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

Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

MEETING OF THE TRUST BOARD IN PUBLIC

FRIDAY 29 JULY 2016

A meeting of the Trust Board in public will take place at 9am on Friday 29 July 2016 in the Boardroom of the Norfolk and Norwich University Hospital

AGENDA

	Item	Lead Director	Purpose	Page No
1	Apologies and Declarations of Interest			
2	Minutes of the Board meeting held in public on 27 May 2016		Approval	**2**
3	Matters arising		Discussion	
4	Chief Executive's Report	CEO	Information	***To Follow***
5	Integrated Performance Report	RP	Information	***11***
6	Risk Management Strategy	EM	Approval	***69***
7	Any other business			

Date and Time of next Board meeting in public

The next Board meeting in public will be at 9am on Friday 30 September 2016 in the Boardroom of the Norfolk and Norwich University Hospital

MINUTES OF TRUST BOARD MEETING IN PUBLIC

HELD ON FRIDAY 27 MAY 2016

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

16/019 **APOLOGIES**

No apologies were received.

16/020 **MINUTES OF PREVIOUS MEETING HELD ON 24 MARCH 2016**

Mr Over asked that the wording in relation to item 16/003 in the Matters Arising section should be amended to replace the word 'sickness' with 'mandatory training' as the sentence should read "...*to exclude from mandatory training reporting* …'.

As amended, the Minutes of the meeting held on Thursday 24 March 2016 were agreed as a true record and signed by the Chairman.

16/021 **MATTERS ARISING**

The Board reviewed the Action Points arising from its meeting held on 24 March 2016 as follows:

16/015(a) Mrs McKay confirmed that the chart of C Difficile cases has been amended to remove the incorrect reference to the ceiling target of 4. The C Difficile ceiling for 2016/17 has remained at 49 cases.

16/015(a) At its meeting in April, the Board was updated on the MRSA bacteraemia that had been reported in the month as follows:

2 hospital acquired MRSA bacteraemias were reported in March. The two cases were unrelated. 1 case related to contamination without MRSA sepsis and the other case related to a central line. A root cause analysis has been undertaken to determine learning outcomes.

16/022 **CHIEF EXECUTIVE REPORT**

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

Mr Davies informed the Board that following a visit to the Trust by Chris Hopson Chief Executive of NHS Providers, there had been national debate concerning increasing demand on the NHS and the level of our national spend on healthcare services. The increasing level of demand on the Trust was highlighted by Chris Hopson in an interview on the Today programme on 20 May. The interview was played to staff at a recent Viewpoint session as an illustration of national issues impacting at a local level.

The Board was informed that we continue to recruit high calibre consultant staff. We are continuing to recruit to vacant consultant posts to reduce reliance on temporary/locum staff. We are also working to convert waiting time initiative work into substantive positions and thereby increase capacity to meet rising demand.

Mr Jeffries asked if the proposal for an Academic Partnership for Norfolk is separate to the Academic Health Science Network (AHSN) of which we are already a part. Mr Davies explained that the AHSN has appointed Dr Steve Feast as its new Managing Director. Dr Feast recently visited the hospital and the Academic Partnership for Norfolk had been one of the ideas that had been discussed.

Concerning the junior doctor dispute, Mr Over informed the Board that junior doctors will vote in the second half of June on the revised national employment contract proposals. Mr Chapman explained that the BMA has written to its members to encourage them to vote in favour of the proposals.

Professor Richardson informed the Board that the NNUH partnership with the UEA Health Sciences School has proved extremely valuable. The School's performance had been rated highly and this puts Norwich in a strong position as we move into the new market for health education. Professor Richardson complimented NNUH on its contribution to achieving this result.

16/023 **INTEGRATED PERFORMANCE REPORT**

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

(a) Quality and Safety

The HSMR in the 12 months to January 2016 is 108. Mr Chapman explained that the report now shows HSMR on a 12 month rolling basis, which should result in less 'month by month' variation. It was noted that the indicator for HSMR on the IPR summary slide is listed as being 'compliant' and this will be reviewed.

Action: Mr Chapman

Mr Chapman tabled a draft of the reporting metrics that will be included in future IPRs to monitor progress towards achieving our 2016/17 Quality Priorities.

One insulin medication error was reported in April but this was not classified as having caused harm or having the potential to cause harm. It is difficult to determine whether the decrease in insulin errors is connected to the introduction of the EPMA system but it is expected that this will become clearer in due course. Focus will continue on increasing reporting of errors so that systems and processes can be continually improved.

3 Serious Incidents were reported in April. 1 Never Event reported in April concerned a retained guidewire following central venous line insertion. This occurred in the context of an emergency life-saving procedure.

Mrs McKay reported that 9 patients acquired a Grade 3 pressure ulcer whilst under our care in April. We continue to admit a significantly high number of patients with existing pressure ulcers from the community (243 in April), indicating a population susceptible to such problems.

A detailed analysis is undertaken to look at any themes arising out of pressure ulcer cases. The average age of patients was found to be 86, in a range of 61-96 years. The average length of stay for patients was 5-6 weeks and 100% of patients had co-morbidities. 37% of patients were in the last stage of life and therefore particularly prone to developing skin lesions. No common themes between cases were identified, other than prolonged length of stay and incomplete documentation.

Miss Smith asked for clarification concerning those pressure ulcer cases where no contributory factors are identified. Mrs McKay explained that where documentation is incomplete then this is interpreted as indicating that all the appropriate inputs had not been completed but this is an issue of documentation rather than practice to be changed.

1 patient fall was reported as having caused harm in April and a Root Cause Analysis is being undertaken to determine learning outcomes.

Slide 8 on the NHS Patient Safety Thermometer has been revised to focus on those metrics that the Trust can influence. In April 2016 our performance was better than the national average for falls with harm; new VTEs and new harms. We were worse than the national average in relation to new pressure ulcers, catheters and UTIs.

Mr Chapman informed the Board that a Recognise and Respond Committee has been established and Dr Michael Irvine (Consultant Anaesthetist) is chairing the Committee. In addition to its work reviewing the care of the deteriorating patient the Committee will also be looking at DNA CPR processes in the Trust.

Following a self-assessment exercise against the NCEPOD best practice guidelines for major lower limb amputations, a new risk with a rating of 15 has been added to the Risk Register. The issue concerned the lack of a specialist MDT around limb amputation and it is expected that, when this MDT has been established, this risk will be removed from the Risk Register.

The Board was informed that a positive test result for Legionella has been received in relation to a room in Coltishall Ward following analysis at a commercial laboratory. Subsequent testing through a Public Health laboratory has been negative and Serco have been asked to use only Public Health laboratories for this type of testing in future.

The inpatient Friends and Family Test (FFT) score was 96% in April. The response rate has increased significantly and the new web-based service is providing more detailed patient feedback. Further work needs to be undertaken to capture increased response rates from the Emergency Department.

Mr Fry asked what themes had been identified in the feedback from the ED FFT. Mrs McKay explained that most concerns relate to waiting times and the environment within the ED. A further analysis of FFT feedback in A&E will be undertaken to identify themes and issues of concern and the outcome of this review will be provided to the next meeting. **Action: Mrs McKay**

In order to improve the quality of care provided at the end of life, documentation and individualised care plans have been produced. A Dashboard is being developed to monitor workload and performance against the End of Life Care Strategy.

Discharge processes have been improved following introduction of a new discharge model which has centralised the discharge coordinators and there has been a reduction in the number of long stay patients and delayed transfers of care.

Mrs McKay explained that 42 contract Quality Issue Reports were received by the Trust in April. Analysis is undertaken to identify any particular themes and the issue raised most frequently in April concerned delays in GPs receiving electronic discharge letters.

It was noted that the previous year data provided for comparison on Core Slide 14 were for 2014/15. As we are now reporting in 2016/17 the figures for 2015/16 should be provided and Core Slide 14 will be updated to reflect this for the next meeting.

Action: Mrs McKay

The average length of time to respond to call bells during the day and night were provided for the new call bell system which has been implemented on a number of wards. Mrs McKay explained that work is ongoing to implement the new system on all wards.

(b) Effectiveness

The Board was informed that the review of each case to determine the correct figure for recruitment to research studies is still ongoing and until this has been completed, it will not be possible to determine if there will be a reduction in funding for 2016/17.

The clinical audit plan for 2016/17 has been approved and has been informed by external report recommendations and national audit requirements. Each Division will closely monitor audit progress.

We achieved a 96.3% data submission to TARN (target 80%). We achieved the best TARN survival rates in the region for 2012-2015 and second in the region for the TARN survival rate for Q1-Q3 in 2015.

(c) Performance

Performance towards the cancer targets continues to show an improvement but remains below the 85% target. In April, the 62 day target performance was 82.5% and the 31 day target performance was 87.6%. The lung and prostate patient pathways are being redesigned in order to remove delays from existing processes.

A&E 4 hour target performance continues to improve and has been better than the national average. In April performance was 85.5% against the 95% target. The discharge team has been focused on reducing the number of patients awaiting discharge and the number of patients who have waited for discharge longer than 2 weeks has reduced from 300 to 200 patients (target 150 patients). Recruitment of additional Emergency Department Consultants continues and clinical leadership is showing signs of improvement. Our performance improvement has been greater than that achieved by peers.

There remain significant capacity challenges in relation to 18 week RTT performance. Additional work is being undertaken with other providers in Norfolk to source additional capacity.

Performance against the indicator for stroke patients admitted to a HASU within 4 hours was 79% in April (target 90%). The target was not achieved due to lack of bed availability on the Stroke Unit. The percentage of patients with access to a brain scan within 60 minutes was 89% in April. Processes are being reviewed with the aim that stroke patients are flagged before they arrive at the hospital and to improve communication regarding stroke patients between the ED and Radiology Department.

Mr Fleming asked about how our stroke service fits within the county-wide service. Mr Parker explained that all three Norfolk acute hospitals offer acute stroke services. The NNUH service is one of the largest in the country and it is well rated. We are encouraging clinicians to work together across the three sites and the topic of how stroke services should be configured across the County is on the agenda of the NPP.

Mr Davies indicated that the two stroke metrics that appear to be most important in indicating timely care are the 'time to brain scan' and the 'door to needle time'. These have an obvious implication for quality of service and it was agreed that the Quality and Safety Committee should look at stroke performance at its next meeting on 15 June. **Action: Mr Garside**

Mr How asked how other parts of the system are assisting in helping return operational performance to a more sustainable position. Mr Parker confirmed that NHS England are in agreement that recovery of performance will only be achievable through system-wide action. Daily discharge teleconferences with our partner organisations have been put in place to raise any issues and ensure that actions are taken. Work is ongoing to reduce the number of patients in the formal delay process.

Mr Jeffries requested for the trajectory line be inserted in the graphs on Core Slide 23 and this change will be reflected in the IPR for June. **Action: Mr Parker**

Mr Fry noted that the 18 week RTT admitted backlog has increased and asked what action was being taken to address this. Mr Parker explained that recovery will depend on sourcing additional temporary capacity until more substantive capacity is in place. Efficiency of theatres will be a key factor and capacity is being increased through extended working hours and weekend working. The number of patients in the admitted backlog currently includes day case procedures and this will be separated to provide more clarity. **Action: Mr Parker**

Mr Parker informed the Board that 75% of patients on the RTT backlog are awaiting day case procedures. A clinical review group has been reviewing patients in each specialty to ensure that patients are being properly prioritised according to their clinical need. As necessary, additional capacity will be purchased from insourcing providers and discussions with our system partners will give consideration to utilising facilities at other trusts in Norfolk to aid recovery of performance in specialties with particularly high demand.

(d) Workforce

Mr Over informed the Board that Core Slide 32 had been produced to provide the monthly agency expenditure by staff group. Plans under the Cost Improvement Programme have been identified to reduce expenditure on pay and this was £700k less than that spent in month 1. Overall pay spend has remained in line with the Plan.

One of the strategies in implementation is 'tiering' of nurse agencies, to prioritise use of less expensive agencies.

Mr How questioned the implications of the figures on pay spend and asked about the process for constructing the plan. If spend is in line with plan, but agency usage is

high this suggests that we are 'short of staff' because temporary staff are expensive. Mrs Budd explained that the plans were established through the budget planning process, incorporating CIP plans, aimed at reducing workforce expenditure from 2015/16 levels. Mrs McKay explained that we know that there are a percentage of shifts that cannot be filled because staff are not available to fill these but the site teams ensure that the available staff are allocated to safeguard safety.

Mrs Robson expressed concern that we are not going to achieve the CIP in this area based on current performance. Mrs Budd explained that increased levels of information are being made available to aid monitoring, detailing those areas that are over or underspent and whether expected levels of activity are being delivered. CIP delivery can be tracked in this way.

Mr Fry asked whether we are going to achieve the forecast of £1.5m for agency spend in May as detailed in Core Slide 32. Mr Over explained that that information is not available yet. Mr How emphasised that the timeliness of management information must be improved. Mr Fry stressed that the Executive need to ensure that there is visibility not only of spend at least on a weekly basis but then also prospectively – so that intervention can be made if appropriate to control overspending. Development of timely management information on temporary staffing spend is a crucial underpinning element of the 2016/17 CIP plans and the Board will be updated at its next meeting on progress in producing management information to enable appropriate control over pay spend. **Action: Mr Over**

Mr Jeffries asked if it is clear where overall control for temporary staff spend sits. Mr Over explained that responsibility for managing the booking process for locum doctors rests with his team. The great majority of agency spend however relates to clinical staff, based on clinical circumstances. The professional leads are able to properly advise on need in relation to safe staffing and clinical staffing at premium rates is approved by the Divisional Nursing Directors.

Mr Over will circulate the 'on a page' summary of the process for authorisation and control of booking of temporary staff. **Action: Mr Over**

Mr Fleming asked about the timeframe for booking agency staff and the cost advantages/disadvantages of booking agency staff some weeks in advance. It was explained that there is a balance to be struck; bookings at very short notice are typically very expensive. Booking some weeks in advance, whilst offering certainty over clinical cover, is discouraged as it is counter to the drive to fill rota gaps by using Bank or substantive staff whenever possible. Where it is necessary to use agency staff we endeavour to use those agencies with the most favourable rates.

(e) Finance

Mrs Budd explained that the financial position at the end of month 1 was £144k behind Plan. The main factor contributing to this was clinical income which was £101k behind Plan. Early indications for May are positive for income. In April, clinical income benefited from the discharge of a number of long stay patients in NICU and Critical Care.

Pay spend in April was under plan by £191k. Plans to reduce pay under the Cost Improvement Programme anticipated delivery of savings of £800k but achieved only £300k. Areas which overspent on pay were Medicine (£0.4m) and Emergency (£0.4m).

The closing cash balance at the end of month 1 was £1.4m ahead of Plan. This was due to short term timing differences in VAT, agency/locum pay costs, Clinical

Excellence Awards and underspend on capital. The closing cash balance is expected to be in line with the Plan in May.

Without financial support, we are projected to run out of cash in November 2016. A formal process to apply for funding support has not yet been agreed by NHS Improvement. The Trust is required to submit a monthly forecast return and a 13 week forecast cycle is being developed. This month's return confirms that there is no change to our forecast.

Mr Parker noted the positive indication on income against Plan, notwithstanding the 3% growth assumed and the 4 days of industrial action by the junior doctors in the period.

Mr Fry asked for a cash flow forecast to be provided to the Board with and without financial support and Mrs Budd will include this in the IPR in future. **Action: Mrs Budd**

16/024 **RESPONSE TO STAFF SURVEY**

The Board received a presentation from Mr Over concerning our response to the 2015 Staff Survey. Mr Over explained that the key elements of this response had been shared with staff at the monthly viewpoint session.

The Board was reminded that the Staff Survey was conducted in November 2015. 3,250 responses were received (49% response rate) and the results of the survey were published in February 2015.

Miss Smith asked if any further action could be taken to increase the response rate for staff surveys. Mr Over explained that in order to increase the response rate, the survey this year had been sent to all Trust staff, as opposed to a selection of staff. The number of surveys sent to staff had therefore increased from 800 to 3,600. The next survey will be undertaken in October 2016.

Professor Richardson shared the experience of UEA in encouraging responses to the student survey. The response rate of 68% at UEA is amongst the highest in the country. This is achieved through events at which students are encouraged to complete their responses and this is an approach that may be helpful for the Trust to adopt. Mr Chapman explained that the GMC requires all doctors to respond to its annual survey.

Mrs Robson asked if there were any emerging themes arising from the responses given by different staff groups. Mr Over explained that response rates could be affected by the extent to which staff feel engaged and there is variation in response rates between Divisions.

Although the responses in a number of areas have improved, the results of the survey have worsened by 2% or more in a number of areas: experience of harassment, bullying or abuse from colleagues; bullying or abuse from patients/public; communication between senior managers and staff; % of staff who have participated in appraisal; and % staff experiencing discrimination at work. The 'recommendation' rate at departmental level ranges from 100% in some cases to as low as 17% in others.

The results have been shared widely with staff, at Management Board meetings, at Viewpoint sessions and with union representatives at the Joint Staff Consultative Committee and with the Council of Governors.

The results have been analysed to gain a clear understanding of any issues and the results have been used to inform discussion at focus groups. The Divisions have been

asked to consider what we can do together to improve NNUH as a place to work and to identify what help is needed to make that happen. The output from all these discussions is reflected in the proposed response.

Issues that worried staff or that staff felt 'got in the way' concerned staffing levels; workload demands; relationships/behaviours between colleagues and in teams; not enough opportunities to meet/see leaders; feeling valued and appreciated; ability to contribute towards improvements and confidence to report safety concerns. Improving recruitment processes has also been identified as an action that would make a real difference to staff.

The Divisions have indicated that they would like organisational support to embed our values in appraisals/recruitment. Divisions would also like support/development for people who manage and lead teams.

Divisions also felt that there should be divisional involvement at the Staff Experience Working Group. This group will focus on projects to improve staff experience using feedback from ongoing discussion from the Divisions. Mr Over informed the Board that a programme of monthly staff awards is being put in place to supplement the annual scheme, and will be sponsored commercially.

Mr How asked whether we invest sufficiently on management training at all levels, including appraisal training. Mr Davies explained that the Divisions are developing and maturing at different rates but that we are increasingly changing the management culture and encouraging staff to take responsibility for taking actions.

At a future meeting the Board will receive information on training for non-clinical staff and any options for this to be improved/enhanced. **Action: Mr Over**

Mr Jeffries suggested that it would be helpful to identify 3 or 4 key things on which we can focus to make a difference about how staff feel about working at the Trust.

Discussion identified an initial list of key issues:

- Potential for career progression;
- Training;
- Appraisals;
- Leadership and management strategy;
- Two-way communication.

It was agreed that a short list of areas for trust-wide focus in response to the Staff Survey will be considered by the Executive and an update provided to a future meeting of the Board. **Action: Mr Over**

16/025 **ANY OTHER BUSINESS**

There was no other business.

16/026 **DATE AND TIME OF NEXT MEETING**

The next meeting of the Trust Board in public will be at 9am on Friday 29 July 2016 in the Boardroom of the Norfolk and Norwich University Hospital.

Signed by the Chairman: …… Date: ……

Action Points Arising:

	Action
16/023(a)	It was noted that the indicator for HSMR on the IPR summary slide is listed as being 'compliant' and this will be reviewed. **Action: Mr Chapman**
16/023(a)	A further analysis of FFT feedback in A&E will be undertaken to identify themes and issues of concern and the outcome of this review will be provided to the next meeting. **Action: Mrs McKay**
16/023(a)	As we are now reporting in 2016/17 the figures for 2015/16 should be provided and Core Slide 14 will be updated to reflect this for the next meeting. **Action: Mrs McKay**
16/023(c)	It was agreed that the Quality and Safety Committee should look at stroke performance at its next meeting on 15 June. **Action: Mr Garside**
16/023(c)	Mr Jeffries requested for the trajectory line be inserted in the graphs on Core Slide 23 and this change will be reflected in the IPR for June. **Action: Mr Parker**
16/023(c)	The number of patients in the admitted backlog currently includes day case procedures and this will be separated to provide more clarity. **Action: Mr Parker**
16/023(d)	Development of timely management information on temporary staffing spend is a crucial underpinning element of the 2016/17 CIP plans and the Board will be updated at its next meeting on progress in producing management information to enable appropriate control over pay spend. **Action: Mr Over**
16/023(d)	Mr Over will circulate the 'on a page' summary of the process for authorisation and control of booking of temporary staff. **Action: Mr Over**
16/023(e)	Mr Fry asked for a cash flow forecast to be provided to the Board with and without financial support and Mrs Budd will include this in the IPR in future. **Action: Mrs Bu**
16/024	At a future meeting the Board will receive information on training for non-clinical staff and any options for this to be improved/enhanced. **Action: Mr Over**
16/024	It was agreed that a short list of areas for trust-wide focus in response to the Staff Survey will be considered by the Executive and an update provided to a future meeting of the Board. **Action: Mr Over**

Integrated Performance Report

July 2016 (June data)

Core Slide 1

IPR Summary – June 2016

		Jun-16	Target
Quality	Serious Incidents (incl. grade 3 pressure ulcers)	8	n/a
	Grade 3 pressure ulcers	0	0
	Grade 4 pressure ulcers	0	0
	MRSA	0	1
	C. difficile Cases	0	4
	Patient falls causing harm	2	n/a
Performance/ Productivity	Cancer 2 WW - all	99.3%	93.0%
	Cancer 31 day target compliance	96.6%	96.0%
	Cancer 31 day target - ACD	100.0%	98.0%
	RTT Non-admitted Backlog	2106	2182
Workforce	Vacancy Rate (maximum)	9.7%	10.0%
	% unregistered care staff day hours filled as planned	112.4%	n/a
	% unregistered care staff night hours filled as planned	123.4%	n/a
	Staff recommendation of NNUH as place to receive care	77.00%	n/a
Finance			

	Jun-16	Target
Grade 2 pressure ulcers	11	0
Patient FFT scores inpatients	94%	100%
HSMR (March 2016)	111.1	100.0
Cancer 62 day target - GP Referral	78.2%	85.0%
18 week RTT target - incomplete	87.5%	92.0%
A&E four hour compliance	88.9%	95.0%
RTT Admitted Backlog	2843	2692
Monthly Average DTOC	54	30
Non-Medical Appraisals Completed	61.0%	90.0%
Staff Turnover	10.5%	10.0%
Planned deficit - cum	£9.257m	£8.979m
In month deficit (£2.8m) being on plan		
CIP – Pay (cum)	£1.2m	£2.7m
CIP – Non-Pay (cum)	£0.8m	£0.8m
Pay (cum)	£80.9m	£79.9m
Pay adverse variance of £1.0m		

Core Slide 2

Quality and Safety Summary

Quality & Safety		Outturn 2015/16	Monthly Target	Jun-16	6 month trend	YTD 2015/16	YTD 2016/17
Morbidity	Core Slide 3						
1 HSMR		111.08	100	111.08		112.16	#N/A
2 Deaths / 100 discharges		15.3	n/a	1.4		3.3	4.3
Incidents	Core Slide 4-5						
3 Serious Incidents		154	n/a	8		33	36
4 Incident Reporting		15499	n/a	1254		3652	4057
5 Zero insulin errors causing NPSA category moderate harm or above		3	n/a	1		0	2
6 Medication Errors			0	128		295	352
7 Patient Falls causing moderate harm or above		42	n/a	2		10	10
8 Never Events		5	0	0		0	2
Pressure Ulcers	Core Slide 6						
9 Grade 2 hospital acquired pressure ulcers		151	0	11		34	35
10 Grade 3 hospital acquired pressure ulcers		58	0	0		13	12
11 Grade 4 hospital acquired pressure ulcers		3	0	0		3	1
Infection Control	Core Slide 7						
12 HAI C. difficile Cases (excluding non-trajectory and pending cases)		32	4	0		6	3
13 Zero Hospital Acquired MRSA bacteraemia		2	0	0		0	0
Other			n/a				
14 EDL to be completed within 24 hours in 95% of discharges		74.01%	95.00%	69.52%		74.93%	69.13%
15 Harm Free Care		91.18%	n/a	91.20%		90.60%	91.60%
16 100% patients in all areas report through FFT that they are satisfied or very satisfied		90.92%	100.00%	94.29%		84.33%	95.61%
17 Complaints		933	n/a	91		217	258

(HSMR reported three months behind)

Key points:

- HSMR 111 (higher than expected) / SHMI 104 (as expected)
- CQC mortality review visit planned for 2-3/8/2016
- CQC awareness of IRU risk
- Increased data collection against quality priorities. Sepsis and thrombosis reporting arrangements agreed but not yet in place for Q1

Core Slide 2a

Quality Priorities – Patient Safety

Quality Priorities - Patient Safety	Measure	Lead	Outturn 2015/16	Monthly Target	Jun-16	6 month trend	YTD 2015/16	YTD 2016/17
Reduction in medication errors	Zero insulin errors causing NPSA category moderate harm or above	Peter Chapman	3	n/a	1		0	2
Prompt recognition and treatment of sepsis	Target to align with CQUIN criteria (% of patients screened. And % of patients treated)	Peter Chapman	0.00%	0.00%	TBC		0.00%	0.00%
Keeping patients safe from hospital acquired thrombosis	95% compliance with TRA assessment as evidenced on EPMA. (and audit of appropriate actions)	Peter Chapman	0.00%	0.00%	TBC		0.00%	0.00%
Incident reporting and management	Remain within top 25% of acute trusts for incident reporting on NLRS with 100% compliance with Duty of Candour	Peter Chapman		100.00%	100.00%			100.00%

Quality Priorities – Patient Experience

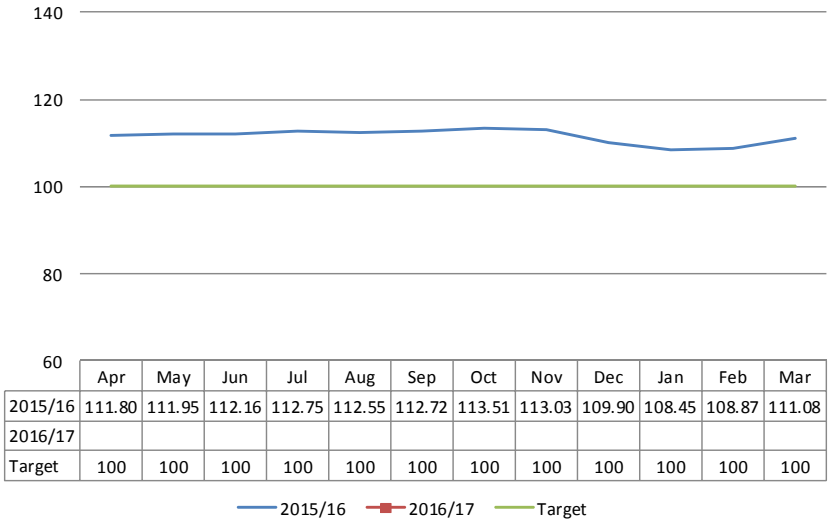
Quality Priorities - Patient Experience	Measure	Lead	Outturn 2015/16	Monthly Target	Jun-16	6 month trend	YTD 2015/16	YTD 2016/17
Treat Patients with privacy and dignity	100% patients in all areas report through FFT that they are satisfied or very satisfied	Emma McKay	90.92%	100.00%	94.29%		84.33%	95.61%
Dementia Friendly/Mental Capacity/Learning Disability	2015/16 CQUIN criteria	Emma McKay	0	0	TBC		0	0
Improved continuity of care and experience through reduced ward moves and reduced numbers of outliers	No more than 20 patients recorded as boarders. Montly average	Richard Parker	523	20	39		102	155
Improved discharge processes	EDL to be completed within 24 hours in 95% of discharges	Richard Parker	74.01%	95.00%	69.52%		74.93%	69.13%

