2019	Director of Strategy	24/01/2019	Poor quality images limits the sensitivity and specificity in making a clinical diagnosis. Limited investigations are scheduled for this equipment. This does not reduce the risk for those patients scheduled on the Mediso camera. Replace camera with modern SPECT CT camera required to maintain service provision. Prioritisation work being undertaken for all imaging failing equipment.
679	Lack of patient voice and engagement	3	5	15	15	15	New	03/01/2019	Chief Nurse	05/03/2019	We do not actively engage with patients/carers to obtain their views to inform how services are delivered or work with them in partnership to shape and design services. Services will not be reflective of patient need and this will lead to criticism from our patients and regulators and adversely affect Trust reputation as a provider of responsive quality services which meet best practise. Lead for Patient engagement and experience commenced in post 01/03/2019.

Core Slide 16

Performance – Monitor KPI's - Lead Director Chris Cobb

Performance		Outturn 2017/18	Monthly Target	Feb-19	6 month trend	YTD 2017/18	YTD 2018/19
Cancer	Core Slide 18-20						
1 Cancer 62 day target for referral to treatment - GP Referral *		81.52%	85.00%	62.84%		81.67%	69.98%
2 Reallocated Cancer 62 day target for referral to treatment (Previous Month) - GP Referral * +		83.04%	85.00%	76.67%		82.80%	73.52%
3 Cancer 2 week wait - all cancers *		94.29%	93.00%	87.93%		94.39%	80.49%
4 Cancer - 62 day screening *		87.41%	90.00%	81.25%		86.82%	82.25%
6 Cancer 31 day target compliance		98.59%	96.00%	93.09%		98.74%	95.37%
7 Cancer 31 day target for subsequent treatments - Surgery *		95.33%	94.00%	86.27%		96.11%	84.47%
8 Cancer 31 day target for subsequent treatments - Anti Cancer Drugs *		99.77%	98.00%	100.00%		99.86%	99.28%
9 Cancer 31 day target for subsequent treatments - Radiotherapy *		98.32%	94.00%	100.00%		98.36%	97.52%
A&E	Core Slide 21						
10 A&E 4 hour target compliance		80.67%	90.00%	66.11%		81.88%	78.83%
11 A&E 4 hour target compliance combined (inc WiC)***		n/a	90.00%	76.00%			85.34%
12 Number of 30 minute handover breaches		6196	0	735		5413	7526
13 Number of 60 minute handover breaches		3698	0	540		3134	4074
14 Arrival to Handover time (>15 minutes)		48.9%		67.5%		46.5%	63.9%
RTT	Core Slide 22						
15 18 week RTT target - Patients on an incomplete pathway		83.91%	92.00%	82.55%		83.99%	83.63%
16 Admitted Backlog		3995.0	n/a	4508		3995	4017
17 Incomplete Non Admitted Backlog		2423	n/a	2675		2423	2744
Stroke	Core Slide 23						
18 Stroke internal overall SSNAP rating		B	B	B	BAABCB	B	B
Patient Flow							
19 Diagnostics		99.14%	99.00%	97.67%		99.13%	98.37%
20 Cancelled Operations		1354	n/a	141		1151	1201
21 Number of 28 day breaches		231	0	28		179	193
22 Average Delayed Transfers of Care		36	n/a	34		36	37
23 30 Day Readmission Rates**		12.43%	n/a	13.10%		12.44%	13.14%
24 Length of Stay (Elective)		3.10	n/a	3.13		3.10	3.25
25 Length of Stay (Non-Elective)		4.23	n/a	4.06		4.23	4.06
26 Average number of patients with LoS >14 days		197	200	180		197	184
*Please note these figures are provisional							
** Reporting one months in arrears							

+ *This metric has been calculated in accordance to NHSI and East of England Cancer Alliance Reallocation policy, which displays the Trust's reallocated position. Please note that this policy came in to affect for August 2017's data. Therefore, all data predating August 2017 should be considered as the Trust's pre-reallocated position.* February 2019's data is subject to final validation and agreement from tertiary provider trusts.

*** Please note that the A&E combined performance for April 2018 has been calculated using the provisional daily figures for the Walk in Centre

Core Slide 17

Performance Summary - Lead Director Chris Cobb

Performance – key issues

1. **Cancer** – Improvement in performance between January and February (64.3% to 72.2%) and reduced 62 day backlog (127 to 50). However, backlog and performance likely to stabilise at February position until further capacity gains made.

2. **ED** – System performance below recovery trajectory at 76.0%. Bed capacity, flu and staff shortages were the main contributory factor in the under delivery of the ED trajectory.
A significant improvement in ambulance handover delays >1 hour commenced towards the end of the month.

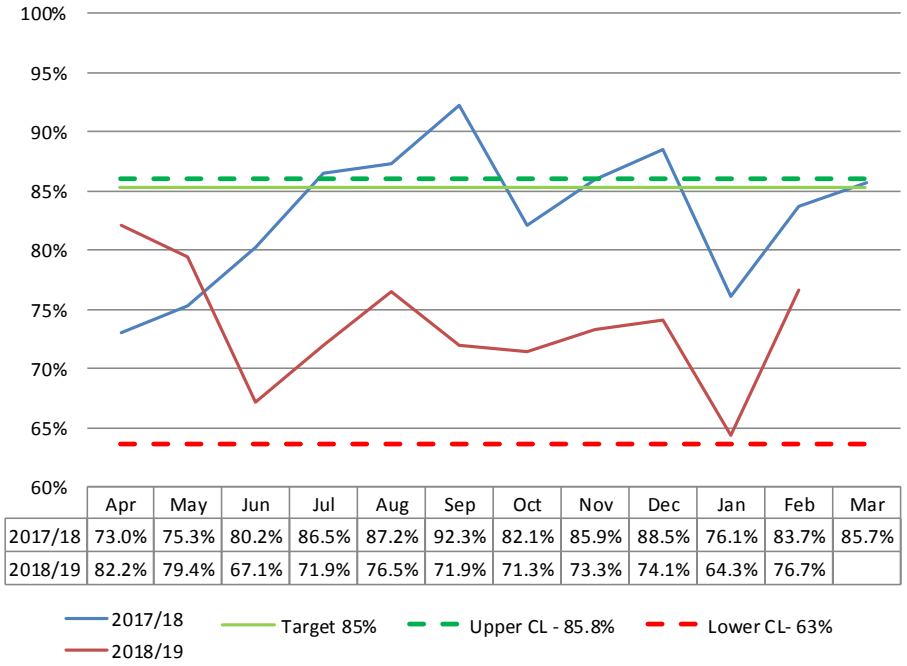
3 **RTT** – A continued increase in 2ww referrals impacting on RTT. Reduction schemes continue to be explored with commissioners as part of mitigating actions within and additional to the RAP. Known issues of an ageing waiting list remain. Organisational commitment on bringing 52 week breach level to zero for March 19 is in place, with extra Sunday lists in Theatres and IRU.

4 **Stroke** – Overall SSNAP rating of 'B' for February The main factors in the B rating were access to the Stroke Unit as a result of hospital wide congestion.

Core Slide 18

Performance (Cancer) - Lead Director Chris Cobb

Reallocated Cancer 62 day target for referral to treatment (Previous Month) - GP Referral *



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	73.0%	75.3%	80.2%	86.5%	87.2%	92.3%	82.1%	85.9%	88.5%	76.1%	83.7%	85.7%
2018/19	82.2%	79.4%	67.1%	71.9%	76.5%	71.9%	71.3%	73.3%	74.1%	64.3%	76.7%	

Issues

- Cancellations, late identification of cancers, less organisational flexibility and a run of complex patients have reduced performance in January and into February.
- Capacity constraints in template biopsies, imaging and surgery leading to increased waits and decreased overall urology performance – likely to plateau until resolved.
- Complex pathways in Breast cancer and spikes in referral leading to increased breaches (temporary impact).
- Large PTL in Colorectal and delayed investigative/administrative pathway

Actions

- Micromanagement of cancer PTL continues. Quantified, dynamic analysis of pathway milestones and demand/activity in progress. Now complete for Prostate.
- Additional 2WW clinics to respond to demand in Breast in March.
- Weekend Urology diagnostics continues to prevent further deterioration.
- Cancer transformation funding allocated for projects to commence and recruitment now underway. Capital funding allocation agreed which will ease pressure on Urology pathway (impact from April 2019).

**This metric has been calculated in accordance to NHSI and East of England Cancer Alliance Reallocation policy, which displays the Trust's reallocated position. Please note that this policy came in to affect for August 2017's data. Therefore, all data predating August 2017 should be considered as the Trust's pre-reallocated position.* January 2019's data is subject to final validation and agreement from tertiary provider trusts. Final position will be confirmed in March 2019.

Core Slide 18a

Performance (Cancer) - Lead Director Chris Cobb

62 Day GP Breaches – January (Open)

	Breast	Gynaecology	Haematology	Head and Neck	Lower GI	Lung	Other	Sarcoma	Skin	Upper GI	Urology	Grand Total
Administrative delay (e.g. failed to be rebooked after Did Not Attend, lost referral)		0	0.5	1.5	1					1	0.5	4.5
Complex diagnostic pathway (many or complex diagnostic tests required)	2	2			3	3	0	1		1	9	21
Elective cancellation (for non-medical reasons)		1										1
Elective capacity inadequate (Patient unable to be scheduled for treatment within standard time)	4	1		0.5					5		9	19.5
Health care provider initiated delay to diagnostic test or treatment planning					1.5	2						3.5
Out-patient capacity inadequate (i.e. no cancelled clinic, but not enough slots for this patient)											3	3
Patient initiated (choice) delay to diagnostic test or treatment planning, advance notice given						1				1	5.5	7.5
Treatment delayed for medical reasons (Patient unfit for treatment episode, excluding planned recovery period following diagnostic test)		1										1
Diagnosis delayed for medical reasons (Patient unfit for diagnostic episode, excluding planned recovery period following diagnostic test)						1						1
(blank)				0	2				0	0	0	2
Patient did not attend treatment appointment									1			1
Inconclusive diagnostic result					1							1
Grand Total	**6**	**5**	**0.5**	**3**	**8.5**	**7**	**0**	**1**	**6**	**3**	**27**	**67**

	Cancer Waiting Times	East of England Reallocation
Activity	183.5	183.5
Breaches	68	66
Performance	62.94%	64.03%

Urology breach share decreasing – however forecast to increase in January and February due to reduction in activity.

Skin breaches forecast to approach 0 in February. Breast and Colorectal remain problematic.

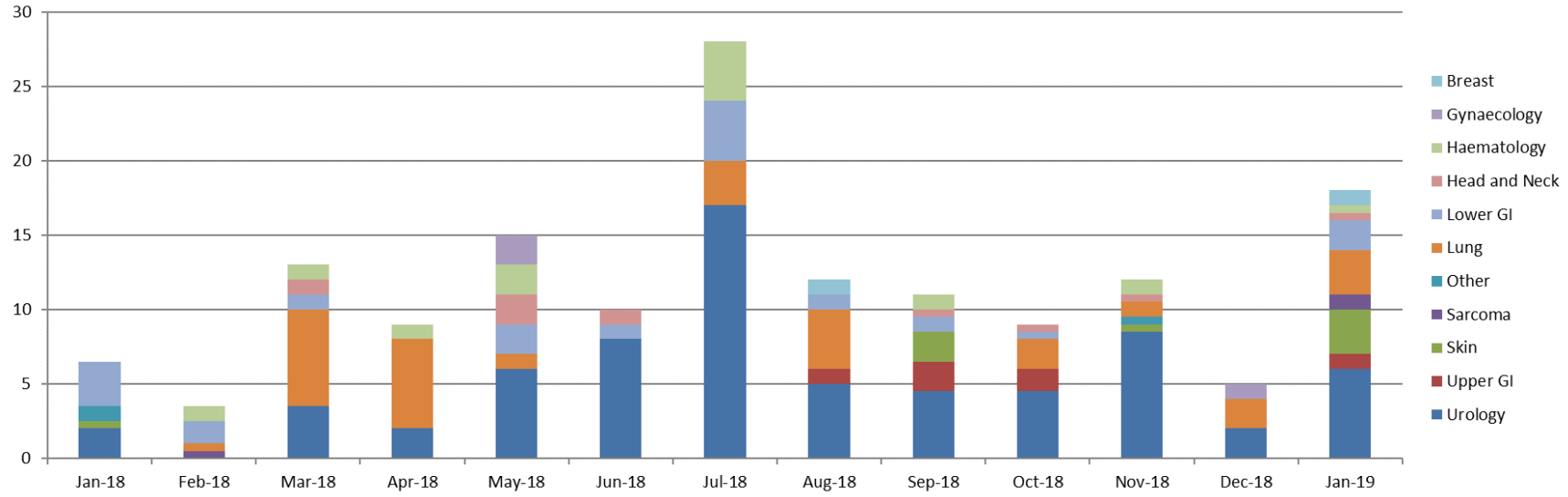
Core Slide 18b

Performance (Cancer) - Lead Director Chris Cobb

62 Day GP Breaches waiting over 104 Days – January (Open)

	Breast	Haematology	Head and Neck	Lower GI	Lung	Sarcoma	Skin	Upper GI	Urology	Grand Total
Administrative delay (e.g. failed to be rebooked after Did Not Attend, lost referral)		0.5	0.5							1
Complex diagnostic pathway (many or complex diagnostic tests required)	1			1	2	1			3	8
Elective capacity inadequate (Patient unable to be scheduled for treatment within standard time)							3		2	5
Health care provider initiated delay to diagnostic test or treatment planning				1						1
Patient initiated (choice) delay to diagnostic test or treatment planning, advance notice given								1	1	2
Diagnosis delayed for medical reasons (Patient unfit for diagnostic episode, excluding planned recovery period following diagnostic test)					1					1
(blank)			0							0
Grand Total	**1**	**0.5**	**0.5**	**2**	**3**	**1**	**3**	**1**	**6**	**18**

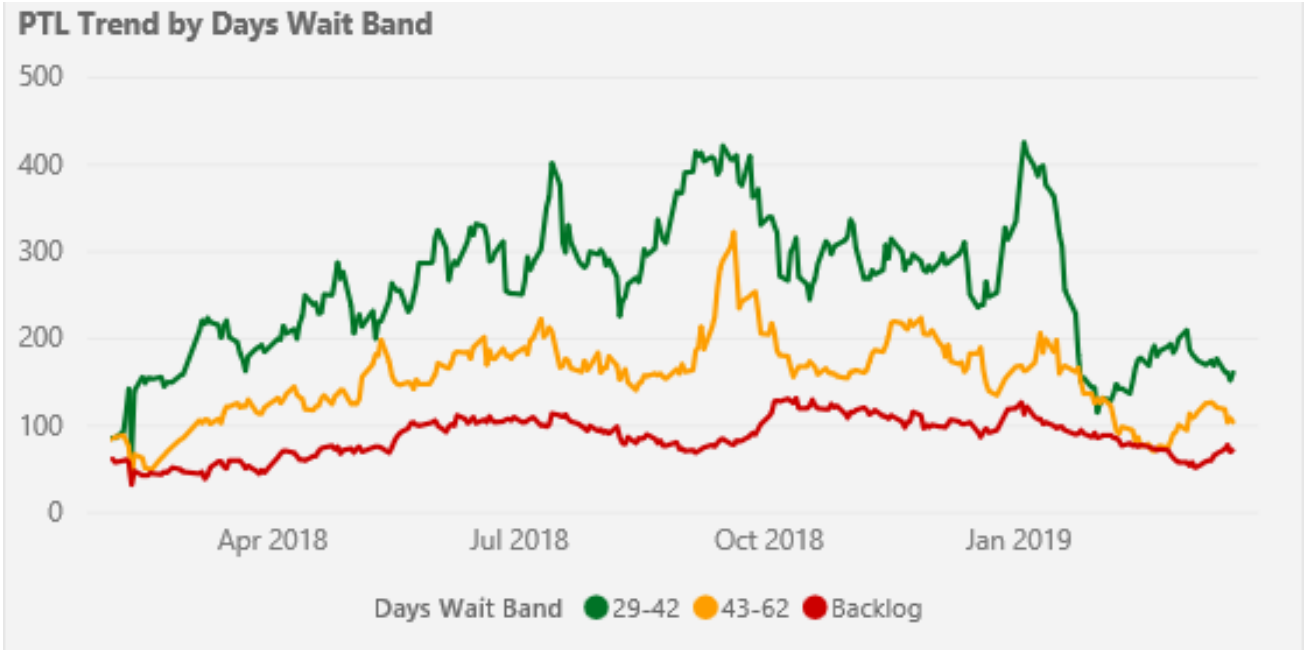
Urology represents most long waiters consisting primarily of Prostate patients. All harm reviews have shown no or low harm (1 patient) caused.



Core Slide 19

Performance (Cancer) - Lead Director Chris Cobb

PTL Date 21/03/2019



0-14	15-28	29-42	43-62	63-76	77-103	104+	Total
1,182.0	470.0	161.0	104.0	34.0	20.0	18.0	1,989.0

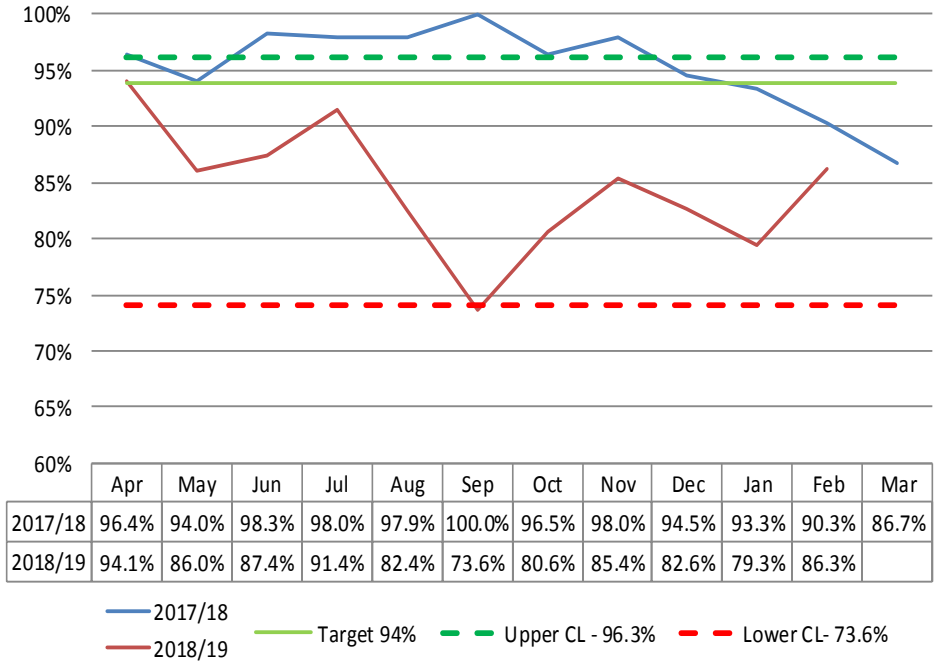
Rollovers	Backlog
25.00	72.0

Significant reductions in PTL size during January especially in Skin and Colorectal – positive indicator for future backlog reduction and sustainability. However, constant backlog in Urology will halt further recovery until resolved.

Core Slide 20

Performance (Cancer) – Lead Director Chris Cobb

Cancer 31 day target for subsequent treatments - Surgery *



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	96.4%	94.0%	98.3%	98.0%	97.9%	100.0%	96.5%	98.0%	94.5%	93.3%	90.3%	86.7%
2018/19	94.1%	86.0%	87.4%	91.4%	82.4%	73.6%	80.6%	85.4%	82.6%	79.3%	86.3%	

Please note data for February 2019 data is provisional

Issues

- Competing targets and pressures in Urology and Plastic Surgery continue to depress performance.
- Actions in place to increase capacity in plastics (from December 18) and Urology.

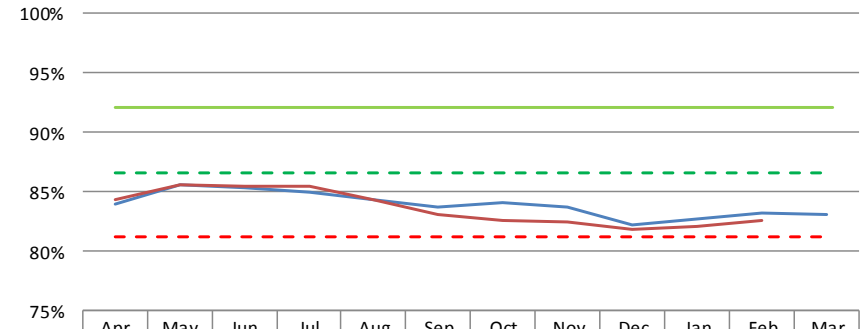
Actions

- Urology cancer priorities for additional lists
- Weekly surgical planning meeting (separate to PTL meeting) now in place to guide prioritisation of patients
- Plastic Surgery activity review undertaken with changes being implemented to balance demand and capacity.