Quality Priorities – Clinical Effectiveness

Quality Priorities - Clinical Effectiveness	Measure	Lead	Outturn 2015/16	Monthly Target	Jun-16	6 month trend	YTD 2015/16	YTD 2016/17
Acute Kidney Injury -Communication with GPs	EDL to contain evidence of required communication as judged by CQUIN criteria	Peter Chapman	0	0	TBC		0	0
Keeping patients safe from infection	HAI C. difficile Cases (excluding non-trajectory and pending cases)	Emma McKay	32	4	0		6	3
Keeping patients safe from infection	Zero Hospital Acquired MRSA bacteraemia	Emma McKay	2	0	0		0	0
Improve quality of care through research	Year on year increase in patients recruited into research studies. Aim to achieve 5000 recruitment into NIHR studies 2016-17.	Peter Chapman	412	5000	99		0	648
Timely medical review of all patients	% of Patients with a Senior Review recorded by 12:00	Richard Parker	0	0	TBC		0	0
Timely medical review of all patients	Average number of patients with LoS >14 days	Richard Parker		200	214			

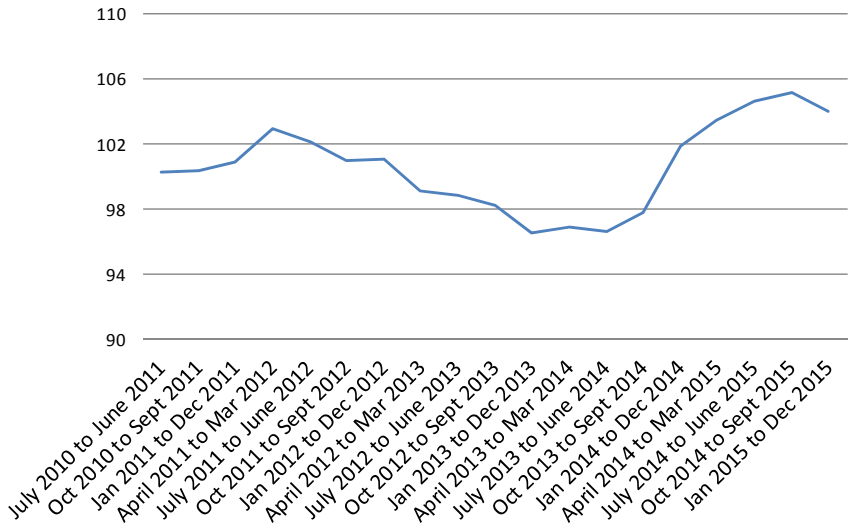
Core Slide 3 — Quality & Safety (Morbidity) – Lead Director Peter Chapman

HSMR



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	111.80	111.95	112.16	112.75	112.55	112.72	113.51	113.03	109.90	108.45	108.87	111.08
2016/17												
Target	100	100	100	100	100	100	100	100	100	100	100	100

SHMI

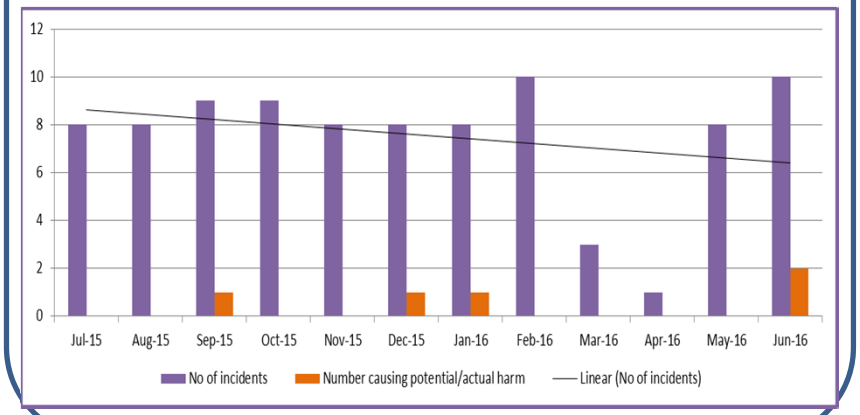


1. HSMR is the risk adjusted ratio of observed to expected in-hospital deaths within 56 clinical groups.
   - Individual months HSMR figures are subject to significant change due to rebasing by Dr Foster so the chart above represents the reported HSMR for each year prior to the month in question. For the year to March 2016 this was 111 – higher then expected. The elevated risk alerts are unchanged from previous months – neoplasm / perinatal conditions / pneumonia / fractured neck of femur and these receive scrutiny through the mortality committee. Pneumonia audit in >80 underway and will report September 2016. Combined orthogeriatric review meeting of the fractured neck of femur pathway arranged.
2. SHMI is the ratio between the actual number of people who die following hospitalisation at a Trust and the number who would be expected to die on the basis of England average figures given the characteristics of patients treated there
   - SHMI is above 100 for the year to Dec 2015 (104.0) and is within the expected range.
3. Information Services are working to produce a more complete mortality report using SHMI data rather than Dr Foster.
4. Mortality template revision in place for 2 months with good return rate in many specialities though lower in some high volume specialities – OPM and Respiratory Medicine. Division will review what is required to improve.
5 Potentially preventable death review process fully established
6. CQC mortality review visit planned 2-3/8/2016.

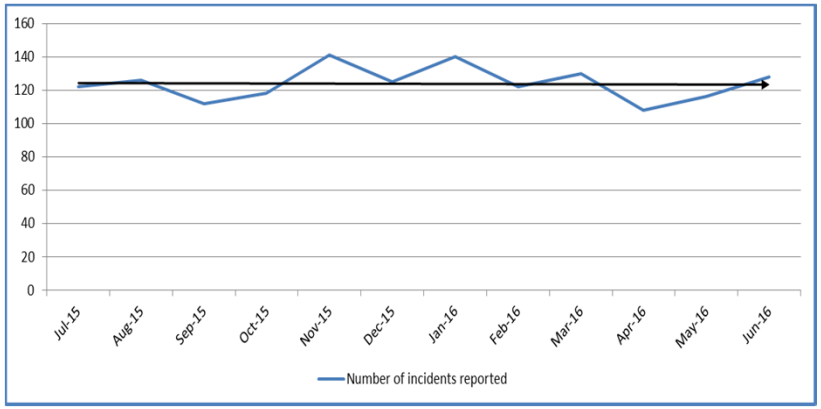
Core Slide 4

Quality & Safety (Incidents) – Lead Director Peter Chapman

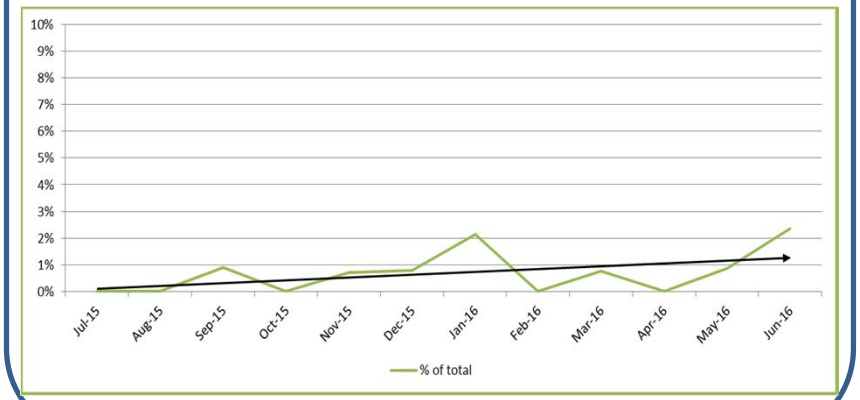
Insulin incidents by month – July 2015 to June 2016



Medication Incidents – July 2015 to June 2016



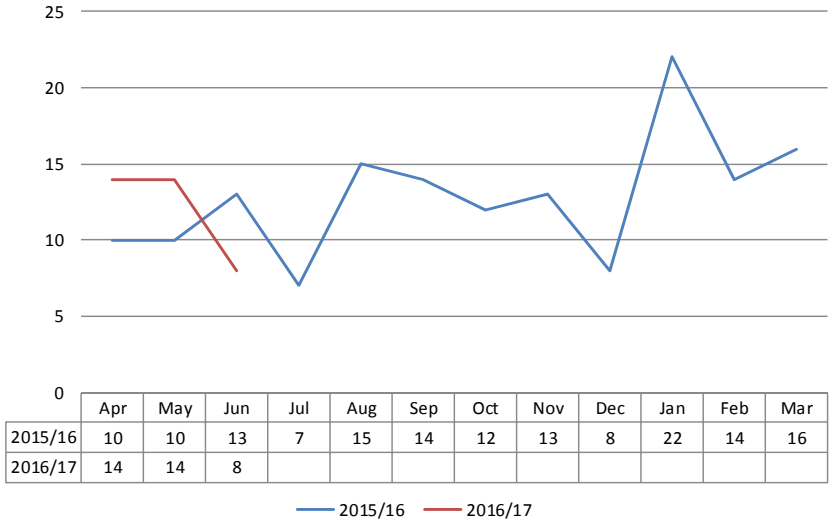
Medication Incidents causing potential/actual harm as a % of total



- We will focus on increasing reporting of medication errors whilst reducing those causing harm and in particular in relation to insulin. This has been agreed as part of our Local Quality Schedule and is an agreed Quality Priority for us for 2016-17.
- The numbers of medication incidents reported over the last year has broadly been constant, as has the small percentage of those rated as causing potential or actual harm
- 10 Insulin related medication incidents were reported in June 2016
- 2 of these insulin incidents are rated as having the potential to cause harm (hypoglyaemic episodes on AMU and EAUS)
- 1 further medication incident is recorded as having caused harm (bleeding following dalteparin administration)

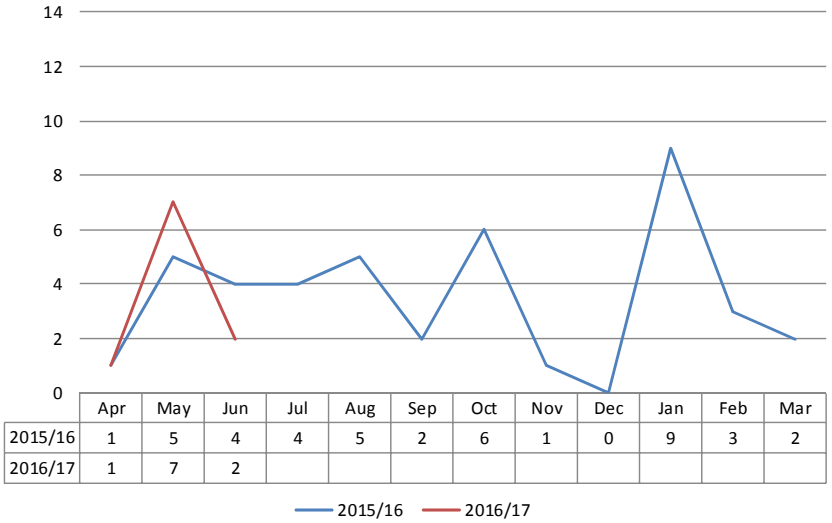
Core Slide 5 Quality & Safety (Incidents) – Lead Director Peter Chapman / Emma McKay

Serious Incidents



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

Patient Falls causing moderate harm or above



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

Serious Incidents and Never Events in June 2016

- There were No Never Event incidents
- There were 6 Serious Incidents reported (in addition to Falls and Pressure Ulcers).
  -1 maternal death (at patients home)
  -1 unexpected neonatal death
  -1 unexpected patient death (Heydon Ward)
  -1 Urethral rupture following catheterisation
  -1 Delay in follow-up (Gastroenterology)
  -1 Delay in diagnosis of cervical spine fracture
  Duty of candour has been confirmed and RCAs are in progress for all.

Falls causing harm

- In June there were **227 inpatient falls**.
- **2** patient falls have been reported to have resulted in the patient sustaining **harm**, both patients suffered **Moderate harm** as a result of sustaining a fracture neck of femur (#NOF). This is a significant decrease from the **7** which were reported in May 2016.

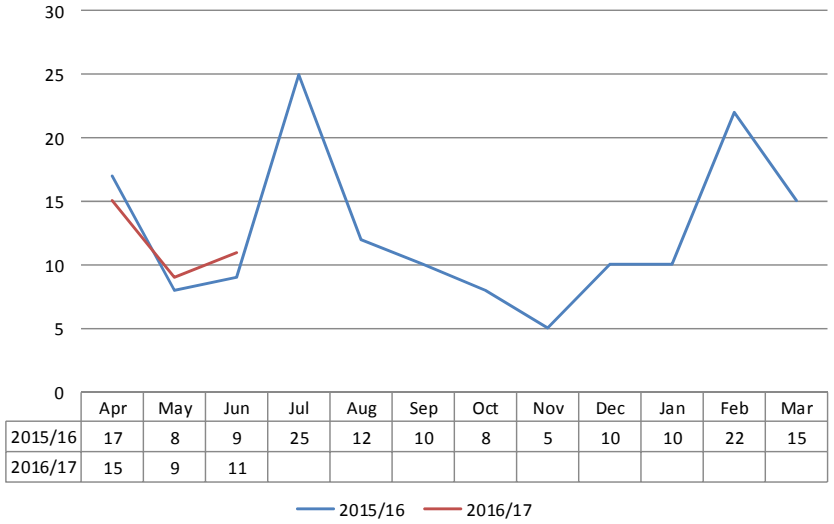
Actions

- All elderly patients with a falls history should have a Laying & Standing BP taken on admission and when clinically indicated.
- Patient in a side room and was not easily visible to staff. Staff to take into consideration the risk of injury from falls and assess this against the risk of why the patient is in a side room – if necessary review and discuss with specialist teams i.e. IP&C.

Core Slide 6

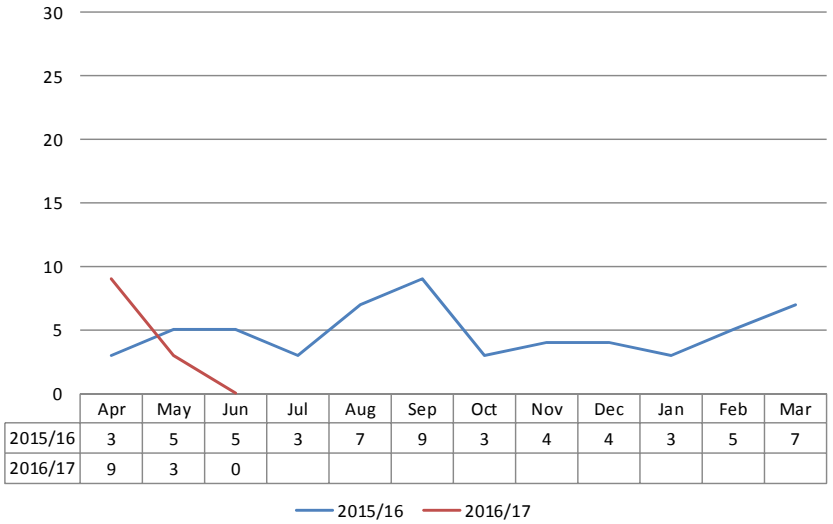
Quality & Safety (Pressure Ulcers) – Lead Director Emma McKay

Grade 2 hospital acquired pressure ulcers



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

Grade 3 hospital acquired pressure ulcers



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

Issues

No patients acquired a Grade 3 Pressure Ulcer whilst in our care in June. This is a significant decrease with 0 Grade 3 hospital acquired pressure ulcers for 7 weeks.

Root cause analysis (RCA) investigations have been completed for the **11 patients** who developed a Grade 2 pressure ulcer during our care in June.

Root cause analysis investigations have identified that **8** of these pressure ulcers were avoidable and that **3** were unavoidable.

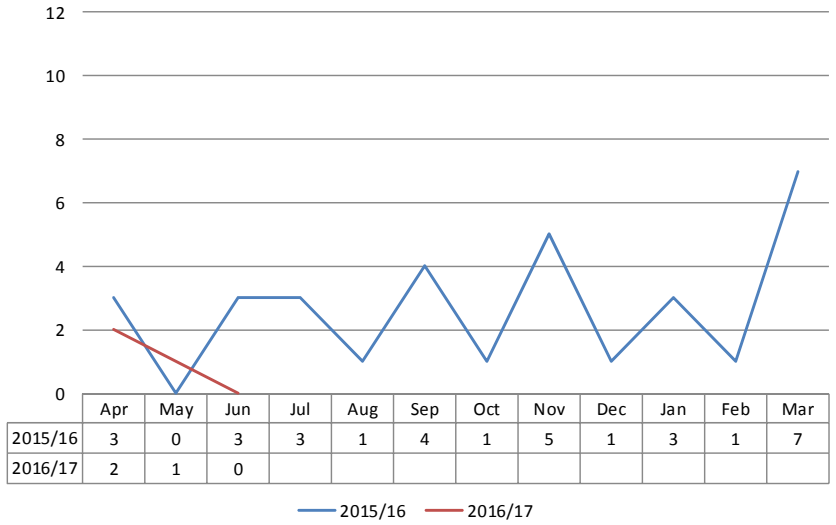
Actions

- Staff have been asked to ensure that patients who are identified as being at risk of developing a pressure ulcer are nursed on a pressure relieving mattress as soon as possible
- Staff have been asked to ensure that patients who are receiving oxygen therapy via a face mask have regular checks of the face mask to ensure that the elastic which holds the mask in place is not held tightly / causing pressure against the skin on top of the ears.

Core Slide 7

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

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



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

Issues

The 2 pending cases of hospital acquired C. difficile from May have been reviewed.1 case was deemed to have lapses in care therefore classed as trajectory, 1 case was classed as non-trajectory (no lapses in care).

4 cases of C. difficile were identified as hospital acquired in June. 1 case deemed non-trajectory and 3 cases are pending awaiting the next post infection review meeting.

Actions

Teams are reminded to be vigilant in isolating patients in a side room at onset of symptoms and to comply with the Hand Hygiene policy & five moments of hand hygiene.

Following the post infection review [PIR] meeting with Trust and CCG's representatives each hospital acquired case of C. difficile is:-

	Trajectory	deemed to have lapses in care
	Non-Trajectory	Deemed to have no lapses in care

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

Summary Table		Non-Trajectory	Trajectory	Pending	Total
Quarter	4				
	3				
	2				
	1	4	3	3	10
Year to date		4	3	3	10
2015/16 Total		*24*	*32*	*0*	*56*

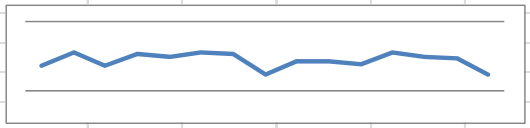
Core Slide 8

Quality & Safety – Lead Director Emma McKay

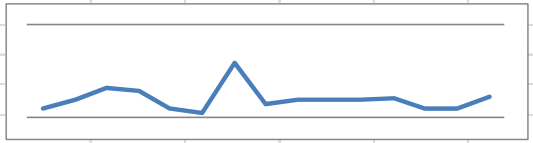
Safety Thermometer Dashboard Comparison Table JUNE 2016

	All Acute		NNUH		Barts Health		Brighton & Sussex		Nott Univ		Royal Free		Royal Liverpool		Sheff Teach		Univ South Man		UCH London	
	Jun-16																			
Pressure Ulcers - New	0.79	711	0.45	4	1.29	22	0.12	1	0.83	12	0.12	1	0.00	0	1.66	22	1.72	14	0.39	3
Falls with Harm	0.38	341	0.45	4	0.41	7	0.12	1	0.07	1	0.49	4	0.42	3	0.45	6	0.26	3	1.29	10
Catheters & NEW UTI's	0.42	379	0.34	3	0.35	6	0.93	8	0.76	11	0.37	3	0.14	1	0.38	5	0.13	1	0.26	2
New VTE's	0.59	533	0.45	4	1.17	20	0.23	2	1.52	22	0.37	3	1.82	13	0.91	12	0.12	1	0.77	6
New Harms	2.13	1925	1.58	15	3.21	55	1.40	12	3.04	44	1.34	11	2.38	17	3.40	45	2.34	21	2.71	21
No. Pt's in sample	90317		889		1711		857		1445		818		713		1232		812		775	

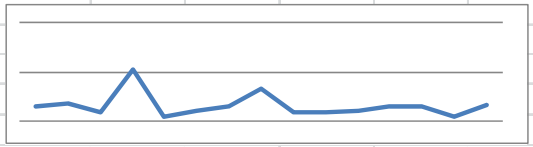
Pressure Ulcers - New



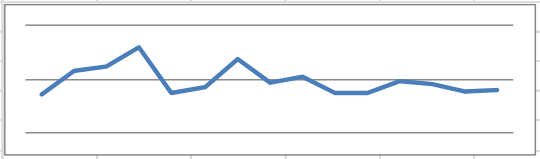
Falls with Harm



Catheters & New UTI's



New VTE's



New Harms

- The above table shows comparative performance of NEW harms reported during June at the NNUH against eight other acute Trusts nationally.
- The NNUH New PU rate for June has fallen again this month for the third month in a row. This is due to a significant decrease in the number of Grade 3 HAPU which have been reported at the Trust over the last six weeks with 0 patients developing a Grade 3 HAPU during this time. The number of patients developing a Grade 2 HAPU has also fallen during this period.
- The graphs show the trend line for each of the New harms as reported by NNUH over the last 12 months.

Core Slide 9

Quality & Safety – Lead Director Peter Chapman

Issues arising from the Safety Sub-Board

Recognise and Respond Committee

- This new committee has good engagement from consultants, resuscitation officers, nurses, ODPs and junior doctors. It focuses on
  - The management of the acutely deteriorating patient
  - Resuscitation processes
  - DNA-CPR
  - Sepsis management
- The Safety Board agreed recommendations to
  - Adopt a redesign of our DNA-CPR form to comply with CQC requirements
  - Include DNA-CPR training within annual resuscitation training for clinical staff
  - Introduce an emergency 2222 'sepsis emergency' pathway across the Trust
  - Investigate the potential for including sepsis awareness within mandatory training for clinical staff groups
  - Introduce a "recognise and Respond" OWL to allow dissemination of learning across the Trust

Eastern Pathology Alliance

- EPA is a managed pathology service comprising laboratory haematology/blood transfusion, clinical biochemistry/immunology, and medical microbiology/virology at NNUH, JPUH, and QEHKL.
- An EPA board meets three monthly under the chairmanship of the JPUH chair and with CEO membership from each of the three Trusts. Key issues are also reported to the Safety Board.
- The service is expecting UKAS inspection to new ISO15189 standards on 12-30/9/16. Discussed at EPA board 20/7/16 and required actions to increase preparation for this inspection agreed.

Core Slide 10

Quality & Safety – Lead Director Peter Chapman

Issues arising from the Safety Sub-Board

Policy / Guideline / Terms of Reference approvals
- Trust Guideline for "Assessment of Mental Capacity and Decision Making for People Lacking Capacity" approved

Risk Register - Safety
- The CSSB reviews in detail all relevant risks 12 and above and seeks assurance that all risks are current and appropriately updated.
- Medical and Emergency department risks reported to have been updated but require entering onto risk register

Divisional Board Reporting by exception
- Medicine. Risk in relation to non-compliance against NICE guidance in relation to the diagnosis of gestational diabetes mellitus is raised. A risk assessment from the team is required and will be followed up.
- A reduction in timely dispatch (~80% to ~65% within 24 hrs) of electronic discharge letters within Women and Children was noted and action required.

CQC action plan
- Safety Board reviewed those CQC actions for which it has oversight and which are still outstanding.

WHO theatre checklist compliance
- Consistently at 100% in most theatres and procedure rooms including Cromer Muriel Thoms Unit where CQC concerns had been raised.

Core Slide 11

Quality & Safety – Lead Director Peter Chapman

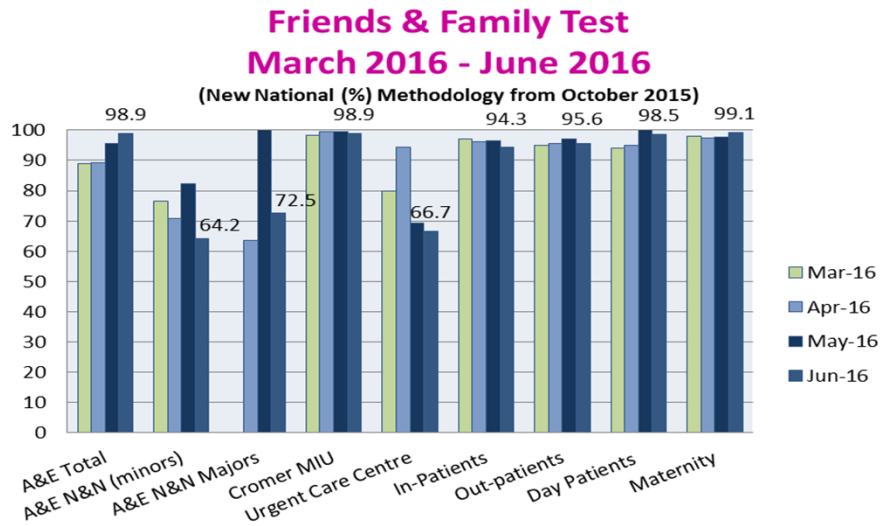
Maternity Dashboard 2016-17

Maternity Dashboard 2016/17		Norfolk and Norwich University Hospitals NHS NHS Foundation Trust															
		Measure	Goal	Red	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Women Delivered	Number of women	Number of women	≤526	≥559	491	526	461										1478
Caesarean Sections	Total rate (elective & emergency)	Caesarean section births % of all deliveries	≤ 25.5%	>27.6%	26.7%	29.5%	28.4%										28.2%
Induction Rates		% of all deliveries	≤26.4%	≥29%	28.9%	29.5%	27.5%										28.6%
No. Black Alerts when women diverted		Number of occassions	0	≥1	0	1	2										3
Number of women diverted when on Black Alert		Number of women diverted			0	4	2										6
Midwife : Birth Ratio inc. band 3 MCA's (funded)	Midwife : Birth Ratio inc. band 3 MCA's (funded)	Ratio	≤1:28	>1:30	1:30.6	1:30.6	1:30.6										
Unplanned NICU Admissions at Term >24hrs requiring ventilation	Unplanned NICU Admissions at Term >24hrs requiring ventilation	Number of babies			0	0	1										1
Number of SI's	Number of SI's	Number per month	0	≥1	0	0	1										1
3rd & 4th Degree Tears	3rd Degree Tears	% of all deliveries	<3.5%	>5%	2.44%	2.47%	1.74%										2.22%
All Stillbirth excluding TOP≥24wks & Severe Anomalies	excluding TOP≥24wks & Severe Anomalies	Number of babies			0	1	3										4
Undiagnosed Breech at Term	Term, Singleton, Breech diagnosed in labour	Number of women			Data reuired not yet agreed												0

- The department was closed on two occasions. In May there was 1 closure and 4 women were transferred to neighbouring units
- The top three indications behind the increased elective caesarean section rate were previous CS, multiple pregnancy, and breech presentation.
- Note that the Midwife to Birth ratios remain higher than recommended following a review of the previous erroneous calculation and will be the subject of urgent review by the new Head of Midwifery.
- The single stillbirth in May 2016 was classified as CMACE 1. There were 3 stillbirths in June 2016. Classification decision awaited.

Caring and Patient Experience

Core Slide 12



Patient Feedback

- During June 2016, **2265** responses were received from our patients (compared to 2065 responses in May 2016).
- Overall Trust-wide in-patient performance was 94% in June 2016
- Performance is other areas: A&E total 85%; Inpatients/Day Patients 99%; Maternity 99%; Out-Patients 96%

Patient Opinion & NHS Choices

- From 1st April 2016 to the end of June 2016 there have been 19 comments left on the Patient Opinion website. For June, four comments were about the N&N and none for Cromer Hospital.
- In June 2016 on the NHS Choices website , two patients commented on services at the Cromer Hospital giving the highest rating of five stars. Four patients commented on services at the N&N and two gave a rating of five stars.

Learning Disabilities & Autism

Work has been ongoing to develop services to individuals with learning disabilities and autism including:

- further standardisation of clinical intervention pathways training
- cross-department support for promotion of individual accountability relating to legislation
- support for in-development Quality Standards
- alternative/augmentative communication
- mortality review

Specific other areas of development and improvement led by the Learning Disability (LD) team include:

- Due to a number of inappropriate referrals, the team is **reviewing the referral categories** for LD liaison intervention to better support those requesting intervention to more clearly identify their needs, and the LD liaison team in prioritising workload.
- The LD liaison team is looking to **purchase various alternative/augmentative communication aids** to support those patients whose communication needs require this.
- Learning Disability Mortality review has already been added to agenda of the Mortality Committee. Recommendation for the Trust to be in a position, proactively, to **name a lead individual to coordinate LD mortality reviews** once the Learning Disabilities Mortality Review (LeDeR) programme comes into effect, and to further consider methods of recording and examining data relating to LD mortality

Patient Advice & Liaison Service

- A total of **300** PALS queries were received in June 2016. The percentage closed within 48 hours was **85%**.
- The two most frequent areas requiring action (excluding General Queries (44) and Thank You/Best Wishes Message (37) were **Clinical Treatment** (total 45) and **Appointments** (35)

Caring and Patient Experience

Core Slide 13

Voluntary Services

- Currently approximately **675 volunteers** are placed on seven sites throughout the Trust (NNUH, Cromer, NCH, Rouen Road, Cotman Centre, Health Records, Henderson Unit)

Volunteer roles have been established in the following areas:

- Wards (general housekeeping, patient companions)
- Clinics (patients escorts, errand running, refreshments)
- Administration (filing, photocopying, pack making etc)
- Reception (way finding, car park validation)
- Meet & Greet (way finding, patient escorting, wheelchair pushing)
- Bleep Buddies (general "ad hoc" duties for staff support)
- Meal time assistants (feeding patients following specialist training)
- Patient Experience (ipad surveys, telephone surveys, card surveys)
- Therapeutic Care (gentle relaxation massage)
- Specialist roles (football highlights, singing)
- Woodland Wellbeing Walk (land clearing around the perimeter of the site)
- External Support Groups (St Johns, HRN, NNAB, UNKPA etc)

Complaints

- **92 complaints** were received in June 2016 compared to 65 in June 2015
- The majority of complaints (63%) related to treatment provided in May and June 2016. Three complaints related to treatment provided over one year ago
- As with previous months**, communication is the largest theme**.
- 11 of 12 complaints received about A&E relate to **clinical treatment**. All will be discussed at the A&E department's Clinical Governance meeting to identify learning and lessons to take forward.
- Appointments including **delays and cancellations**, returns as a top five subject of complaint in June.
- The number of complaints **relating to discharges** does not follow the national trend and **has fallen over the last three years**. Notwithstanding the reduction, there are still a significant number of complaints relating to the hospital discharge arrangements and these accounted for 5% of all complaints last year.

Quality Assurance Audits

- **33 planned QAA audits** including five out of hours (20 supported by external auditors) were undertaken during June 2016
- With a small 3.5% increase from May, findings overall have continued to be positive with **84.5% of standards** audited being rated as either 'good' or 'outstanding'.
- The one 'Inadequate' rating relating to Cleanliness and Infection Prevention and Control in one of our Outpatient Areas was immediately investigated and a plan of action initiated. A minor works process has been expedited to facilitate complete rectification.
- Additional audit tools and processes continue to be developed for Outpatients, with a trial on the 4th July 2016.
- The diversity of the Audit team has broadened with Biomedical Scientists, Therapist and Medical staff

Patient Experience Working Group

- The group had a presentation on the Trust's new *settle in service*.
- Volunteers in the scheme meet patients when they arrive back home to help with tasks such as making sure heat is on, basic provisions are in the house and to do all those things that a relative or neighbour might do if available.
- As well as helping the patient settle back into home it may also help to speed up discharge for patients who may be fit for discharge but do not have support at home.

Local & National Surveys

- ***National Cancer Patient Expérience Survey 2015*** results were published. The survey was designed to monitor national progress on cancer care; to provide information to drive local quality improvements; to assist commissioners and providers of cancer care; and to inform the work of the various charities and stakeholder groups supporting cancer patients.
- Respondents rated their cancer care at the Trust **on average as 8.7** on a scale of 0 – very poor and 10 – very good. High ratings were given for knowing their clinical nurse specialist, knowing who to contact and treated with dignity and respect. GP and practice staff support and involvement with clinical decision making was not rated as highly

Core Slide 14

Nursing Dashboard – Lead Director Emma McKay

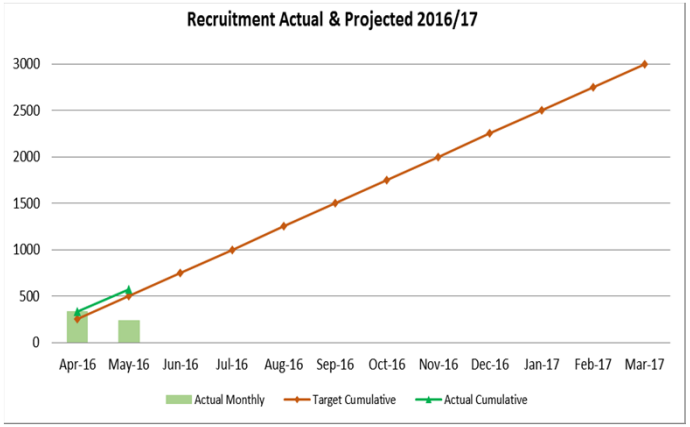
Clinical Safety	Outturn 2015/16	Monthly Target	Jun-16	6 month trend	YTD 2015/16	YTD 2016/17
C Diff cases (hospital acquired)	54	3	4		9	10
MRSA bacteraemias (hospital acquired)	2	0	0		0	0
Norovirus (confirmed cases)	133	1	1		73	37
Elective MRSA Screening Breaches	388	0	28		49	59
Emergency MRSA Screening Breaches (Provisional)	1954	0	141		513	461
Hand Hygiene Compliance	98%	100%	95.9%		96.7%	97.5%
Dress Code Compliance	99%	100%	99.0%		98.1%	99.4%
Commode Audits	94%	100%	91.9%		95.3%	93.5%
Needlestick Incidents	93	0	6		34	20
Medication Incidents (total reported)	1150	N/A	110		241	358
Medication incidents with potential to cause harm (IHI)	8	0	3		2	4
Total Number of Datix Incidents in month	12638	N/A	1076		3062	2304
Datix Incidents (reported in month) Finally Approved within 14 Days	7706	N/A	592		1952	2113
Number of Datix Incidents reported in month not closed within 14 Days	4502	0	472		992	1285
Total Open Datix Incidents: 2010 to month end (incl incidents that have been open for under 14 days)	8833	N/A	610		1653	1626
C4C Audit Results	96%	95%	95.7%		95.7%	96.1%
C4C Audit Results if Re-Audited	891%	95%	95.7%		96.4%	96.2%
Day Wandsworth Call Bell: Patient Call (total if not separated)	00:03:04	00:02:30	00:03:05		00:02:40	00:03:04
Day Wandsworth Call Bell: Bathroom Call (total if not separated)	00:01:59	00:02:00	00:02:02		00:01:49	00:02:06
Night Wandsworth Call Bell: Patient Call	00:01:56	00:02:30	00:01:54		00:01:52	00:01:53
Night Wandsworth Call Bell: Bathroom Call	00:01:16	00:02:00	00:01:05		00:01:19	00:01:10

Core Slide 15

Effectiveness - Lead Director Peter Chapman

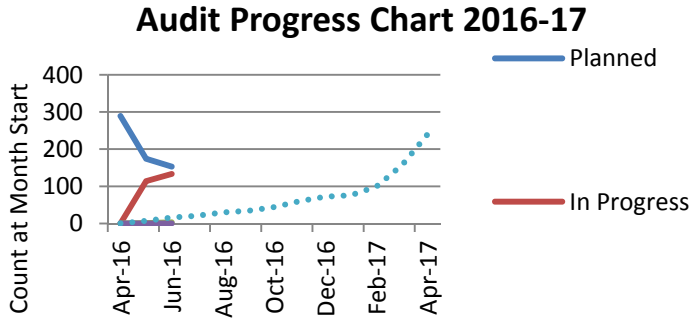
RESEARCH AND DEVELOPMENT

•NNUH CRN recruitment target for 2016-17 = 3000 (250/month)
•Target reduced compared to last years achievement due to the closure of the National Diabetes Patient Survey (NDPS)
•NNUH currently on trajectory – see chart
•New Health Research Authority (HRA) approval process fully implemented and replaces NIHR
•Positive engagement with CRN to support a senior joint research management post between UEA and NNUH. Chief of R&I taking forward.
•Genomic Medicine Project has started to recruit very successfully in Norwich against a background of relatively poor national performance
•8 new serious adverse events recorded (all hospitalisations)
- •1 attributable to research study and reported to sponsor. Patient has fully recovered from allergic reaction to Humira medication.
- •None reportable as SIs



CLINICAL STANDARDS

- Terms of Reference for CSG approved
- Progress against Trust agreed audit plan summarised



- NICE guidance status review. Divisions to require resolution for older outstanding items
- New therapy application for bedside PICC service has been approved
- National Confidential Enquiries and Inquiries audit of compliance being undertaken following revisions to policy and new divisional structure. The following are open / recently completed and will be reported through the Effectiveness Board:
  - Acute pancreatitis
  - Mental health
  - Non-invasive ventilation
  - Young peoples mental health
  - Chronic neurodisability in children

Core Slide 16

Effectiveness - Lead Director Peter Chapman

RISKS AND DIVISION REPORTING BY EXCEPTION

•No new 12+ risks

•Women and Children

- •Further audit will be carried out in relation to termination of pregnancy services - documentation

NORWICH CLINICAL ETHICS GROUP

•Terms of reference agreed – annual review

•Work programme includes discussion and advice in relation to the ethical dimension of specific topics or cases, and delivery of ethics training to medical staff particularly at FY1 and 2.

•Group is a member of the UK Clinical Ethics Network

PROMs

•Reviewed monthly

•EQ-5D, EQ-VAS and condition specific questionnaires

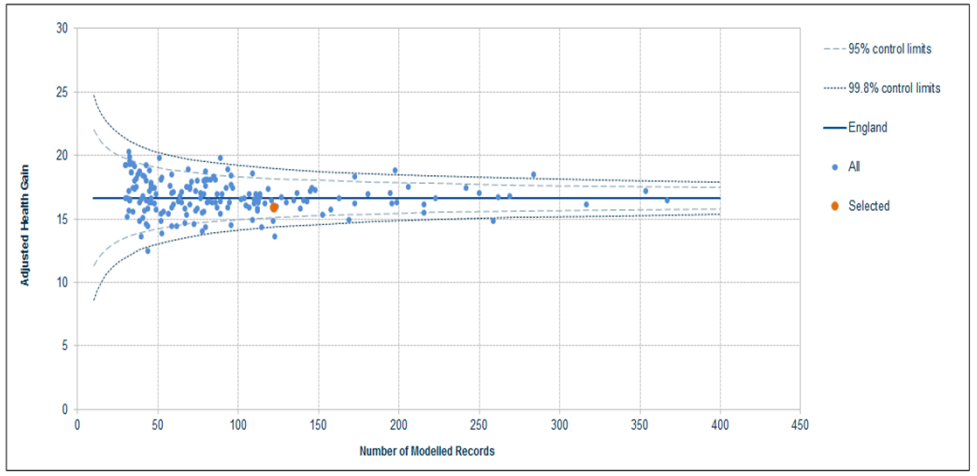
•Health improvement above national average for varicose vein surgery and hernia repair, but below national average for hip and knee replacements but within tolerance limits – funnel plot below

•Previously agreed measures in relation to TKRs in progress

Funnel Plot – casemix-adjusted average Health Gain

April 2015 to December 2015, provisional data (published 12 May 2016)

Procedure	Measure	Organisation level	Organisation name
Knee Replacement Primary	Oxford Knee Score	Provider	NORFOLK AND NORWICH UNIVERSITY HOSPITALS NHS FOUNDATION TRUST (RM1)



Core Slide 17 Performance – Monitor KPI's - Lead Director Richard Parker

Performance		Outturn 2015/16	Monthly Target	Jun-16	6 month trend	YTD 2015/16	YTD 2016/17
Cancer	Core Slide 19-21						
1 Cancer 62 day target for referral to treatment - GP Referral *		77.06%	85.00%	78.15%		76.36%	80.97%
2 Cancer 2 week wait - all cancers *		96.69%	93.00%	99.29%		93.79%	98.92%
4 Cancer 31 day target compliance		97.40%	96.00%	96.62%		97.40%	97.12%
5 Cancer 31 day target for subsequent treatments - Surgery *		91.66%	94.00%	94.38%		89.21%	91.99%
6 Cancer 31 day target for subsequent treatments - Anti Cancer Drugs *		99.26%	98.00%	100.00%		99.14%	99.75%
7 Cancer 31 day target for subsequent treatments - Radiotherapy *		97.77%	94.00%	99.41%		98.65%	98.00%
A&E	Core Slide 22						
9 A&E 4 hour target compliance		85.33%	95.00%	88.90%		91.36%	87.77%
10 Number of 30 minute handover breaches		364	0	29		15	124
11 Number of 60 minute handover breaches		148	0	7		1	46
12 Recording of Handover Times		96.45%	n/a	96.91%		97.56%	96.60%
13 Number of patient handover times recorded		39578	n/a	3422		9717	9578
14 Arrival to Handover time (>15 minutes)		75.10%	n/a	76.01%		81.69%	75.82%
RTT	Core Slide 23						
15 18 week RTT target - Patients on an incomplete pathway		87.49%	92.00%	87.50%		89.39%	87.15%
16 Admitted Backlog		3039	2692	2843		2098	2843
17 Incomplete Non Admitted Backlog		27429	2182	2106		5794	6496
Stroke	Core Slide 24-25						
18 Percentage of patients with 90% of their length of stay on the stroke unit		80.26%	80.00%	82.00%		74.93%	83.30%
19 Patients with primary diagnosis of stroke admitted to a HASU within 4 hrs		74.08%	90.00%	82.65%		76.40%	82.07%
20 % of urgent Stroke patients with access to brain scan within 60 mins		86.27%	90.00%	73.70%		87.13%	85.81%
21 % Door to needle time of <= 60 minutes for eligible thrombolysis patients		79.22%	90.00%	100.00%		78.47%	80.00%
22 % of high risk TIA patients treated within 24 hour of first contact		91.84%	90.00%	93.75%		100.00%	87.63%
Patient Flow	Core Slide 26						
23 Diagnostics		95.93%	99.00%	97.99%		97.70%	98.10%
24 Cancelled Operations		1360	n/a	96		216.0	253.0
25 Number of 28 day breaches		267	0	27		23	63
26 Average Delayed Transfers of Care		552	30	54		101	212
27 28 Day Readmission Rates		7%	n/a	6.86%		7.28%	6.51%
28 Length of Stay (Elective)		3.27	n/a	3.09		3.15	3.09
29 Length of Stay (Non-Elective)		5.61	n/a	5.26		5.122431322	5.26
30 Average number of patients with LoS >14 days			200	214			
*Please note these figures are provisional							

Core Slide 18

Performance - Lead Director Richard Parker

Performance – key issues

1. **Cancer**
   62-day GP referral performance remains a priority for recovery. Performance against the 62 day target has been maintained at 80% or above for 3 consecutive months which is a significant step forward. Two key actions have bene identified to achieve 85% by October – the consistent booking of 2WW appointments within 7 days, and the implementation of the Best Practice Prostate Pathway. Progress continues to be made against the Remedial Action Plan to ensure marginal gains and sustainable performance is realised in other tumour sites

2. **A&E** - ED transit time performance is improving in line with the recovery trajectory. The revised System Wide plan is in place and is focussed on performance stabilisation. Key issues continue to be Exit Block and ED systems and processes and robust improvement plans are in place to address both.

3. **RTT** recovery is subject to a formal contractual remedial action plan process; agreement of a recovery trajectory is a key part of that process and current agreed trajectories place aggregated achievement of 8% open pathways at January 2017.

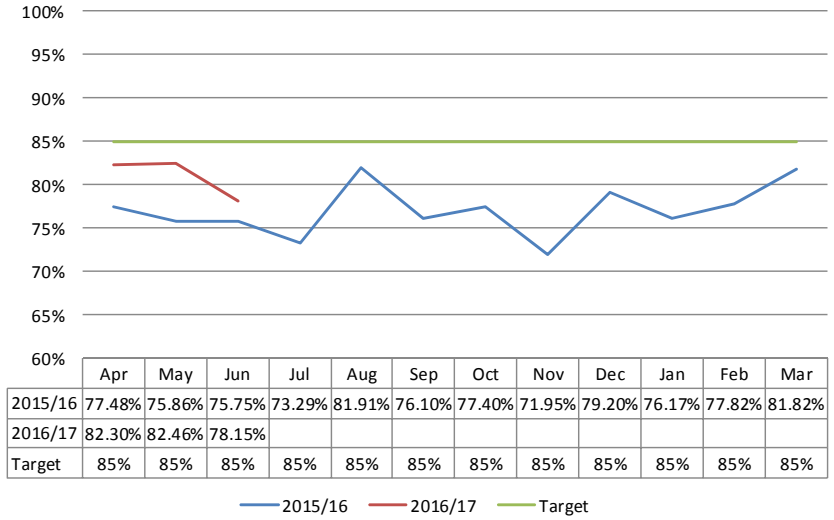
4. **Stroke -** Whilst significant progress had been made against the Stroke care standards, a mixture of demand and pathway issues continue to restrict progress. Plans are in place to improve the pathway issues.

5. **Diagnostics**
   Measures put in place to improve the diagnostic performance have seen a significant improvement additional actions have been identified and achievement in June was above trajectory.

Core Slide 19

Performance (Cancer) - Lead Director Richard Parker

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	77.48%	75.86%	75.75%	73.29%	81.91%	76.10%	77.40%	71.95%	79.20%	76.17%	77.82%	81.82%
2016/17	82.30%	82.46%	78.15%									
Target	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%	85%

Issues

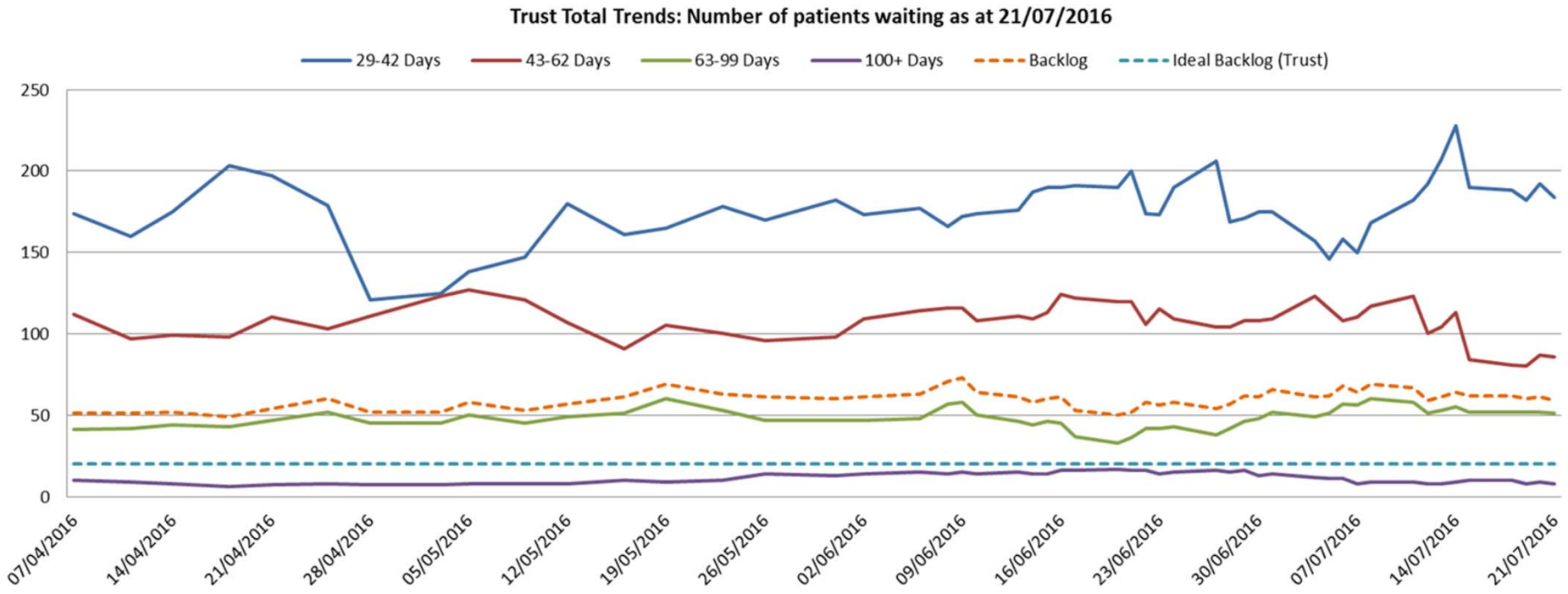
- Backlog clearance remains a priority for achieving the 62 day target.
- Sustained Increase in 2WW referrals
- Built in delays in Prostate Pathway

Actions

Body site targeted action plan developed and agreed includes:

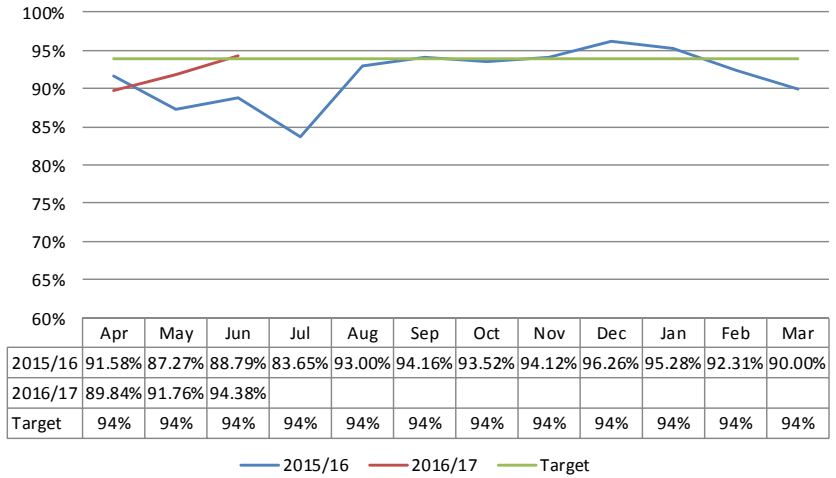
- Reduction of time to first 2ww appointment
- Implementation of Best Practice Prostate Pathway
- Pathway reviews underway in Urology, Lung, Upper GI and colorectal
- Admin process review in Gynaecology
- Additional MDT capacity

Core Slide 20 Performance (Cancer) - Lead Director Richard Parker



Core Slide 21 Performance (Cancer) – Lead Director Richard Parker

Cancer 31 day target for subsequent treatments - Surgery *



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	91.58%	87.27%	88.79%	83.65%	93.00%	94.16%	93.52%	94.12%	96.26%	95.28%	92.31%	90.00%
2016/17	89.84%	91.76%	94.38%									
Target	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%

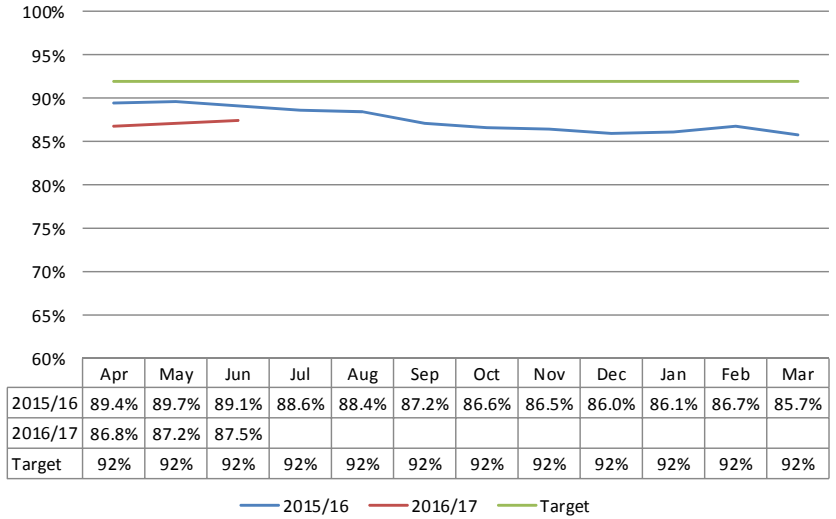
Issues
- Late identification of potential breaches

Actions
- Performance has been regained for June
- Importance of communication of target patients from clinicians to WL Co-ordinators to Pathway Co-ordinators has been re-iterated

Core Slide 22

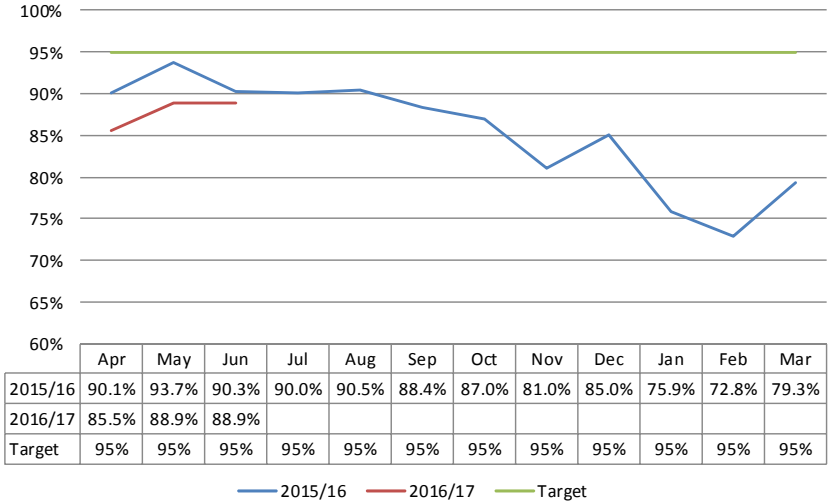
Performance (RTT and A&E) – Lead Director Richard Parker

18 week RTT target - Patients on an incomplete pathway



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

A&E 4 hour target compliance



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

Issues
- Recruitment issues remain in all specialities for both medical and admin staff. There have been instances when potential candidates have been lost due to the length of recruitment time running, this will soon impact retention of staff over the next few months.