Core Slide 21

Performance (RTT and A&E) – Lead Director Chris Cobb

18 week RTT target - Patients on an incomplete pathway

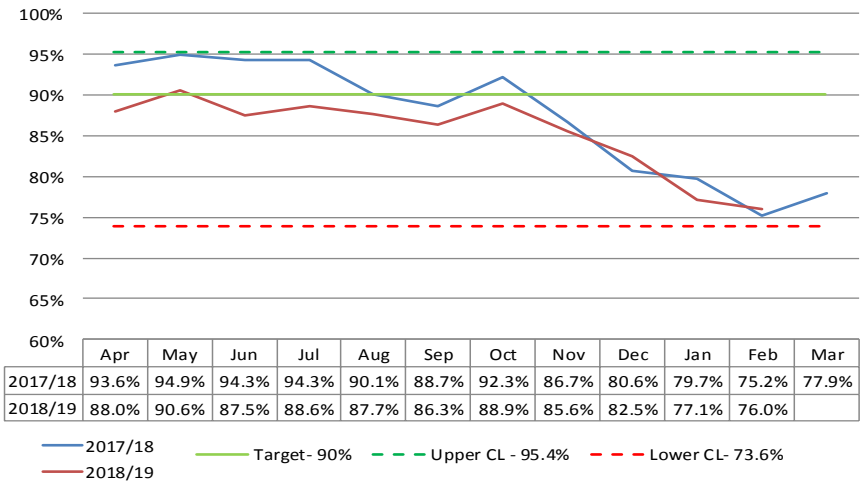


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	84.0%	85.6%	85.4%	85.0%	84.3%	83.8%	84.1%	83.7%	82.2%	82.7%	83.2%	83.1%
2018/19	84.3%	85.7%	85.4%	85.5%	84.3%	83.1%	82.6%	82.5%	81.8%	82.0%	82.5%	

Issues
- Waiting list showing slight increase with increasing backlog over 18 weeks due to cancellations and an increase in Cancer and urgent work.
- Corresponding increase in 40+weeks

Actions
- New RTT RAP produced with Ops Teams to revisit schemes for delivery of business plan
- Initiatives planned to reduce 52 week breaches to zero for end March 19 – underway and delivering with zero 52 week breaches expected

System Performance



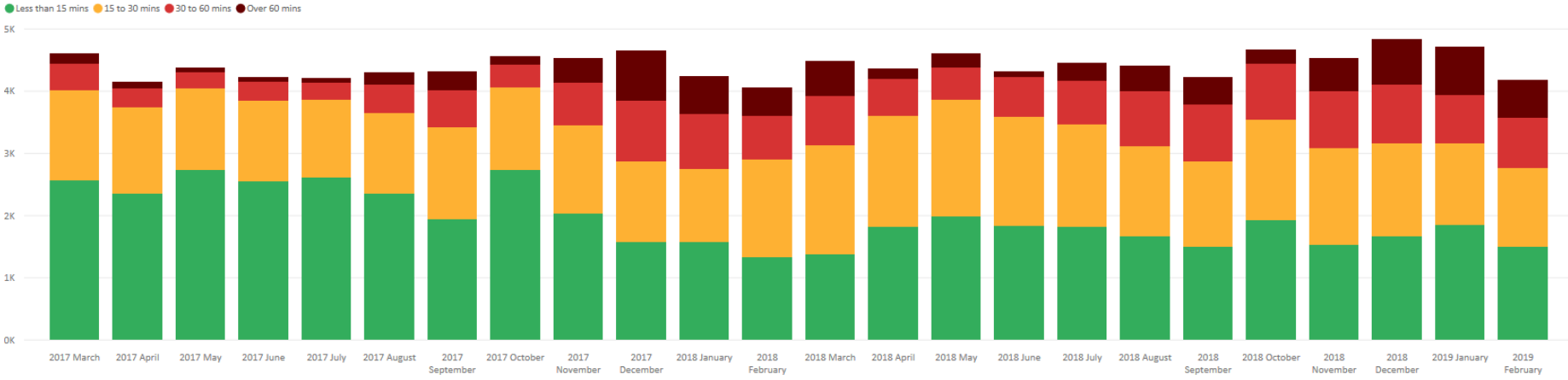
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	93.6%	94.9%	94.3%	94.3%	90.1%	88.7%	92.3%	86.7%	80.6%	79.7%	75.2%	77.9%
2018/19	88.0%	90.6%	87.5%	88.6%	87.7%	86.3%	88.9%	85.6%	82.5%	77.1%	76.0%	

Issues
- NNUH performance at 66.1% compared to 62.8% last February
- System wide performance 76% compared to 75.2% last February
- Attendances up by 15.4% with ambulance arrivals up by 3.3% compared to last February

Actions
- Ambulance Handover recovery plan to continue
- ECIST support for "perfect week" in April
- Enrolled in Same Day Emergency Care (SDEC) pilot scheme

Core Slide 21a

>60 Min Ambulance Handover Performance



Year, Month	Less than 15 mins	15 to 30 mins	30 to 60 mins	Over 60 mins
2017, April	2354	1389	296	110
2017, May	2732	1313	261	77
2017, June	2555	1295	296	82
2017, July	2619	1246	266	84
2017, August	2356	1294	452	197
2017, September	1945	1481	591	301
2017, October	2729	1332	363	136
2017, November	2035	1418	684	394
2017, December	1579	1288	973	815
2018, January	1577	1169	885	606
2018, February	1330	1567	705	460
2018, March	1381	1753	783	564
2018, April	1825	1783	589	165
2018, May	1979	1882	521	222
2018, June	1833	1762	634	96
2018, July	1816	1645	709	292
2018, August	1669	1447	880	420
2018, September	1502	1370	920	432
2018, October	1926	1614	896	229
2018, November	1526	1566	913	529
2018, December	1673	1488	949	721
2019, January	1846	1315	780	781
2019, February	1491	1268	818	601

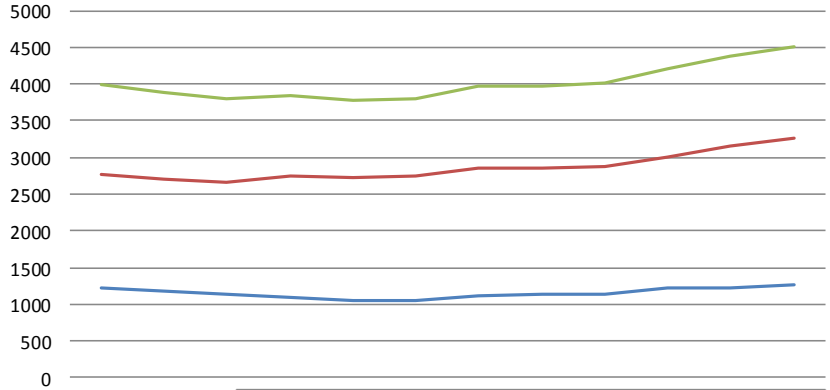
Ambulance Handover >60 mins - Feb 19

Trajectory to Achieve Zero Tolerance for >1 Hour Ambulance Handover Delays	Date	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Predicted Max	Actual Total	Difference
		28/01/2019	29/01/2019	30/01/2019	31/01/2019	01/02/2019	02/02/2019	03/02/2019			
	Predicted	5	5	5	5	4	4	10	38	222	184
	Actual	18	21	27	44	16	43	53			
	Variance	13	16	22	39	12	39	43			
		04/02/2019	05/02/2019	06/02/2019	07/02/2019	08/02/2019	09/02/2019	10/02/2019			
	Predicted	3	3	3	3	3	3	8	26	216	190
	Actual	28	50	40	16	19	30	33			
	Variance	25	47	37	13	16	27	25			
		11/02/2019	12/02/2019	13/02/2019	14/02/2019	15/02/2019	16/02/2019	17/02/2019			
	Predicted	2	2	2	2	2	2	6	18	94	76
	Actual	26	13	1	21	0	20	13			
	Variance	24	11	-1	19	-2	18	7			
		18/02/2019	19/02/2019	20/02/2019	21/02/2019	22/02/2019	23/02/2019	24/02/2019			
	Predicted	2	2	2	2	2	2	6	18	74	56
	Actual	16	1	22	1	1	26	7			
	Variance	14	-1	20	-1	-1	24	1			
		25/02/2019	26/02/2019	27/02/2019	28/02/2019	01/03/2019	02/03/2019	03/03/2019			
	Predicted	2	2	2	2	1	1	5	15	74	59
	Actual	5	7	22	9	0	22	9			
	Variance	3	5	20	7	-1	21	4			
		04/03/2019	05/03/2019	06/03/2019	07/03/2019	08/03/2019	09/03/2019	10/03/2019			
	Predicted	1	1	1	1	1	1	5	11	34	23
	Actual	12	20	2	0	0	0	0			
	Variance	11	19	1	-1	-1	-1	-5			
		11/03/2019	12/03/2019	13/03/2019	14/03/2019	15/03/2019	16/03/2019	17/03/2019			
	Predicted	1	1	1	1	1	1	3	9	0	-9
	Actual	0	0	0	0	0	0	0			
	Variance	-1	-1	-1	-1	-1	-1	-3			
		18/03/2019	19/03/2019	20/03/2019	21/03/2019	22/03/2019	23/03/2019	24/03/2019			
	Predicted	1	0	0	0	0	0	0	1	0	-1
	Actual	0	0	0							
	Variance	-1	0	0	0	0	0	0			

Core Slide 22

Performance (RTT) – Lead Director Chris Cobb

Admitted Backlog



	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Admitted IP Backlog	1224	1172	1126	1095	1059	1055	1119	1129	1145	1223	1222	1262
Admitted DC Backlog	2771	2707	2667	2744	2720	2751	2858	2853	2874	2995	3163	3273
Admitted Backlog	3995	3879	3793	3839	3779	3806	3978	3977	4019	4218	4386	4508

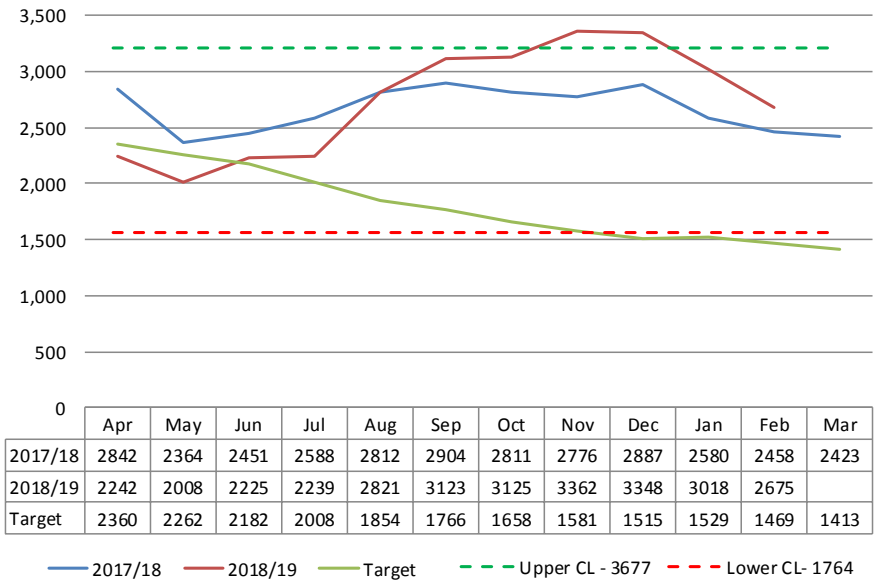
Issues

- Increased cancer demand and Urgent case mix impacting on delivery of routine work.
- 52 week breaches managed for March 19, with likelihood of breaches in April due to lack of capacity.
- Cancellations due to bed pressures impacting performance

Actions

- Theatre efficiency programme in place, week on week improvements continue to be seen
- Initiatives delivering to minimise 52 week breaches at end March
- Case to utilise Turnstone court theatres declined – exploring insourcing options

Incomplete Non Admitted Backlog



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2017/18	2842	2364	2451	2588	2812	2904	2811	2776	2887	2580	2458	2423
2018/19	2242	2008	2225	2239	2821	3123	3125	3362	3348	3018	2675	
Target	2360	2262	2182	2008	1854	1766	1658	1581	1515	1529	1469	1413

Issues

- Non admitted backlog reduced slightly
- Increase in 2ww referrals impacting on overall waiting list size and will continue to impact on backlog in future months

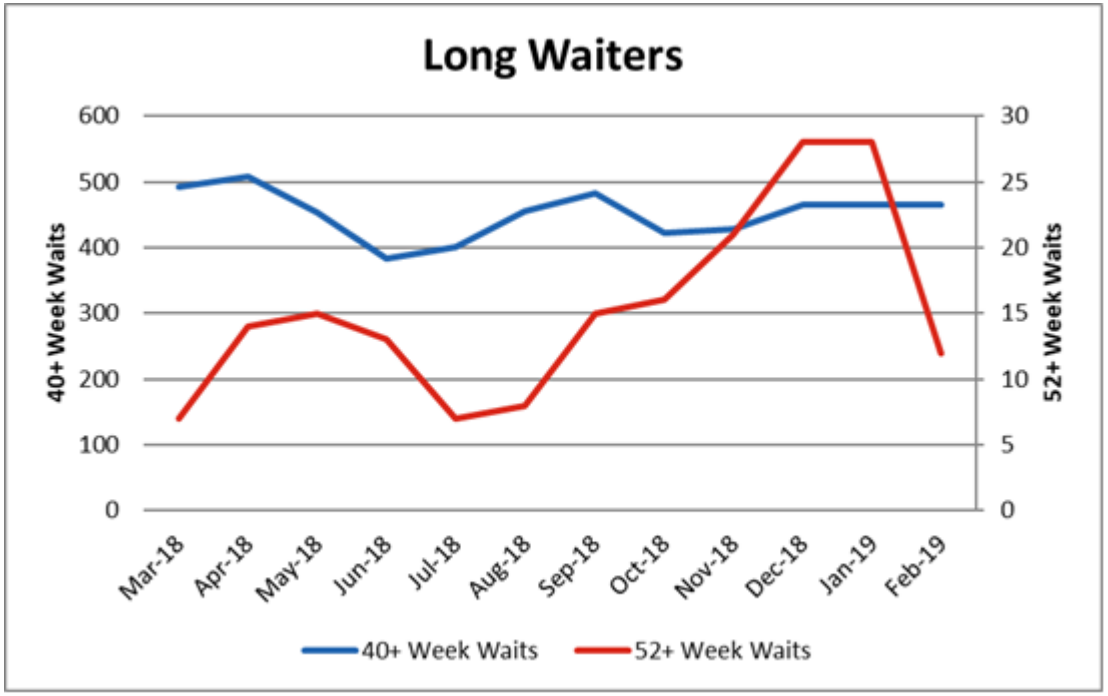
Actions

- Additional OP capacity across all specialities in progress
- Targeted validation of waiting lists in place
- Working with clinical teams to ensure correct application of RTT
- Working with commissioners on demand management

Additional Slide 22a

Performance (RTT) – Lead Director Chris Cobb

Long Waiters – Over 40 and 52 Weeks*



Comments

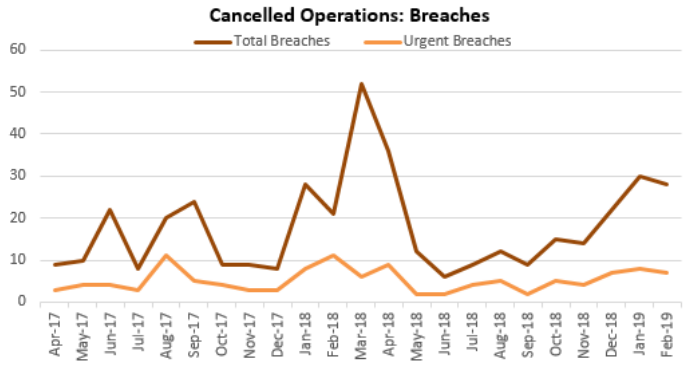
- Increase in 52wk patient numbers due to IRU capacity and limited Theatre capacity, with cancellations for bed pressures impacting on 40+ weeks. Interim plans developed and in play to increase IRU capacity and reduce number of 52 week waits. Plans to deliver zero 52 week breaches by 31/3 in place; however, expect to see further 52 week breaches in April due to increase in demand and emergency pressures over winter.
- Rigorous monitoring of clinical harm in place
- Proactive management of long-waiting patients continues but with an increasing spread across several specialities.

Additional Slide 22b

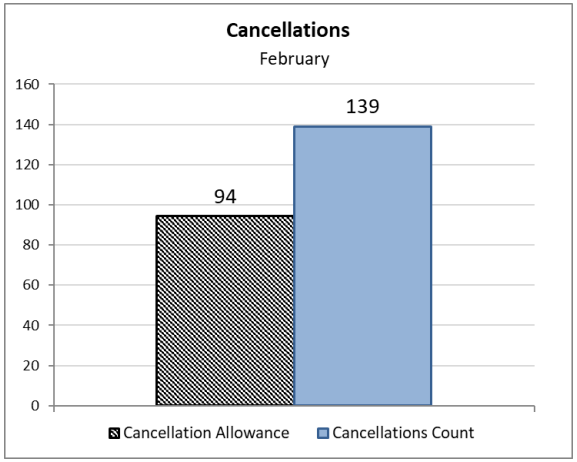
Performance (RTT) – Lead Director Chris Cobb

Cancelled Operations

Targets based on the previous four quarters of the QMCO aim for NNUH to reflect NHS England's trajectory for last minute cancelled operations, as well as breaches of the 28 day target. *N.B. QMCO data has now been updated to include 2018/19 Q1 data.*

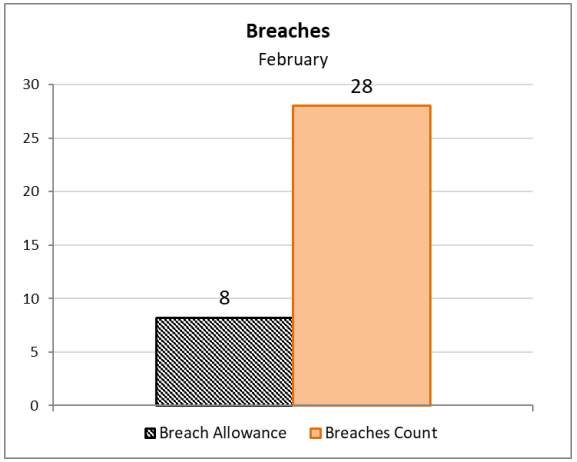


Month	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Total Breaches	9	10	22	8	20	24	9	9	8	28	21	52	36	12	6	9	12	9	15	14	22	30	28
Urgent Breaches	3	4	4	3	11	5	4	3	3	8	11	6	9	2	2	4	5	2	5	4	7	8	7



Target: NHS England's last minute cancelled operations rate is c. **1.10%** of all elective activity.

- Based on February's elective activity this would equate to **94** cancellations.
- NNUH saw **139** cancellations.
- This represented **1.61%** of elective activity.



Target: NHS England's breach percentage is c. **8.71%** of last minute cancelled operations.

- Based on February's last minute cancellations this would equate to **8** breaches.
- NNUH saw **28** breaches.
- This represented **20.14%** of cancellations.

Core Slide 23
Internal Sentinel Stroke Audit Programme (SSNAP) Dashboard

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

PERIOD	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
OVERALL SSNAP SCORE	84.0	74.0	72.0	74.0	82.0	76.0	80.0	82.0	82.0	80.0	70.0	80.0
OVERALL SSNAP RATING	A	B	B	B	A	B	B	A	A	B	C	B
POTENTIAL STROKES	310	310	311	283	281	299	287	279	295	295	258	248
DIAGNOSED STROKES	112	106	93	80	103	91	91	104	96	107	101	72

DOMAIN 1 score	CT Scanning	96.7	87.7	93.3	82.5	96.7	93	82.59	92.4	89	90.2	89.2	83.7
DOMAIN 1 rating		A	B	B	C	A	A	C	B	B	B	B	C
DOMAIN 2 score	Stroke Unit	60.8	69.5	69	67	74.5	74.9	73.6	83.2	75.7	77.4	77.1	72.9
DOMAIN 2 rating		D	D	D	D	C	C	C	B	C	C	C	C
DOMAIN 3 score	Thrombolysis	71	55.3	66.4	65.7	75.8	75.4	72.4	77.4	65.9	70.7	70.3	71.1
DOMAIN 3 rating		B	D	C	C	B	B	B	B	C	B	B	B
DOMAIN 4 Score	Specialist Assessments	89.3	86.7	88	85.1	88	91	88.7	92.2	91.3	92.8	93.6	89.7
DOMAIN 4 Rating		B	B	B	B	B	A	B	A	A	A	A	B
DOMAIN 5 Score	Occupational Therapy	82.5	76.2	67	75.9	77.2	74.7	83.62	76.6	85.5	76.2	68.6	92
DOMAIN 5 Rating		A	B	C	B	B	C	A	B	A	B	C	A
DOMAIN 6 Score	Physiotherapy	80.2	78.6	73.2	75	76	75.1	80.21	78.5	75.2	76	65.3	82.2
DOMAIN 6 Rating		B	B	C	B	B	C	B	B	B	B	D	B
DOMAIN 7 Score	SALT	70.5	65.7	62.8	62.5	59.5	53.6	56.6	63.6	66.2	57	50.9	57.5
DOMAIN 7 Rating		B	B	C	C	C	D	C	C	B	C	D	C
DOMAIN 8 Score	MDT Working	82	79.5	75.8	80.9	81.9	79.2	81.0	81.0	84.7	82.6	79.7	85.3
DOMAIN 8 Rating		B	C	C	B	B	C	B	B	B	B	C	A
DOMAIN 9 Score	Standards by Discharge	97.9	98.7	95.7	97.9	98.3	92.0	98.5	91.0	88.1	81.5	93.5	94.4
DOMAIN 9 Rating		A	A	A	A	A	B	A	B	B	B	B	B
DOMAIN 10 Score	Discharge Process	100	100	100	100	100	98.3	100	100	96.2	100	98.3	100
DOMAIN 10 Rating		A	A	A	A	A	A	A	A	A	A	A	A

Internal overall SSNAP Rating for February 2019

B 80%

Overall Summary:

- Achieved a B in Stroke unit with ongoing flow pressures
- Significant improvement with Therapies
- The SSNAP QUIP team are focusing on CT Scanning and Stroke Unit

Action:

- Ongoing education & awareness planning inside and outside of the Trust
- Therapy Workforce plan being developed for 2019/20

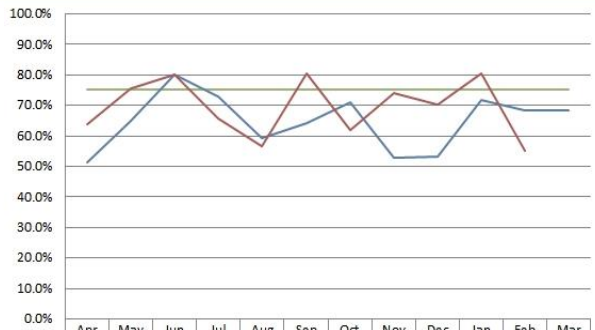
Core Slide 24

Performance (Cardiology) - Lead Director Chris Cobb

% NSTEMI Time to Procedure < 72 Hours

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%	60.0%
2017-18	61.5%	89.7%	63.3%	56.5%	83.3%	70.6%	82.1%	64.9%	66.7%	43.5%	48.5%	75.8%
2018-19	83.3%	54.5%	71.8%	68.4%	80.0%	81.8%	83.3%	71.4%	68.1%	77.4%	76.0%	

% PPCI Call to Balloon < 150 Minutes



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%
2017-18	51.4%	64.9%	80.0%	73.0%	59.4%	64.3%	71.1%	52.9%	53.3%	71.8%	68.4%	68.4%
2018-19	63.9%	75.7%	80.0%	65.8%	56.8%	80.6%	61.8%	74.1%	70.4%	80.6%	55.2%	

% PPCI Door to Balloon < 60 Minutes

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Target	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%
2017-18	71.1%	78.4%	74.3%	78.9%	87.5%	67.9%	73.7%	82.4%	60.0%	87.2%	86.8%	79.5%
2018-19	75.0%	83.8%	85.4%	79.5%	86.5%	83.9%	79.4%	77.8%	74.5%	81.8%	71.0%	

NSTEMI standard consistently delivered since June 2018

Reasons for not achieving Target:

There were 29 PPCI calls in February of which we did not meet the target in 13.
8 of the 13 incidents were primarily due to delayed inital attendance and/or lengthy journeys times. If these issues had not occured we could have achieved 82%

Of the 5 additional PPCI's who did not meet the target, 4 were complex cases needing further medical assessment pre PPCI, 1 of these 4 being an out of hospital arrest.
The final PPCI was assessed in AMU before primary activation, having already waited to be seen.

PLAN:

Cardiology Cath Lab Manager & Team to meet with EEAST and share detials of issues idetnified for them.
Cardiology Cath Lab Manager, PCI Team and Ops Manager to review the additional 5 PPCI where we did not meet the target, to identify and implement improvements.
Details to be shared at Cardiology Governance & Risk Meetings.

Reasons for not achieving Target:

There were 31 PPCI door to balloon events in February.
We did not meet the target for 9 of the patients.
In 4 of these PPCI's, a contibuting factor was that another pateint was already on the table .
2 additional PPCI patients required further medical assessment pre PPCI and 1 patient was delayed in A&E.

(Of note we have consistently met this target from January 2018 until December 2018. Currently we are at at 79.8% compliance this financial year. If we had met the target in an additional 2 pateints we would have achieved 77% for February 2019)

PLAN:

Cardiology Cath Lab Manager, PPCI Team & Ops Manager to review all incidents where we did not meet the target. A plan to be devised to deal with incidents where we already have a patient on the table.
Findings to be shared at Cardiology Governance & Risk Meetings.

Core Slide 25 Performance (Productivity) Summary – Lead Director Chris Cobb

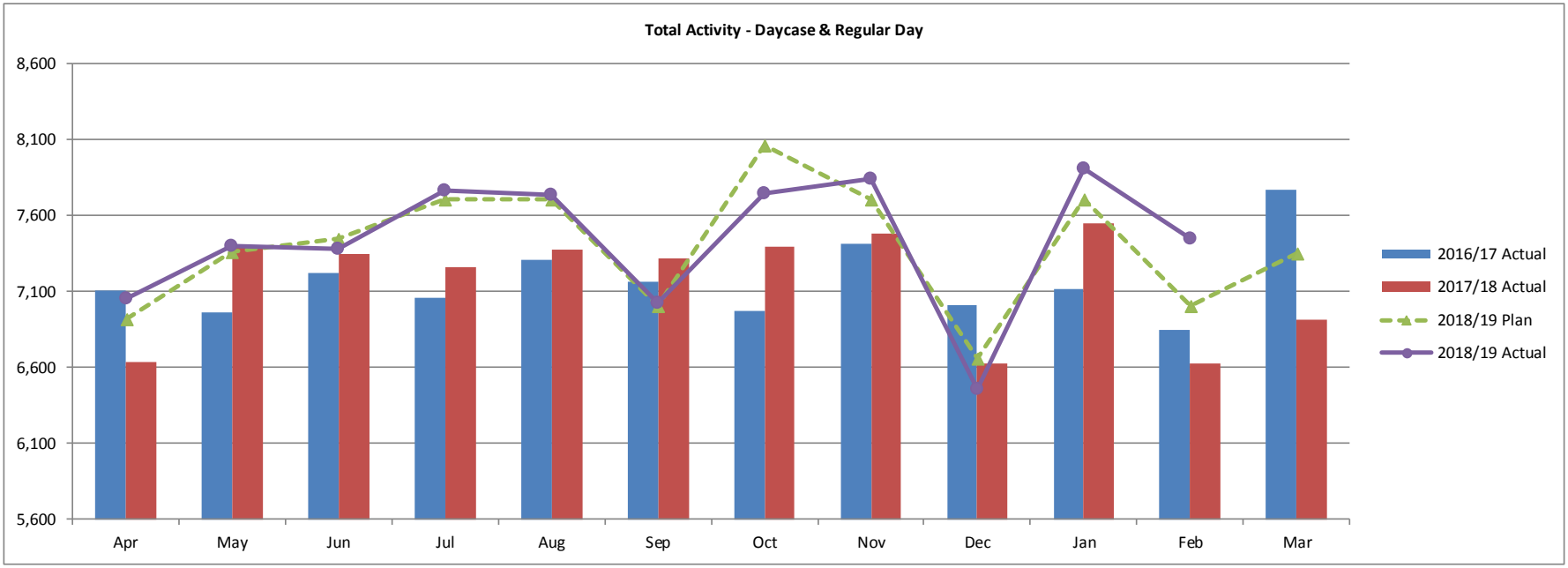
Productivity		Outturn 2017/18	Monthly Target	Feb-19	6 month trend	YTD 2017/18	YTD 2018/19
A&E Activity (attendances)		131235	11534	11203		120256	129527
Elective Activity - Day case spells	Core Slide 26	85923	7010	7448		79012	81775
Elective Activity - Elective inpatient spells	Core Slide 26a	13330	1087	906		12177	11504
Emergency Admissions	Core Slide 26b	56018	4215	4447		51142	53518
Outpatient Activity (consultant led & non-consultant led)	Core slide 26c	725710	57260	61531		664801	706921

Core Slide 26

Performance (Productivity) – Lead Director Chris Cobb

Activity & Income
2016/17 vs 2017/18 vs 2018/19 YTD
Daycase and Regular Day Attenders

Activity	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Full Year
2016/17 Actual	7,111	6,959	7,219	7,063	7,311	7,161	6,970	7,419	7,013	7,113	6,846	7,774	**78,185**	**85,959**
2017/18 Actual	6,636	7,402	7,346	7,263	7,372	7,316	7,400	7,481	6,627	7,546	6,623	6,912	**79,012**	**85,924**
2018/19 Plan	6,920	7,360	7,449	7,709	7,709	7,006	8,064	7,707	6,656	7,708	7,010	7,356	**81,298**	**88,654**
2018/19 Actual	7,053	7,398	7,385	7,770	7,738	7,029	7,744	7,844	6,459	7,907	7,448		**81,775**	**81,775**
Variance to 2017/18	417	(4)	39	507	366	(287)	344	363	(168)	361	825		**2,763**	**2,763**
Variance to 2017/18 %	6.3%	-0.1%	0.5%	7.0%	5.0%	-3.9%	4.6%	4.9%	-2.5%	4.8%	12.5%		**3.50%**	
Variance to Plan	133	38	(64)	61	29	23	(320)	137	(197)	199	438		**477**	**477**
Variance to Plan %	1.9%	0.5%	-0.9%	0.8%	0.4%	0.3%	-4.0%	1.8%	-3.0%	2.6%	6.2%		**0.59%**	



Issues and Comment

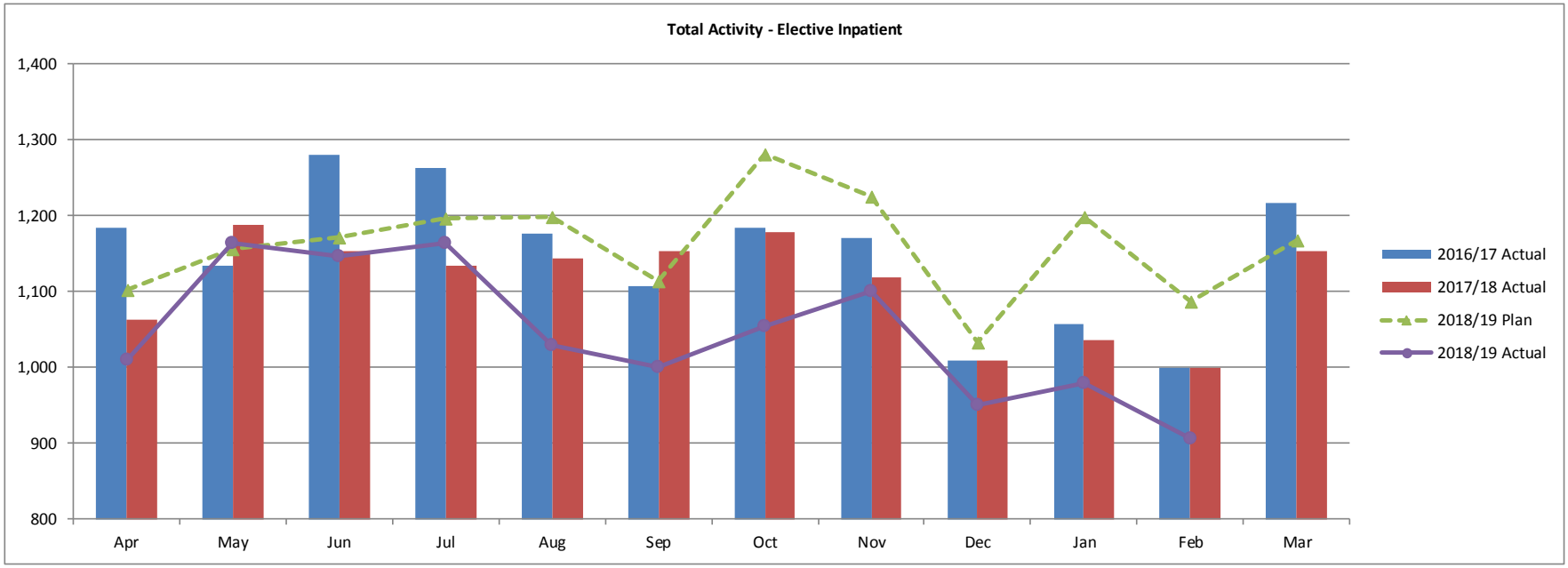
- Overall daycase performance was over plan by 438 cases (6.2%) and 825 ahead of February 2018 levels (12.5%)
- This performance was again a mixed picture with medicine over performing by 561 cases (mainly gastro, clinical haematology and cardiology) and surgery 134 cases down compared to plan (predominantly Ophthalmology, Pain Management and Dermatology). Dermatology have an ongoing challenge with capacity and demand, new outpatients prioritised to manage 2ww referrals, full compliment of Junior doctors from September will see an improving picture.
- Case mix shift in Surgery work with a high level of non-elective activity particularly in general surgery, plastics and ENT, limiting over performance in day cases and electives as a result of theatre productivity programme

Additional Slide 26a

Performance (Productivity) – Lead Director Chris Cobb

Activity & Income
2016/17 vs 2017/18 vs 2018/19 YTD
Elective Inpatient

Activity	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Full Year
2016/17 Actual	1,184	1,134	1,280	1,263	1,177	1,107	1,184	1,171	1,009	1,057	999	1,217	**12,565**	**13,782**
2017/18 Actual	1,063	1,188	1,153	1,134	1,143	1,154	1,179	1,118	1,009	1,036	1,000	1,153	**12,177**	**13,330**
2018/19 Plan	1,101	1,156	1,172	1,197	1,198	1,114	1,282	1,225	1,033	1,199	1,087	1,167	**12,765**	**13,933**
2018/19 Actual	1,010	1,163	1,147	1,163	1,029	1,000	1,055	1,101	950	980	906		**11,504**	**11,504**
Variance to 2017/18	(53)	(25)	(6)	29	(114)	(154)	(124)	(17)	(59)	(56)	(94)		**(673)**	**(673)**
Variance to 2017/18 %	-5.0%	-2.1%	-0.5%	2.6%	-10.0%	-13.3%	-10.5%	-1.5%	-5.8%	-5.4%	-9.4%		**-5.53%**	
Variance to Plan	(91)	7	(25)	(34)	(169)	(114)	(227)	(124)	(83)	(219)	(181)		**(1,261)**	**(1,261)**
Variance to Plan %	-8.3%	0.6%	-2.2%	-2.8%	-14.1%	-10.2%	-17.7%	-10.1%	-8.1%	-18.3%	-16.7%		**-9.88%**	



Issues and Comment

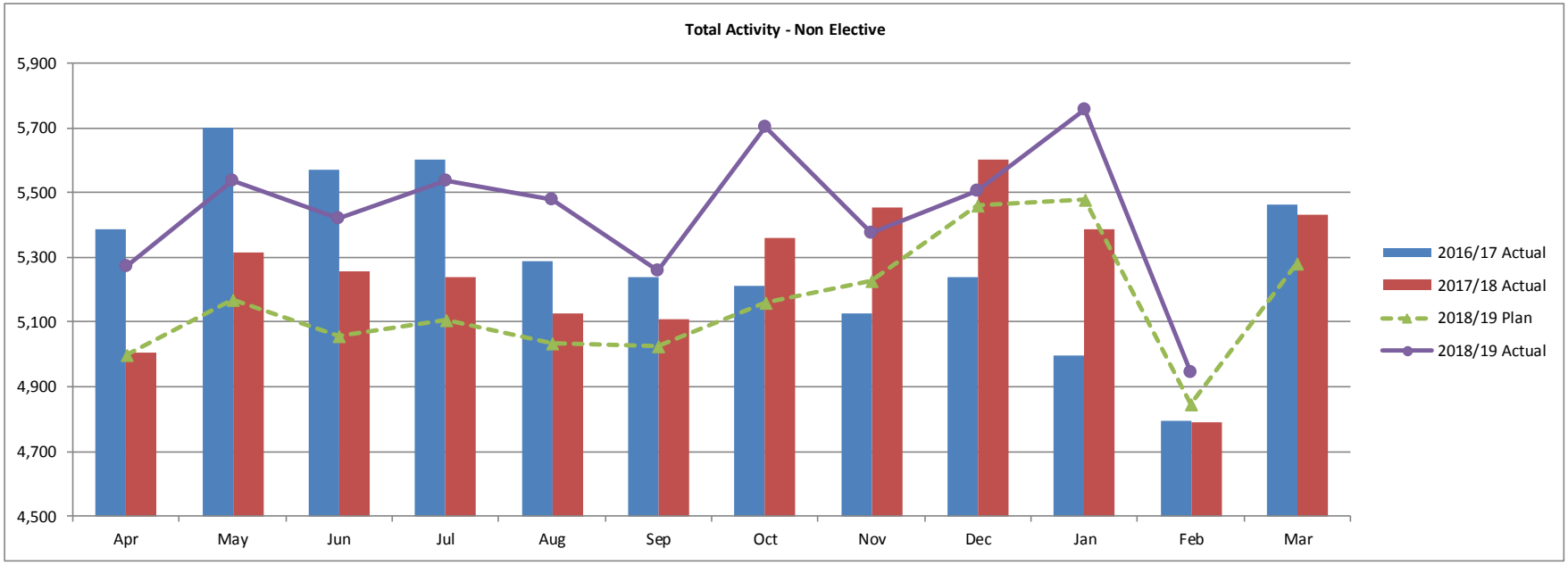
- Elective activity was 181 cases behind plan (-16.7%) and 94 cases (-9.4%) behind February 2018 levels.
- Surgery were 75 cases behind plan in month (due to T&O/spinal and urology). Cardiology were 97 cases behind plan. High levels of non-elective activity within the hospital and surgical specialities has had a knock on impact on electives.
- Theatre productivity programme focusses on d/c electives. This is not reflected in current reporting therefore the plan will be corrected for future months i.e. the elective plan reduces and the day-case plan increases

Additional Slide 26b

Performance (Productivity) – Lead Director Chris Cobb

Activity & Income
2016/17 vs 2017/18 vs 2018/19 YTD
Non Elective (exlcuding Marginal Rate)

Activity	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Full Year
2016/17 Actual	5,385	5,703	5,572	5,602	5,289	5,240	5,212	5,128	5,240	4,998	4,794	5,464	**58,163**	**63,627**
2017/18 Actual	5,006	5,314	5,255	5,239	5,127	5,111	5,359	5,453	5,601	5,388	4,788	5,432	**57,641**	**63,073**
2018/19 Plan	5,000	5,169	5,057	5,107	5,034	5,025	5,162	5,229	5,460	5,478	4,845	5,280	**56,567**	**61,847**
2018/19 Actual	5,274	5,539	5,421	5,539	5,478	5,260	5,702	5,376	5,508	5,757	4,945		**59,799**	**59,799**
Variance to 2017/18	268	225	166	300	351	149	343	(77)	(93)	369	157		**2,158**	**2,158**
Variance to 2017/18 %	5.4%	4.2%	3.2%	5.7%	6.8%	2.9%	6.4%	-1.4%	-1.7%	6.8%	3.3%		**3.74%**	
Variance to Plan	274	370	364	432	444	235	540	147	48	279	100		**3,232**	**3,232**
Variance to Plan %	5.5%	7.2%	7.2%	8.5%	8.8%	4.7%	10.5%	2.8%	0.9%	5.1%	2.1%		**5.71%**	



Issues and Comment

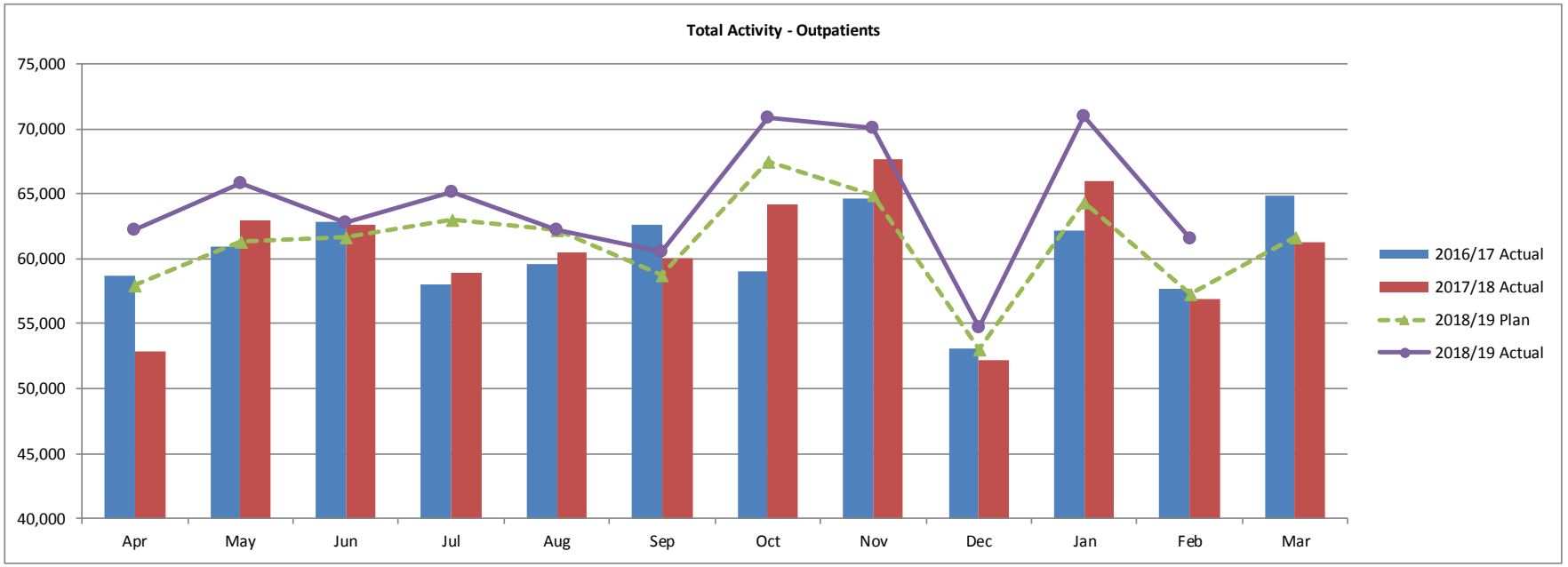
- Non-electives were 2.1% (100 cases) above business plan and 3.3% (157 cases) above prior year levels. The levels of non-elective admissions remain a cause for concern re the impact on elective capacity.
- An early warning contract notice has been issued to commissioners to highlight concern around growing levels of non-elective demand.
- The main areas of over performance were across medicine (+104 cases) as well as women & children (+56 cases) – with the worst hit specialities being Paediatrics (+117) and OPM /Stroke (+86)

Additional Slide 26c

Performance (Productivity) – Lead Director Chris Cobb

Activity & Income
2016/17 vs 2017/18 vs 2018/19 YTD
Outpatient - All (Consultant & Non Consultant Led, New & Follow Up)

Activity	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Full Year
2016/17 Actual	58,647	60,971	62,885	58,054	59,595	62,622	59,078	64,679	53,131	62,166	57,652	64,853	**659,480**	**724,333**
2017/18 Actual	52,854	63,012	62,641	58,913	60,491	60,005	64,170	67,685	52,135	65,980	56,915	61,313	**664,801**	**726,114**
2018/19 Plan	58,005	61,327	61,643	63,068	62,229	58,746	67,457	64,977	53,084	64,342	57,259	61,639	**672,138**	**733,777**
2018/19 Actual	62,223	65,871	62,750	65,151	62,216	60,550	70,858	70,043	54,724	71,004	61,531		**706,921**	**706,921**
Variance to 2017/18	9,369	2,859	109	6,238	1,725	545	6,688	2,358	2,589	5,024	4,616		**42,120**	**42,120**
Variance to 2017/18 %	17.7%	4.5%	0.2%	10.6%	2.9%	0.9%	10.4%	3.5%	5.0%	7.6%	8.1%		**6.34%**	
Variance to Plan	4,218	4,544	1,107	2,083	(13)	1,804	3,401	5,066	1,640	6,662	4,272		**34,783**	**34,783**
Variance to Plan %	7.3%	7.4%	1.8%	3.3%	0.0%	3.1%	5.0%	7.8%	3.1%	10.4%	7.5%		**5.17%**	

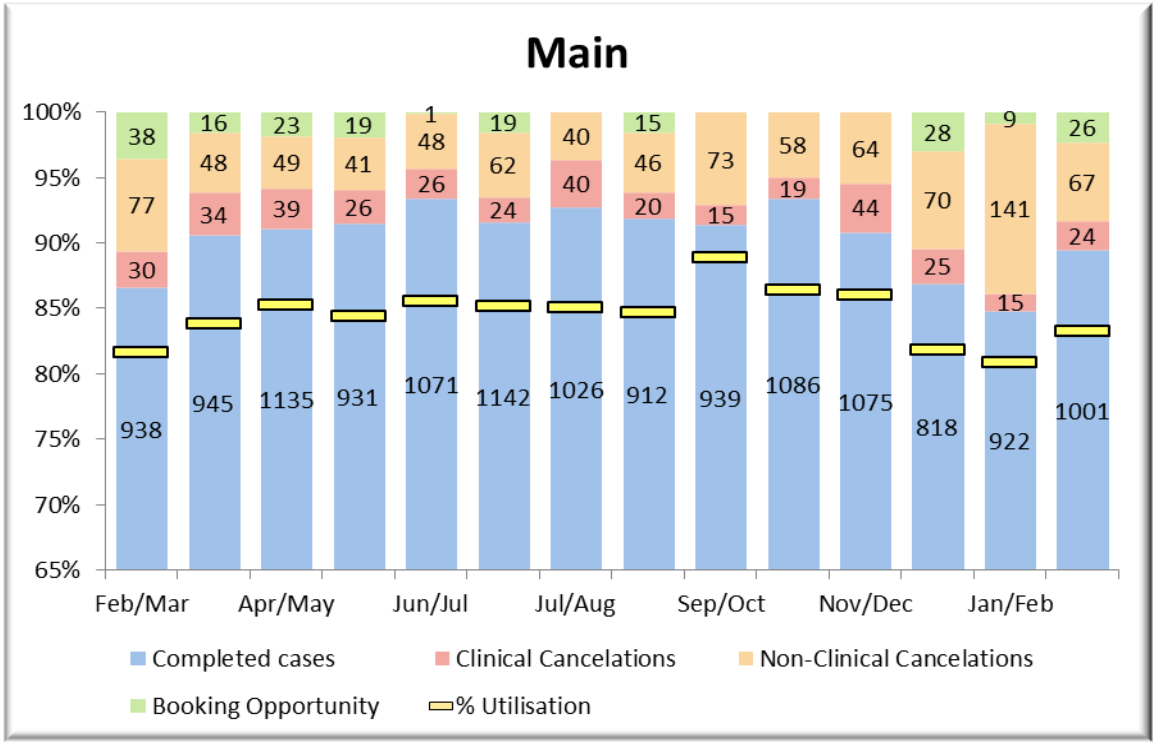


Issues and Comment

- OP activity performance for February was 7.5% ahead of plan and 8.1% ahead of February 2018 levels
- Overall consultant OP news were ahead of plan by 933 driven by increases in medicine (particularly Gastro and Clinical Oncology) and Paediatrics (+114).
- Overall consultant follow-ups were over plan (+4,201) with gains in medicine (+2,292) and surgery (+1,732). The biggest areas of over performance was cardiology (+885)