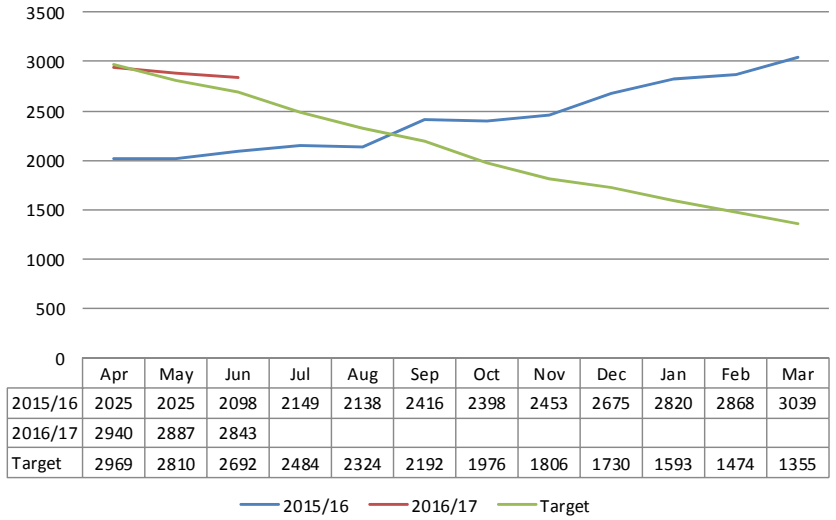
Actions
- Specialities reviewing recovery plans and taking additional actions

Issues
- Over-achieved against recovery trajectory
- Bed availability & ED processes remain the main reasons for failure.
- ED Attendances 5.21% increase on 2015
- Ambulance arrivals 8.62% increase on 2015

Actions
- Continue focus on System Recovery Plan
- Focus on expansion of AEC and creation of CDU
- Focus on delayed discharge and “stranded patients” > 14 days.

Core Slide 23 Performance (RTT) – Lead Director Richard Parker

Admitted Backlog

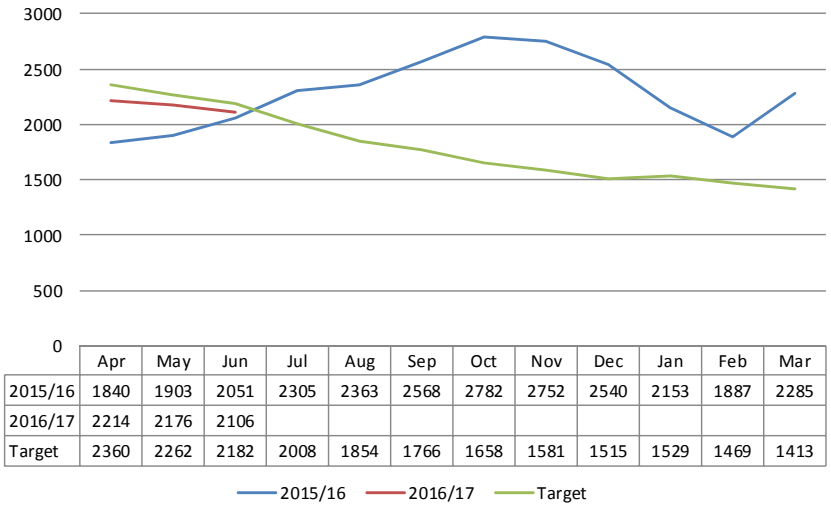


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	2025	2025	2098	2149	2138	2416	2398	2453	2675	2820	2868	3039
2016/17	2940	2887	2843									
Target	2969	2810	2692	2484	2324	2192	1976	1806	1730	1593	1474	1355

Issues
- Cancer activity continues to be prioritised over RTT.
- Currently unable to fill weekend Theatre lists due to lack of Anaesthetics support and theatre staff not volunteering to cover extra sessions.

Actions
- Recruitment into posts identified in RTT recovery business case to reduce reliance on WLI spend
- NNUH have invited NHSI Assurance to complete Data Review – 20th July.
- NHSE / NHSI confirmation that locally agreed recovery (Aggregate 92% in Jan 2017) will be 'allowed'/contractual impact

Incomplete Non Admitted Backlog



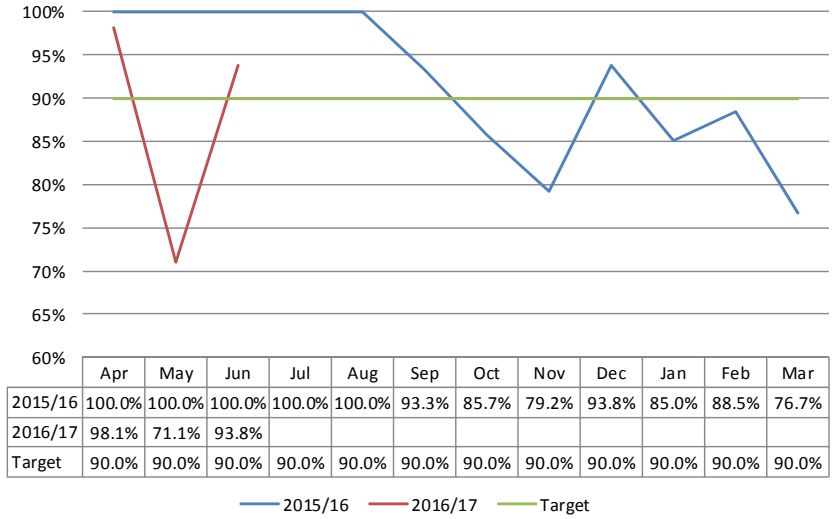
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	1840	1903	2051	2305	2363	2568	2782	2752	2540	2153	1887	2285
2016/17	2214	2176	2106									
Target	2360	2262	2182	2008	1854	1766	1658	1581	1515	1529	1469	1413

Issues
- Lack of Cath lab capacity is now affecting RTT Elective waits for Cardio patients.
- Lack of IRU capacity remains an issue - the routine dates for IRU are now being pushed out into 53 weeks

Actions
- Continue to plan Increased Outpatient activity,
- Other agencies being considered for other specialities.
- Enablement of pathway distribution at point of referral & support for commissioners
- Norfolk acute provider-wide capacity & demand support drawing on NHSI expertise

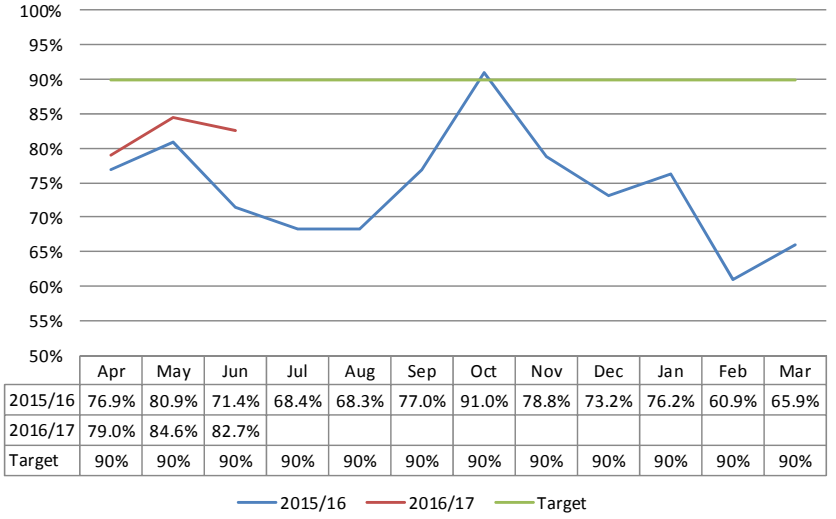
Core Slide 24 Performance (Stroke) – Lead Director Richard Parker

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	100.0%	100.0%	100.0%	100.0%	100.0%	93.3%	85.7%	79.2%	93.8%	85.0%	88.5%	76.7%
2016/17	98.1%	71.1%	93.8%									
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%

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



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

Issues
- Standard delivered

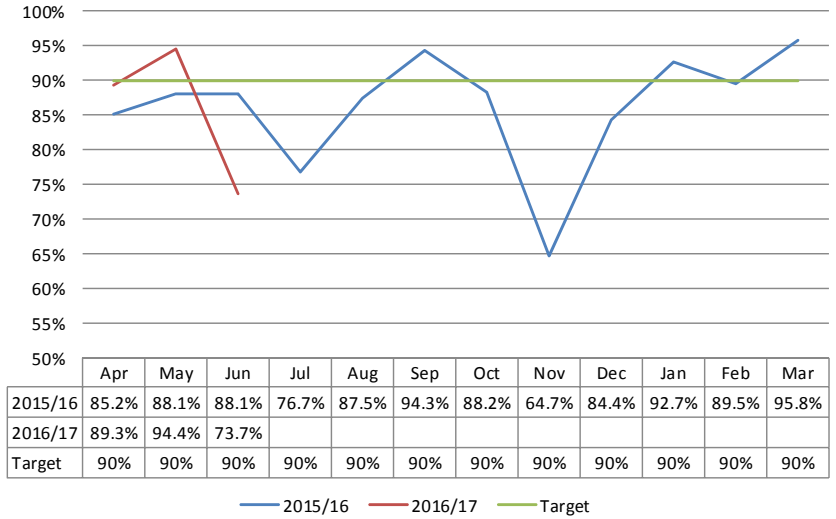
Actions
- Escalated to Radiology Operational Manager and DOD for Clinical Support Services – recovery plan to be developed

Issues
- 81 of 98 patients admitted to stroke unit within 4 hours
- 17 Patients did not meet the standard:
  - 11 patients delayed due to bed availability
  - 3 patients were not diagnosed by the stroke team

Actions
- Ring-fence Stroke bed to ensure admission pathway is maintained
- Linked to Emergency Pathway Improvement work

Core Slide 25 Performance (Stroke) – Lead Director Richard Parker

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



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

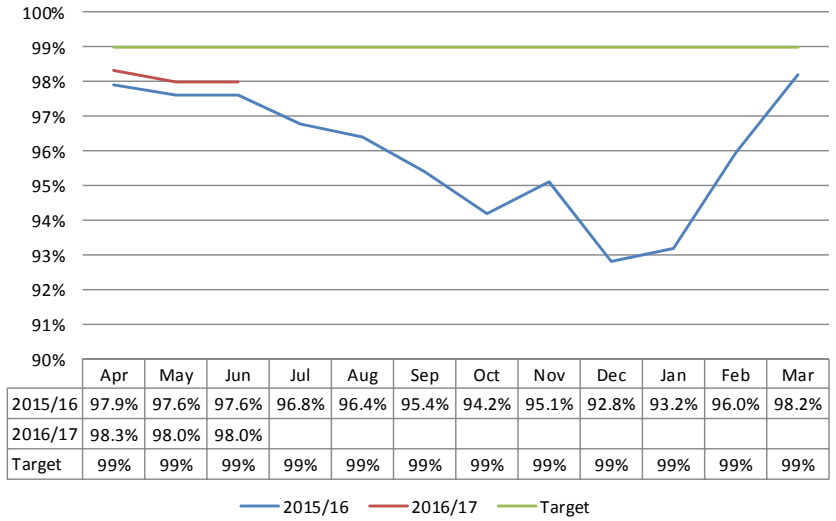
Issues
- 28 out of 38 urgent scans done in 60 min
- 4 patients delayed by ED
- 3 Stroke nurse busy with multiple patients
- 1 patient not diagnosed as stroke
- 1 Inpatient stroke team not alerted in time, delay in scan request
- 1 Delay in CT as one CT scanner was out of order

Actions
- Continue to communication with ED

Core Slide 26

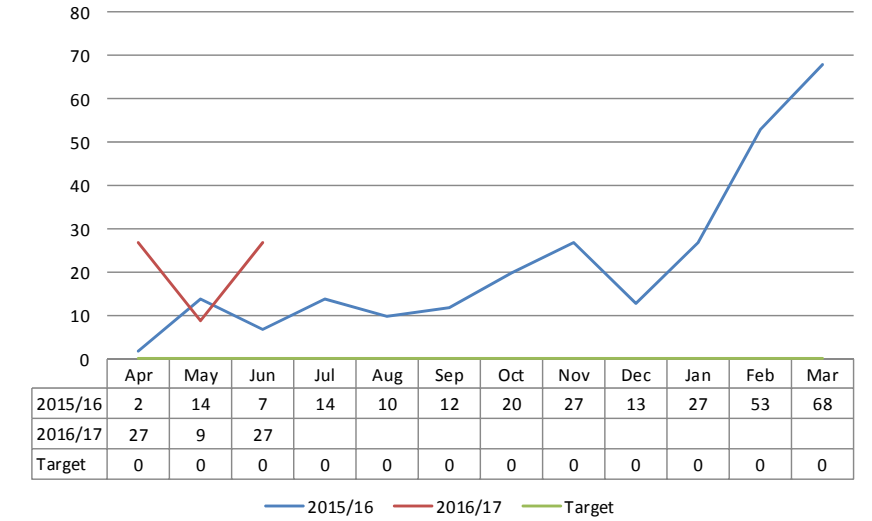
Performance (Patient Flow) – Lead Director Richard Parker

Diagnostics



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	97.9%	97.6%	97.6%	96.8%	96.4%	95.4%	94.2%	95.1%	92.8%	93.2%	96.0%	98.2%
2016/17	98.3%	98.0%	98.0%									
Target	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%	99%

Number of 28 day breaches



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	2	14	7	14	10	12	20	27	13	27	53	68
2016/17	27	9	27									
Target	0	0	0	0	0	0	0	0	0	0	0	0

Issues
- Performance in June at 97.99% above trajectory of 97.6%

Issues
- Cancellations of electives arising from patients being found unfit on the day and list overruns. Priority given to Cancer patients with routines falling of the end of lists.
- Inadequate capacity to rebook within 28days. Cancers prioritised.

Actions
- Cancer cases continue to be prioritised above other cases

Core Slide 27

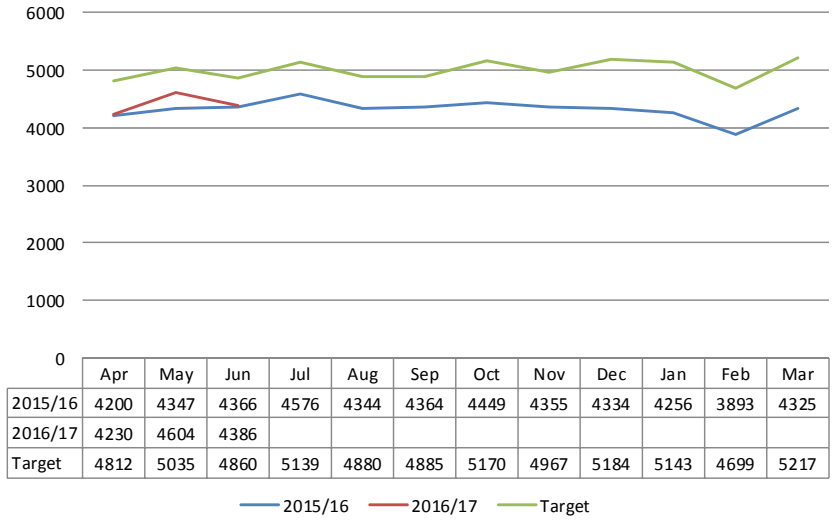
Performance (Productivity)

Productivity		Outturn 2015/16	Monthly Target	Jun-16	6 month trend	YTD 2015/16	YTD 2016/17
A&E Activity (attendances)		120062	10652	10653		29589	31605
Emergency Admissions	Core Slide 28	51809	4860	4386		12913	13220
Outpatient Activity (consultant led & non-consultant led)	Core Slide 28	692747	62609	62085		167570	181632
Elective Activity - Elective inpatient spells	Core Slide 29	14038	1282	1302		3465	3618
Elective Activity - Day case spells	Core Slide 29	83710	7259	7152		20785	21116
Theatre Utilisation		87.54%	90.00%	88.60%		86.27%	86.70%

- Overall increase in activity. A number of surgical specialities have seen an increase in activity on previous months but behind on overall plan. Recruitment underway to increase Surgeon capacity with options to increase physical capacity included in the RTT recovery plan.

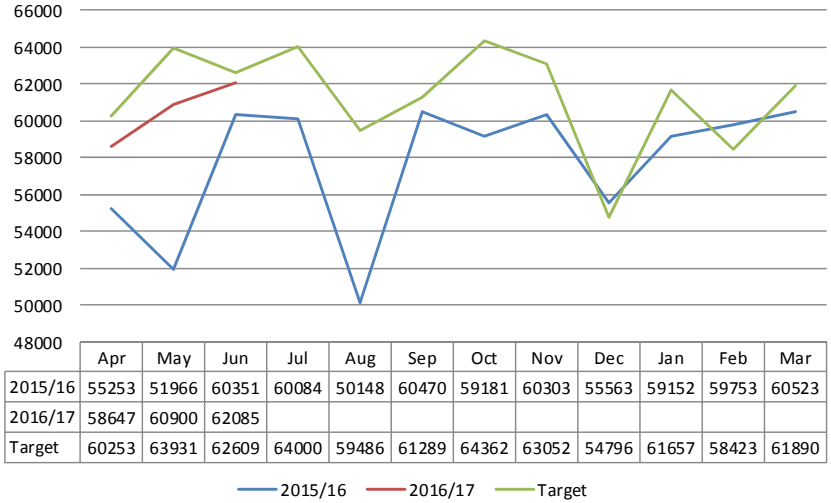
Core Slide 28 Performance (Productivity) – Lead Director Richard Parker

Emergency Admissions



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	4200	4347	4366	4576	4344	4364	4449	4355	4334	4256	3893	4325
2016/17	4230	4604	4386									
Target	4812	5035	4860	5139	4880	4885	5170	4967	5184	5143	4699	5217

Outpatient Activity (consultant led & non-consultant led)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	55253	51966	60351	60084	50148	60470	59181	60303	55563	59152	59753	60523
2016/17	58647	60900	62085									
Target	60253	63931	62609	64000	59486	61289	64362	63052	54796	61657	58423	61890

Issues
- 5.21% increase in ED attendances and high number of admissions.
- Conversion rate of ED attendance to admission was 26.7%: an improvement of 1.3% on June 15.
- ED : 2848: above average
- AMU 672: average.
- EAUS : 513: average.
- Direct to wards: 354 above average.

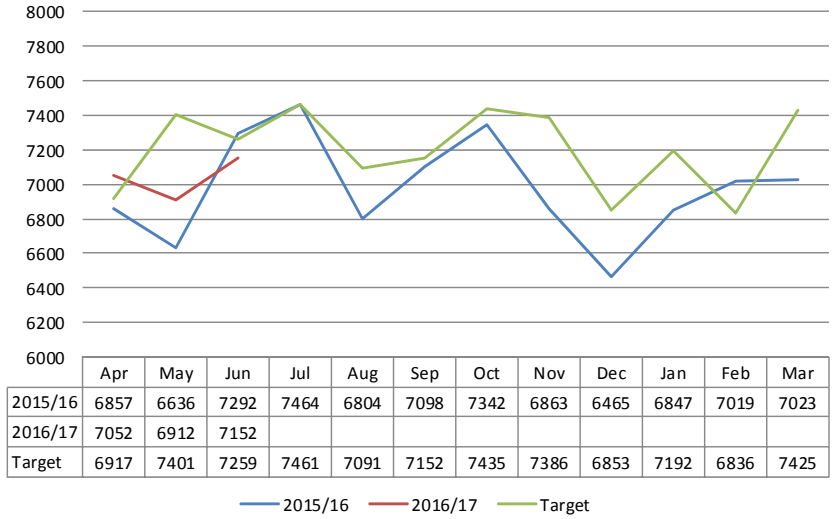
Actions
Continue to focus on AEC. Launch the CDU and focus on revised pathways of care.

Issues
- General increase in outpatient activity across a number of specialities

Actions
- Medinet providing outpatient capacity for ENT
- Additional clinics in place in most specialities

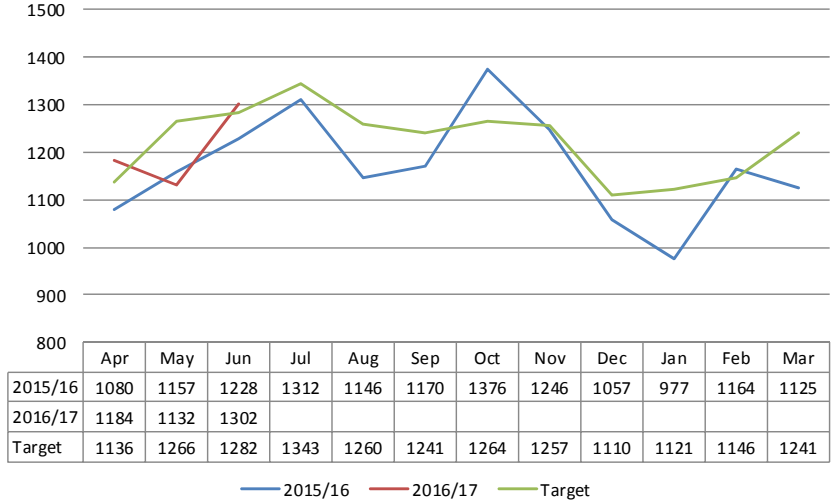
Core Slide 29 Performance (Productivity) – Lead Director Richard Parker

Elective Activity - Day case spells



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	6857	6636	7292	7464	6804	7098	7342	6863	6465	6847	7019	7023
2016/17	7052	6912	7152									
Target	6917	7401	7259	7461	7091	7152	7435	7386	6853	7192	6836	7425

Elective Activity - Elective inpatient spells



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	1080	1157	1228	1312	1146	1170	1376	1246	1057	977	1164	1125
2016/17	1184	1132	1302									
Target	1136	1266	1282	1343	1260	1241	1264	1257	1110	1121	1146	1241

Issues
- Vanguard fully on line from January
- Additional Saturday lists in DPU now in place

Issues
- None arising. Marked increase in elective volume.

Actions
- Investigating use of Medinet/Vanguard/18 week solutions to provide increased day case capacity at weekends.
- Provisional plans to start 18 week solutions activity in August.

Core Slide 30

Workforce Summary – Lead Director Jeremy Over

Workforce		Outturn 2015/16	Monthly Target	Jun-16	6 month trend	YTD 2015/16	YTD 2016/17
Payroll							
1 Budgeted WTE*		6819	n/a	6967		6630	6967
2 Actual WTE*		6266	n/a	6293		6020	6293
3 Vacancy maximum (%)		8.04%	10.00%	9.68%		8.70%	9.71%
Pay Spend							
4 Pay spend - % employed (%)*		88.24%	n/a	86.53%		90.77%	85.31%
5 Pay spend - % bank (%)*		2.34%	n/a	3.25%		2.25%	2.74%
6 Pay spend - % agency (%)*		5.40%	n/a	6.03%		4.23%	7.03%
7 Pay Spend - % Medical Locum (%)*		4.02%	n/a	4.19%		2.75%	4.92%
Staffing Numbers	Core Slide 37						
8 % of registered nurse day hours filled as planned		93.31%	n/a	94.70%		94.19%	95.10%
9 % of unregistered care staff day hours filled as planned		105.22%	n/a	112.40%		100.31%	113.50%
10 % of registered nurse night hours filled as planned		90.92%	n/a	94.30%		90.23%	94.99%
11 % of unregistered care staff night hours filled as planned		113.76%	n/a	123.40%		110.02%	122.64%
12 RGN % Actual to planned		92.27%	n/a	94.60%		92.48%	95.08%
13 HCA % Actual to planned		108.68%	n/a	116.88%		104.17%	117.24%
Other							
14 Non-Medical Appraisals completed	Core Slide 34	58.71%	90.00%	61.00%		68.63%	59.43%
15 Staff Turnover rate	Core Slide 35	10.63%	10.00%	10.50%		10.77%	10.42%
16 Mandatory Training	Core Slide 35	76.43%	90.00%	75.60%		74.07%	74.72%
17 Sickness levels**	Core Slide 36	4.28%	3.50%	3.77%		3.77%	4.06%
Staff Survey							
18 Staff FFT – recommendation of NNUH as a place to receive care	Core Slide 36		n/a	77.00%			
19 Staff FFT – recommendation of NNUH as a place to work	Core Slide 36		n/a	51.00%			
* Please note these figures are provisional							
** Reported one month in arrears							

Core Slide 31

Workforce – Lead Director Emma McKay

Nurse Staffing ('Red Flags)

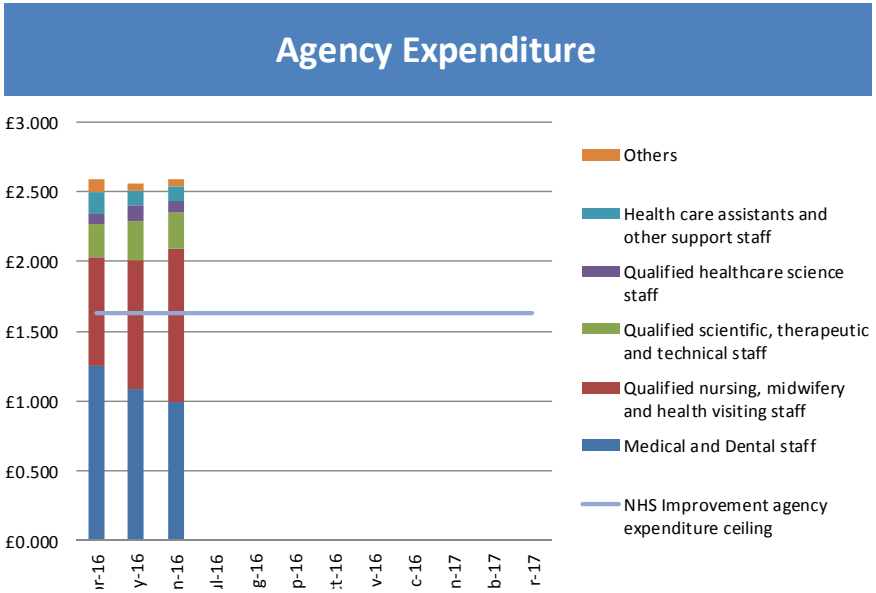
The common themes across all red flags are level of vacancies, impact of sickness absence and inability to provide specials due to patient acuity.