Additional Slide 26d

Theatre Productivity (Main) – Lead Director Chris Cobb



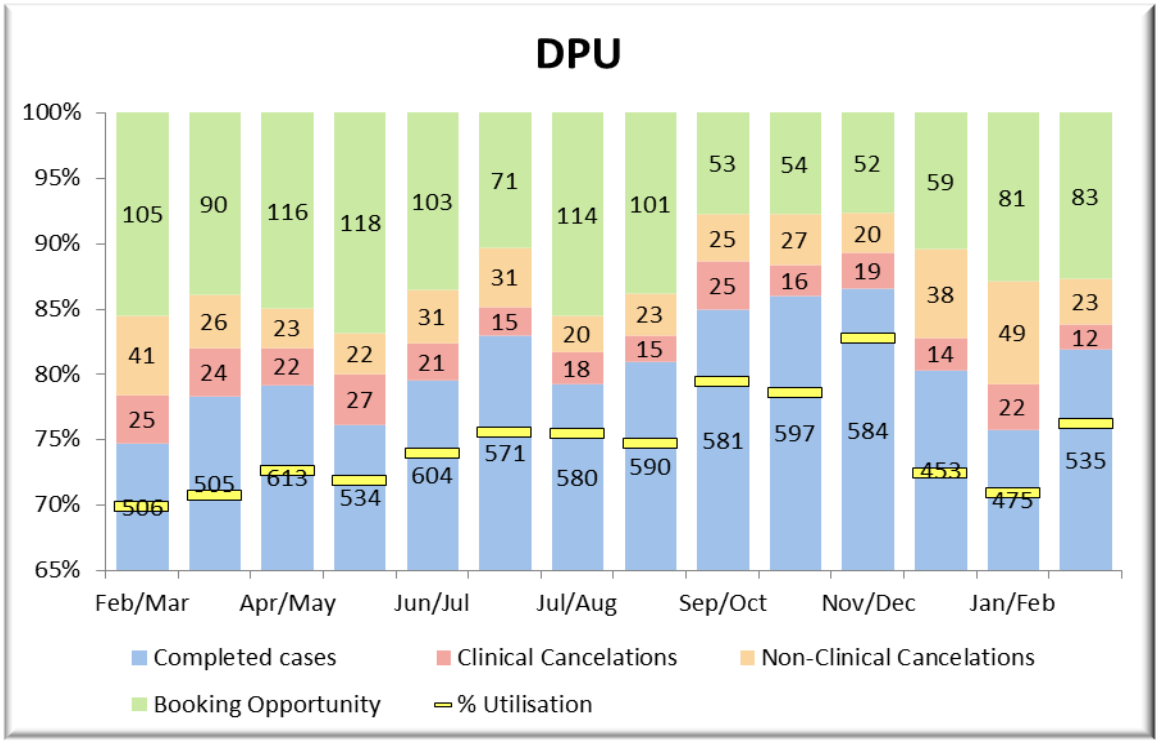
Utilisation up at 83%
- **Highest figure since November**
- **Up y.o.y – 81.6%**

91 on the day cancellations - significant improvement on previous month (156) and compared to 2018 (107)

1,001 cases completed, up 79 on January and 63 compared to 2018

Additional Slide 26e

Theatre Productivity (DPU) – Lead Director Chris Cobb



Utilisation up at 76%
- **Highest figure since November**
- **Up y.o.y – 69.9%**

35 on the day cancellations - significant improvement on previous month (71) and compared to 2018 (66)

535 cases completed, up 60 on January and 29 compared to 2018

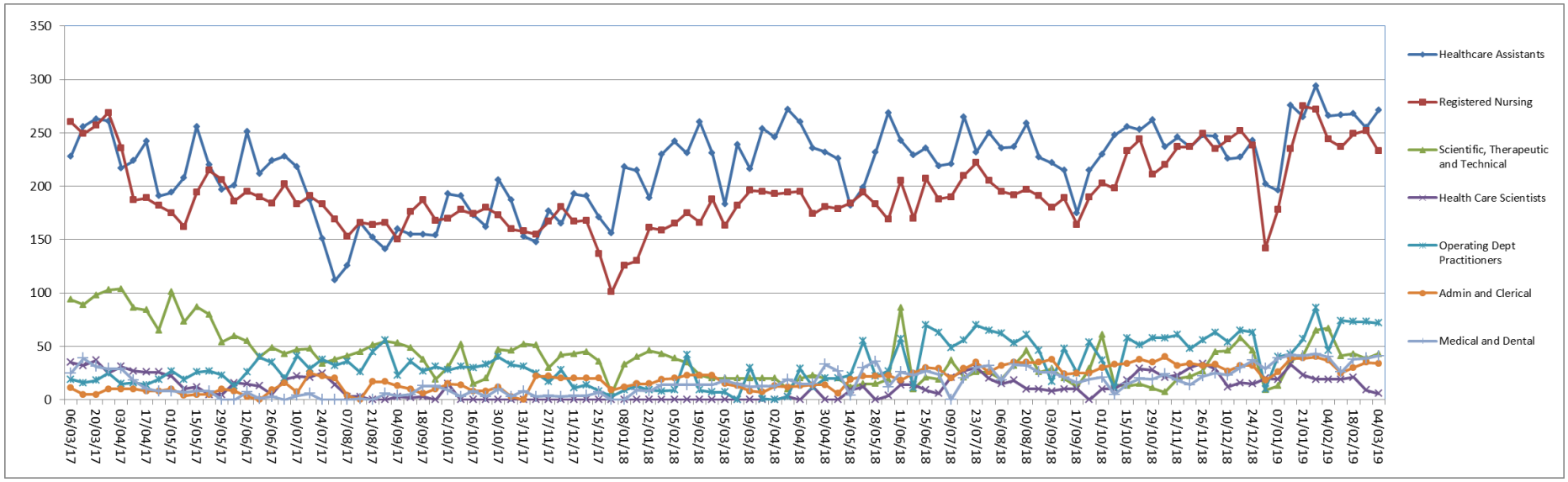
Core Slide 27

Workforce Summary – Lead Director Jeremy Over

Workforce		Outturn 2017/18	Monthly Target	Feb-19	6 month trend	YTD 2017/18	YTD 2018/19
Payroll							
1 Budgeted WTE*		7360	n/a	8069		7360	7996
2 Actual WTE*		6830	n/a	7224		6830	6983
3 Vacancy maximum (%)		7.20%	10.00%	10.47%		7.20%	12.67%
Pay Spend							
4 Pay spend - % employed (%)*		90.13%	n/a	89.68%		90.16%	89.51%
5 Pay spend - % bank (%)*		3.29%	n/a	3.28%		3.28%	3.60%
6 Pay spend - % agency (%)*		2.56%	n/a	3.12%		2.54%	2.76%
7 Pay Spend - % Medical Locum (%)*		2.38%	n/a	2.14%		2.38%	2.30%
Staffing Numbers	Core Slide 36						
8 % of registered nurse day hours filled as planned		92.30%	n/a	87.92%		92.52%	88.72%
9 % of unregistered care staff day hours filled as planned		123.24%	n/a	98.80%		124.59%	106.54%
10 % of registered nurse night hours filled as planned		93.85%	n/a	90.40%		93.85%	92.22%
11 % of unregistered care staff night hours filled as planned		138.08%	n/a	124.86%		138.35%	135.86%
12 RGN % Actual to planned		92.96%	n/a	88.96%		93.09%	90.18%
13 HCA % Actual to planned		129.30%	n/a	108.87%		130.25%	117.73%
14 Care hours per patient day (registered)		3.9	n/a	3.9		3.9	4.1
15 Care hours per patient day (Non-registered)		3.3	n/a	3.4		3.3	3.6
16 Care hours per patient day (Total)		7.3	n/a	7.4		7.3	7.7
Other							
17 Appraisals completed	Core Slide 32	65.80%	80.00%	80.27%		65.92%	75.56%
18 Staff Turnover rate	Core Slide 33	10.43%	10.00%	10.93%		10.47%	10.60%
16 Mandatory Training	Core Slide 34	83.13%	90.00%	87.68%		83.08%	84.23%
17 Sickness levels**	Core Slide 35	4.02%	3.50%	5.16%		4.01%	4.09%
18 Time to Hire (All)		68.5	n/a	72.0		68.5	74.5
Staff Survey							
19 Staff FFT – recommendation of NNUH as a place to receive care		72%	n/a	76%		TBC	TBC
20 Staff FFT – recommendation of NNUH as a place to work		56%	n/a	62%		TBC	TBC
* Please note these figures are provisional							
** Reported one month in arrears							

Core Slide 28 — Workforce - Lead Director Jeremy Over

Agency and Locum Shifts Booked

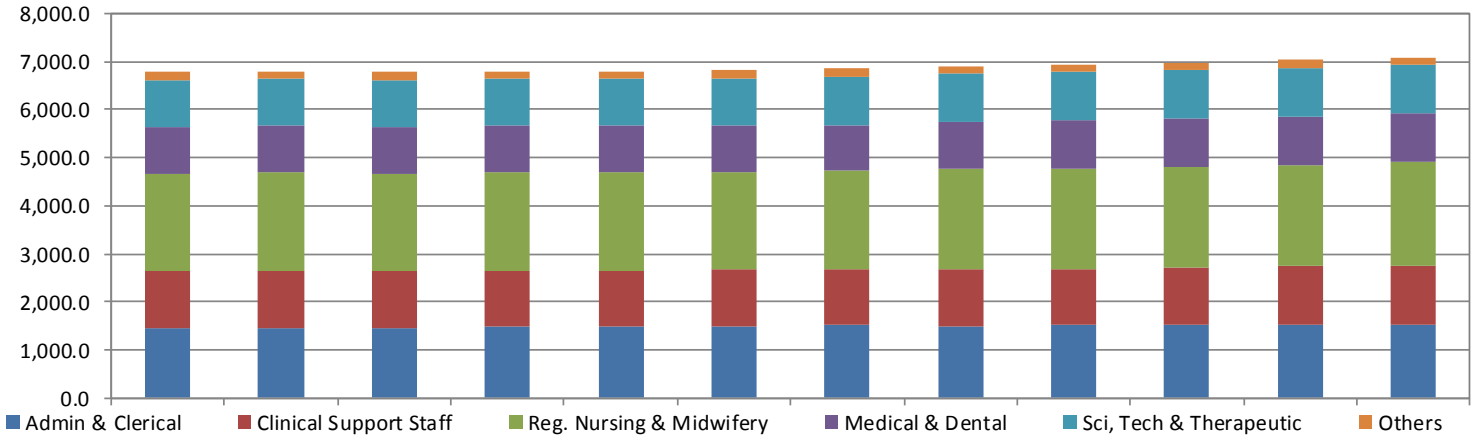


Commentary

- The latest monthly agency expenditure is detailed in the Finance IPR section
- The Finance section of the IPR details the expenditure for the month.
- Bank incentives have had a positive impact on RN 'bank hours worked'.
- Overall workforce utilisation (WTE) is within agreed workforce plans (see finance section of IPR).
- Recruitment Oversight Group is in operation and applies controls to avoid cost pressures and assists with speedy recruitment.
- A Workforce CIP is meeting regularly with the support of PwC. An overtime CIP and enhanced temporary workforce controls are going through the appropriate governance arrangements. The controls will reinforce:
    - Controls continue to be effective and responsive to situations where temporary workers are absolutely required based on clinical need and safety grounds.
    - Break glass arrangements only for exceptional reasons.
    - Pre-authorisation check and challenge.

Core Slide 29 — Workforce - Lead Director Jeremy Over

Workforce Staff in Post - WTE



Staff Group	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Difference	*% change*
Admin & Clerical	1,452.0	1,458.5	1,461.7	1,478.8	1,481.3	1,490.1	1,505.8	1,503.7	1,505.3	1,522.0	1,537.4	1,539.0	1,563.7	111.7	*7.7*
Clinical Support Staff	1,170.4	1,171.0	1,167.3	1,169.3	1,171.8	1,173.5	1,171.9	1,175.0	1,184.1	1,196.5	1,208.8	1,225.9	1,256.1	85.7	*7.3*
Reg. Nursing & Midwifery	2,043.7	2,048.1	2,045.0	2,035.7	2,031.2	2,040.1	2,036.6	2,079.3	2,088.1	2,096.7	2,097.3	2,146.4	2,162.9	119.2	*5.8*
Medical & Dental	966.1	973.5	965.3	970.7	968.8	955.3	971.2	985.9	988.0	991.4	999.0	1,000.2	1,011.1	45.0	*4.7*
Sci, Tech & Therapeutic	983.3	978.9	973.8	977.3	978.1	983.9	997.6	1,003.1	1,011.9	1,018.4	1,019.6	1,012.4	1,011.8	28.5	*2.9*
Others	164.9	164.9	161.0	161.6	163.4	162.0	160.0	158.0	156.8	158.6	159.4	160.7	162.9	-2.0	*-1.2*
Grand Total	**6,780.4**	**6,794.9**	**6,774.0**	**6,793.4**	**6,794.5**	**6,804.9**	**6,843.2**	**6,905.0**	**6,934.2**	**6,983.6**	**7,021.6**	**7,084.6**	**7,168.5**	**388.1**	***5.7***

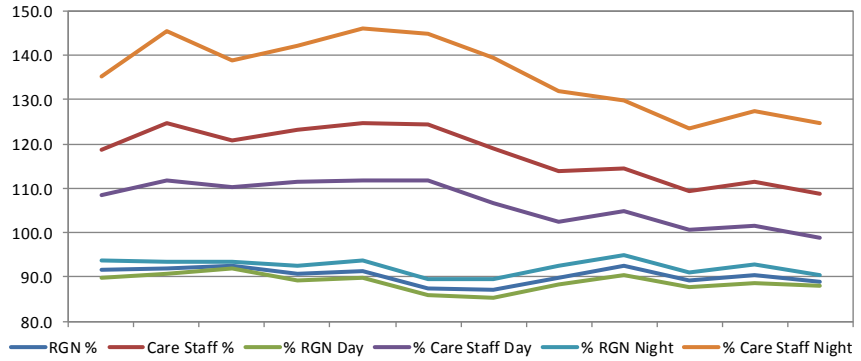
Commentary

- This slide / graph details the numbers of staff in post (WTE) at month end.
- The graph stacks the staff in post by staff group.
- Overall, in the last twelve months, there are 388.1 additional staff, an increase of 5.7% across NNUH as a result of service developments and capacity and quality investments.
- In the last 24 months there has been an increase of 728.9 WTE.
- It should be noted that the establishment (budgeted WTE) has increased from 7,360 (Mar-2018) to 8,069.0 (Feb-19)

Core Slide 30

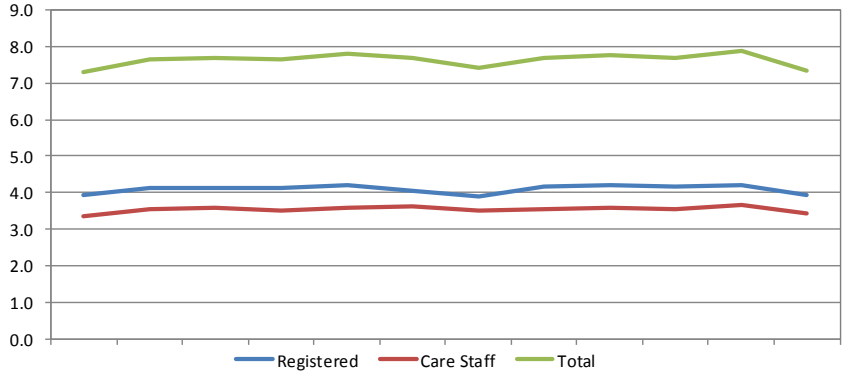
Workforce - Lead Director Jeremy Over

Ward Nursing fill-rate Analysis



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
RGN %	91.6	91.9	92.7	90.7	91.4	87.4	87.1	90.0	92.4	89.2	90.3	89.0
Care Staff %	118.8	124.7	120.8	123.3	124.8	124.4	119.1	113.8	114.5	109.4	111.5	108.9
% RGN Day	89.9	90.6	92.1	89.3	89.7	85.8	85.4	88.2	90.6	87.8	88.5	87.9
% Care Staff Day	108.4	111.9	110.2	111.5	111.7	111.7	106.6	102.6	104.8	100.6	101.5	98.8
% RGN Night	93.9	93.6	93.5	92.7	93.7	89.7	89.5	92.5	95.0	91.1	92.9	90.4
% Care Staff Night	135.1	145.3	138.9	142.2	146.1	145.0	139.4	131.9	129.9	123.4	127.4	124.9

Care Hours per Patient Day - CHPPD



	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Registered	3.9	4.1	4.1	4.1	4.2	4.0	3.9	4.2	4.2	4.2	4.2	3.9
Care Staff	3.3	3.5	3.6	3.5	3.6	3.6	3.5	3.5	3.6	3.5	3.7	3.4
Total	7.3	7.6	7.7	7.7	7.8	7.7	7.4	7.7	7.8	7.7	7.9	7.4

Escalations

<80% RN fill rate for February:

Ward	RN Fill Rate %
MLBU	79.5
NICU	77.5

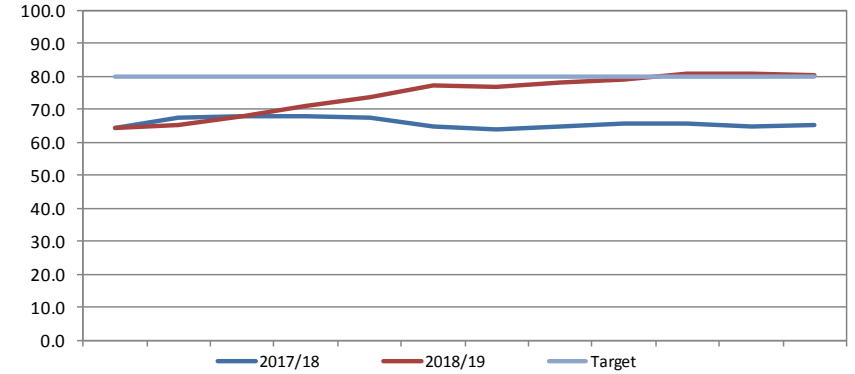
Commentary

- The first graph (Ward nursing fill rate) shows our planned nursing versus actual staffing levels in percentage terms.
- 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 (e.g. a third nursing assistant, compared with a staffing plan of 2 for the shift will result in a fill-rate of 150%).
- The fill rate for unregistered staff in day time hours remains above 100%.
- Care hours per patient day is calculated as: The total number of patient days in the month (Using the actual number of patients on the ward at 23:59 each day) / Total hours worked in the month (Total combined number of hours worked for both registered staff and care staff)

Core Slide 31

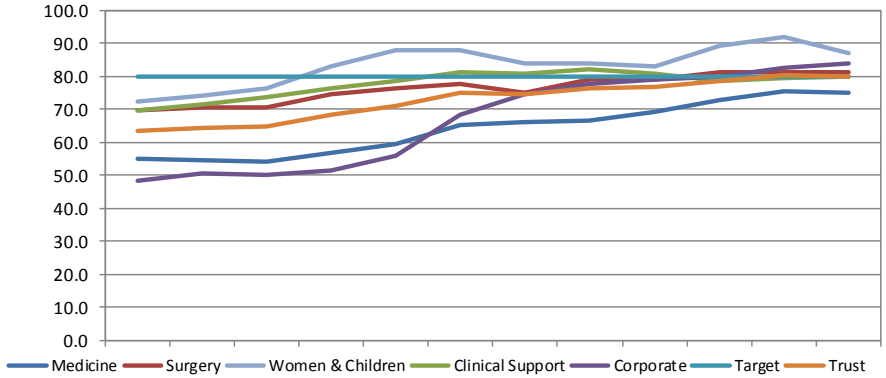
Workforce - Lead Director Jeremy Over

Appraisals completed* - Trust



Division	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
2017/18	64.4	67.3	67.8	67.8	67.5	64.9	64.0	64.6	65.6	65.5	65.0	65.1
2018/19	64.5	65.3	68.0	71.2	73.6	77.0	76.6	78.3	79.2	80.8	80.8	80.3
Target	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0

Appraisals completed - Divisions



Division	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Medicine	55.0	54.5	54.3	56.9	59.5	65.1	65.9	66.4	69.4	72.6	75.6	75.1
Surgery	69.9	70.6	70.8	74.7	76.5	77.6	74.8	79.2	78.8	81.3	81.4	81.2
Women & Children	72.5	74.1	76.5	83.1	88.0	88.0	83.7	83.7	82.9	89.2	91.7	87.1
Clinical Support	69.7	71.6	73.6	76.6	78.4	81.3	80.9	82.2	80.8	78.5	79.7	79.8
Corporate	48.2	50.5	50.3	51.5	55.7	68.2	74.6	77.6	79.0	79.8	82.4	84.1
Trust	63.5	64.3	65.0	68.4	71.1	74.9	74.5	76.4	76.9	78.8	80.5	80.0
Target	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0	80.0

Commentary

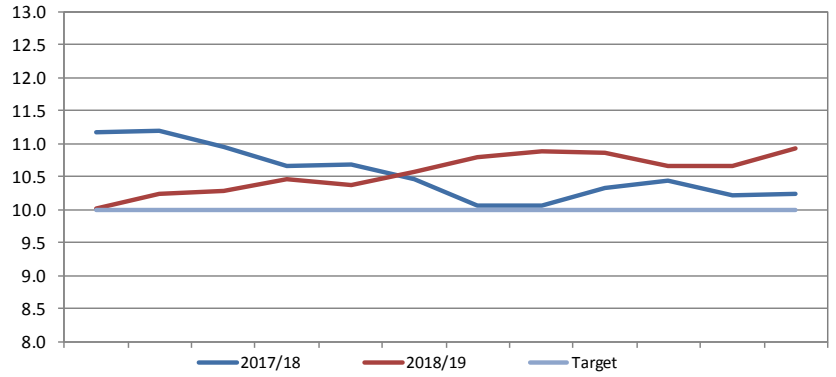
- 80.3% of eligible staff (Non-Medical and Medical Staff) have had an appraisal during the last 12 months.
- Furthermore the rate of Non-Medical only appraisals has increased to 80%
- Surgery, Women and Children Divisions and Corporate departments are above 80%.
- Medicine Division has improved significantly in recent months, but remains an outlier at 75.1%
- The NHS Staff Survey results 2018 suggest that 87% of our staff have responded that they have been appraised in the last 12 months (up from 83% in 2017).