The following actions are being taken:

- Recruitment: 100 newly-qualified nurses join NNUH in September. International recruitment of registered nurses is also in progress.
- Daily evaluation of staffing allocations by the operations centre with flexible deployment of staff to address specific vacant shifts
- Growth of the NNUH staff bank to increase fill rate of vacant shifts with our own staff
- Launch of new attendance policy, manager briefing sessions and specific support to areas experiencing higher rates of sickness absence

	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
Medicine	386	660	431	404	345	321	348	330	357	374	219	256
Surgery	398	868	629	746	519	630	533	694	727	531	487	591
Women and Children	67	84	72	68	66	66	81	91	102	77	82	75
Maternity	496	683	523	722	568	376	431	487	373	245	62	510

Core Slide 32 Workforce - Lead Director Jeremy Over



Issues

Agency/locum expenditure for June 2016 was £2.6m equating to 10% of total pay expenditure

- Broadly similar to April and May 2016 & £0.6m lower than March
- Further £0.1m reduction in medical locum expenditure, the lowest monthly spend since December 2015
- Whilst not included in the graph, WLI also saw a small reduction in June compared to May
- Nursing agency expenditure increased by £0.2m compared to May – related to the need to cover high vacancy levels on particular medical wards. The positive impact of successful recruitment and reduction in average agency rates has been offset by an overall increase in nursing establishment over past 12 months – c. 60 registered nurse WTE growth, and 66 HCA WTE

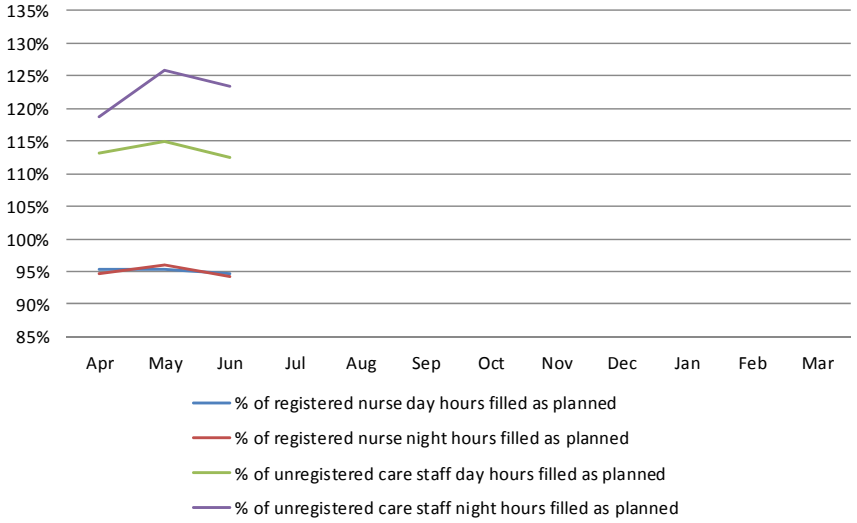
Actions

- 'Premium Pay' is a work stream of the Financial Improvement Programme (FiP)
- Recent programme achievements include:
  - Agreement of programme architecture and priority projects through PMO (e.g. bank processes and growth of the bank
  - New weekly and monthly dashboards and enhanced reporting have been launched to divisions
  - Establishment of fortnightly Workforce CIP meetings with divisions chaired by the Turnaround Director
  - Tightening of agency approval authorisation & timeframes, with clear process to escalate safety concerns
  - Reduced rates negotiated with A&E medical locum supplier

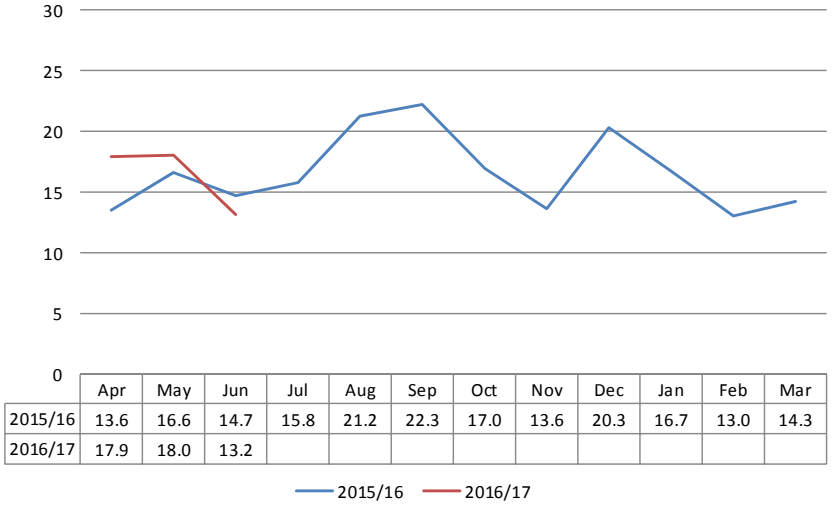
Core Slide 33

Workforce - Lead Director Jeremy Over

Ward Nursing fill-rate Analysis



Turnover - Registered Nursing and Midwives



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	13.6	16.6	14.7	15.8	21.2	22.3	17.0	13.6	20.3	16.7	13.0	14.3
2016/17	17.9	18.0	13.2									

Issues
- The graph shows our nursing planned versus actual staffing levels.
- The percentage of shift hours worked versus planned may be greater than 100% where additional staff have been deployed to meet the needs of patients requiring 1-to-1 care.
- Successful recruitment to vacancies over past 12 months offset by growth in nursing establishment

Actions
- The agency rules, as they impact on registered nursing, is being closely monitored by Senior Nurses and HR and is a consideration of the Premium Pay FIP

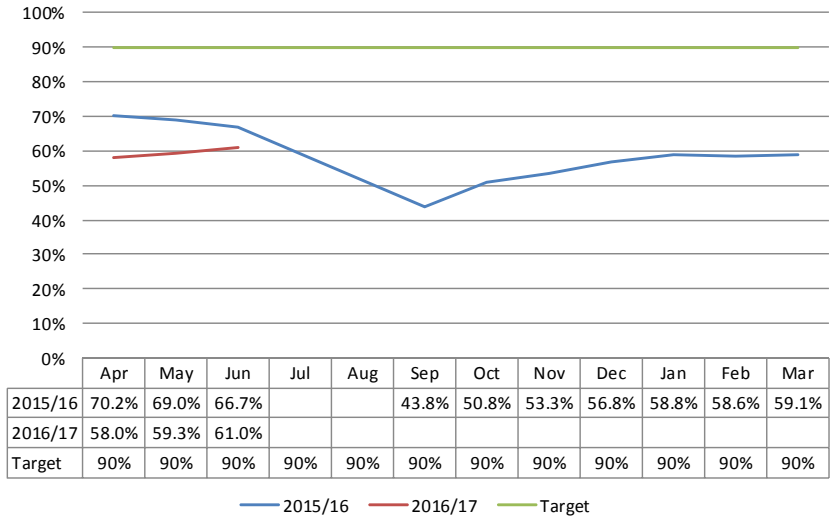
Issues
- The number of nursing/ midwifery leavers is averaging 16.9 per month.
- In the last 12 months, where reasons for leaving are known, it mirrors that for all leavers – with most related to retirement or promotion/ relocation reasons.

Action
- The international nurses recruitment initiative has commenced with the first appointments scheduled for July.
- Newly qualified nurses are being prepared for arrival in September and October.

Core Slide 34

Workforce - Lead Director Jeremy Over

Non-Medical Appraisals completed



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	70.2%	69.0%	66.7%			43.8%	50.8%	53.3%	56.8%	58.8%	58.6%	59.1%
2016/17	58.0%	59.3%	61.0%									
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

Non-Medical Appraisal Completion	Achievement %
Trust	61.0%
by Division	
Medicine	59.4%
Surgery	57.8%
Women & Children	69.9%
Clinical Support Services	62.8%
Corporate	61.2%
Nursing & Education	43.7%
Research	59.6%
Resources	62.3%
Strategy & Planning	84.4%
Workforce	83.3%

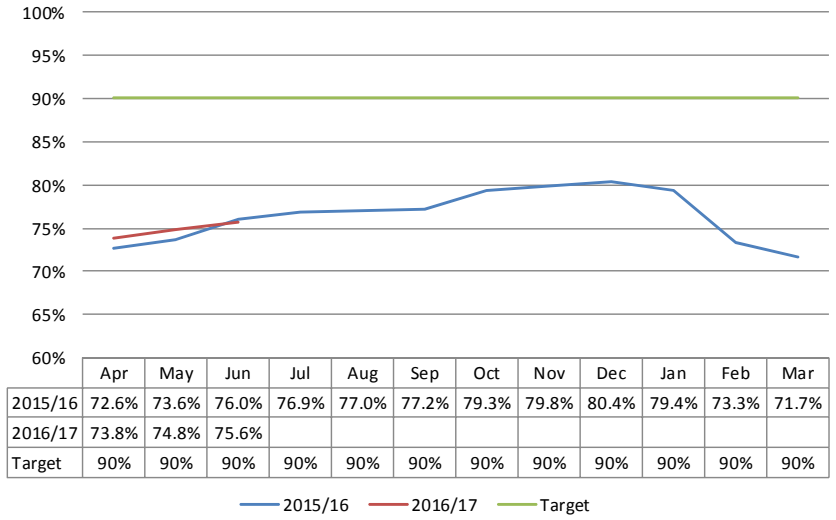
Issues
- The new appraisal system went live on 6 July 2015.
- To date, 3,039 appraisals have been completed using the new appraisal system.
- In total, 3,286 appraisals have been undertaken within timescales.
- Compliance rates have broken through the 60% barrier for the first time since the new appraisal system was introduced.

Actions
- Appraisal rates are discussed with divisions at monthly performance committee meetings.
- The CEO and Executive Directors continue to stress the importance of the appraisal experience

Core Slide 35

Workforce - Lead Director Jeremy Over

Mandatory Training

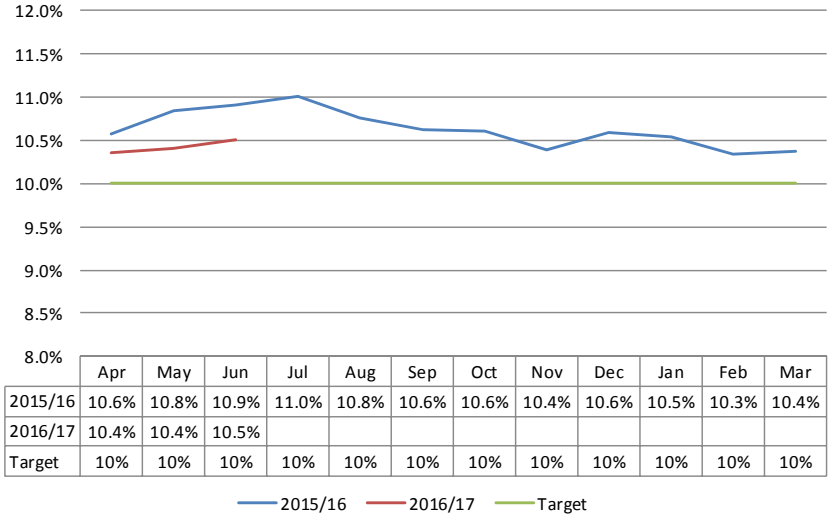


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	72.6%	73.6%	76.0%	76.9%	77.0%	77.2%	79.3%	79.8%	80.4%	79.4%	73.3%	71.7%
2016/17	73.8%	74.8%	75.6%									
Target	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

Issues
- The overall compliance rate has started to improve following changes in the training requirements for Fire Safety and Safeguarding Adults, with the addition of 'level 2' for clinical staff, which introduces some additional learning outcomes.

Actions
- Divisional level mandatory training rates are discussed at executive performance committee.
- The new Head of OD & Learning is reviewing options for strengthening e-learning arrangements, with the support of the IT department

Staff Turnover rate



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

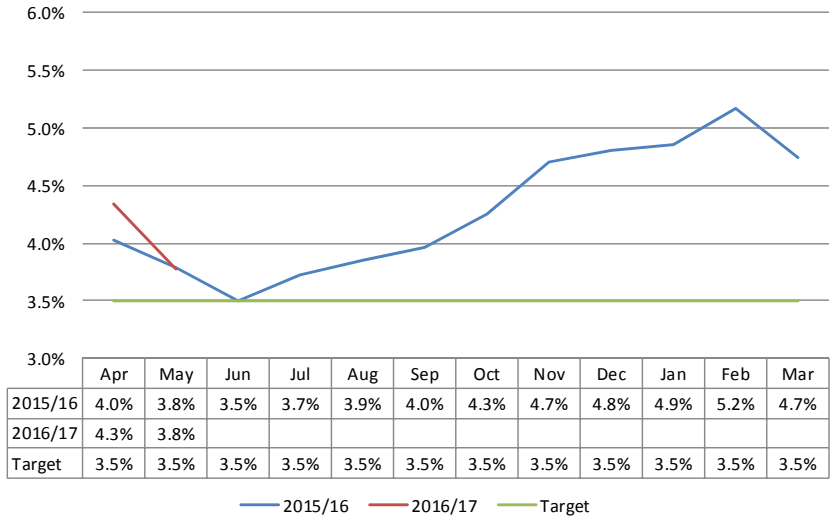
Issues
- Staff turnover has continued in the range 10.3% to 10.6% for the past 10 months.
- Turnover rates for April, May and June 2016 are all lower than the corresponding months in 2015.

Actions
- The current trajectory is consistent.
- The newly-formed Staff Experience Working Group has established a working group to focus on turnover.
- Of the known reasons for leaving, two-thirds are for retirement or promotion/relocation-related reasons.

Core Slide 36

Workforce - Lead Director Jeremy Over

Sickness levels**



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015/16	4.0%	3.8%	3.5%	3.7%	3.9%	4.0%	4.3%	4.7%	4.8%	4.9%	5.2%	4.7%
2016/17	4.3%	3.8%										
Target	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%

Issues

- Significant 0.5% reduction in sickness absence for May 2016 – now 1.4% lower than February peak and lowest figure since July 2015
- For data accuracy purposes, sickness figures are reported one-month in arrears.
- The 12 month seasonally adjusted figure is 4.31%, and is identical to the position 12 months ago. Latest national benchmarking report show NNUH as 75th of list of c.150 trusts in terms of sickness absence rates

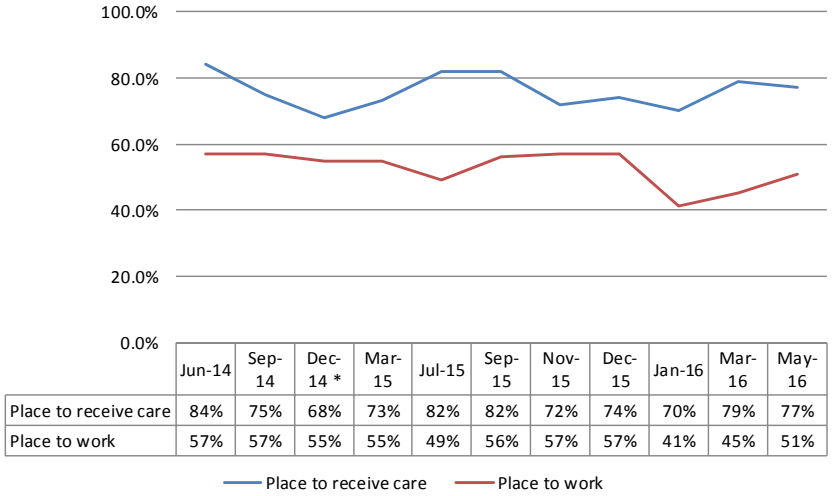
Actions

- Sickness is discussed in detail at divisional Performance Committees.
- The new Attendance Policy launched in May. To date, 400+ managers have attended more than 30 briefings.
- The policy emphasises the need to 'know your staff' – involving a positive, supportive relationship/ engagement between the managers and their staff and a focus on supporting attendance and return to work, rather than simply penalising absence.

Core Slide 36a

Workforce - Lead Director Jeremy Over

Friends and Family Test Scores



	Jun-14	Sep-14	Dec-14 *	Mar-15	Jul-15	Sep-15	Nov-15	Dec-15	Jan-16	Mar-16	May-16
Place to receive care	84%	75%	68%	73%	82%	82%	72%	74%	70%	79%	77%
Place to work	57%	57%	55%	55%	49%	56%	57%	57%	41%	45%	51%

Division	Place to Work %	Place to receive care %
NNUH	51	77
Medicine	45	71
Surgery	59	77
Women & Children	57	93
Clinical Support Servs	44	83
Corporate depts	60	80

Issues
- The 'Place to Work' measure improved in May 2016
- There was a slight reduction in the 'Place to receive care' measure

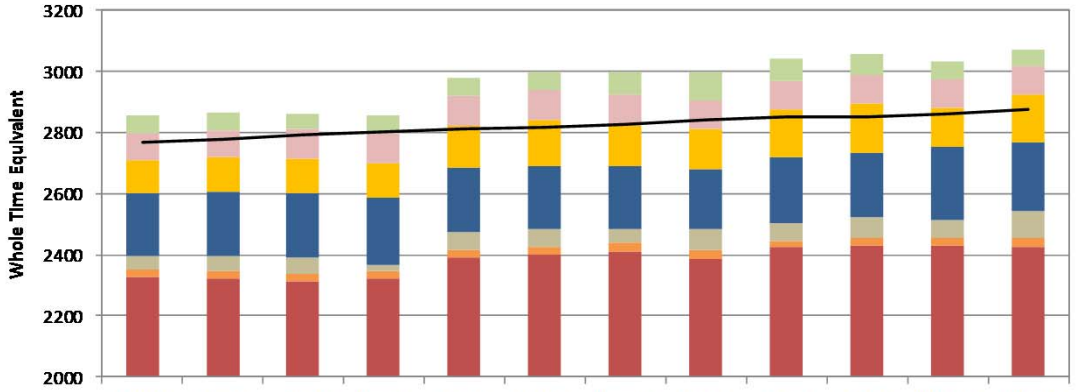
** December 14 – National Staff Survey*
*** Combined metric due to National Staff Survey*

Actions
- Staff FFT scores are now available divisionally and this information is being shared with divisions as part of their work to improve staff experience and engagement
- Our 'PRIDE Values into Action' campaign has been launched, with a week of events involving staff, patients and managers to take place in October. This is a crucial opportunity to learn from staff and patient experience and collectively address poor scores highlighted by staff surveys including bullying and harassment at work, supportive management and the opportunity to be involved in improvements.

Core Slide 37

Workforce - Lead Director Jeremy Over

Registered & Unregistered Nursing Workforce Metrics (all areas)



	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Establishment	2767.3	2778.5	2792.6	2803.0	2809.3	2814.0	2824.6	2842.3	2848.8	2851.0	2857.9	2876.1
Resourcing - surplus(+) gap(-)	+90.0	+86.2	+70.1	+52.3	+166.5	+183.2	+172.0	+153.2	+190.9	+204.1	+175.6	+193.4
SIP - Long Term Sick*1	58.5	58.8	50.4	61.0	56.1	57.6	72.0	89.0	72.5	69.0	61.6	52.0
SIP - Maternity & Other*2	91.7	89.5	98.5	95.9	100.4	100.5	101.0	95.4	91.9	91.1	93.9	92.6
Agency*3	105.4	109.6	113.0	111.6	135.8	148.3	134.6	130.9	157.9	161.9	124.7	160.1
Bank*3	204.5	210.2	211.6	218.6	211.0	206.1	206.4	198.1	214.0	211.4	241.5	224.0
Overtime*3	45.8	50.6	51.8	23.9	57.1	59.7	43.0	68.9	56.8	66.9	55.7	87.4
Excess Hours*3	23.9	21.8	23.5	23.5	23.8	26.8	28.0	25.7	22.4	25.9	28.5	28.6
'Attending' Staff in Post *4	2327.5	2324.2	2314.1	2320.9	2391.7	2398.2	2411.6	2387.6	2424.3	2428.8	2427.7	2425.0
Staff in Post (SIP)	2477.8	2472.6	2462.9	2477.8	2548.2	2556.3	2584.6	2572.1	2588.6	2588.9	2583.1	2569.5
'Vacancy' level interpretations												
Establishment less SIP	289.6	305.9	329.7	325.2	261.1	257.7	240.0	270.3	260.3	262.1	274.7	306.6
Establishment less attending SIP	439.8	454.2	478.5	482.0	417.6	415.8	413.0	454.7	424.6	422.2	430.2	451.1

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

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

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

Source - Establishment from Finance 18/5/2016, Staff in post from ESR 19/5/2016, Bank & Agency from e-Roster 6/5/2016, OT & excess hours from Finance 18/5/2016

- This analysis reflects nursing workforce data incorporating equivalent figures for employed, bank, agency, overtime and excess hours. June data is not available at the time these slides were produced.
- The information identifies that, despite vacancies, temporary resources are supplementing the workforce.

Additional updates from Workforce sub-board:

- Our 'PRIDE Values into Action' campaign has been launched, which culminates in a week of events in October for staff, patients and leaders to learn from their experiences (positive and negative) and deal with issues raised through the staff survey. Our staff experience is in the lowest 20% of trusts for:
    - effective teamwork, communication with management and feeling valued
    - being able to contribute to improvements and effective use of patient feedback
    - bullying, harassment and abuse from colleagues
- Reaction to the campaign has has been positive thus far and it is recognised as an significant opportunity to improve the experience of staff at NNUH, and in turn help us to improve patient care even further.

- An NNUH Workplace Health and Well-being Strategy has been created and submitted to commissioners which is the foundation of delivery of a £2.2m CQUIN which encompasses staff health & well-being support, healthy food options and 'flu vaccine uptake. The strategy includes a work programme and a copy for board members is available upon request.
- Our newly, monthly staff awards programme is now active. The winners for June were Sarah Harper, Asthma Nurse Specialist, who was nominated by a patient saying that Sarah had gone out of her way to provide care that was above and beyond what was expected and Katie Symonds, Cringleford Ward Sister, nominated by a colleague who said Katie was always positive and professional, considering the needs of patients and staff at all times. And Nurse Abigail Law, who is based in the hospital's operations centre was highly commended for organising a special day for a young patient who was celebrating their birthday in hospital.

CORE SLIDE 38

Finance Summary – Lead Director Sheila Budd

	Finance	Full Year Plan 16/17	Jun-16 Actual	YTD Actual	YTD Plan	Variance from YTD Plan
1	Total income excluding interest	£562,083k	£46,870k	£138,196k	£138,897k	(£701k)
2	Total Pay Costs	£320,459k	£27,232k	£80,871k	£79,886k	(£985k)
3	Other Operating Expenditure (excluding drugs)	£158,847k	£13,355k	£38,471k	£39,331k	£860k
4	EBITDA	£13,582k	£888k	£1,803k	£2,464k	(£661k)
5	CIP Savings Achieved	£17,632k	£509k	£1,986k	£3,416k	(£1,430k)
6	Closing Cash balance	£1,205k	£15,777k	£15,777k	£12,457k	£3,320k
7	Capital expenditure	£16,000k	£680k	£1,443k	£2,221k	(£778k)
8	Non-Elective Activity - marginal rate - Financial Impact *	£7,756k	£782k	£2,265k	£1,901k	(£364k)
9	Emergency readmissions penalties: Following Elective & Non Elective *	£2,125k	£172k	£460k	£521k	£61k
10	Financial Sustainability Risk Rating (FSRR)	1		2/2*	1	
11	Deficit for the year	(£32,064k)	(£2,806k)	(£9,257k)	(£8,979k)	(£278k)

***Please note these figures are provisional**

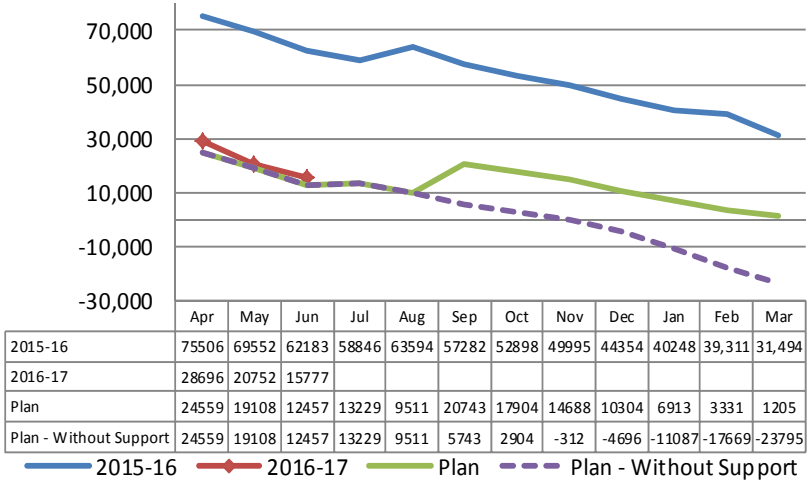
- The YTD cumulative position is an adverse variance of £278k. The result for M3 (discrete) was £135k adverse to plan. The key items in month are overspends in Pay (£712k) & Non-Clinical Supplies (£195k) offset by Clinical Income (£179k), other income excl Drugs, (£266k), other non pay and non opex (£327k)
- The M3 Pay overspend of £712k compares to overspends in prior months of M01 (£191k underspend) & M2 (£464k). This continual rise in cost is concerning and compliance with controls over locum and agency cost is in review.
- NHSI have, in writing, stated that we should not commit to any additional uncommitted expenditure, this is in the context of pay expenditure and NHSI's focus on pay growth.
- Penalties for Q1 of £222k have been reflected in the M03 position.
- Cash is £3.3m ahead of plan, explained by capital expenditure and other short term timing differences.
- A new 13 week rolling cash forecast is included in the appendices. It shows cash pinch points in September and a serious cash issue in November - consistent with the annual plan. We have been advised by NHSI that we should not stretch creditor days. Because of this we shall need cash in September, earlier than plan. The process to set up and access a working capital facility is now in train.
- Pay is £712k (2.7%) overspent. The overspending areas are Surgery (£0.4m), Medicine (£0.4m), Emergency (£0.2m), Clinical Support (£0.2m), Services (£0.2m). This is mitigated in part by contingency & other reserves slippage.
- Locum costs were £1.0m in month being £0.3m lower than both M1/M2 respectively (see graph for more details). £0.4m in Emergency.
- Agency costs were £1.6m in month being £0.3m/£0.1m higher than M1/M2 respectively: Emergency (£0.3m), Medicine (£0.7m) and Clinical Support (£0.3m), Surgery (£0.3m), (see graph for more details).
- Non Clinical Supplies were £0.2m over plan in M3. £61k relates to FIP costs being more than envisaged at the time of the annual plan.
- Clinical Supplies were £0.1m under plan in M3. See Clinical Supplies section.
- CIP plan for the month was £1.3m, of which £1.0m relates to Pay costs. The Pay CIP achieved was £0.2m thus underachieving by £0.8m. The main underachieving areas are Emergency, Medicine & Surgery. Focus on controls & remedial action driven by the PMO. It is possible that the overall CIP performance may improve following review – through allocation of reserves where overspends can be matched to reserve development plans.
- The Non-Pay element of the M03 CIP delivered 'net' the £0.3m of savings assumed. Proper plans for savings are in development with the PMO.
- Cumulatively the CIP is £1.5m behind, relating to Pay.
- NHSI has requested a forecast update for 2016/17 as part of the quarterly return for June 2016. It is again proposed that a no change overall forecast is submitted based on the very small variance to plan at M3.