Corporate Breakdown	Eligible	Current	%
Communications	3	3	100.0%
Improvement Team	6	6	100.0%
Clinical Effectiveness & Audit	12	12	100.0%
Safeguarding	8	8	100.0%
Ops Centre	23	22	95.7%
Practice Development	18	17	94.4%
Commisioning, Data Quality, Coding	51	48	94.1%
Infection Control	14	13	92.9%
Estates & Facilities	41	37	90.2%
Integrated Discharge	38	34	89.5%
Human Resources	66	59	89.4%
Workplace Health & Wellbeing	33	29	87.9%
Information Technology	60	51	85.0%
Finance	33	28	84.8%
Complaints & Legal	13	11	84.6%
Training, Learning & Development	30	22	73.3%
Research*	90	65	72.2%
PMO	3	2	66.7%
Risk Mgt & Incident Reporting	6	4	66.7%
Other**	49	31	63.3%
Corporate	**597**	**502**	**84.1%**

Core Slide 32

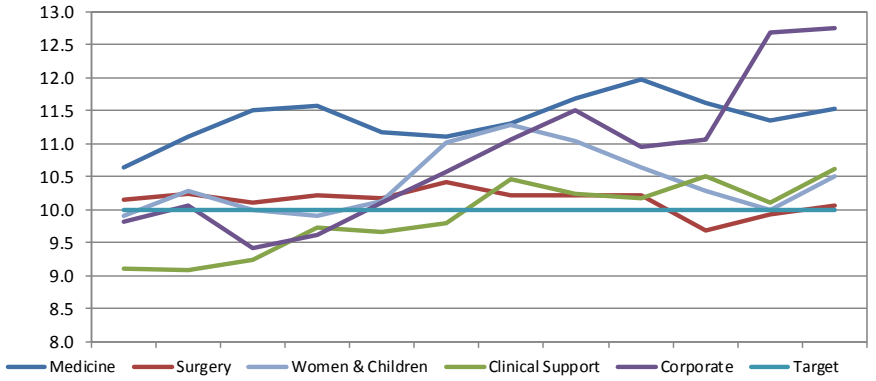
Workforce - Lead Director Jeremy Over

Annualised Staff Turnover rate - Trust



Division	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
2017/18	11.2	11.2	11.0	10.7	10.7	10.5	10.0	10.0	10.3	10.4	10.2	10.2
2018/19	10.0	10.2	10.3	10.5	10.4	10.6	10.8	10.9	10.9	10.7	10.7	10.9
Target	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0	10.0

Annualised Staff Turnover rate - Divisions



Division	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Medicine	10.63	11.11	11.50	11.58	11.16	11.10	11.30	11.69	11.96	11.62	11.36	11.52
Surgery	10.14	10.23	10.10	10.21	10.18	10.42	10.22	10.21	10.22	9.69	9.93	10.06
Women & Children	9.91	10.27	9.99	9.91	10.13	11.01	11.27	11.04	10.65	10.28	9.99	10.51
Clinical Support	9.10	9.07	9.24	9.72	9.65	9.80	10.45	10.24	10.17	10.51	10.11	10.62
Corporate	9.81	10.05	9.42	9.61	10.11	10.57	11.06	11.52	10.94	11.06	12.69	12.75
Target	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00	10.00

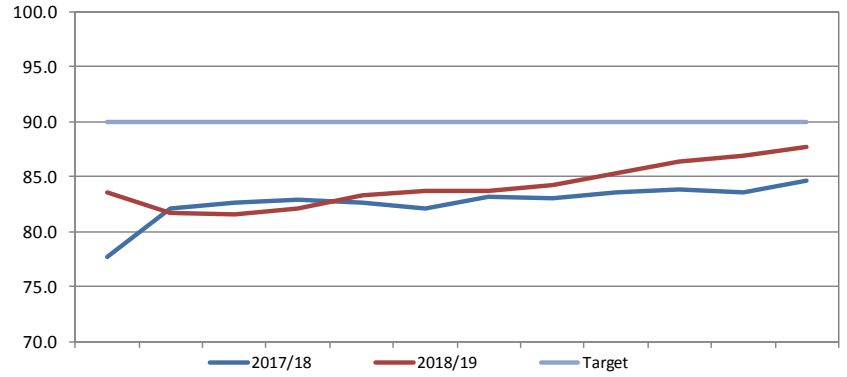
Commentary

- The Turnover rate is the percentage of the workforce that has left NNUH over the past twelve months. It is a 12-month rolling figure.
- The calculation excludes fixed-term contracts, (for instance junior doctors on rotational training programmes).
- The turnover rate for the six months to February 2019 has remained at 10.8% (+/- 0.1%)
- Positively, the numbers of Registered Nursing and Midwifery leavers in February was below the second lowest recorded crude figure (9.9 WTE).
- Please note the scale on the right hand graph distorts the variance – the corporate turnover figures for January and February 2019 actually represents just 11 staff.
- Reduced turnover means greater retention of knowledge and skill in our teams, and reduced volume of replacement recruitment activity and induction / on-boarding.

Core Slide 33

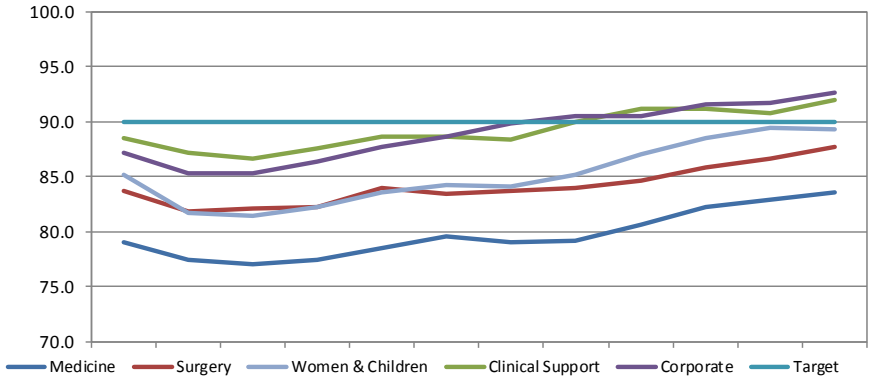
Workforce - Lead Director Jeremy Over

Mandatory Training - Trust



Division	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
2017/18	77.6	82.0	82.6	82.9	82.6	82.1	83.2	83.0	83.5	83.8	83.6	84.6
2018/19	83.6	81.7	81.6	82.1	83.3	83.7	83.6	84.2	85.3	86.4	86.9	87.7
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

Mandatory Training - Divisions



Division	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Medicine	79.00	77.46	77.06	77.45	78.50	79.60	79.09	79.15	80.60	82.22	82.89	83.54
Surgery	83.72	81.81	82.15	82.21	83.90	83.40	83.73	83.91	84.69	85.79	86.64	87.66
Women & Children	85.20	81.71	81.40	82.20	83.60	84.27	84.07	85.13	87.08	88.50	89.41	89.28
Clinical Support	88.52	87.12	86.66	87.56	88.57	88.68	88.42	90.00	91.13	91.21	90.80	91.98
Corporate	87.17	85.27	85.27	86.41	87.69	88.70	89.83	90.48	90.56	91.51	91.64	92.59
Target	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00	90.00

Commentary

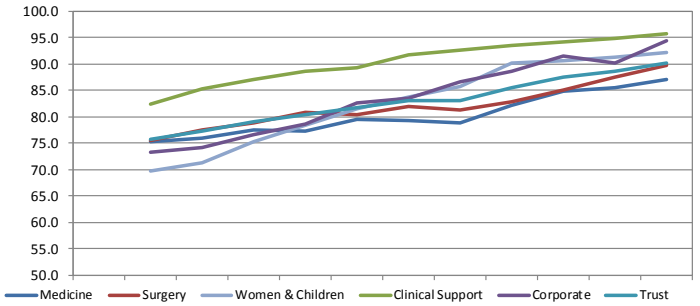
- Improvement of mandatory training attendance is a must do from the CQC inspection.
- All Divisions and Corporate areas have compliance rates above 80% with two areas (CSS and Corporate) above the target rate of 90%.
- A series of improvements and interventions are in place to support enhanced compliance. These include training days/events where support is available to maximise mandatory training and a range of support options for staff accessing eLearning.
- Divisional level mandatory training rates are discussed at divisional 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 which is resulting in ongoing improvements.
- Each month specific mandatory topics are targeted with emails to non-compliant staff to raise their awareness that their training is out of date and signpost them to all the support available. This approach continues to have a direct positive impact in improving compliance rates.

Additional Slide 33a

Workforce - Lead Director Jeremy Over

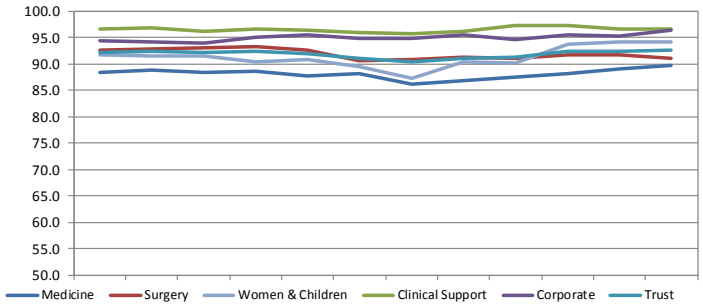
Mandatory Training – CQC 'must do'

MCA/DoLS Training - Divisions



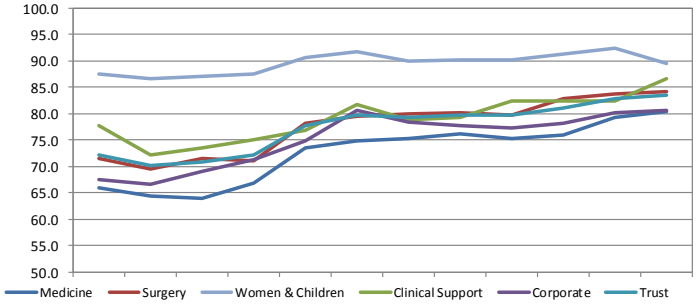
Division	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Medicine		75.37	76.01	77.45	77.36	79.56	79.26	78.78	82.27	84.77	85.47	87.04
Surgery		75.44	77.50	78.84	80.87	80.44	82.02	81.21	82.79	85.13	87.41	89.79
Women & Children		69.81	71.33	75.17	78.29	81.41	83.80	85.71	90.09	90.53	91.39	92.11
Clinical Support		82.46	85.29	86.97	88.53	89.27	91.80	92.59	93.63	94.15	94.74	95.81
Corporate		73.33	74.07	76.69	78.68	82.61	83.58	86.67	88.72	91.60	90.23	94.49
Trust		75.72	77.29	79.12	80.49	81.83	82.95	83.04	85.58	87.47	88.60	90.28

Safeguarding Children Training - Divisions



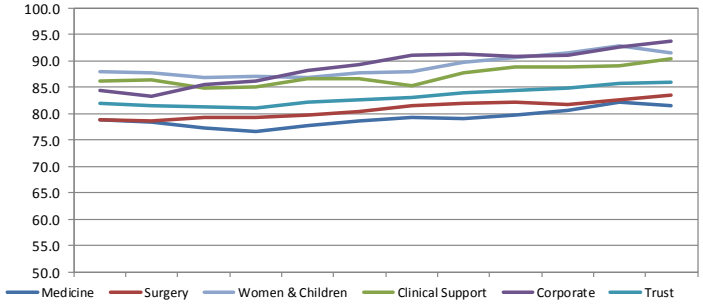
Division	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Medicine	88.38	88.91	88.50	88.55	87.72	88.13	86.17	86.83	87.41	88.28	89.05	89.74
Surgery	92.57	92.79	93.08	93.22	92.67	90.55	90.95	91.27	90.96	91.71	91.84	91.00
Women & Children	91.66	91.60	91.53	90.41	90.92	89.44	87.19	90.37	90.19	93.78	94.15	94.20
Clinical Support	96.73	96.89	96.11	96.71	96.50	95.88	95.83	96.15	97.24	97.25	96.62	96.65
Corporate	94.45	94.15	94.04	95.02	95.56	94.89	94.95	95.56	94.63	95.54	95.37	96.42
Trust	92.19	92.42	92.19	92.33	91.96	91.16	90.36	91.12	91.33	92.31	92.47	92.54

Resus (Adult) Training - Divisions



Division	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Medicine	66.00	64.43	63.97	66.90	73.53	74.85	75.36	76.27	75.35	75.88	79.26	80.32
Surgery	71.53	69.45	71.44	70.98	78.16	79.39	79.88	80.23	79.74	82.74	83.72	84.21
Women & Children	87.60	86.72	87.17	87.52	90.65	91.71	89.94	90.19	90.09	91.32	92.40	89.55
Clinical Support	77.71	72.22	73.40	75.04	76.89	81.83	78.83	79.20	82.40	82.37	82.45	86.59
Corporate	67.57	66.49	68.95	71.28	74.87	80.61	78.31	77.78	77.35	78.09	80.11	80.70
Trust	72.26	70.09	70.87	72.16	77.72	79.64	79.23	79.73	79.63	80.98	82.78	83.57

Infection Control Training - Divisions



Division	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
Medicine	78.76	78.31	77.24	76.52	77.81	78.70	79.23	79.07	79.76	80.63	82.22	81.58
Surgery	78.94	78.66	79.27	79.34	79.74	80.37	81.44	82.02	82.10	81.79	82.58	83.40
Women & Children	88.06	87.73	86.88	87.12	86.81	87.70	87.95	89.84	90.63	91.59	92.95	91.47
Clinical Support	86.13	86.34	84.81	84.98	86.57	86.52	85.21	87.79	88.94	88.92	89.17	90.41
Corporate	84.44	83.23	85.60	86.25	88.13	89.18	91.07	91.39	90.91	91.07	92.53	93.72
Trust	81.86	81.55	81.19	81.11	82.07	82.72	83.07	83.93	84.44	84.76	85.78	86.00

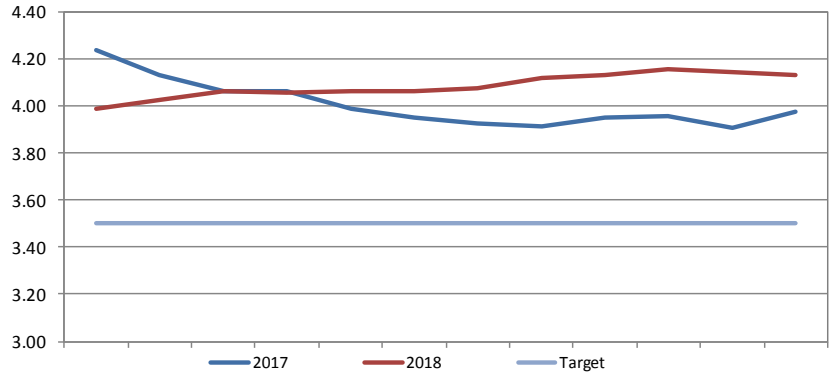
Commentary

- These tables are a sub-set of all mandatory training compliance and reflect some of the mandatory training compliance issues highlighted in the recent CQC inspection.

Core Slide 34

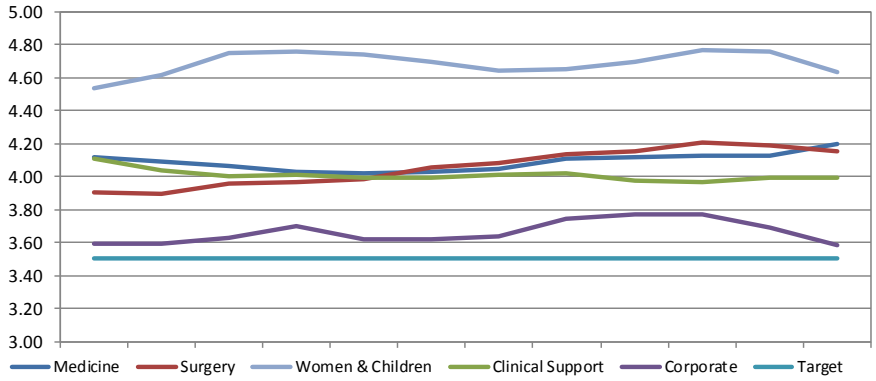
Workforce - Lead Director Jeremy Over

Sickness levels (12 month rolling average)



Division	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
2017	4.23	4.13	4.06	4.06	3.99	3.95	3.93	3.92	3.95	3.95	3.91	3.97
2018	3.99	4.02	4.06	4.05	4.06	4.06	4.08	4.12	4.13	4.15	4.14	4.13
Target	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50

Sickness levels (12 month rolling average)



Division	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Medicine	4.12	4.09	4.06	4.03	4.02	4.03	4.05	4.11	4.12	4.13	4.12	4.20
Surgery	3.90	3.90	3.96	3.97	3.98	4.05	4.08	4.13	4.15	4.21	4.19	4.16
Women & Children	4.54	4.62	4.75	4.76	4.74	4.70	4.64	4.65	4.70	4.77	4.76	4.64
Clinical Support	4.11	4.03	4.00	4.01	4.00	3.99	4.01	4.02	3.98	3.97	4.00	3.99
Corporate	3.60	3.60	3.63	3.70	3.62	3.62	3.64	3.74	3.77	3.77	3.69	3.58
Target	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50	3.50

** Reported one month in arrears

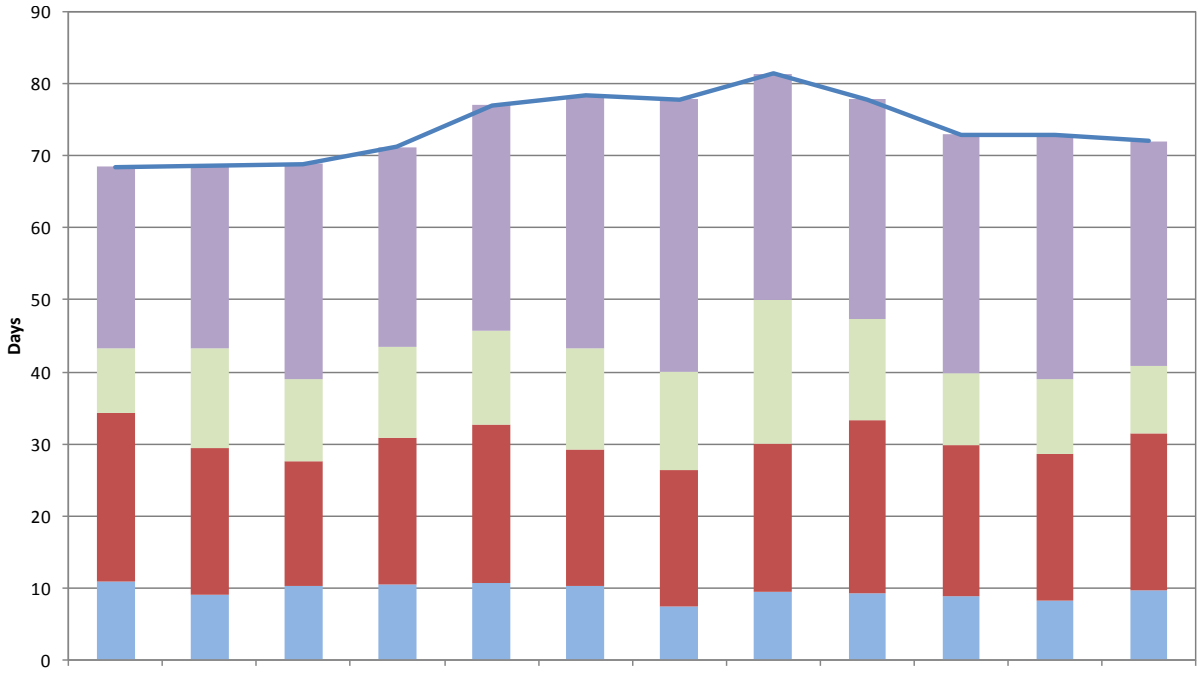
Commentary

- The most significant indicator is the rolling 12-month average sickness rate.
- As at 31 January 2019, the rate is 4.13%.
- This still represents a significant reduction in excess of 6% on the peak from August 2016 and equates to the equivalent of approximately 21 additional staff (headcount) being available every day.
- Of concern is the unexpectedly high level of musculoskeletal absences. Interventions are encouraged to support an early return to work, even if the individual is not capable of performing their full duties.
- It is also disappointing that, on face value, there has been an increase in the number of sick days due to coughs/cold/flu when compared to last winter, which is surprising given the impact of proper flu last winter.
- Analysis confirms the vast majority of sickness absence is longer term and HRBP's are supporting divisional colleagues to intervene to support returns to work.
- NB. For data accuracy and reliability purposes, sickness figures are reported one-month in arrears.

Core Slide 35

Workforce - Lead Director Jeremy Over

Recruitment Time to Hire



Recruitment Stage	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Total Time to Hire	68.5	68.6	68.9	71.2	77.0	78.4	77.9	81.4	77.8	73.0	73.0	72.0
Checks Complete	25.2	25.3	29.9	27.8	31.3	35.0	37.9	31.4	30.4	33.1	34.0	31.1
Time to Offer	9.1	13.9	11.4	12.5	13.0	14.1	13.7	20.0	14.2	10.0	10.4	9.4
Time with Manager	23.3	20.3	17.4	20.5	22.2	19.0	18.8	20.6	23.9	21.1	20.2	21.9
Time to advert close	10.9	9.1	10.3	10.5	10.6	10.2	7.5	9.4	9.3	8.8	8.3	9.7
Number at checks complete	109	105	130	140	122	111	123	185	166	157	196	182

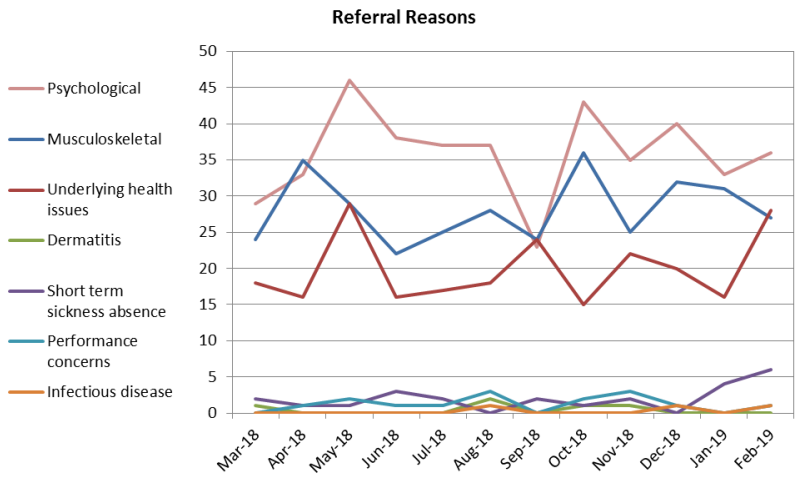
Commentary

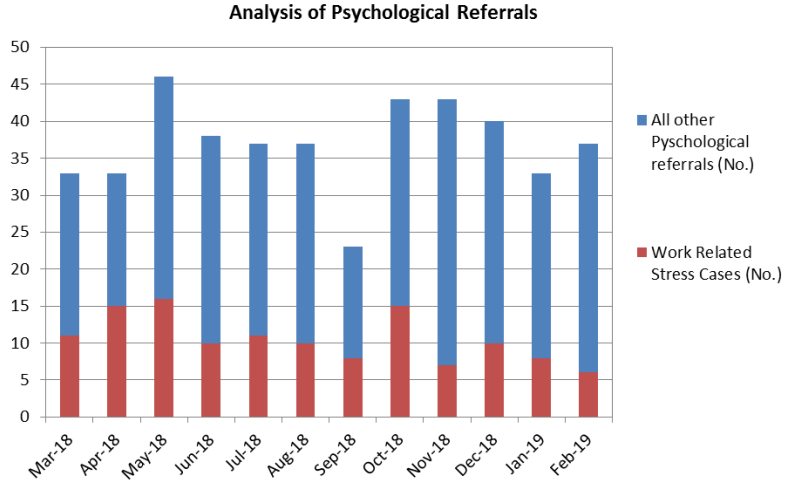
- This data reflects all substantive recruitment through our Trac system.
- The Time to Hire measure has reduced to 72.0 days, a reduction of 9.4 days since October.
- The Time to Hire measure includes a Time to Offer measure which has more than halved in the same period.