Finance

CORE SLIDE 39

Lead Director - Sheila Budd

Closing Cash balance



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015-16	75506	69552	62183	58846	63594	57282	52898	49995	44354	40248	39,311	31,494
2016-17	28696	20752	15777									
Plan	24559	19108	12457	13229	9511	20743	17904	14688	10304	6913	3331	1205
Plan - Without Support	24559	19108	12457	13229	9511	5743	2904	-312	-4696	-11087	-17669	-23795

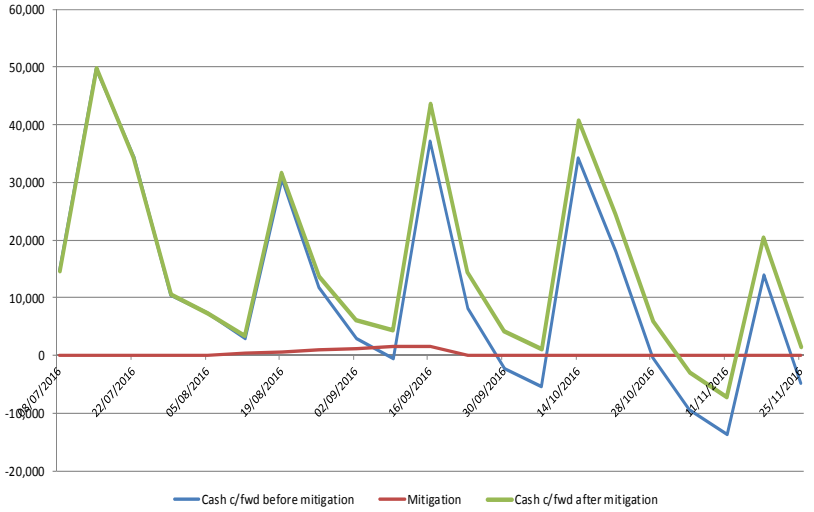
Issues

- Closing cash at the end of M3 was £15.8m being £3.3m better than plan.
- The main reason is short term timing differences on capital expenditure (£800k) & working capital movements, which will reverse.

Actions

- A 13 week rolling cash flow forecast has been developed and is included as appendix 4 to the financial appendices. It shows the pinch points within months and a negative position in September. Access to a working capital facility is now in train.
- A tight focus on working capital management is being maintained & improved.

Rolling week cash flow forecast



Issues

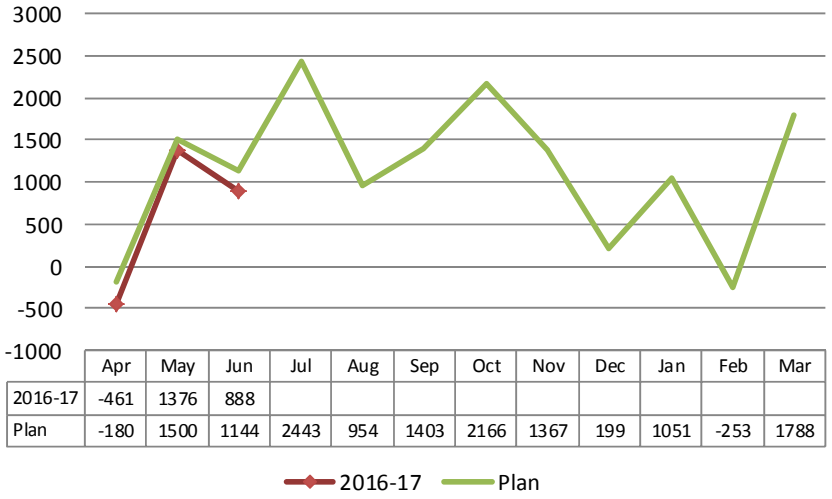
- Pattern of income and expenditure creates pinch point weeks within a monthly 'period'.
- Annual Plan included £3m cash flow improvement through stretching payment terms, however NHSI advised that this should not be implemented.
- Formal agreements with DH are in train to confirm a working capital facility.
- **Risks include**; ***(i) timing*** - clinical income over-performance being withheld by CCGs pending queries, other NHS bodies implementing similar strategies & delaying payment to the NNUH and ***(ii) amount*** – penalties, CQUIns and commissioner QIPPS.

Finance

CORE SLIDE 39

Lead Director - Sheila Budd

EBITDA



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2016-17	-461	1376	888									
Plan	-180	1500	1144	2443	954	1403	2166	1367	199	1051	-253	1788

Issues

- At the end of month 3, EBITDA is £661k behind plan due to clinical income and non-NHS income being behind plan & underspends within Operating Expenses.

Actions

- Focus on forward review of planned activity to inform actions to improve clinical income & productivity.
- Improve scrutiny of all variances and holding to account for actions needs to form part of the monthly operational performance review.
- All variances, no matter how small, are important to our financial performance.

CIP Performance

Issues

- The CIP for Pay is being assessed cumulatively by specialty. Those specialties within budget on a cumulative basis have delivered their CIP which in aggregate is £1,201k. This ignores those specialties who are over budget & who have not met their CIP. The Pay CIP for the quarter was £2,660k.
- It is important to view the Trust-wide position as this shows an overspend on Pay by £985k. The Trust-wide position shows an aggregation of all over & underspent budgets.

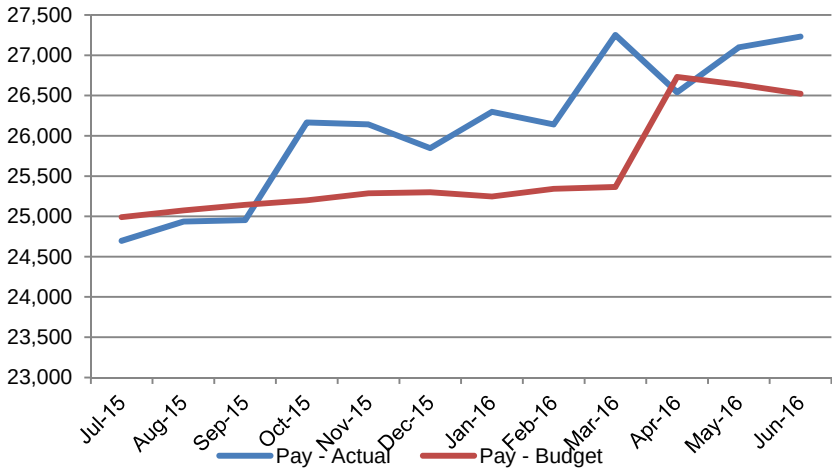
CIP backdrop

- The cost improvement target for 2016/17 is £17,632k (3.1% of turnover).
- The focus is cost savings – not income generation.
- Plans have been produced by Divisions to save £14.1m of pay costs mainly through reducing agency and locum costs via recruitment and compliance with required 'caps'.
- FIP PMO view is that plans are more akin to ideas / aspiration and need detailed work up – hence risk over full delivery in year.
- The remainder of £3.5m will be delivered through cost savings in non pay - Clinical Supplies (£1,463k), Non-clinical supplies (£2,068k). Development of specific plans needs prioritisation & is being addressed in monthly performance review meetings.
- Existing 'Newton' productivity plans along with the delayed Outpatient plan will continue as CIP's and contribute to the capacity required to deliver the stretching activity plan assumed for 2016/17.
- Review and challenge of CIP performance is subject to fortnightly meetings between divisional and board execs.
- **Achievement is imperative. It will require a whole team effort and focus.**

CORE SLIDE 40

Lead Director - Sheila Budd

Pay – Plan & Actual rolling 12 months



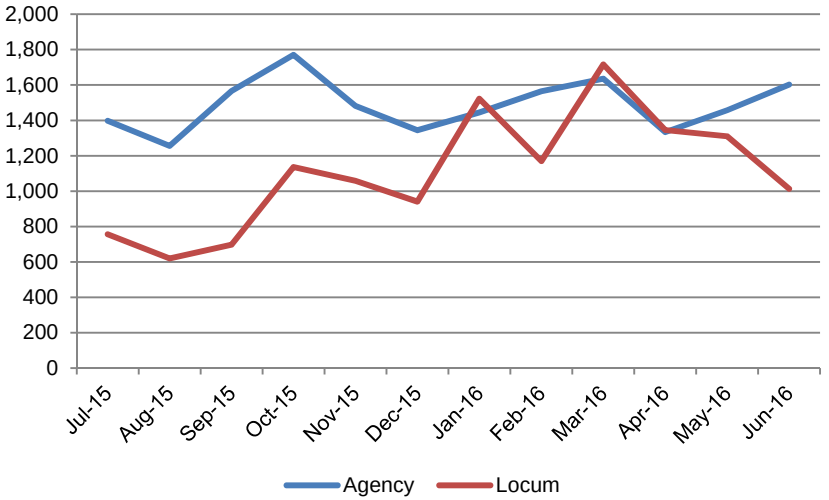
Issues

- In June, Pay was overspent by £712k, being 2.7%.
- In month overspends within the Divisions included Surgery (£0.4m), Medicine (£0.4m), Emergency (£0.2m), Clinical Support (£0.2m), Services (£0.2m).
- Underspend on reserves including Contingency.
- Pay CIP has under-delivered by £1.5m cumulatively.
- Cumulative overspend included CIP failure mitigated in large part by £2.6m underspend on Reserves YTD

Planned Actions

- PWC/FIP focusing on premium cost reduction in particular controls over associated spend. The FIP looks to address non-compliance with operational & financial controls in use of premium paid staff.
- Focus on recruitment to vacant posts to limit reliance on locums, agency & other premium payroll costs
- Active planning for every locum post to displace it.
- Further development of new locum and agency reports which now provide granular detail ,in progress led by workforce and FIP team.

Pay – Locums & Agency (actual) rolling 12 months



Issues

- Agency spend in M3 was £1,602k. The average cost of all agency (month 1-12/7-12) for 15/16 was £1,379k/£1,540k pm.
- Agency spend in M3 was £207k higher than current year average & £34k lower than M12 (15/16).
- Locum spend in M3 was £1,014k. The average cost of all locums (month 1-12/7-12) for 15/16 was £942k/£1,257k pm.
- Locum spend in M3 was £702k lower than M12 15/16.

Planned Actions

- PWC/FIP focusing on premium cost reduction in particular controls over associated spend.
- FIP to focus on securing good 'reason' analysis / explanations.
- Continued focus on use of framework agencies which adhere to the Cap to minimize premium payments.
- Locum spend - drive usage of internal locums and recruitment to vacancies.
- Active planning for every locum post to displace it.

CORE SLIDE 41

Lead Director - Sheila Budd

Key Risks to Financial Plan

- The Annual Plan for 2016/17 projects a deficit of £32.1m.
- The Cash Flow shows a cash balance of £1.2m at 31 March 2017. This is after assuming receipt of distressed funding totalling £25m (£15m revenue, £10m capital).
- Without support the Trust will run out of cash in November 2016. Formal agreement to provide support has not yet been progressed with NHSI
- Capacity risk - failure to deliver planned clinical activity has significant financial consequences. The plan assumes 3% more activity than 2015/16 outturn plus additional to meet targets. The 3% contributes £6.1m to our net position.
- Penalty risk – dependent upon agreement of deliverable trajectories for target achievement and robust contractual protection against all penalties. £245k incurred to date (see new financial appendix).
- CIP plans under-deliver / slip. A 25% slippage is £4.4m. It is dependent upon quick reduction of premium pay costs.
- CQUIN risk - @ £9m of clinical income is dependent upon ownership of and tight focus on delivery of the CQUIN measures
- CCG savings plans risk of £10m. We have assumed that we can mitigate this in full. This is dependent on delivery of a number of, projects which require ownership and management.

Securing support funding

- Our going concern assessment is predicated upon receipt of support / distressed funding from the Department of Health.
- The Annual Plan assumes receipt of £15m revenue support and £10m capital support.
- Since providing our 13 week rolling cash flow forecast, NHSI have started the formal process for us to access a working capital support facility.
- Security over funding is fundamental.

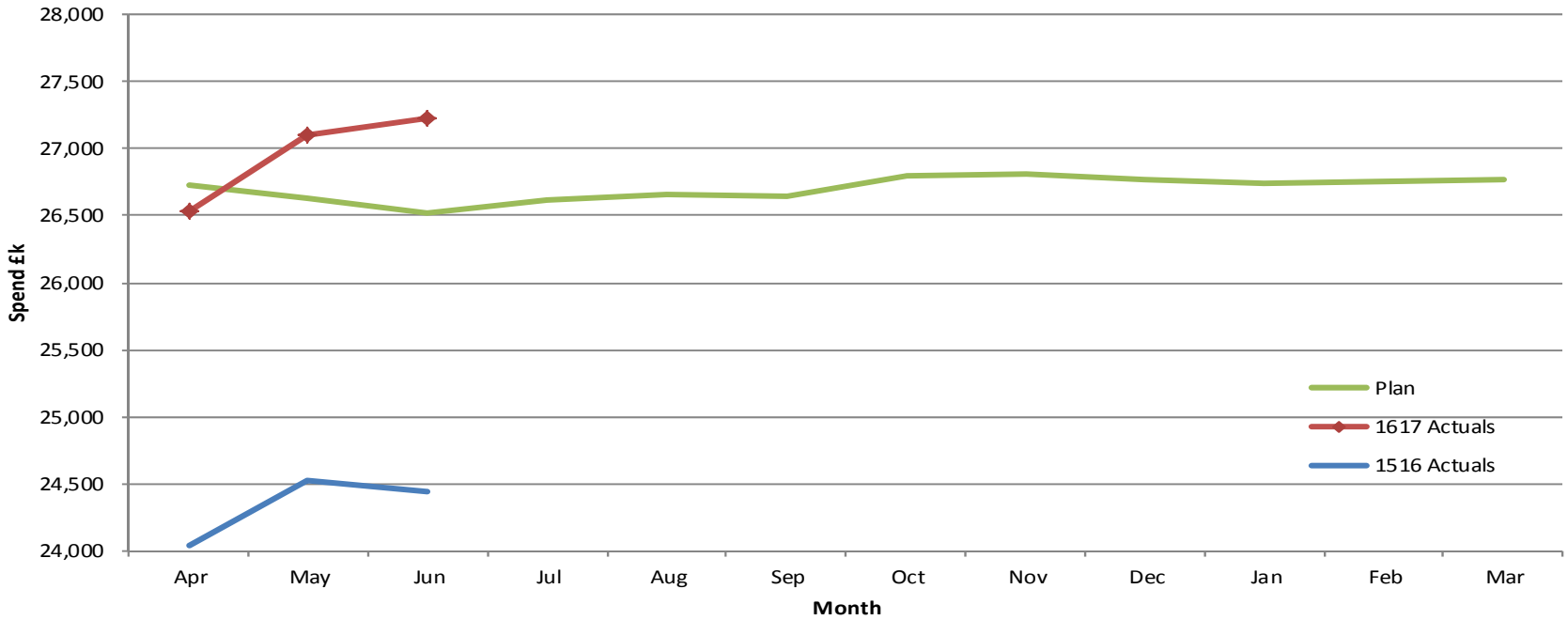
Key Risks to Financial Plan

Risk	Comment/concern
Cash	Cash is reducing as envisaged. Now in the process for securing formal access to a working capital support facility.
Capacity	To date, value of work done supports planned income. Capacity remains a risk.
Penalty	Penalties for M1 & M2 total £1.9m After agreed re-investment the cost falls to £173k. The estimate for Q1 is £245k which has been reflected in the Q1 position. This area remains a key risk.
CIP	The CIP Pay plans are being reviewed by the PMO. We are behind plan, thus this is risk is crystallising. Remedial action is imperative.
CQUIN	Evaluation of Q1 is full delivery. An update on full year risk will be provided at the meeting.
CCG QIPP	Agreement with CCGs on local prices remains in discussion. Concern is that CCGs apply their savings threshold from 1 July. Dialogue ongoing. This is a significant risk.

CORE SLIDE 42

Lead Director - Sheila Budd

Pay actual v budget for 2016/17

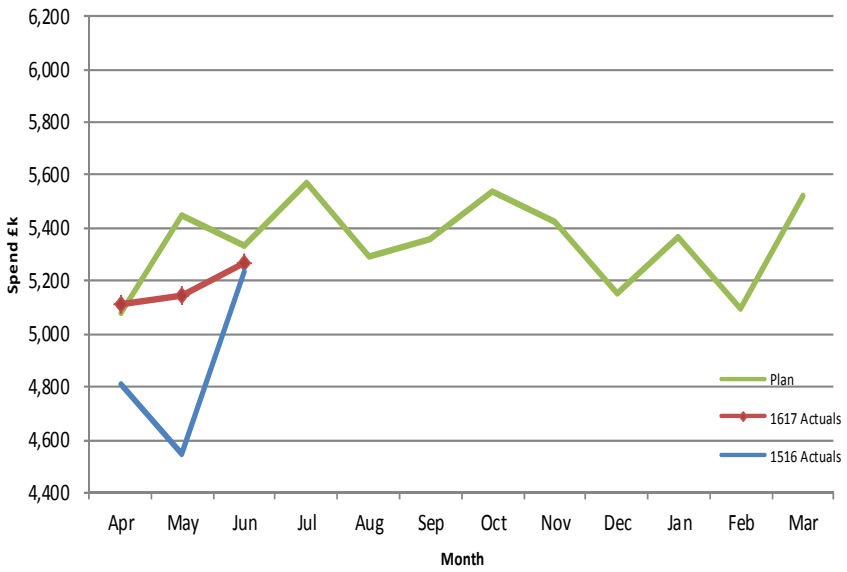


- The Pay cost for the Trust is rising on a monthly basis. Whilst locums have reduced in M3, this was offset by an increase in agency.
- M3 saw increases in Pay costs relative to the average cost in M1-M2 of £0.4m; being agency £0.2m & bank £0.2m.
- The Divisions experiencing increases in Pay costs relative to the average cost in M1-M2 were; Surgery £0.2m, Services £0.1m, Clinical Support £0.1m, Cancer £0.1m. Emergency Pay costs reduced in M3 by £0.2m.
- Cumulative Pay expenditure is £80,871k against a budget of £79,886k. An adverse variance of £985k (1.2%)
- The on going increase in monthly cost needs focused attention. Controls over booking locum and agency staff are being tightened to ensure adhered to. Consideration should be given to taking control of this centrally.
- NHSI have, in writing, stated that we should not commit to any additional uncommitted expenditure. This is in the context of pay growth nationally.

CORE SLIDE 43

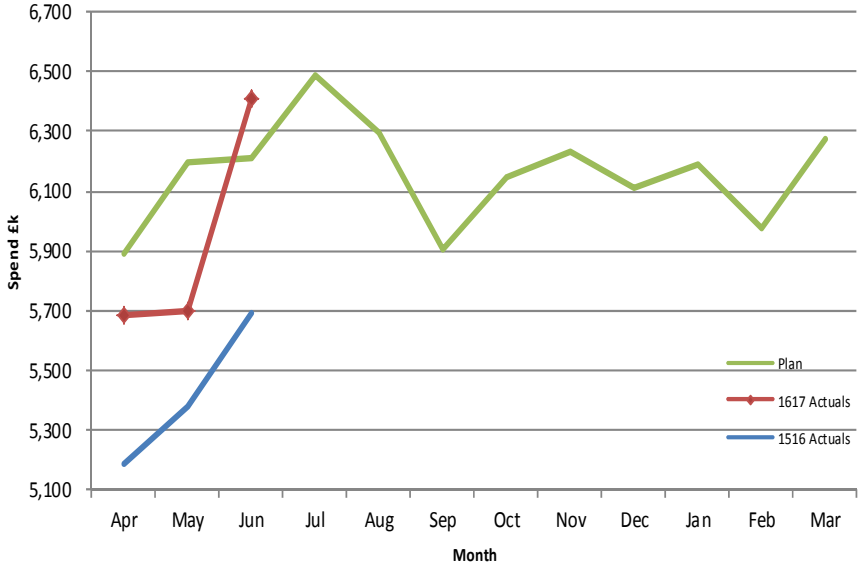
Lead Director - Sheila Budd

Clinical Supplies



- M3 was £64k (1.2%) underspent against the plan for the month. Cumulatively £330k (2.1%) underspent.
- The overall favourable variance of £330k in the YTD relates to underspends in Surgery (Pain Relief Clinic £0.1m & Urology Theatres £0.2m) with other variances netting and covering the CIP to date of £305k. The CIP needs a proper plan. FIP working on this.

Non-Clinical Supplies

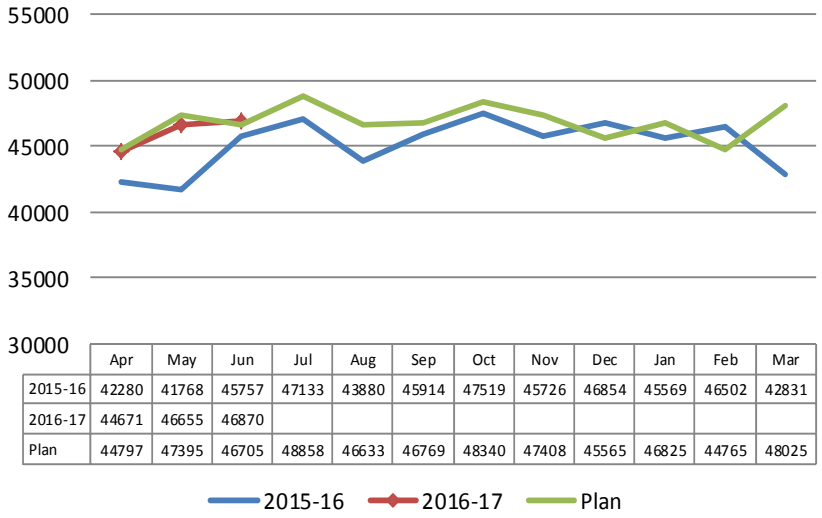


- M3 was £195k (3.1%) overspent against the plan for the month. However, cumulatively it is £505k (2.8%) underspent.
- The main driver of the M3 increase in cost is the £443k PWC fee relating to the FIP, being £61k more than budget.
- The favourable variance of £505k in the YTD relates to underspends in R&D and Clinical Trials (£516k – which is matched by an underachievement in income) and a number of underspends / reserves which 'cover' the CIP expectation of £516k to date. The CIP needs a proper plan. FIP working on this.

CORE SLIDE 44

Lead Director - Sheila Budd

Total income excluding interest



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015-16	42280	41768	45757	47133	43880	45914	47519	45726	46854	45569	46502	42831
2016-17	44671	46655	46870									
Plan	44797	47395	46705	48858	46633	46769	48340	47408	45565	46825	44765	48025

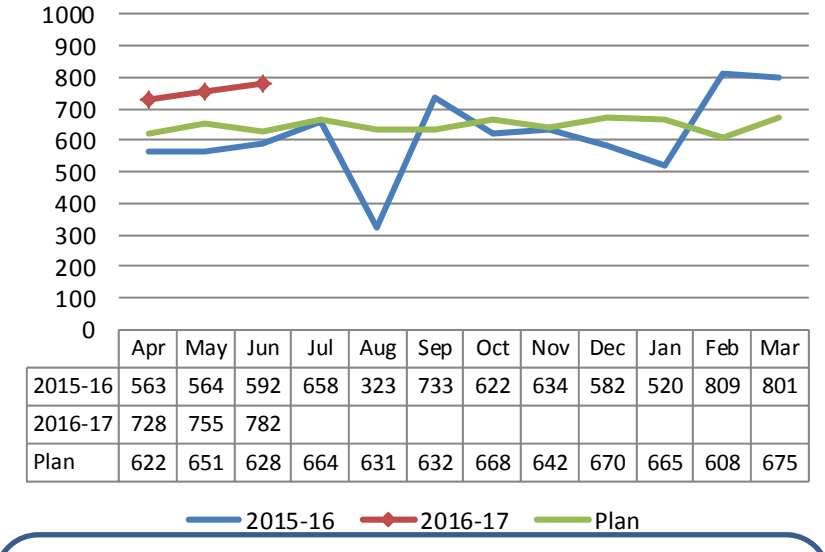
Issues

- Total income is £138.2m, £0.7m behind plan. Excluding non-tariff drugs, which are largely offset by additional drug costs, it is £0.674m behind plan.
- Clinical income for M3 is on plan – per fast track assessment.
- Penalty costs of £245k have been reflected.

Actions

- Actively manage clinical income query process to secure cash and be clear on real income risk.
- Actively manage the commissioner QIPPS as these 'bite' in M4 onwards.
- Agreement over proposals to mitigate Commissioner QIPPS has not yet been reached – hence concern over risk in clinical income for M4 onwards until agreements made.

Non-Elective Activity - marginal rate - Financial Impact



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2015-16	563	564	592	658	323	733	622	634	582	520	809	801
2016-17	728	755	782									
Plan	622	651	628	664	631	632	668	642	670	665	608	675

Issues

- The reduction in income relating to the marginal rate associated with the volume of non-elective admissions is £2,265k to date. This is £364k worse than plan.
- The reduction in income relating to readmissions within 30 days is £461k to date. This is in line with plan.

Actions

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

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

Income Statement

3 month position to 30 June 2016

	Ledger Plan £'000	YT Jun-15 Actual £'000	Year to date Actual £'000	Year to date Budget £'000	Year to date Variance £'000	Forecast to 31st March 2016 Forecast £'000	Forecast to 31st March 2016 Budget £'000	Forecast to 31st March 2016 Variance £'000
INCOME								
NHS clinical income								
Clinical Income	427,619	97,223	105,557	105,812	(255)	427,619	427,619	
NT Drugs	58,268	12,544	14,470	14,497	(27)	58,268	58,268	
Total NHS clinical income	**485,887**	**109,767**	**120,027**	**120,309**	**(282)**	**485,887**	**485,887**	
Non NHS clinical income								
Private patients	2,021	435	256	505	(249)	2,021	2,021	
Other - RTA	1,376	299	256	344	(88)	1,376	1,376	
Total Non NHS clinical income	**3,397**	**734**	**512**	**849**	**(337)**	**3,397**	**3,397**	
Other Income								
R&D	23,188	5,509	5,550	5,797	(247)	23,188	23,188	
Education & Training	20,713	4,839	4,975	5,178	(203)	20,713	20,713	
Other non patient care income	28,898	8,956	7,132	6,764	368	28,898	28,898	
Total other Income	**72,799**	**19,304**	**17,657**	**17,739**	**(82)**	**72,799**	**72,799**	
TOTAL OPERATING INCOME	**562,083**	**129,805**	**138,196**	**138,897**	**(701)**	**562,083**	**562,083**	
EXPENDITURE								
Employee benefit expenses	(320,459)	(73,003)	(80,871)	(79,886)	(985)	(321,444)	(320,459)	(985)
Drugs	(69,195)	(14,463)	(17,051)	(17,216)	165	(69,195)	(69,195)	
Clinical supplies	(64,169)	(14,588)	(15,530)	(15,860)	330	(63,839)	(64,169)	330
Non clinical supplies	(73,930)	(16,264)	(17,797)	(18,302)	505	(73,425)	(73,930)	505
PFI operating expenses	(20,748)	(5,221)	(5,144)	(5,169)	25	(20,723)	(20,748)	25
TOTAL OPERATING EXPENSES	**(548,501)**	**(123,539)**	**(136,393)**	**(136,433)**	**40**	**(548,626)**	**(548,501)**	**(125)**
Profit/(loss) from operations	**13,582**	**6,266**	**1,803**	**2,464**	**(661)**	**13,457**	**13,582**	**(125)**
Non-operating income								
Interest	177	70	29	45	(16)	177	177	
Profit/(loss) on asset disposals	(40)	9	14	(10)	24	(40)	(40)	
Total non-operating income	**137**	**79**	**43**	**35**	**8**	**137**	**137**	
Non-operating expenses								
Interest on PFI and Finance leases	(17,812)	(4,473)	(4,419)	(4,419)		(17,812)	(17,812)	
Depreciation	(13,837)	(3,394)	(3,236)	(3,615)	379	(13,712)	(13,837)	125
PDC	(2,866)	(596)	(717)	(717)		(2,866)	(2,866)	
Other - Contingent Rent	(11,268)	(2,528)	(2,731)	(2,727)	(4)	(11,268)	(11,268)	
Total non operating expenses	**(45,783)**	**(10,991)**	**(11,103)**	**(11,478)**	**375**	**(45,658)**	**(45,783)**	**125**
Surplus (deficit) after tax from continuing operations	**(32,064)**	**(4,646)**	**(9,257)**	**(8,979)**	**(278)**	**(32,064)**	**(32,064)**	
Memo:								
Donated Asset Additions		27						
Surplus (deficit) after tax and Donated Asset Additions	**(32,064)**	**(4,619)**	**(9,257)**	**(8,979)**	**(278)**	**(32,064)**	**(32,064)**	

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

Statement of Position

Position as at 30 June 2016

	2016/17 £'000 Actual Year to Date	2016/17 £'000 Budget Year to Date	2016/17 £'000 Plan Full Year	2015/16 £'000 Audited Actual Full Year
Assets				
Assets, Non-Current				
Property, Plant and Equipment, Net	73,717	74,091	82,370	73,912
PFI: Property, Plant and Equipment, Net	208,199	208,214	208,979	209,798
NHS Trade Receivables, Non-Current				
Non NHS Trade Receivables, Non-Current	1,277	1,364	1,364	2,629
Prepayments, Non-Current	64,021	64,097	63,401	61,241
Assets, Non-Current, Total	**347,214**	**347,766**	**356,114**	**347,580**
Assets, Current				
Inventories	8,715	8,434	8,434	8,434
NHS Trade Receivables, Current	13,337	22,167	25,758	13,929
Non NHS Trade Receivables, Current	3,096	5,110	5,110	5,110
PDC Receivables, Current				232
Accrued Income	10,369	3,963	3,415	3,415
Prepayments, Current, non-PFI related	3,933	3,585	3,023	3,023
Cash	15,777	12,457	1,205	31,494
Assets, Current, Total	**55,227**	**55,716**	**46,945**	**65,637**
ASSETS, TOTAL	**402,441**	**403,482**	**403,059**	**413,217**
Liabilities				
Liabilities, Current				
Deferred Income, Current	(22,860)	(21,548)	(20,084)	(21,784)
Provisions, Current	(806)	(671)	(202)	(862)
Current Tax Payables	(6,413)	(5,594)	(5,594)	(5,594)
Trade Creditors, Current	(10,833)	(16,331)	(18,846)	(15,846)
Other Creditors, Current	(4,280)	(5,854)	(5,854)	(5,854)
Capital Creditors, Current	(1,305)	(1,835)	(1,835)	(1,835)
Accruals, Current	(32,129)	(27,485)	(27,384)	(27,384)
Finance Leases, Current	(121)	(121)	(168)	(162)
PFI leases, Current	(2,514)	(2,514)	(2,972)	(3,360)
Liabilities, Current, Total	**(81,261)**	**(81,953)**	**(107,939)**	**(82,681)**
NET CURRENT ASSETS (LIABILITIES)	**(26,034)**	**(26,237)**	**(60,994)**	**(17,044)**
Liabilities, Non-Current				
Deferred Income, Non-Current	(7,308)	(7,306)	(7,228)	(7,333)
Provisions, Non-Current	(2,779)	(2,852)	(2,748)	(2,852)
Finance Leases, Non-current	(335)	(335)	(167)	(335)
PFI leases, Non-Current	(199,076)	(199,076)	(196,102)	(199,076)
Liabilities, Non-Current, Total	**(209,498)**	**(209,569)**	**(206,245)**	**(209,596)**
TOTAL ASSETS EMPLOYED	**111,682**	**111,960**	**88,875**	**120,940**
Taxpayers' and Others' Equity				
Taxpayers Equity				
Public dividend capital	25,105	25,105	25,105	25,105
Retained Earnings (Accumulated Losses)	21,217	21,336	(1,443)	30,214
Revaluation Reserve	65,360	65,519	65,213	65,621
TAXPAYERS EQUITY, TOTAL	**111,682**	**111,960**	**88,875**	**120,940**
TOTAL ASSETS EMPLOYED	**111,682**	**111,960**	**88,875**	**120,940**

Cash Flow Statement

Position as at 30 June 2016

	£'000 Actual Year to Date	2016/17 £'000 Budget Year to Date	£'000 Variance Year to Date	2016/17 £'000 Plan Full Year	2015/16 £'000 Audited Actual Full Year
(Deficit) after tax including donated assets	**(9,257)**	**(8,979)**	**(278)**	**(32,064)**	**(21,930)**
Non-cash flows in operating surplus					
Finance income/charges	7,121	7,101	20	28,903	27,611
Depreciation and amortisation, total	3,236	3,615	(379)	13,837	13,843
(Loss) on disposal of property plant and equipment	(14)	10	(24)	40	63
PDC dividend expense	717	717		2,866	1,869
Non-cash flows in operating surplus, Total	**11,060**	**11,443**	**(383)**	**45,646**	**43,386**
Operating Cash flows before movements in working capital	**1,803**	**2,464**	**(661)**	**13,582**	**21,456**
Increase/(Decrease) in working capital					
(Increase) in inventories	(281)		(281)		(190)
Decrease in NHS Trade Receivables	592	(8,238)	8,830	(11,829)	(6,615)
Decrease in Non NHS Trade Receivables	2,014		2,014		(943)
(Increase) in accrued income	(6,954)	(548)	(6,406)		(471)
(Increase) in prepayments	(910)	(562)	(348)		(956)
Increase in Deferred Income (excluding Donated Assets)	1,051	(263)	1,314	(1,805)	(8,217)
(Decrease) in provisions	(129)	(191)	62	(764)	(1,141)
Increase in tax payable	819		819		154
(Decrease) in Trade Creditors	(5,498)		(5,498)	3,000	(878)
(Decrease) in Other Creditors	(1,574)		(1,574)		1,008
Increase in accruals	4,745	101	4,644		933
Increase in other Other Financial liabilities					(180)
(Decrease) in working capital, Total	**(6,125)**	**(9,701)**	**3,576**	**(11,398)**	**(17,496)**
Net cash inflow/(outflow) from operating activities	**(4,322)**	**(7,237)**	**2,915**	**2,184**	**3,960**
Net cash flow from investing activities					
Property, plant and equipment - non-maintenance expenditure	(619)	(2,221)	1,602	(21,517)	(8,710)
Proceeds on disposal of property, plant and equipment	14		14		10
(Decrease) in Capital Creditors	(1,354)		(1,354)		976
Other cash flows from investing activities	(2,780)		(2,780)		(6,254)
Net cash (outflow) from investing activities, Total	**(4,739)**	**(2,221)**	**(2,518)**	**(21,517)**	**(13,978)**
Net cash inflow/(outflow) before financing	**(9,061)**	**(9,458)**	**397**	**(19,333)**	**(10,018)**
Net cash inflow/(outflow) from financing activities					
PDC Dividends paid				(2,634)	(1,954)
Interest element of finance lease rental payments - *Other*	(7)	(7)		(27)	(18)
Interest element of finance lease rental payments - *On-balance sheet PFI*	(4,412)	(4,412)		(17,596)	(17,878)
Interest element of finance loans				(189)	
Capital element of finance lease rental payments - *Other*	(41)	(41)		(162)	(172)
Capital element of finance lease rental payments - *On-balance sheet PFI*	(846)	(846)		(3,362)	(3,541)
Interest received on cash and cash equivalents	29	45	(16)	177	231
Movement in Other grants/Capital received					15
(Increase)/decrease in non-current receivables	1,352	(1,591)	2,943	(895)	637
Distressed funding required - Revenue cash requirement				15,000	
Distressed funding required -Capital cash requirement				10,000	
Other cash flows from financing activities	(2,731)	(2,727)	(4)	(11,268)	(9,946)
Net cash (outflow) from financing activities, Total	**(6,656)**	**(9,579)**	**2,923**	**(10,956)**	**(32,626)**
Net increase/(decrease) in cash and cash equivalents	**(15,717)**	**(19,037)**	**3,320**	**(30,289)**	**(42,644)**
Opening cash and cash equivalents	31,494	31,494		31,494	74,138
Closing cash and cash equivalents	**15,777**	**12,457**	**3,320**	**1,205**	**31,494**

CURRENT WEEK - SUMMARY

Consolidated short term cash forecast

RAG	£'000 Week ended	Actual 01 Jul	Actual 08 Jul	Forecast 15 Jul	Forecast 22 Jul	Forecast 29 Jul	Forecast 05 Aug	Forecast 12 Aug	Forecast 19 Aug	Forecast 26 Aug	Forecast 02 Sep	Forecast 09 Sep	Forecast 16 Sep	Forecast 23 Sep	Forecast 30 Sep	Forecast 07 Oct	Forecast 14 Oct	Forecast 21 Oct	Forecast 28 Oct	Forecast 04 Nov	Forecast 11 Nov	Forecast 18 Nov	Forecast 25 Nov
		Jul-16					Aug-16				Sep-16					Oct-16				Nov-16			
	Balance B/F	**13,923**	**15,863**	**6,634**	**49,785**	**34,413**	**10,485**	**7,294**	**3,004**	**30,502**	**11,725**	**2,902**	**(556)**	**37,102**	**8,067**	**(2,290)**	**(5,302)**	**34,297**	**18,065**	**(410)**	**(9,414)**	**(13,671)**	**14,023**
	Clinical Income (inflow)																						
G	Clinical Income	184	15	32,740					32,925				32,925				32,925					32,925	
A	Drugs	57	19	4,594					4,623				4,623				4,623					4,623	
A	Over/Under performance	536							2,099				2,234				2,278					2,372	
	Other income (inflow)																						
G	Health Education		1,596	168					1,764				1,764				1,764					1,764	
A	NHS	263	1,048	595	195	685	195	195	595	305	195	775	595	195	305	195	916	595	685	195	195	595	305
A	NON NHS	561	245	365	245	244	245	391	245	244	245	392	245	244	244	392	245	245	244	244	392	245	244
A	R&D			1,690					1,690				2,000				1,690					1,690	
G	VAT	1,368					1,519				1,519					1,519				1,519			
		2,969	**2,923**	**40,152**	**440**	**929**	**1,959**	**586**	**43,941**	**549**	**1,959**	**1,167**	**44,386**	**439**	**549**	**2,106**	**44,441**	**840**	**929**	**1,958**	**587**	**44,214**	**549**
	Payroll (outflow)																						
G	Salaries	1,462	560	500	500	14,400	500	500	500	14,500	500	500	500	14,500	450	500	500	500	14,500	500	500	500	14,770
G	Superannuation				4,087				4,137					4,167				4,167				4,167	
G	Inland Revenue				6,477				6,556					6,603				6,603				6,603	
	Non-pay (outflow)																						
R	NON NHS	2,435	3,183	3,231	3,395	3,392	3,703	3,429	3,398	3,391	3,705	3,393	3,437	3,392	3,390	3,704	3,432	3,405	3,394	3,708	3,435	3,403	3,396
A	NHS	262	189	117	517	437	579	579	626	579	437	437	437	517	437	546	546	626	546	541	541	621	541
A	Pharmacy	997																					
G	Litigation			862					862				862					862				862	
A	R&D	117	200	295	295	295	368	368	368	368	295	295	295	295	295	368	368	368	368	368	368	368	368
G	Standing Order				541													541					
G	Octagon	5,660				5,845					5,845				5,845					5,845			
		10,933	**4,132**	**5,005**	**15,812**	**24,369**	**5,150**	**4,876**	**16,447**	**18,838**	**10,782**	**4,625**	**5,531**	**29,474**	**10,417**	**5,118**	**4,846**	**17,072**	**18,808**	**10,962**	**4,844**	**16,524**	**19,075**
	Cash from operations	**(7,964)**	**(1,209)**	**35,147**	**(15,372)**	**(23,440)**	**(3,191)**	**(4,290)**	**27,494**	**(18,289)**	**(8,823)**	**(3,458)**	**38,855**	**(29,035)**	**(9,868)**	**(3,012)**	**39,595**	**(16,232)**	**(17,879)**	**(9,004)**	**(4,257)**	**27,690**	**(18,526)**
	Finance and capital																						
G	PDC												1,201										
G	Investments made/(returned)	(10,000)	8,000	(8,000)																			
A	Capital programme	97	20			488				488					489				596				342
G	Interest paid/received	(1)		(4)					(4)				(4)				(4)					(4)	
		(9,904)	**8,020**	**(8,004)**	**0**	**488**	**0**	**0**	**(4)**	**488**	**0**	**0**	**1,197**	**0**	**489**	**0**	**(4)**	**0**	**596**	**0**	**0**	**(4)**	**342**
	Net Inflow / (Outflow)	**1,940**	**(9,229)**	**43,151**	**(15,372)**	**(23,928)**	**(3,191)**	**(4,290)**	**27,498**	**(18,777)**	**(8,823)**	**(3,458)**	**37,658**	**(29,035)**	**(10,357)**	**(3,012)**	**39,599**	**(16,232)**	**(18,475)**	**(9,004)**	**(4,257)**	**27,694**	**(18,868)**
	Forecast Balance C/F - excluding mitigation	**15,863**	**6,634**	**49,785**	**34,413**	**10,485**	**7,294**	**3,004**	**30,502**	**11,725**	**2,902**	**(556)**	**37,102**	**8,067**	**(2,290)**	**(5,302)**	**34,297**	**18,065**	**(410)**	**(9,414)**	**(13,671)**	**14,023**	**(4,845)**
	Non NHS stretching								299	597	896	1,195	1,493	1,493									
	NHS stretching								61	90	49	69	97	82									
	Forecast Balance C/F - incl mitigation excl WCF	**15,863**	**6,634**	**49,785**	**34,413**	**10,485**	**7,294**	**3,363**	**31,549**	**13,717**	**6,157**	**4,290**	**43,523**	**14,488**	**4,131**	**1,119**	**40,718**	**24,486**	**6,011**	**(2,993)**	**(7,250)**	**20,444**	**1,576**
	Working Capital facility drawdown (inflow)																						
	Working Capital facility repayment (outflow)																						
	Forecast Balance C/F	**15,863**	**6,634**	**49,785**	**34,413**	**10,485**	**7,294**	**3,363**	**31,549**	**13,717**	**6,157**	**4,290**	**43,523**	**14,488**	**4,131**	**1,119**	**40,718**	**24,486**	**6,011**	**(2,993)**	**(7,250)**	**20,444**	**1,576**
	CASH INVESTED NOT INCLUDED IN C/F ABOVE	*0*	***8,000***	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*	*0*

Norfolk and Norwich University Hospitals NHS Foundation Trust

Set out below is the YTD capital spend, together with the plan - consistent with the submission made to NHSI as part of the Annual Plan. Following the Annual Plan submission, we are now in the process of updating the 5 year plan however, we know we will add of the order of £51m capital expenditure for the Electronic Patient Record (EPR) requirement, of which @ £28m will be required in the next two years ending 2018/19. The remainder will be incurred in the following eight years. Additional revenue expenditure will also be incurred. The business case for the EPR has already been provided to NHSI. An updated five year plan will be submitted to NHSI for the end of July.

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

2016/17 Capital Programme

Position as at 30 June 2016

		3 Year Planned Future Spend			2016/17 Annual Plan										
	3 Year Plan Total £'000	2016/17 £'000	2017/18 £'000	2018/19 £'000	M01 £'000	M02 £'000	M03 £'000	M04 £'000	M05 £'000	M06 £'000	Q3 £'000	Q4 £'000	Total 2016/17 £'000	Actual Spend YTD 2016/17 £'000	Variance to Reforecast Plan (over) / under £'000
Annual Plan Projects															
Mattishall Ward Fit Out	2,765	70	2,695	-	70	-	-	-	-	-	-	-	**70**	291	(221)
Weybourne Oncology Day Unit	985	985	-	-	-	146	146	146	146	147	254	-	**985**	-	292
Institute of Food, Health and Gut[1]	3,300	-	1,800	1,500	-	-	-	-	-	-	-	-	**-**	-	-
Monitoring Equipment	833	833	-	-	-	-	833	-	-	-	-	-	**833**	337	496
Pathology / EPA	720	720	-	-	60	60	60	60	60	60	180	180	**720**	2	178
E-Prescribing	334	334	-	-	28	28	28	28	28	28	84	82	**334**	-	84
Children's A&E Unit *	10,000	-	10,000	-	-	-	-	-	-	-	-	-	**-**	-	-
Ambulatory Care and Diagnostic Centre (ACAD) *	35,000	-	35,000	-	-	-	-	-	-	-	-	-	**-**	**-**	-
Total Annual Plan	**53,937**	**2,942**	**49,495**	**1,500**	**158**	**234**	**1,067**	**234**	**234**	**235**	**518**	**262**	**2,942**	**629**	**830**
Capital - Business as usual															
Med & Surg	3,964	1,938	264	1,762	161	161	161	161	161	161	483	489	**1,938**	731	(248)
IT	1,532	543	120	869	45	45	45	45	45	45	135	138	**543**	21	114
Estates	1,565	577	119	869	48	48	48	48	48	48	144	145	**577**	62	82
Total - Trust Funded Capital Through Performance Against Plan	**60,998**	**6,000**	**49,998**	**5,000**	**412**	**488**	**1,321**	**488**	**488**	**489**	**1,280**	**1,034**	**6,000**	**1,443**	**778**
Other Items															
IRU & Cardiology Capacity *	10,000	10,000	-	-	-	-	-	-	-	-	-	10,000	**10,000**	-	-
Donated Assets	-	-	-	-	-	-	-	-	-	-	-	-	**-**	-	-
TOTAL CAPITAL	**70,998**	**16,000**	**49,998**	**5,000**	**412**	**488**	**1,321**	**488**	**488**	**489**	**1,280**	**11,034**	**16,000**	**1,443**	**778**

[1] Contractually committed amount of £8.6m in total

Capital Commitments	**£'000**	**£'000**
Total Capital for 2016/17		16,000
Less: Centrally Funded Capital		(10,000)
Total Trust Funded Capital		**6,000**
Committed Spend from end of 2015/16 - orders placed	2,550	
Capital Committee & Chair Approvals Year to 30 June 2016	1,412	
Total Committed and Spent		(3,961)
Trust Funded Capital - Uncommitted		**2,039**

Breakdown of Committed and Spent Capital:	**£'000**
Purchases made and invoices received	1,443
Chair & Committee approvals awaiting order and orders placed not received	2,518
	3,961

Application of ratings system to current NNUH Performance

FSRR Metrics

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

What This Means

Net Current Assets Excluding Inventories x 360 / Total Operating Expenses

Profit/(loss) from operations + Interest Receivable / Non-Operating Expenses (Excluding Depreciation) + Capital Elements of Finance & PFI Leases

Surplus/(Deficit) + (Gains)/losses on Asset Disposal / Operating Income + Non-operating Income

Actual I&E Margin - Planned I&E Margin

Calculation of a FSRR score

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

Current Performance to 30 June 2016

Capital Service Capacity Metric

Profit / Loss from Operations	(Appendix 1)	1,803
Interest Receivable	(Appendix 1)	29
Total		**1,832**
Non-Operating Costs	(Appendix 1)	11,103
Less: Depreciation	(Appendix 1)	(3,236)
Add: Capital Elements of Lease Payments	(Appendix 3)	887
Total		**8,754**

Revenue generated covers commitments 0.21 times

Liquidity Metric

Net Current Assets	(Appendix 2)	(26,034)
Less: Inventories	(Appendix 2)	(8,715)
Total		**(34,749)**
Total Operating Expenses	(Appendix 1)	136,393
Annualised (x 12/3)		**545,572**

-22.9 Days worth of expenses held as cash equivalents

I&E Margin Metric

Surplus/(Deficit)	(Appendix 1)	(9,257)
(Gains)/losses on Asset Disposal	(Appendix 1)	(14)
Total		**(9,271)**
Operating Income	(Appendix 1)	138,196
Non- Operating Income	(Appendix 1)	43
Total		**138,239**

Actual I&E Margin is -6.71%

Variance in I&E Margin Metric

Surplus/(Deficit)	(Appendix 1)	(8,979)
(Gains)/losses on Asset Disposal	(Appendix 1)	10
Total		**(8,969)**
Operating Income	(Appendix 1)	138,897
Non- Operating Income	(Appendix 1)	35
Total		**138,932**

Planned I&E Margin is -6.46%

I&E Margin Variance is -0.25%

Summary - Score is 2/2*

Current Capital service capacity of 0.21 gives a score of 1 for this metric.
Current Liquidity of -22.9 days gives a score of 1 for this metric.
Current I&E Margin of -6.71% gives a score of 1 for this metric.
Current Variance in I&E Margin of -0.25% gives a score of 3 for this metric.