Core Slide 36

Workforce - Lead Director Jeremy Over

Staff Health, Safety and Wellbeing





Commentary

- The first graph reflects the trend in respect of all referrals (by managers, or self-referral) to Workplace, Health and Wellbeing.
- There were 99 referrals assessments undertaken in February 2019.
- The second graph reflects the trend for psychological referrals (by managers, or self-referral) received by Workplace, Health and Wellbeing.
- Of the new psychological referrals seen in this month 6 were considered to be work caused (January - 8, December – 10, November - 7.

Additional Slide 36a

Workforce - Lead Director Jeremy Over

Consultant Job Plans

Stage	Trust	Medicine	Surgery	Women & Children	Clinical Support	Other
Total Consultants	482	159	190	58	73	1
Job plans signed off	246	69	112	24	40	1
	51.0%	43.4%	58.9%	41.4%	54.8%	100.0%
In discussion stage/ draft stage	111	39	31	20	20	0
	23.0%	24.5%	16.3%	34.5%	27.4%	0.0%
Awaiting sign off	125	51	47	14	13	0
	25.9%	32.1%	24.7%	24.1%	17.8%	0.0%

Commentary

- The above chart reflects progress in respect of the introduction of Electronic Job Planning for Consultants as at 10 March 2019
- E-job planning was introduced from April 2017 with extensive engagement and consultation with Consultants.
- Oversight of e-job planning sits with an E-job Planning Advisory Panel which reports into the Medical Workforce Group, chaired by the Director of Workforce, and attended by senior clinicians from each Division.
- There is a need to accelerate the sign off of the first round of e-job plans.

Core Slide 37

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Core Slide 38

Finance - Lead Director John Hennessey

Executive Summary

- The reported deficit for the year to date is £58.6m, being £6.4m worse than budget.
- The in-month position, before mitigation is £1.37m worse than budget, mainly due to clinical income being £1.3m worse (Surgery down £1.3m) , Pay costs being £1m worse , Education income being better by £0.5m and depreciation better by £0.2m. Mitigated in part by a £0.54m adjustment in month, to reflect an assumed £8m income block agreement - prorated, with our main commissioners. The latter is uncertain. This mitigation improved the position by £0.54m resulting in a reported position of £0.83m down in month.
- Year to date, we have mitigated the reported adverse variance by £0.88m in total, from a review of the opening balance sheet. Without this we would be £7.28m behind budget at M11.
- Clinical Income at end M11 is £9.6m worse then budget (2.3%). Opex at end M10, net of drugs income is £4m worse than budget (0.8% small variance) comprising: Pay of £3.6m (1.1%) adv, Drugs- net £0.8m fav, Clinical Supplies of £1.5m adv (2.5%) and Non Clinical Supplies of £0.7m fav (0.8%), PFI £0.3m adv.
- The CIP target is £30m. The YTD CIP budget is £25.0m with actual YTD being £23.6m. The profile of CIPs is £18.7m in the first 9 months and £11.3m (37%) in the last quarter – with M12 assuming a £5m target.

Key Risks

- Successful negotiation of an £11m block income contract. Note an £8m 'block', with no CQUIN or penalty risks - as a minimum is assumed pro rata in the reported position cum at M11. This remains uncertain.
- Operating expenditure – containing to forecast budget M12
- Delivering the £30m CIP and identifying the remaining £1.5m yet to reach Gateway 2.
- Income – delivery of planned activity for non-Norfolk CCGs.

Forecast – The Trust formally reforecast its 2018/19 plan at a deficit of £58.8m to NHSI. **This is dependent upon agreeing an additional £3m income from CCGs commissioners above currently assumed £8m.**

FINANCIAL SUMMARY

I&E Performance YTD	(£58.6m)	Deficit
I&E Variance against budget YTD	(£6.4m)	Adverse
In month variance to in month budget	(£0.8m)	Adverse
Cash at Bank - actual	£8.8m	£7.5m Fav
Rev Borrowings - actual	£102.8m	£0.6m Adv
CIP Variance against budget YTD	£-1.4m	Adverse
Full Year CIP Target of £30m identified	£28.5m	£1.5m remaining

SUMMARY INCOME AND EXPENDITURE ACCOUNT	In Month			Year to Date			Full Year Forecast		
	Actual £m	Budget £m	Variance (adv)/fav £m	Actual £m	Budget £m	Variance (adv)/fav £m	Forecast £m	Budget £m	Variance (adv)/fav £m
Clinical Income excluding NT Drugs	34.9	36.2	(1.3)	406.5	416.2	(9.7)	449.8	454.9	(5.1)
NT Drugs	5.1	5.8	(0.7)	60.6	63.5	(2.9)	66.9	69.2	(2.3)
Other Income	7.3	6.1	1.2	75.8	70.1	5.7	83.5	76.3	7.2
TOTAL OPERATING INCOME	47.3	48.1	(0.8)	542.9	549.8	(6.9)	600.2	600.4	(0.2)
Pay Costs	(30.4)	(29.4)	(1.0)	(326.5)	(322.8)	(3.7)	(355.0)	(351.0)	(4.0)
Drugs	(6.0)	(6.8)	0.8	(71.7)	(75.4)	3.7	(79.2)	(82.3)	3.1
Other Non Pay Costs	(15.2)	(14.9)	(0.3)	(164.5)	(163.3)	(1.2)	(182.0)	(177.7)	(4.3)
TOTAL OPERATING EXPENSES	(51.6)	(51.1)	(0.5)	(562.7)	(561.5)	(1.2)	(616.2)	(611.0)	(5.2)
EBITDA	(4.3)	(3.0)	(1.3)	(19.8)	(11.7)	(8.1)	(16.0)	(10.6)	(5.4)
Depreciation	(0.7)	(1.0)	0.3	(9.5)	(10.0)	0.5	(10.6)	(11.0)	0.4
Finance Costs	(2.7)	(2.9)	0.2	(29.5)	(30.5)	1.0	(32.4)	(33.4)	1.0
Other - PDC, Disposals & Interest Income	0.0	0.0	0.0	0.2	0.0	0.2	0.2	0.0	0.2
(Deficit)/surplus after tax excluding Donated Additions	(7.7)	(6.9)	(0.8)	(58.6)	(52.2)	(6.4)	(58.8)	(55.0)	(3.8)

Core Slide 39

Finance - Lead Director John Hennessey

Income and Expenditure Summary as at February 2019

The reported I&E position for M11 is a deficit of £7.7m, against a planned deficit of £6.9m. This results in a £0.8m adverse variance in month (adverse variance of £6.4m YTD). The M11 reported position is after recognising a £0.54m adjustment to reflect an assumed £8m income block agreement - prorated, with our main commissioners. The income adjustment is uncertain. Without this, the in-month position would have been £1.3m worse than budget.

Clinical Income, is £1.3m worse than budget in month, and pay and clinical supplies are £1.1m worse than budget in month – Pay being £1.0m worse (3%), Clinical Supplies £0.1m worse (3%) and Non clinical supplies £0.1m worse (1%).

The mitigation of £0.54m is reported within other non clinical income.

Summary of I&E Indicators

Income and Expenditure	Actual / Forecast £'000	Budget / Target £'000	Variance to Budget (adv) / fav £'000	Direction of travel (variance)	RAG
In month (deficit) / surplus	(7,732)	(6,907)	(825)	↓	Red
YTD (deficit) / surplus	(58,632)	(52,204)	(6,428)	↓	Red
Forecast (deficit) / surplus	(58,800)	(55,000)	(3,800)	↓	Red

NHS Clinical Income (exc Drugs) YTD	406,537	416,196	(9,659)	↓	Red
Non Clinical Income YTD	72,845	67,259	5,586	↑	Green
Pay YTD	(326,479)	(322,827)	(3,652)	↓	Red
Non Pay YTD	(236,156)	(238,727)	2,571	↑	Green
Non Opex YTD	(38,991)	(40,505)	1,514	↑	Green
CIP Target YTD	23,645	25,049	(1,404)	↓	Red

Criteria:

Green	Favourable or nil variance
Amber	Adverse Variance less than £200k
Red	Adverse Variance more than £201k

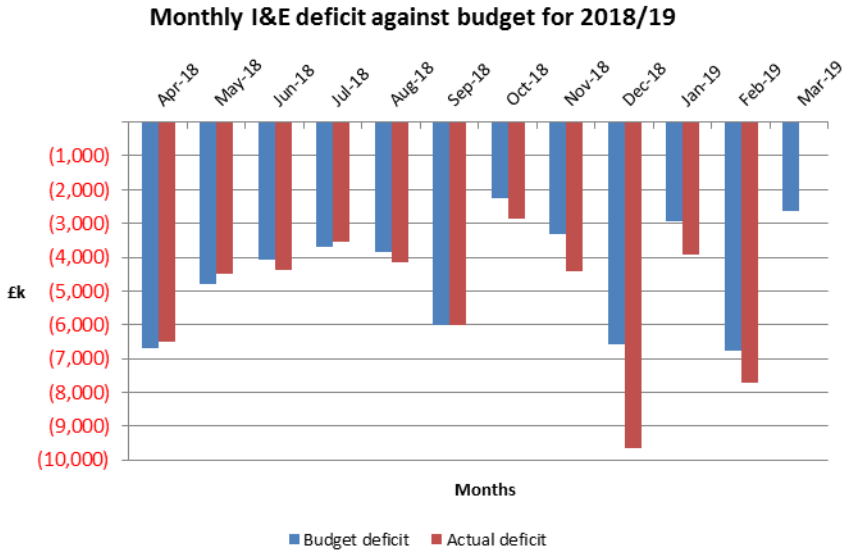
↑ In month improvement and YTD favourable

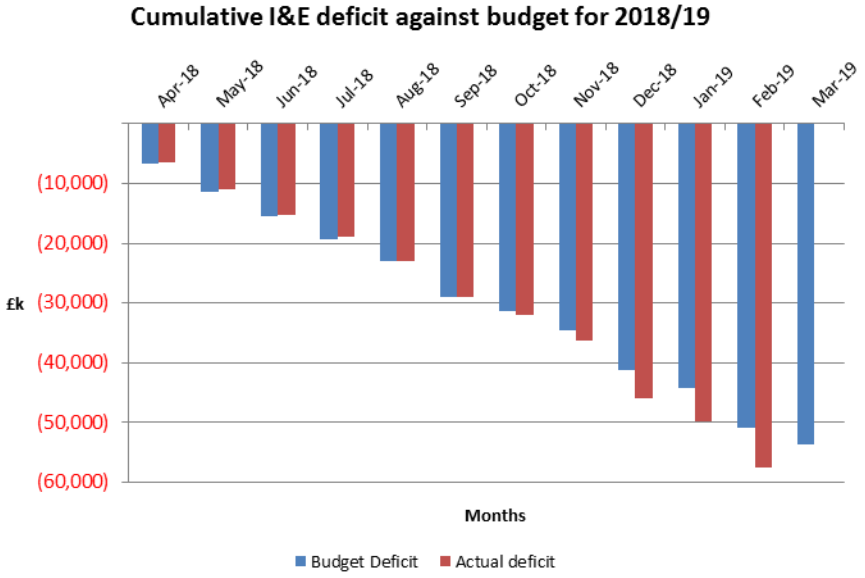
↑ In month improvement and YTD adverse

↔ No change

↓ In month deterioration and YTD favourable

↓ In month deterioration and YTD adverse

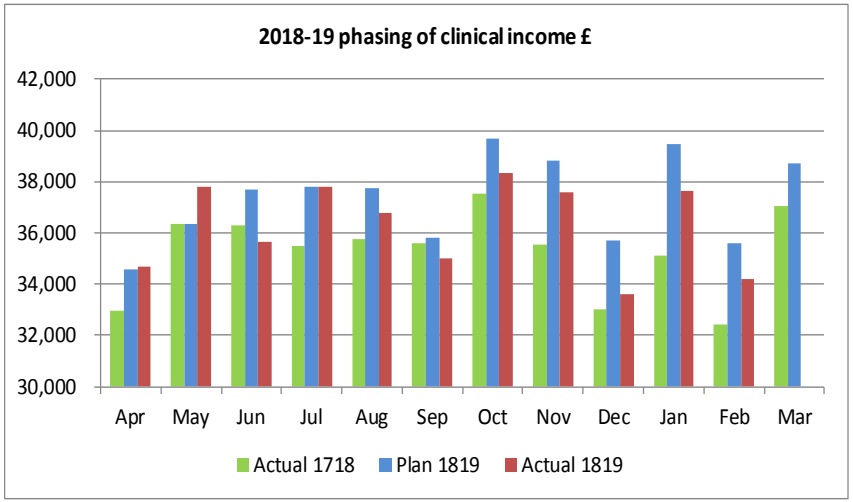




Core Slide 40 Finance - Lead Director John Hennessey

Income Analysis

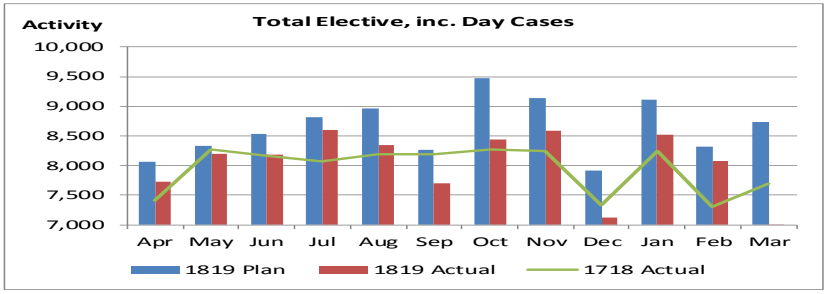
The chart below sets out the monthly phasing of the clinical income plan (exc. Spire to aid prior year comparison) for 2018/19. This phasing is in line with activity phasing which is how the income is recognised. The phasing is responsive to actual days and working days, hence the monthly variation.

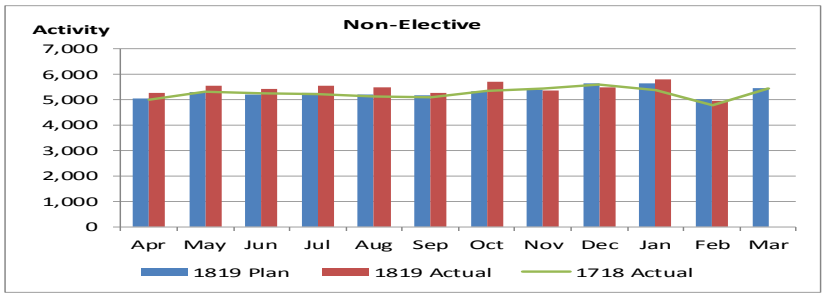


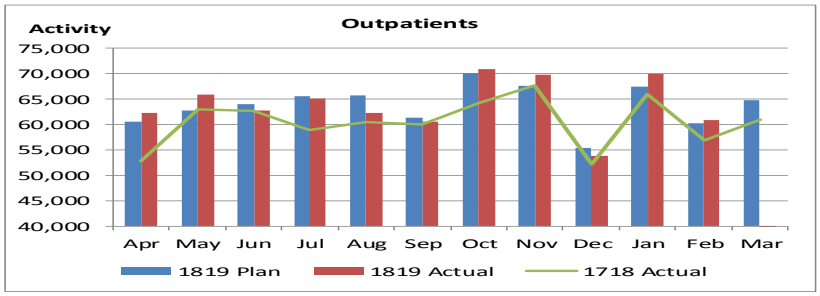
The income position was behind plan for February by £1.25m, with the under-performance within; Surgery (£1.25m). Mainly: Electives £0.5m, C&V by £0.25m & unidentified CIPs of £0.6m – all underperformed.

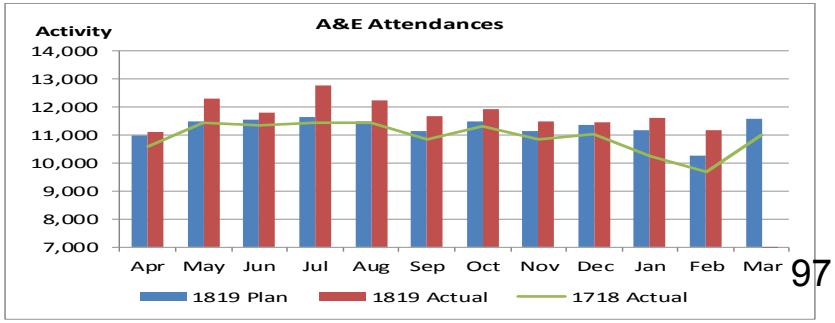
	Current month			Year to date		
Income (£'000s)	**Plan**	**Actual**	**Variance**	**Plan**	**Actual**	**Variance**
Daycase (inc. Reg Day Attd)	4,294	4,277	-18	48,189	46,605	-1,585
Elective	3,674	3,142	-532	43,345	39,724	-3,621
Non Elective	11,133	11,286	152	128,789	133,907	5,118
Marginal Rate Reduction	-659	-884	-225	-7,763	-9,818	-2,056
Accident & Emergency	1,278	1,394	116	15,405	16,121	717
Outpatients	6,197	6,241	44	72,110	71,958	-152
CQUIN	753	769	16	8,070	9,014	943
C&V	5,575	5,317	-258	64,947	64,428	-519
Other*	3,971	3,422	-548	43,103	34,599	-8,504
Total	**36,216**	**34,964**	**-1,252**	**416,196**	**406,537**	**-9,659**

* includes M11 YTD adverse variance on block (£1.6m) & a non finalised clinical income CIP target YTD (£3.6m)









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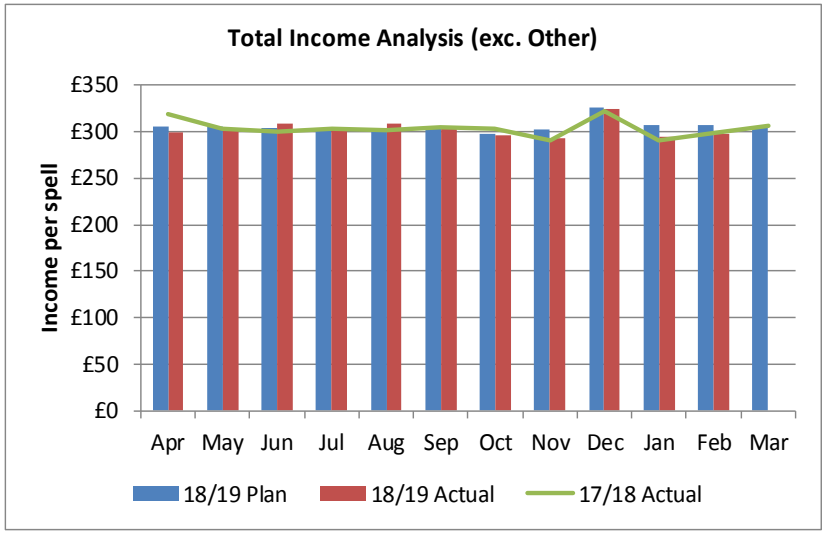
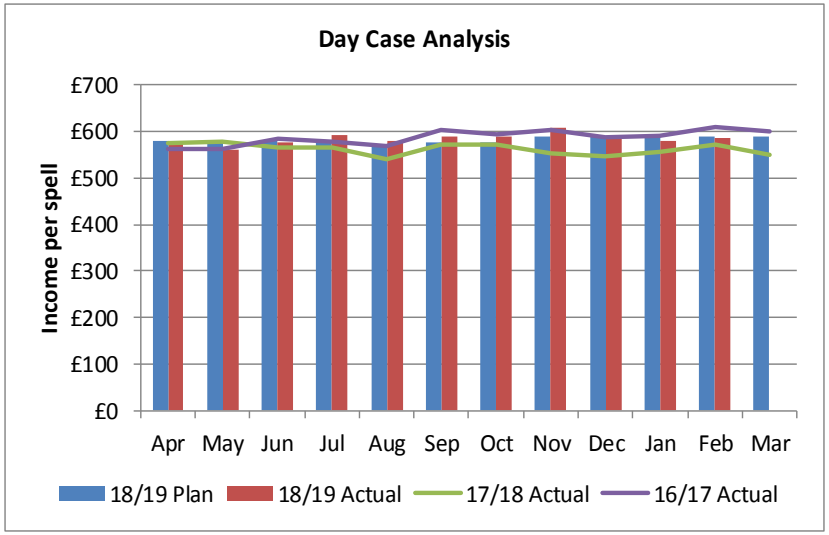
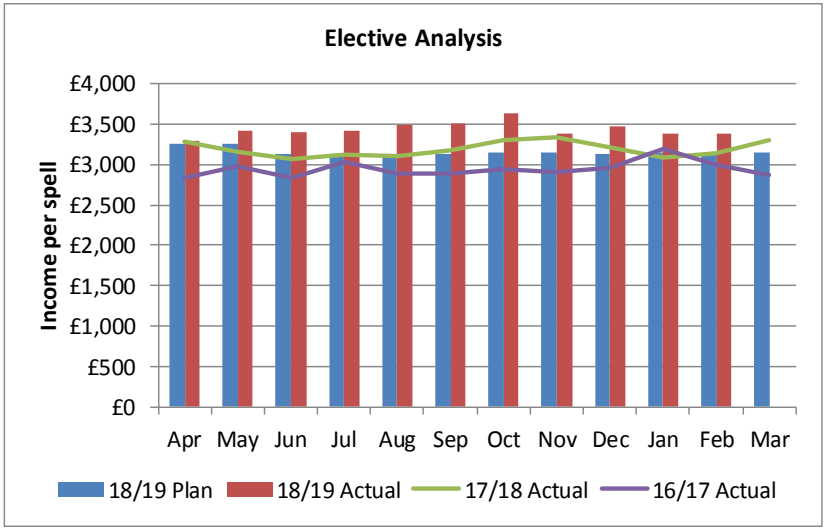
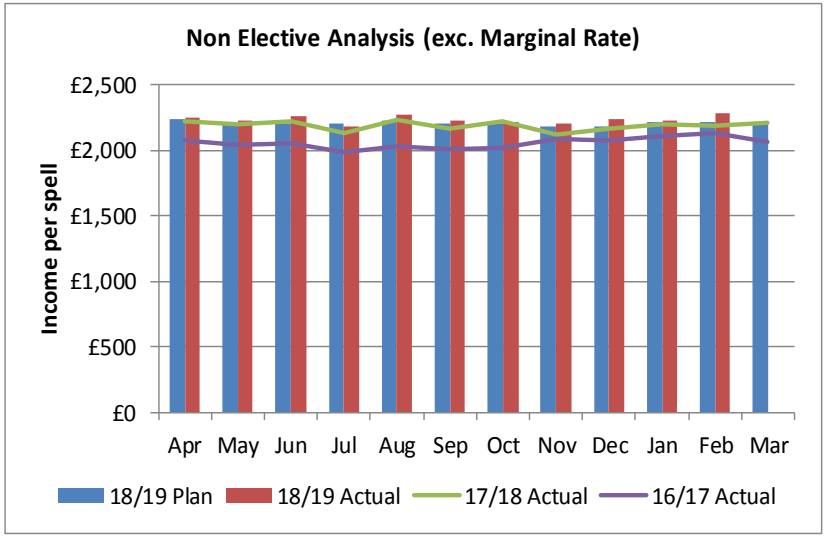
Finance - Lead Director John Hennessey









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Finance - Lead Director John Hennessey

Pay cost by 'type'

Monthly Expenditure (£)				
As at February 2019	Feb-19	Jan-19	Feb-18	YTD 2018-19
	£'000	£'000	£'000	£'000
Budgeted costs in month	**29,422**	**29,402**	**28,439**	**322,827**
Actuals:				
Substantive staff	**26,521**	**26,659**	**25,045**	**284,564**
Medical External Locum Staff*	255	241	137	**2,313**
Medical Internal Locum Staff	486	531	596	**6,030**
Additional Medical Sessions	452	441	406	**4,933**
Nursing Agency Staff*	706	728	552	**6,615**
Nursing Bank Staff	848	611	785	**10,144**
Other Agency Staff (AHPs/A&C)*	241	307	266	**2,383**
Other Bank Staff (AHPs/A&C)	148	108	138	**1,599**
Overtime	542	510	520	**5,747**
On Call	198	200	196	**2,153**
Total temporary expenditure	**3,876**	**3,678**	**3,596**	**41,914**
Total Pay costs	**30,397**	**30,337**	**28,641**	**326,479**
Variance Fav / (Adv)	(975)	(935)	(202)	(3,651)
Temp Staff costs % of Total Pay	**13%**	**12%**	**13%**	**13%**
Memo: Total agency spend in month*	**1,202**	**1,276**	**955**	**11,310**

Headcount

Monthly Whole Time Equivalents (WTE)			
As at February 2019	Feb-19	Jan-19	Feb-18
	WTE	WTE	WTE
Budgeted WTE in month	**8,069**	**8,042**	**7,361**
Employed substantive WTE in month	**7,178**	**7,122**	**6,783**
Medical External Locum Staff*	15	12	7
Medical Internal Locum Staff	71	76	80
Additional Sessions	13	13	13
Nursing Agency*	109	119	72
Nursing Bank	75	75	72
Other Agency (AHPs/A&C)*	118	131	124
Other Bank (AHPs/A&C)	316	351	311
Overtime	147	138	145
On Call Worked	39	39	39
Total equivalent temporary WTE	**903**	**954**	**864**
Total equivalent WTE	**8,081**	**8,076**	**7,647**
Variance Fav / (Adv)	(12)	(34)	(286)
Temp Staff WTE % of Total WTE	**11%**	**12%**	**11%**
Memo: Total agency WTE in month*	**241.82**	**261.39**	**202.85**
Sickness Rates	**5.16%**	**4.64%**	**5.50%**
Mat Leave	**2.40%**	**2.48%**	**2.30%**

Data taken from the workforce return as agreed with deputy workforce director each month. Sickness and Mat leave calculations provided by data workforce analyst.

Actuals taken from NHSI return which is generated from our ledger.

Employed substantive provided by payroll. Medical Agency/locum WTE generated via an average cost per grade applied to the total spend.

Additional sessions, overtime & on call sourced from payroll.

Agency & Bank are generated via hours worked from our E-Roster system. This is then converted into WTE.

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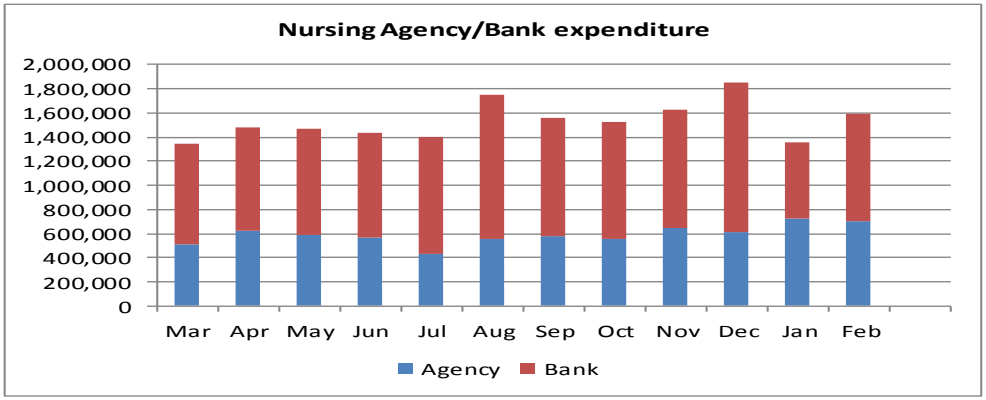
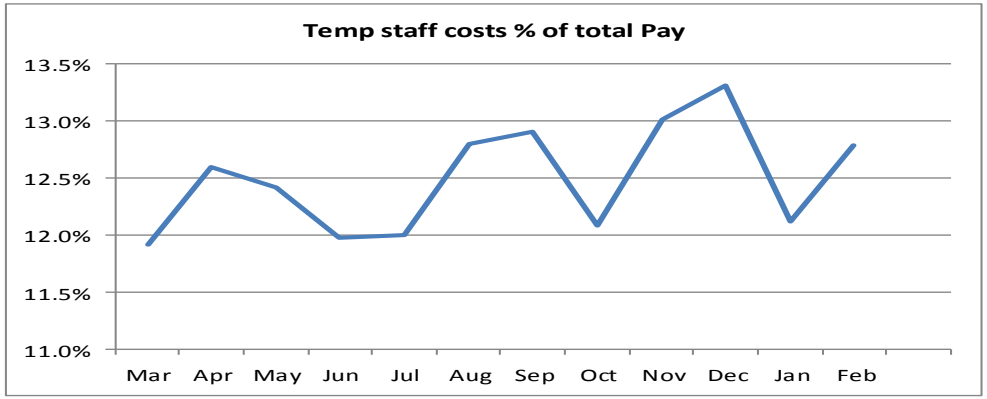
Finance - Lead Director John Hennessey

Pay Trends & Analysis

Medical staff premium Pay YTD (source: budget statements)	WLI	Internal Locum	External Locum & NAG	Total
Emergency	2,252	2,504,851	513,939	**3,021,042**
Surgical Support	817,848	116,667	817,577	**1,752,092**
General Surgery	399,873	273,667	213,178	**886,718**
Older Peoples Medicine	66,139	595,938	40,905	**702,981**
Imaging	669,359	8,985	0	**678,343**
Oral Surgery	22,247	360,866	185,643	**568,756**
Plastic Surgery	219,296	268,131	40,499	**527,926**
Urology	462,134	53,463	9,372	**524,969**
Ophthalmology	366,443	143,152	0	**509,594**
Dermatology	318,205	82,643	16,791	**417,638**
Paediatrics	89,517	294,633	27,859	**412,010**
Respiratory Medicine	169,518	146,023	66,129	**381,670**
Gastroenterology	312,134	60,920	0	**373,054**
Cellular Pathology	143,199	24,427	201,655	**369,281**
Cardiology	188,143	51,893	90,538	**330,574**
Obstetrics And Gynaecology	154,610	157,385	5,834	**317,829**
Neurosciences	125,011	171,786	3,937	**300,734**
Ear Nose And Throat	169,647	79,674	21,100	**270,421**
Trauma And Orthopaedics	207,842	84,179	-25,052	**266,969**
Services	523	223,027	17,883	**241,433**
Oncology & Haematology	22,264	160,694	25,666	**208,624**
Laboratory Medicine	0	50,824	23,758	**74,582**
Palliative Care	0	60,957	0	**60,957**
Endocrinology	4,843	27,457	5,332	**37,633**
Therapies & Support Services	0	21,608	0	**21,608**
Renal	0	3,810	10,000	**13,810**
Rheumatology	1,957	1,863	0	**3,820**
Total	**4,933,004**	**6,029,521**	**2,312,545**	**13,275,070**





- The Pay budget YTD is £322.8m v £326.5m actual cost delivering an overspend of £3,651k.
- Emergency has overspent in the YTD by £2,638k through additional Locum spend, additional floor coordinators & doctor cover in the evening of circa two doctors. The locum overspend is being reviewed within the division.
- Premium pay (all temp costs exc. on-call) is currently running at circa £3.6m per month (£3.7m in M11), & totals £39.8m YTD. Key areas of focus is control on overtime payments £5.75m YTD, WLI 4.9m YTD & Agency 9.0m YTD

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CIP Performance

CIP Plan Development

- To date £28.5m of cost improvement initiatives have been approved through Gateway 2 and into delivery against the £30.0m CIP target with further schemes continuing to be developed through the governance process, with £1.6m through 'Gateway 1'.
- The Trust should consider 'hard stop' actions across M12 to reduce discretionary spend where clinically safe to do so to deliver further initiatives to reduce the risk adjusted delivery gap.

CIP Performance

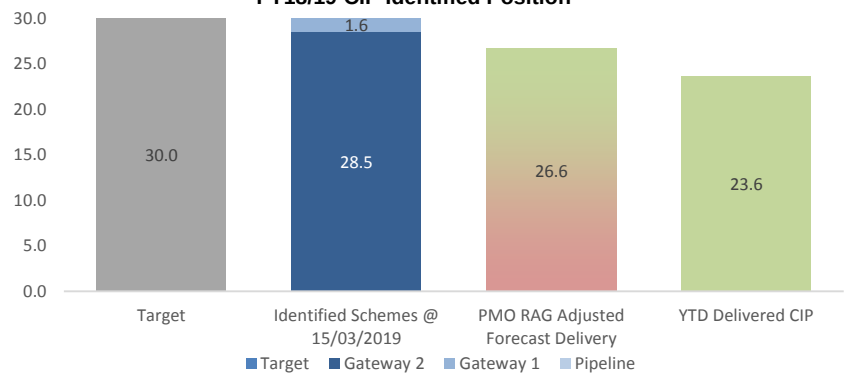
- YTD the Trust has delivered £23.64 of CIPs against a FIP Board approved YTD plan of £24.18m (YTD plan per annual plan is £25.0m), an under-performance of £0.54m arising through adverse performance in private patient initiatives offset by over-performance of clinical income schemes in medicine.
- The risk adjusted forecast delivery for Gateway 2 schemes is currently £26.6m based on the YTD financial performance of 'in delivery' CIPs, progress against milestone delivery and performance against quality and performance indicators. This presents a significant risk to achievement of the £30.0m target.
- The PMO is working with divisions to identify any initiatives, recurrent or non-recurrent, which can be delivered in M12 to increase the likelihood of delivering the full CIP target.

FY18/19 Performance by Division

Division	Number of schemes 'In Delivery'	CIP Delivery		
		YTD FIP Board Approved Plan £'000	YTD Actual £'000	YTD Variance £'000
Medicine	35	8,207.2	8,945.6	738.3
Surgery	30	8,003.1	7,025.6	(977.4)
Women & Children's	16	2,273.5	2,196.4	(77.1)
Clinical Support Services	19	3,813.5	3,823.0	9.4
Corporate	14	1,881.5	1,654.4	(227.1)
Cross-Divisional*	2	-	-	-
	116	**24,178.8**	**23,644.9**	**(533.9)**
YTD per Annual Plan		24,986.9		
Variance to Annual Plan		**(808.1)**		

*Cross-divisional plan and actuals have been allocated to the relevant divisions

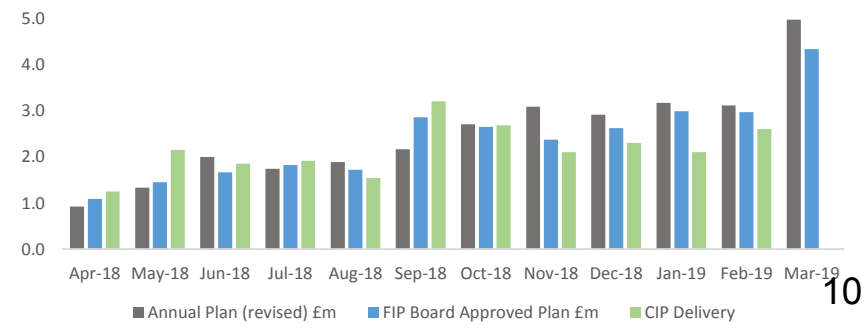
FY18/19 CIP Identified Position



Category	Annual Plan £'000	FIP Approved Plan YTD £'000	Actual YTD £'000	Variance £'000
Clinical Income	17,580.3	15,342.3	15,771.2	428.9
Pay*	8,530.8	6,088.4	5,903.9	(184.5)
Non-pay*	2,191.3	1,110.5	1,714.8	604.3
Other Income*	1,000.2	1,431.3	47.2	(1,384.1)
Non-Opex	697.4	206.8	207.8	1.5
	30,000.0	**24,178.8**	**23,644.9**	**(533.9)**

*Information is shown as the savings identified net of any costs associated with the delivery of clinical income initiatives, which is £2.1m across the categories.

FY18/19 Monthly CIP Phasing



Core Slide 45

Finance - Lead Director John Hennessey

Summary by Division

DIRECTORATES INCOME & EXPENDITURE	Feb-19 Budget £k	Feb-19 Actual £k	Feb-19 Variance F/(A) £k	Year to date Budget £k	Year to date Actual £k	Year to date Variance F/(A) £k
MEDICINE & EMERGENCY						
Total Income	18,921	18,797	(124)	213,104	218,225	5,121
Pay Costs	(9,419)	(10,076)	(657)	(103,542)	(107,271)	(3,730)
Non-Pay Costs	(7,475)	(6,672)	803	(80,064)	(80,834)	(770)
Total Expenditure	(16,895)	(16,748)	147	(183,606)	(188,105)	(4,499)
SURPLUS/(DEFICIT)	**2,026**	**2,048**	**22**	**29,498**	**30,120**	**622**
SURGERY						
Total Income	14,332	12,934	(1,398)	163,428	152,886	(10,542)
Pay Costs	(8,749)	(8,892)	(143)	(95,610)	(96,176)	(566)
Non-Pay Costs	(4,249)	(4,006)	243	(46,620)	(45,017)	1,603
Total Expenditure	(12,998)	(12,898)	99	(142,230)	(141,193)	1,037
SURPLUS/(DEFICIT)	**1,334**	**36**	**(1,298)**	**21,198**	**11,693**	**(9,505)**
WOMENS & CHILDREN						
Total Income	5,060	4,682	(378)	59,321	58,285	(1,036)
Pay Costs	(3,174)	(3,247)	(73)	(35,349)	(35,787)	(438)
Non-Pay Costs	(560)	(521)	39	(6,410)	(6,388)	23
Total Expenditure	(3,734)	(3,768)	(34)	(41,759)	(42,175)	(415)
SURPLUS/(DEFICIT)	**1,326**	**914**	**(412)**	**17,561**	**16,110**	**(1,451)**
CLINICAL SUPPORT						
Total Income	4,056	4,134	79	44,977	45,519	542
Pay Costs	(5,224)	(5,379)	(154)	(58,023)	(57,719)	304
Non-Pay Costs	(2,415)	(3,027)	(612)	(26,664)	(30,082)	(3,418)
Total Expenditure	(7,640)	(8,406)	(766)	(84,687)	(87,801)	(3,114)
SURPLUS/(DEFICIT)	**(3,584)**	**(4,272)**	**(688)**	**(39,710)**	**(42,282)**	**(2,572)**
SERVICES						
Total Income	626	559	(66)	7,134	7,602	468
Pay Costs	(2,408)	(2,393)	15	(25,769)	(25,464)	305
Non-Pay Costs	(5,351)	(6,047)	(696)	(56,669)	(58,476)	(1,807)
Total Expenditure	(7,759)	(8,439)	(681)	(82,438)	(83,940)	(1,502)
SURPLUS/(DEFICIT)	**(7,133)**	**(7,880)**	**(747)**	**(75,304)**	**(76,338)**	**(1,034)**
OTHER inc. NON OPEX						
Total Income	4,847	6,321	1,474	58,323	60,477	2,154
Pay Costs	(447)	(410)	37	(4,535)	(4,062)	473
Non-Pay Costs	(5,277)	(4,490)	788	(59,235)	(54,350)	4,885
Total Expenditure	(5,724)	(4,900)	825	(63,770)	(58,412)	5,358
SURPLUS/(DEFICIT)	**(877)**	**1,421**	**2,298**	**(5,447)**	**2,065**	**7,512**
TOTAL						
Total Income	48,101	47,428	(673)	549,855	542,994	(6,861)
Pay Costs	(29,422)	(30,397)	(975)	(322,827)	(326,479)	(3,652)
Non-Pay Costs	(25,586)	(24,763)	823	(279,232)	(275,147)	4,085
Total Expenditure	(55,008)	(55,159)	(152)	(602,059)	(601,626)	433
SURPLUS/(DEFICIT)	**(6,907)**	**(7,732)**	**(825)**	**(52,204)**	**(58,632)**	**(6,428)**

Medicine

The Medicine and Emergency division remains ahead of plan £622k cumulatively; in month performance is just ahead of plan at £22k.

Pay remains a concern in the Emergency & OPM sub-division with overspend YTD of £2.6m. Increased activity has driven spend, and a subset of this is an additional two junior doctors to ensure the trust meets the NHSI targets. The on boarding of Doctors from the overseas recruitment is gathering pace which has helped reduce the reliance on Locums going forward. Further adverse variance is due to increased activity; Sleep Apnoea £236k and Cardiology Devices £430k.

Surgery

Performance YTD for the Surgical Division is behind plan by £9.5m, a deterioration of £1.3m in the month. Total Income is £10.5m behind the YTD plan. Clinical Income drives this variance, currently c.£9.3m behind plan.

Vacancies, long term sickness, aggressive CIP plans & cancellations from winter pressures continue to impact surgical specialties. Activity within T&O suffered in M11. The specialty under-performed against plan by £0.7m. Electives were down against plan by £0.2m whilst non-elective income (inc. marginal rate) was down £0.3m. Ophthalmology (£0.1m), Plastics (£0.1m) &Urology (£0.1m) each under-performed against income plans.

Pay costs YTD are overspent against plan by £0.6m, due to increased spend against vacancies. Non-Pay is £1.6m underspent resulting from the delay in opening additional CCC beds and a reduction in spend due to reduced activity relative to Clinical Income CIPs.

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Finance - Lead Director John Hennessey

Summary by Directorate (cont.)

Women's and Children's

Performance YTD has deteriorated in M11 by £412k and is now behind plan £1.45m YTD.

The main cause of this is due to clinical income which is £1.5m behind plan YTD with Outpatients being the significant driver of the deterioration.

Pay is also deteriorating month on month with a YTD overspend of £438k overspent in month by £73k, the vacancies in Paeds nursing and Student Midwives YTD has now been offset by the commencement of the unidentified pay CIP from M07 of £90k per month.

Non pay expenditure is slightly underspent YTD (£23k) £313k underspend is due to no spend on SHS, and Medinet being lower than plan, this underspend is reduced by the increase in drugs spend which mainly flows through into income as well as the unidentified CIP plan of £21k per month from M07.

Clinical Support

Performance for DCSS has deteriorated from M10, with an under performance against plan in M11 of £2.57m YTD.

Total Income is ahead of plan by £542k, with increased direct access radiology and EPA work above the CIP (£259k), & an increased EPA recharge (£694k) due to overspends in Non-Pay. Cell Path income is down due to failure to progress a CIP on taking additional work from other trusts (£632k).£140k overachievement on Pharmacy recharges, partially offset by drugs costs

Pay remains underspent YTD by £304k, with underspends across the directorates (particularly in Pharmacy and Radiology). This is inclusive of £2.06m of YTD Pay CIP and the £675k vacancy factor.

Non-Pay remains the primary reason behind the overspend, with a YTD adverse variance of £3,418k. Main driver is consumables and MSC spend in EPA and laboratory Medicine (£1,923k). This is due to the increased activity in the labs (£397k more GP direct access activity than previous year), double running the new haematology analysers (currently repeating 15% of haematology test – £70k), £450k variance relating to the Delay in the Abbott Contract) and the recent pick up in Microbiology relating to flu season (£156k overspent in month). Blood products are £190k overspent, due to a small number of patients requiring high quantities them, some of which are rechargeable to commissioners. £503k YTD of SHS expenditure in Cell Path to maintain reporting on the cancer work, £343k on radiology consumables (mainly CT and IRU), and £397k unidentified non-pay CIPs. £113k on Air pressure mattress hire (invoices for repairs) & HODs and other send away testing (£114k).

Services

YTD Services are behind by £1,034k. A driver for this has been driven through the underachievement of the £300k income CIP for fund raising of the QI building

Pay is £305k underspent against budget YTD. Pay is anticipated to carry on in line with budget due to savings at the start of the year being non-recurrent.

Non-Pay however is overspent YTD against budget by £1,807k. This includes an adjustment to the procurement contract agreement as well as management consultancy being provided externally for the financial improvement programme.

Other - YTD

The income variance of £2.1m favourable is a net of an adverse clinical income variance of £3.3m and a favourable 'other income' variance of £5.4m.

Note that the drugs inflation income budget of £3.6m to date has been netted off the inflation cost budget for drugs in this presentation, and reversed back for the overall Trust position on slide 45.

Clinical Income is where contract risks and issues are posted - away from the divisional performance. It is worse than plan by £3.3m being; Specialised Block where we have done more work than the block contract will pay - £1.6m, Readmissions costs £0.3m worse than plan, Cancelled Operations £0.3m, Cancer 62 day target penalties £0.7m and other risks provided.

'Other Income' is a net £5.4m fav variance, with key items being: £1.2m additional income assumed to reflect forecast clin income including a clinical income block of £8m pro rata. This is uncertain. Also a £0.88m release of opening balance sheet review, £1.0m re Education and training / RTA etc, adverse R&D income variance of £0.3m, and £2.2m re CQUIN and related challenges now within assumed clinical income block.

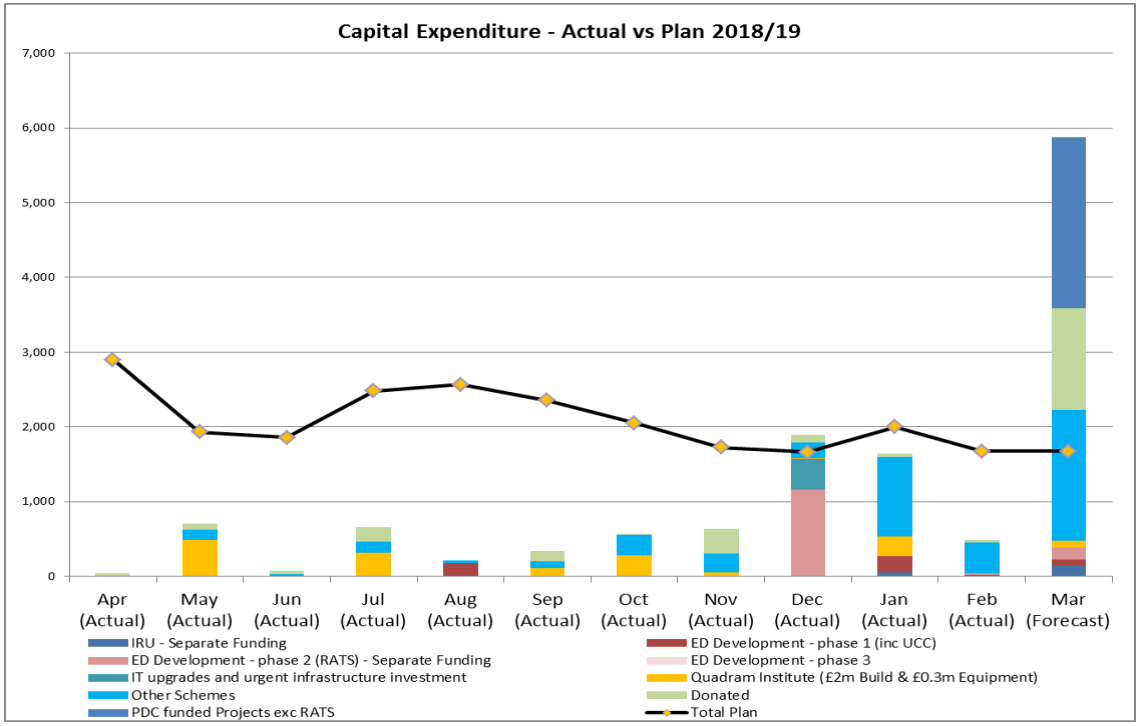
Non-Pay is £4.9m better than budget being: £1.8m general inflation cost pressure not allocated to specific costs, £0.3m fav on R&D, £0.7m on winter / related pressures, £0.5m slippage and £1.7m fav on non opex – see below.

Non-Opex is £1.7m better than budget: Depreciation £0.6m from slippage in spend, Interest on borrowings £0.8m from interest rate and borrowing variances and Contingent Rent £0.2m from RPI being less than assumed and £0.1m on interest receivable and asset disposals.

Core Slide 47

Finance - Lead Director John Hennessey

Capital Progress Report



The original plan for the year was expenditure of £25.8m.

The current forecast for the year is £13.2m and its monthly phasing is shown in the graph to the left.

Of this £7.3m has been spent to date, leaving £5.9m for the final month. Key items of the £5.9m are £2.3m of PDC funded expenditure – which must be spent in year, £1.4m regarding donated additions – mainly Cromer. The remainder is across a number of smaller projects.

A loan of £0.2m for IRU has been confirmed for 2018/19, with no other central funding being provided in this financial year.

Internally generated funding for capital is £7.0m, comprising, depreciation net of balance sheet cash items of £1.0m, STF of £4.5m, and capital assets disposals of £1.5m as part of the move to a managed service relating to QI.

	Apr Actual £'000	May Actual £'000	Jun Actual £'000	Jul Actual £'000	Aug Actual £'000	Sep Actual £'000	Oct Actual £'000	Nov Actual £'000	Dec Actual £'000	Jan Actual £'000	Feb Actual £'000	Mar Forecast £'000	TOTAL Forecast £'000
IRU - Separate Funding	0	0	0	0	0	0	0	6	0	54	17	148	**224**
ED Development - phase 1 (inc UCC)	0	0	0	0	175	0	0	0	0	217	0	73	**465**
ED Development - phase 2 (RATS) - Separate Fundin	0	0	0	0	0	0	0	0	1,159	0	20	165	**1,343**
ED Development - phase 3	0	0	0	0	0	0	0	0	0	0	0	0	**0**
IT upgrades and urgent infrastructure investment	0	0	0	0	0	0	0	0	411	0	0	0	**411**
PDC funded Projects exc RATS	0	0	0	0	0	0	0	0	0	0	0	2,290	**2,290**
Quadram Institute (£2m Build & £0.3m Equipment)	0	489	0	312	0	116	280	49	17	265	0	91	**1,620**
Other Schemes	0	133	30	158	44	85	272	254	203	1,057	419	1,750	**4,406**
Donated	42	86	50	188	0	135	14	323	106	54	35	1,363	**2,396**
Total Actual to Date / Forecast	**42**	**708**	**80**	**658**	**220**	**335**	**566**	**632**	**1,896**	**1,647**	**491**	**5,880**	**13,155**
Cumulative Actual to Date	**42**	**750**	**831**	**1,489**	**1,709**	**2,044**	**2,610**	**3,242**	**5,138**	**6,785**	**7,276**		
Total Plan	**2,896**	**1,933**	**1,858**	**2,479**	**2,592**	**2,356**	**2,118**	**1,894**	**1,832**	**2,173**	**1,849**	**1,846**	**25,826**

Core Slide 48

Finance - Lead Director John Hennessey

Statement of Financial Position at 28th February 2019

	Opening Balance as at 1 April 2018 £'000	Plan 31 March 2019 £'000	Plan YTD 28 February 19 £'000	Actual YTD 28 February 19 £'000	Variance YTD 28 February 19 £'000
Property, plant and equipment	234,749	249,516	248,652	231,090	(17,562)
Trade and other receivables	71,245	77,940	77,379	77,695	316
Other financial assets	0	0	0	0	0
Total non-current assets	**305,994**	**327,456**	**326,031**	**308,785**	**(17,246)**
Inventories	9,369	9,369	9,369	9,895	526
Trade and other receivables	28,621	24,040	26,187	28,107	1,920
Non-current assets for sale	0	0	0	0	0
cash and cash equivalents	5,733	1,681	1,244	8,771	7,527
Total Current assets	**43,723**	**35,090**	**36,800**	**46,773**	**9,973**
Trade and other payables	(61,085)	(61,256)	(61,011)	(74,993)	(13,982)
Borrowing repayable within 1 year	0	0	0	0	0
Current provisions	(308)	(307)	(307)	(307)	0
Deferred Income	(5,138)	(4,764)	(4,764)	(5,802)	(1,038)
Total current liabilities	**(66,531)**	**(66,327)**	**(66,082)**	**(81,102)**	**(15,020)**
Total assets less current liabilities	**283,186**	**296,219**	**296,749**	**274,456**	**(22,293)**
Borrowings - PFI & Finance Lease	(193,856)	(190,761)	(191,248)	(191,251)	(3)
Borrowings - Revenue Support	(52,393)	(103,493)	(102,257)	(102,846)	(589)
Borrowings - Capital Support	0	(18,601)	(17,224)	0	17,224
Provisions	(2,159)	(1,892)	(1,914)	(2,116)	(202)
Deferred Income	(4,606)	(4,875)	(4,883)	(4,470)	413
Total non-current liabilities	**(253,014)**	**(319,622)**	**(317,526)**	**(300,683)**	**16,843**
Total assets employed	**30,172**	**(23,403)**	**(20,777)**	**(26,227)**	**(5,450)**
Financed by					
Public dividend capital	28,408	28,408	28,408	29,608	1,200
Retained Earnings (Accumulated Losses)	(13,239)	(66,814)	(64,188)	(70,826)	(6,638)
Revaluation reserve	15,003	15,003	15,003	14,991	(12)
Total Taxpayers' and others' equity	**30,172**	**(23,403)**	**(20,777)**	**(26,227)**	**(5,450)**

Non-Current Assets

There is some slippage on the capital programme primarily due to a delay in receiving capital support from DHSC of £17.2m YTD.

Trade and Other Receivables

This balance is £2.2m higher than plan YTD. Various - key driver is timing.

Cash

Cash is £7.5m higher than plan at the end of February due to short term timing differences and operational performance. Loan drawdowns continue to be delayed as long as possible.

Trade and other payables

This is £14.0m higher than plan YTD.

Increased levels of general trade payables – timing difference.

Increase in N.I. and tax liability following AfC pay increase.

Deferred Income

This balance is £0.6m higher than plan YTD. These are small timing differences.

Borrowings

Total overall borrowings are £16.6m lower than plan. Mainly related to capital loans.

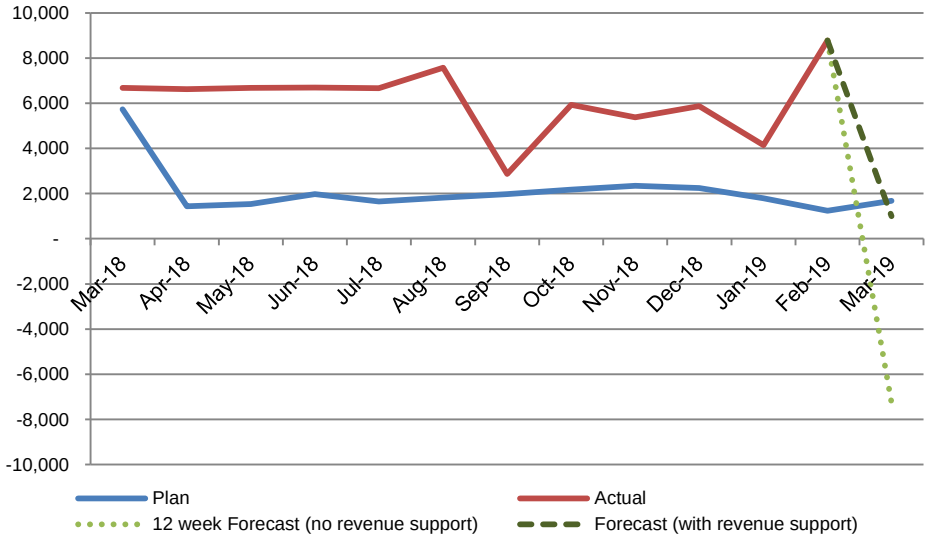
In year revenue borrowings are £50.5m against a YTD plan of £49.9m. Being £0.6m higher than plan.

In year capital borrowings are £0m against a YTD plan of £17.2m. Being £17.2m lower than plan. The Trust has been notified that only £0.2m of capital loans have been approved in 2018/19. The remainder of the amount requested will not be approved in this financial year.

Core Slide 49

Finance - Lead Director John Hennessey

Cash Balance actual and forecast versus plan



	Opening	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
Cum. Rev. Borrowings-Plan	52,393	55,393	57,393	63,531	67,019	72,142	78,234	81,853	86,150	93,419	97,011	102,257	103,493
Cum. Rev. Borrowings-Actual	52,393	57,671	61,450	65,142	73,369	74,906	76,425	82,544	88,296	93,534	98,416	102,846	
Variance - (Adverse) / Favourable	0	(2,278)	(4,057)	(1,611)	(6,350)	(2,764)	1,809	(691)	(2,146)	(115)	(1,405)	(589)	

- The graph shows the cash levels since the end of March 2018. Short term timing differences drive the difference between actual and plan.
- The Trust is required to keep a minimum balance of £1 million, hence the closing cash plan every month is circa £1m.
- The future cash loan requirements on current projections are: £8.258m in March (received) and £4.636m in April.
- The borrowings of £102.8m at the end of M11 comprise: £16m in 2016/17, £36.4m in 2017/18 & £50.4m in 2018/19.
- The interest rates are: 3.5% on £57.7m. 1.5% on the remainder of £45.1m.

NOTE:

- The plan for 2018/19 assumed in year borrowings of £51.1m for revenue. It is expected to be £58.7m, bringing total revenue borrowings to £111m.
- The Trust Board approved borrowing 'limit' is £120m revenue and £25m capital.
- The need for the funds is driven by our operational performance.

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

Income Statement Comparison - for the Month of February

	For the month			Variances Fav / (Adv)			
	Actual	Budget	Prior year	To Budget		To prior year	
	£'000	£'000	£'000	£'000	%	£'000	%
INCOME							
NHS clinical income							
Clinical Income	34,213	35,584	32,591	(1,371)	(4%)	1,622	5%
Clinical Income - Spire Contract	751	632	641	119	19%	110	17%
NT Drugs	5,050	5,771	4,655	(721)	(12%)	395	8%
Total NHS clinical income	**40,014**	**41,987**	**37,710**	**(1,973)**	**(5%)**	**2,304**	**6%**
Non NHS clinical income							
Private patients	90	158	84	(68)	(43%)	6	7%
Other - RTA	153	110	176	43	39%	(23)	(13%)
Total Non NHS clinical income	**243**	**268**	**260**	**(25)**	**(9%)**	**(17)**	**(7%)**
Other Income							
R&D	1,795	1,810	1,907	(15)	(1%)	(112)	(6%)
Education & Training	2,387	1,928	1,978	459	24%	409	21%
STF Income							
Winter Pressures Funding			125				
Other non patient care income	2,973	2,110	2,199	863	41%	774	35%
Total other Income	**7,155**	**5,848**	**6,209**	**1,307**	**22%**	**1,071**	**17%**
TOTAL OPERATING INCOME	**47,412**	**48,103**	**44,179**	**(691)**	**(1%)**	**3,358**	**8%**
EXPENDITURE							
Employee benefit expenses	(30,397)	(29,422)	(28,121)	(975)	(3%)	(2,276)	(8%)
Drugs	(6,018)	(6,834)	(5,590)	816	12%	(428)	(8%)
Clinical supplies	(5,699)	(5,555)	(4,879)	(144)	(3%)	(820)	(17%)
Non clinical supplies	(7,497)	(7,431)	(7,047)	(66)	(1%)	(450)	(6%)
- Fixed	*(1,785)*	*(1,785)*	*(1,534)*		*0%*	*(251)*	*(16%)*
- Capacity	*(505)*	*(503)*	*(468)*	*(2)*	*(0%)*	*(37)*	*(8%)*
- Income Backed including Spire	*(2,676)*	*(2,477)*	*(2,442)*	*(199)*	*(8%)*	*(234)*	*(10%)*
- £2m Contingency Reserve	*70*	*(180)*		*250*	*139%*	*70*	
- Variable	*(2,601)*	*(2,486)*	*(2,603)*	*(115)*	*(5%)*	*2*	*0%*
PFI operating expenses	(2,026)	(1,931)	(1,750)	(95)	(5%)	(276)	(16%)
TOTAL OPERATING EXPENSES	**(51,637)**	**(51,173)**	**(47,387)**	**(464)**	**(1%)**	**(4,250)**	**(9%)**
Profit/(loss) from operations	**(4,225)**	**(3,070)**	**(3,208)**	**(1,155)**	**38%**	**(892)**	**28%**
Non-operating income							
Interest	16	2	9	14	(700%)	7	78%
Profit/(loss) on asset disposals		(4)		4	100%		
Total non-operating income	**16**	**(2)**	**9**	**18**	**(900%)**	**7**	**78%**
Non-operating expenses							
Interest on PFI and Finance leases	(1,419)	(1,419)	(1,438)		0%	19	(1%)
Interest on Non Commercial Borrowing	(204)	(300)	(82)	96	32%	(122)	149%
Depreciation	(760)	(965)	(895)	205	21%	135	(15%)
PDC			(25)			25	(100%)
Other - Contingent Rent	(1,140)	(1,151)	(1,048)	11	1%	(92)	9%
Total non operating expenses	**(3,523)**	**(3,835)**	**(3,488)**	**312**	**8%**	**(35)**	1%
Surplus (deficit) after tax from continuing operations	**(7,732)**	**(6,907)**	**(6,687)**	**(825)**	**(12%)**	**(920)**	**(14%)**
Memo:							
Donated Asset Additions	35	155	182	(120)	(77%)	(147)	(81%)
Surplus (deficit) after tax and Donated Asset Additions	**(7,697)**	**(6,752)**	**(6,505)**	**(945)**	**(14%)**	**(1,067)**	**(16%)**

Notes:

Calendar Days	28	28	28
Working Days	20	20	20

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

Income Statement Comparison - Year to 28 February 2019

	FULL YEAR BUDGET	Year to date			Variances Fav / (Adv)			
		Actual	Budget	Prior year	To Budget		To prior year	
	£'000	£'000	£'000	£'000	£'000	%	£'000	%
INCOME								
NHS clinical income								
Clinical Income	*447,320*	399,121	409,249	387,105	(10,128)	(2%)	12,016	3%
Clinical Income - Spire Contract	*7,578*	7,416	6,947	1,159	469	7%	6,257	540%
NT Drugs	*69,230*	60,553	63,459	57,510	(2,906)	(5%)	3,043	5%
Total NHS clinical income	***524,128***	**467,090**	**479,655**	**444,843**	**(12,565)**	**(3%)**	**22,247**	**5%**
Non NHS clinical income								
Private patients	*1,899*	1,411	1,741	1,521	(330)	(19%)	(110)	(7%)
Other - RTA	*1,318*	1,490	1,208	1,168	282	23%	322	28%
Total Non NHS clinical income	***3,217***	**2,901**	**2,949**	**2,689**	**(48)**	**(2%)**	**212**	**8%**
Other Income								
R&D	*21,644*	19,557	19,834	19,722	(277)	(1%)	(165)	(1%)
Education & Training	*23,267*	22,317	21,338	21,691	979	5%	626	3%
STF Income				3,853			(3,853)	(100%)
Winter Pressures Funding				2,007				
Other non patient care income	*28,176*	30,971	26,087	37,429	4,884	19%	(6,458)	(17%)
Total other Income	***73,087***	**72,845**	**67,259**	**84,702**	**5,586**	**8%**	**(9,850)**	**(12%)**
TOTAL OPERATING INCOME	***600,432***	**542,836**	**549,863**	**532,234**	**(7,027)**	**(1%)**	**12,609**	**2%**
EXPENDITURE								
Employee benefit expenses	*(351,045)*	(326,479)	(322,827)	(302,437)	(3,652)	(1.1%)	(24,042)	(8%)
Drugs	*(82,270)*	(71,665)	(75,435)	(68,874)	3,770	5.0%	(2,791)	(4%)
Clinical supplies	*(65,909)*	(61,937)	(60,408)	(59,750)	(1,529)	(2.5%)	(2,187)	(4%)
Non clinical supplies	*(90,230)*	(82,059)	(82,741)	(70,544)	682	0.8%	(11,515)	(16%)
- Fixed	*(21,365)*	*(19,581)*	*(19,581)*	*(16,259)*		*0%*	*(3,322)*	*(20%)*
- Capacity	*(6,213)*	*(5,743)*	*(5,715)*	*(5,531)*	*(28)*	*(0%)*	*(212)*	*(4%)*
- Income Backed including Spire	*(29,721)*	*(27,430)*	*(27,244)*	*(21,196)*	*(186)*	*(1%)*	*(6,234)*	*(29%)*
- £2m Contingency Reserve	*(2,000)*	*(970)*	*(1,720)*		*750*		*(970)*	
- Variable	*(30,931)*	*(28,335)*	*(28,481)*	*(27,558)*	*146*	*1%*	*(777)*	*(3%)*
PFI operating expenses	*(21,568)*	(20,495)	(20,143)	(19,080)	(352)	(1.7%)	(1,415)	(7%)
TOTAL OPERATING EXPENSES	***(611,022)***	**(562,635)**	**(561,554)**	**(520,685)**	**(1,081)**	**(0%)**	**(41,950)**	**(8%)**
Profit/(loss) from operations	***(10,590)***	**(19,799)**	**(11,691)**	**11,549**	**(8,108)**	**69%**	**(29,341)**	**(254%)**
Non-operating income								
Interest	*32*	143	29	49	114	(393%)	94	192%
Profit/(loss) on asset disposals	*(40)*	15	(37)	9	52	141%	6	67%
Total non-operating income	***(8)***	**158**	**(8)**	**58**	**166**	**(2075%)**	**100**	**172%**
Non-operating expenses								
Interest on PFI and Finance leases	*(17,085)*	(15,666)	(15,667)	(15,911)	1	0%	245	(2%)
Interest on Non Commercial Borrowing	*(2,799)*	(1,683)	(2,447)	(777)	764	31%	(906)	117%
Depreciation	*(11,021)*	(9,472)	(10,046)	(9,725)	574	6%	253	(3%)
PDC				(271)			271	(100%)
Other - Contingent Rent	*(13,497)*	(12,170)	(12,345)	(11,149)	175	1%	(1,021)	9%
Total non operating expenses	***(44,402)***	**(38,991)**	**(40,505)**	**(37,833)**	**1,514**	**4%**	**(1,158)**	3%
Surplus (deficit) after tax from continuing operations	***(55,000)***	**(58,632)**	**(52,204)**	**(26,226)**	**(6,428)**	**(12%)**	**(30,399)**	**(116%)**
Memo:								
Donated Asset Additions	*1,425*	1,033	1,255	1,642	(222)	(18%)	(609)	(37%)
Surplus (deficit) after tax and Donated Asset Additions	***(53,575)***	**(57,599)**	**(50,949)**	**(24,584)**	**(6,650)**	**(13%)**	**(31,008)**	**(126%)**

The table below shows the position on a control total basis. Although the control total has not been accepted, the Trust is obliged to report against this on a monthly basis to NHSI.

Deficit on a control total basis - reportable to NHSI:								
Surplus (deficit) after tax and Donated Asset Additions	*(53,575)*	(57,599)	(50,949)	(24,584)	(6,650)	(13%)	(33,015)	134%
Remove: Donated Asset Additions	*(1,425)*	(1,033)	(1,255)	(1,642)	222	(18%)	609	(37%)
Add back: Donated Depreciation	*807*	781	749	625	32	4%	156	25%
Adjusted financial performance surplus/(deficit)	***(54,193)***	**(57,851)**	**(51,455)**	**(25,601)**	**(6,396)**	**(12%)**	**(32,250)**	**126%**
CONTROL TOTAL	***10,683***	**8,001**	**8,001**	**3,462**		**0%**	**4,539**	**131%**
Performance against control total	***(64,876)***	**(65,852)**	**(59,456)**	**(29,063)**	**(6,396)**	**(11%)**	**(36,789)**	**127%**

Notes:

Calendar Days	334	334	334
Working Days	232	232	230