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

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

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

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

Income Statement Comparison - for the Month of June

	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	35,716	35,537	34,436	179	1%	1,280	4%
NT Drugs	4,578	4,858	4,423	(280)	(6%)	155	4%
Total NHS clinical income	**40,294**	**40,395**	**38,859**	**(101)**	**(0%)**	**1,435**	**4%**
Non NHS clinical income							
Private patients	108	168	258	(60)	(36%)	(150)	(58%)
Other - RTA	123	115	161	8	7%	(38)	(24%)
Total Non NHS clinical income	**231**	**283**	**419**	**(52)**	**(18%)**	**(188)**	**(45%)**
Other Income							
R&D	1,908	1,932	1,881	(24)	(1%)	27	1%
Education & Training	1,733	1,725	1,592	8	0%	141	9%
Other non patient care income	2,704	2,370	3,006	334	14%	(302)	(10%)
Total other Income	**6,345**	**6,027**	**6,479**	**318**	**5%**	**(134)**	**(2%)**
TOTAL OPERATING INCOME	**46,870**	**46,705**	**45,757**	**165**	**0%**	**1,113**	**2%**
EXPENDITURE							
Employee benefit expenses	(27,232)	(26,520)	(24,437)	(712)	(3%)	(2,795)	(11%)
Drugs	(5,395)	(5,769)	(5,063)	374	6%	(332)	(7%)
Clinical supplies	(5,271)	(5,335)	(5,234)	64	1%	(37)	(1%)
Non clinical supplies	(6,409)	(6,214)	(5,692)	(195)	(3%)	(717)	(13%)
PFI operating expenses	(1,675)	(1,723)	(1,784)	48	3%	109	6%
TOTAL OPERATING EXPENSES	**(45,982)**	**(45,561)**	**(42,210)**	**(421)**	**(1%)**	**(3,772)**	**(9%)**
Profit/(loss) from operations	**888**	**1,144**	**3,547**	**(256)**	**(22%)**	**(2,659)**	**(75%)**
Non-operating income							
Interest	9	15	25	(6)	(40%)	(16)	(64%)
Profit/(loss) on asset disposals	7	(4)		11	275%	7	
Total non-operating income	**16**	**11**	**25**	**5**	**45%**	**(9)**	**(36%)**
Non-operating expenses							
Interest on PFI and Finance leases	(1,473)	(1,473)	(1,491)		0%	18	1%
Depreciation	(1,087)	(1,205)	(1,145)	118	10%	58	5%
PDC	(239)	(239)	(198)		0%	(41)	21%
Other - Contingent Rent	(911)	(909)	(843)	(2)	(0%)	(68)	(8%)
Total non operating expenses	**(3,710)**	**(3,826)**	**(3,677)**	**116**	**3%**	**(33)**	**1%**
Surplus (deficit) after tax from continuing operations	**(2,806)**	**(2,671)**	**(105)**	**(135)**	**(5%)**	**(2,701)**	**(2572%)**
Memo:							
Donated Asset Additions							
Surplus (deficit) after tax and Donated Asset Additions	**(2,806)**	**(2,671)**	**(105)**	**(135)**	**(5%)**	**(2,701)**	**(2572%)**

Notes:

Calendar Days	30	30	30
Working Days	22	22	22

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

Income Statement Comparison - 3 month position to 30 June 2016

	Year to Date			Variances Fav / (Adv)			
	Actual	Budget	Prior year	To budget		To prior year	
	£'000	£'000	£'000	£'000	%	£'000	%
INCOME							
NHS clinical income							
Clinical Income	105,557	105,812	97,223	(255)	(0%)	8,334	9%
NT Drugs	14,470	14,497	12,544	(27)	(0%)	1,926	15%
Total NHS clinical income	**120,027**	**120,309**	**109,767**	**(282)**	**(0%)**	**10,260**	**9%**
Non NHS clinical income							
Private patients	256	505	435	(249)	(49%)	(179)	(41%)
Other - RTA	256	344	299	(88)	(26%)	(43)	(14%)
Total Non NHS clinical income	**512**	**849**	**734**	**(337)**	**(40%)**	**(222)**	**(30%)**
Other Income							
R&D	5,550	5,797	5,509	(247)	(4%)	41	1%
Education & Training	4,975	5,178	4,839	(203)	(4%)	136	3%
Other non patient care income	7,132	6,764	8,956	368	5%	(1,824)	(20%)
Total other Income	**17,657**	**17,739**	**19,304**	**(82)**	**(0%)**	**(1,647)**	**(9%)**
TOTAL OPERATING INCOME	**138,196**	**138,897**	**129,805**	**(701)**	**(1%)**	**8,391**	**6%**
EXPENDITURE							
Employee benefit expenses	(80,871)	(79,886)	(73,003)	(985)	(1%)	(7,868)	(11%)
Drugs	(17,051)	(17,216)	(14,463)	165	1%	(2,588)	(18%)
Clinical supplies	(15,530)	(15,860)	(14,588)	330	2%	(942)	(6%)
Non clinical supplies	(17,797)	(18,302)	(16,264)	505	3%	(1,533)	(9%)
PFI operating expenses	(5,144)	(5,169)	(5,221)	25	0%	77	1%
TOTAL OPERATING EXPENSES	**(136,393)**	**(136,433)**	**(123,539)**	**40**	**0%**	**(12,854)**	**(10%)**
Profit/(loss) from operations	**1,803**	**2,464**	**6,266**	**(661)**	**(27%)**	**(4,463)**	**(71%)**
Non-operating income							
Interest	29	45	70	(16)	(36%)	(41)	(59%)
Profit/(loss) on asset disposals	14	(10)	9	24	240%	5	56%
Total non-operating income	**43**	**35**	**79**	**8**	**23%**	**(36)**	**(46%)**
Non-operating expenses							
Interest on PFI and Finance leases	(4,419)	(4,419)	(4,473)		0%	54	1%
Depreciation	(3,236)	(3,615)	(3,394)	379	10%	158	5%
PDC	(717)	(717)	(596)		0%	(121)	(20%)
Other - Contingent Rent	(2,731)	(2,727)	(2,528)	(4)	(0%)	(203)	(8%)
Total non operating expenses	**(11,103)**	**(11,478)**	**(10,991)**	**375**	**3%**	**(112)**	**(1%)**
Surplus (deficit) after tax from continuing operations	**(9,257)**	**(8,979)**	**(4,646)**	**(278)**	**(3%)**	**(4,611)**	**(99%)**
Memo:							
Donated Asset Additions			27			(27)	(100%)
Surplus (deficit) after tax and Donated Asset Additions	**(9,257)**	**(8,979)**	**(4,619)**	**(278)**	**(3%)**	**(4,638)**	**(100%)**

Notes:

Calendar Days to Date	91	91	91
Working Days to Date	63	63	61

Contract Tracker - Commissioning Information
3 month position to 30 June 2016
April 2016 - March 2017

Appendix 9

GROSS TOTAL (BEFORE REINVESTMENT)

Operational Standards

Estimate

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
18 Weeks	£765,300	£709,320											£1,474,620
Diagnostic Waiting Times	£10,400	£16,600											£27,000
A&E Waits	£113,640	£81,240											£194,880
Cancer Waits - 2 Week Wait													£0
Cancer Waits - 31 Days			£7,000										£7,000
Cancer Waits - 62 Days			£25,000										£25,000
Mixed Sex Accomdation Breaches	£0	£1,000	£500										£1,500
Cancelled Operations	£114,166	£38,370	£8,000										£160,536
Total	£1,003,506	£846,530	£40,500	£0	£0	£0	£0	£0	£0	£0	£0	£0	£1,890,536

Quality Requirements

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
MRSA	£0	£0	£0										£0
C Difficile													£0
52 Week Waiters	£0	£15,000											£15,000
Ambulance Handovers - more than 30 minutes	£13,800	£7,800											£21,600
Ambulance Handovers - more than 60 minutes	£27,000	£9,000											£36,000
A&E Trolley Waits	£0	£0											£0
Multiple Urgent Cancelled Operations	£15,000	£0	£7,500										£22,500
Duty of Candour													£0
NHS Number - OP/APC Datasets (SUS)	£0	£0	£0										£0
NHS Number - A&E Datasets (SUS)	£0	£0	£0										£0
Total	£55,800	£31,800	£7,500	£0	£0	£0	£0	£0	£0	£0	£0	£0	£95,100

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Other - Never Events	£2,807	£1,774	£2,291										£6,872
Other - GC9													£0

Grand Total	£1,062,113	£880,104	£50,291	£0	£0	£0	£0	£0	£0	£0	£0	£0	£1,992,508

NET PENALTY (AFTER REINVESTMENT AGREEMENT)

Operational Standards

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
18 Weeks													£0
Diagnostic Waiting Times													£0
A&E Waits													£0
Cancer Waits - 2 Week Wait													£0
Cancer Waits - 31 Days			£7,000										£7,000
Cancer Waits - 62 Days			£25,000										£25,000
Mixed Sex Accomdation Breaches	£0	£1,000	£500										£1,500
Cancelled Operations	£114,166	£38,370	£8,000										£160,536
Total	£114,166	£39,370	£40,500	£0	£0	£0	£0	£0	£0	£0	£0	£0	£194,036

Quality Requirements

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
MRSA	£0	£0	£0										£0
C Difficile	£0	£0	£0										£0
52 Week Waiters													£0
Ambulance Handovers - more than 30 minutes													£0
Ambulance Handovers - more than 60 minutes													£0
A&E Trolley Waits													£0
Multiple Urgent Cancelled Operations	£15,000	£0	£7,500										£22,500
Duty of Candour	£0	£0	£0										£0
NHS Number - OP/APC Datasets (SUS)	£0	£0	£0										£0
NHS Number - A&E Datasets (SUS)	£0	£0	£0										£0
Total	£15,000	£0	£7,500	£0	£0	£0	£0	£0	£0	£0	£0	£0	£22,500

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Other - Never Events	£2,807	£1,774	£2,291										£6,872
Other - GC9	£0	£0	£0										£0

Grand Total	£131,973	£41,144	£50,291	£0	£0	£0	£0	£0	£0	£0	£0	£0	£223,408

Source: Commissioning x5865

REPORT TO THE TRUST BOARD	
Date	29 July 2016
Title	Risk Management Strategy
Author(s)	Emma McKay, Director of Nursing
Purpose	• The purpose of this Strategy is to present a clear overview of the Trust's intentions in relation to risk management. It sets out the principles, framework, and objectives for managing risk, so that a consistent approach is adopted across the Trust, from Ward to Board through the identification, assessment, management, reporting and assurance of risk at all levels. • It is supplemented by a Risk Management Policy, which details the 'who, how, where and when' of Risk Management in the Trust, within the framework set out in this Strategy.
Action Required	For approval.

RISK MANAGEMENT STRATEGY

Name of document author:	Risk Management
Job title of document author:	
Name of document author's Line Manager:	Emma McKay
Job title of author's Line Manager:	Director of Nursing
Division responsible for document:	Corporate
Date document written / revised:	02/03/2016
Assessed and approved by (committee):	Hospital Management Board
Ratified by or reported as approved to (if applicable)**:**	Trust Board of Directors
To be reviewed before: This document remains current after this date but will be under review	Date: 02/04/2018 – not to be amended without the approval of the Board of Directors
For use in:	Organisation-wide
For use by:	All staff
Key words:	Risk, Incident, Risk Register, Risk Management, Strategy
Reference and / or Trust Docs ID No:	Trust Docs ID.1046
Version No:	V8.0
Description of changes (for revised versions):	Updated to reflect organisational changes and to define Risk Appetite
Compliance links: (is there any NICE related to guidance)	CQC. Reg.17

Contents

1. INTRODUCTION

Not all risks can or should be avoided or eliminated. Even benevolent actions carry the risk of unintended consequences and complications can arise from well-intended endeavours. The risk that such negative outcomes might eventuate should not automatically result in the cessation or avoidance of actions or activities that are necessary or intended to bring benefit. It does however lead to an obligation to put in place appropriate systems and processes to prepare for such risks and, if possible, to reduce their likelihood or detrimental impact.

The Trust is committed to ensuring that its services are provided to a high quality and that risks to patients, staff, stakeholders, the public or the Trust are minimised by a process of Risk Management (i.e. the identification, assessment, and, where possible, reduction, elimination or mitigation of risk).

Effective risk management systems will contribute to the Trust's delivery of high quality and safe patient care, as well as supporting the Trust and its staff to realise the Trust's strategic objectives.

It must be recognised that within healthcare some of the most common or impactful risks are those arising from individual patient care e.g. the risks of side effects from drug treatments or the risks of complications from necessary surgery. In many such cases, the decision on what level of risk to accept is one to be taken by the patient through the established process of medical consent. This Strategy, and the associated policies and procedures, should not be interpreted or applied in such a way as to interfere with the autonomy of appropriately informed and mentally capacitate patients to make such decisions about their own treatment or care.

This Strategy provides a framework of principles to be applied across all levels and parts of the Trust, ensuring that risk management is integral to business planning and service delivery. The effective identification and management of risk is a core organisational process and Risk Management is a responsibility of everyone in the Trust.

2. DEFINITION AND EXPLANATION OF TERMS

Risk - The potential for damage, injury, liability, loss, or other negative impact to arise.

Risk Appetite – the upper limit of risk that the Trust Board has determined as being appropriate for the Trust to accept in pursuit of its strategic and operational objectives.

Risk Management - the method of systematic identification, assessment, monitoring, and treatment of risks with a view to minimising the likelihood or impact of risks.

Risk Mitigation – actions or decisions that may be taken on a pre-emptive basis so as to reduce the likelihood or impact of identified risks.

Risk Register - a register of all active risk assessments within the Trust.

High Risk Tracker – a summary drawn from the Risk Register of those risks with a Current Risk Rating of 15 or greater.

Current Risk Rating - the assessed score of an identified risk following application of existing actions and control measures.

Board Assurance Framework - the record of risks identified as threatening achievement of the Trust's strategic objectives, together with detail of associated mitigation and monitoring.

3. PURPOSE, PRINCIPLES AND OBJECTIVES

3.1 The purpose of this Strategy is to present a clear overview of the Trust's intentions in relation to risk management. It sets out the principles, framework, and objectives for managing risk, so that a consistent approach is adopted across the Trust, from Ward to Board through the identification, assessment, management, reporting and assurance of risk at all levels.
It is supplemented by a Risk Management Policy, which details the 'who, how, where and when' of Risk Management in the Trust, within the framework set out in this Strategy.

3.2 The Trust's approach to risk management is designed to achieve the following objectives:

- to drive a standardised approach to risk management which is consistently applied;
- to ensure that risk management is an integral part of the Trust's culture, business planning and operational activities;
- to identify on a pro-active basis those risks which require intervention; and
- to promote quality, safety, economy and delivery of the Trust's strategic objectives by effectively addressing identified risks.

3.3 The Trust will establish and maintain an effective risk management system to ensure that:

- risks to the achievement of Strategic Objectives are identified and appropriately managed in order to ensure their achievement;

- risks that threaten the Trust's Licence with NHS Improvement and registration with the Care Quality Commission are identified and appropriately managed;
- Leaders across the Trust are aware of risks relevant to their area of responsibility and the actions being taken to reduce risk exposure;
- Service teams are enabled and required to identify and manage risks within their service and escalate those risks which cannot be brought under reasonable control;
- All staff have a clear understanding of their personal contribution to ensuring the continued provision of safe and effective services for all.

3.4 The management of risks requires their identification and reporting. A pre-condition for this to operate effectively is that Trust staff should feel able to raise concerns and identify risks. The Trust has a formal Speak Up Policy which identifies the safeguards in place to protect staff who raise concerns and all staff should feel free to contact any member of the Board of Directors if they perceive that there are serious risks which they cannot address through the established Risk Management system.

4. APPROACH TO RISK MANAGEMENT

4.1 The operation of the Trust's Risk Management system will ensure the timely and proactive identification, assessment and reporting of risks to enable the implementation of mitigating actions.

4.2 The process for identifying risks will be as specified from time to time by the Hospital Management Board in the Risk Management Policy. The process is overseen by the Hospital Management Board, not least through the operation of its governance sub-boards and the Executive Performance Committee.

4.3 Key risks will fall under a number of inter-related categories:

(i) *Quality, safety and patient experience* – including risks associated with compliance with the registration standards of the CQC. These risks typically fall under the remit of the Clinical Safety Governance Sub-Board and the Caring and Patient Experience Governance Sub-Board;

(ii) *Financial sustainability* – threats to the Trust's ability to continue as a 'going concern', arising as a consequence of the national NHS pricing and commissioning regimes or potential failure of the Trust to operate with adequate economy or efficiency;

(iii) *Regulatory compliance* – a high registration rating with the CQC and compliance with the requirements of the Trust's NHSI Provider Licence is threatened by pressure on the Trust's finances, operational performance, and clinical standards;

(iv) *Workforce risks* – the availability of staff in adequate numbers and expertise is of particular relevance to healthcare due to its reliance on high numbers of specialist staff, within the context of a relatively limited pool of such staff and limited control over the number of newly qualified registrants. Further risks arise in the context of nationally negotiated contracts and T&Cs and pressures on staff morale. Tthese risks will be overseen by the Workforce Governance Sub-board;

(v) *Operational risks* – typically associated with waiting times, Access Targets and CQC Responsiveness standards. Experience suggests that these are heavily influenced by imbalance between demand and capacity - and may be affected by secondary risks to the Trust arising from failures or adverse actions in the health and social care system or other organisations impacting on the Trust. These risks will be overseen by the Executive Performance Committee;

(vi) *Strategic risks* – failure to deliver the Trust's strategic potential and objectives as a leading provider of healthcare, clinical education and research. Each year the Trust Board will agree its annual objectives and undertake a threat assessment exercise identifying risks to achieving those objectives. These risks will form the Board Assurance Framework;

(vii) *Reputational risk* – potential damage to the reputation and standing of the Trust, both within the health and social care system and in the broader public view.

5. RESPONSE TO RISK

5.1 Risk Appetite

5.1.1 Where risks have been identified our response should be informed by the Risk Appetite agreed by the Trust Board. For these purposes, the Risk Appetite represents the upper limit of risk appropriate for the Trust to accept in pursuit of its strategic and operational objectives; where a Low Risk Appetite implies a greater priority or imperative for action relative to one that is Moderate or High.

5.1.2 Risk Appetite should vary depending upon the issue and area of Trust activity. Each risk must be considered individually in the context of all relevant circumstances. In broad terms, the Risk Appetite applied to those categories of risk identified in Section 4 may be stated as follows

(i) *Quality, Safety and Patient Experience* – the Trust is committed to the provision of safe services and, as such, has **Low** appetite for risks that compromise patient safety. There will be times when operational demands and the 'competing' needs of different patients require that the ideal level of

patient experience and quality cannot be delivered. Within the context of a Low appetite for risk associated with patient safety, and multiple competing demands and priorities, a **Moderate** appetite for risk associated with patient experience must be applied in appropriate circumstances.

(ii) *Financial/VfM* – the Trust is operating in a time of financial instability and significant cost pressures. There are challenges to the Trust's financial sustainability and consequent threats to our ability to invest in services for patients. The duty under our regulatory Licence to safeguard the financial sustainability of the Trust is concurrent with the regulatory standards concerning quality and safety. On balance the Trust will accept the possibility of short-term limited financial loss where this is necessary to maintain quality, safety and service to patients and whilst management action is taken to mitigate such financial loss through efficiencies or service redesign. The Trust therefore has a **Moderate** appetite with regards to financial risks.

In some cases the national pricing regime will be such that certain procedures, specialities or service lines may consistently run at a financial loss. These should be identified and escalated, ultimately to the Hospital Management Board, so that a decision can be made as to whether these should be discontinued or what other remedial action can be taken. In some cases the level of strategic and service importance is such that a **High** Risk Appetite should be accepted with regard to the financial risk associated with continuing such loss-making strategic and clinically important service lines.

In other cases the Trust has historically accepted service arrangements that generate limited recompense to the Trust, notably in joint working arrangements with some other Trusts. The deterioration of the financial position in 2015/16 and the level of CIP challenge in 2016/17 is such that the Trust should accept a **Low** risk appetite for financial risks associated with discretionary spend and renegotiation of joint working arrangements.

(iii) *Regulatory Compliance* – the Trust continues to be under scrutiny by Regulatory Authorities, and has a **Low** appetite for risks that present a threat to a return to regulatory compliance.

(iv) *Workforce* – the risks associated with the availability/non-availability of service-crucial staff is such that a **Low** risk appetite must be applied. The financial challenges associated with over-reliance on temporary staff are however such that a **Moderate** risk appetite may be accepted relation to other workforce risks.

(v) *Operational* – achievement of national performance standards is of acute importance to the Trust with respect to its reputation and regulatory compliance, in addition to ensuring that patients have access to

appropriately 'responsive' services. In the circumstances, the Trust has a **Low/Moderate** risk appetite in relation to operational risks;

(vi) *Strategic Risks* – the NHS is undergoing significant system change driven, not least, by the need for re-organisation to achieve financial and clinical sustainability. At the same time the Trust faces very specific challenges associated with an imbalance between excess demand and the available capacity to meet that demand. The balance between strategic importance and limited finance is such that a **Moderate** risk appetite should be accepted.

(vii) *Reputation* – The Trust's appetite for reputational risk is **Moderate**, in that it will accept risks where there is little chance of any significant repercussion for the organisation in the event of failure, and where there is mitigation in place to proactively communicate our position or to respond to any external interest.

5.2 Response options

Where risks have been identified, there are a number of options for response, informed by the relevant Risk Appetite, as follows:

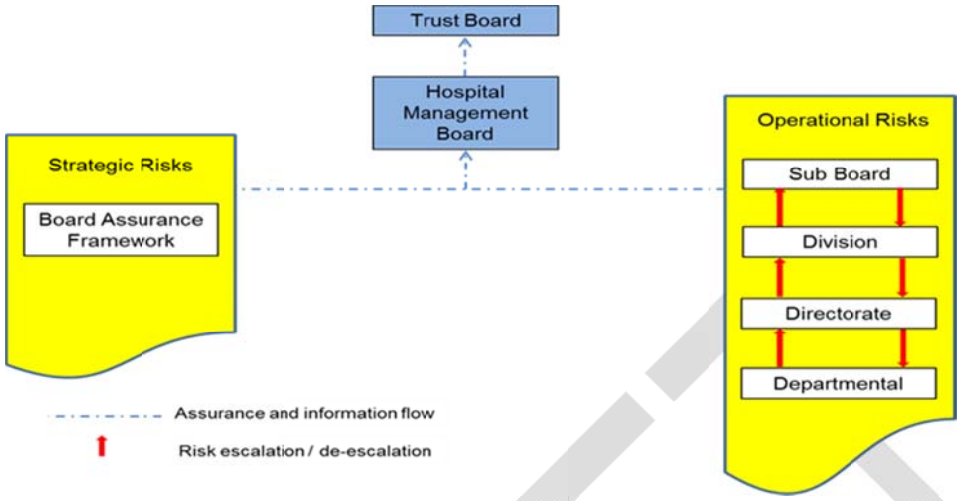
(i) **Terminate** – avoid the risk by cessation of relevant activity making its occurrence impossible;
(ii) **Tolerate** – accept that the likelihood or effects of the risk following mitigation are reduced to an acceptable level;
(iii) **Transfer** – involve a 3rd party to share some degree of risk via contract terms or insurance;
(iv) **Treat** – take action to reduce the overall risk score (weaken the link between cause and risk to reduce likelihood and/or weaken the link between risk and effect to reduce impact).

All risks that are not terminated must be escalated for Divisional review and be considered for inclusion on the Trust's Risk Register, in line with the Risk Management Policy.

5.3 Risk Tolerance

It is imperative that significant risks facing the organisation are managed as effectively as possible. Risks are therefore escalated and de-escalated as appropriate through service management and governance arrangements (as illustrated in Fig 1 below).

Fig 1. Risk Assurance and Escalation Flow



5.3.1 The Trust has delegated levels of tolerance within its escalation process:

(i) Divisional Management Teams are assigned a tolerance level which allows them to accept and manage those operational risks with a Residual Risk of below 12.

(ii) The Governance Sub Boards are assigned a tolerance level which requires them to have oversight of and advise on the management of operational risks that have exceeded the Divisional level of tolerance, i.e. where the anticipated Residual Risk is above 12.

(iii) Any operational risk with an anticipated residual risk grade of 15+ (Red) is considered to have exceeded the Trust's overall risk tolerance and the following response will be followed:

- the Hospital Management Board will review the risk and where possible to identify steps to mitigate the risk;
- If, after three months, the risk continues to exceed risk tolerance, the Hospital Management Board shall;
  - Receive a full resume of the risk and actions to reduce risk to date from the Chief of Division
  - Where appropriate, request further investigation, oversight and risk control to be applied by the Chief of Division.
  - Escalate the continued breach of risk tolerance to the Trust Board through the High Risk Tracker.

(iv) Upon receipt of notice of breach, the Trust Board will

- Bring about additional resource to increase risk control and return the risk to within risk appetite, or
- Formally agree to tolerate the risk.

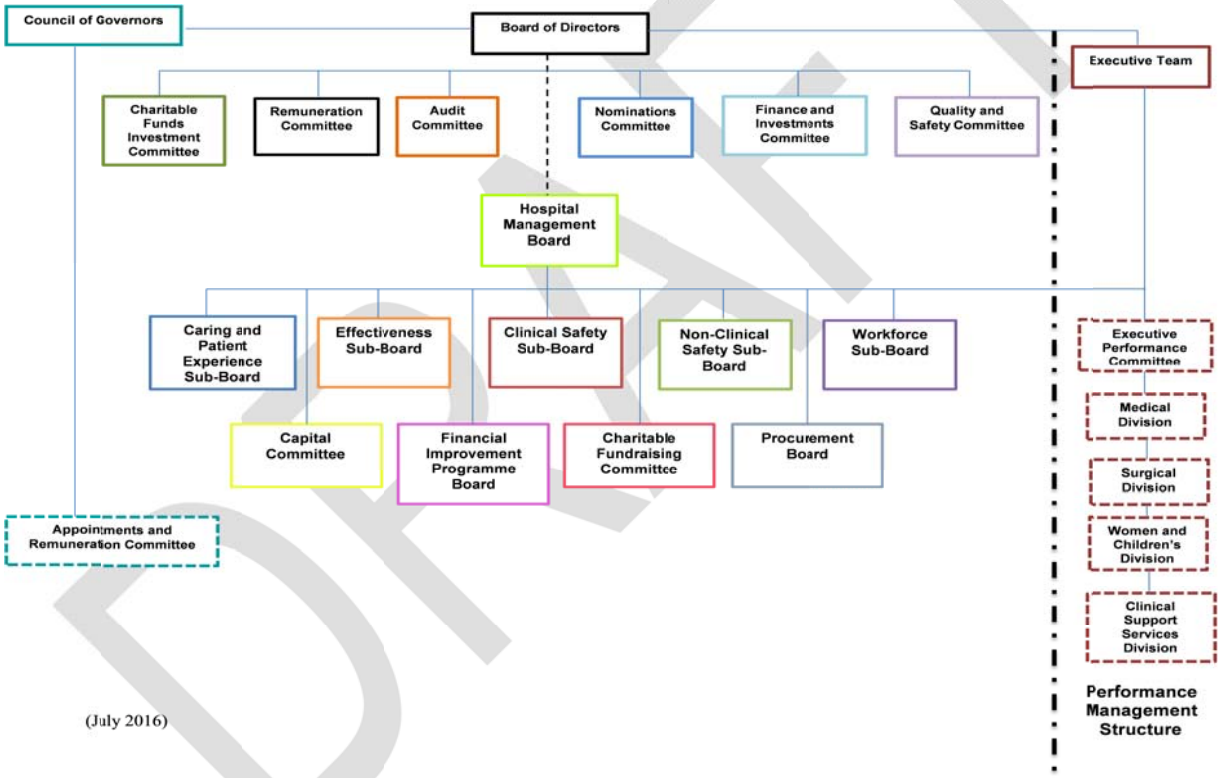
6. RISK MANAGEMENT STRUCTURE

6.1.1 A key component of an effective risk management system is a clearly defined structure to implement the scheme of accountability/responsibility for risk management actions, escalation and reporting.

6.1.2 Assurance on the effectiveness of risk management actions and processes is provided to Divisional leaders, the Hospital Management Board and Trust Board through the Trust's governance structure

6.1.3 Detail of roles and responsibilities is as detailed below, within the framework set out in Fig 2:

Fig 2 – Risk Management and Governance Structure



7. ROLES AND RESPONSIBILITIES

7.1 <u>Board of Directors</u>

The Trust Board has overall responsibility for establishing a strategic approach to risk management across the organisation. It is responsible for monitoring the implementation and effectiveness of this Strategy through:

- assurance from the Audit Committee, who oversee the work of Internal Audit and the efficacy of the Risk Management structure;

- assurance from the Quality and Safety Committee with regard to quality and safety related risks;
- monthly report from the Executive Directors detailing any new 15+ risks via the High Risk Tracker;
- monthly reports on the work of the Hospital Management Board and, through the IPR, on the governance sub-boards;
- Quarterly consideration of the Board Assurance Framework.

7.2 Hospital Management Board (HMB)

The Hospital Management Board has responsibility as specified in its Terms of Reference to support the Chief Executive to exercise his duties as Accountable Officer regarding the management of risk. The HMB will do this through:

- overseeing the operation of the governance sub-boards;
- receiving reports from each of the Sub Boards highlighting any new corporate or divisional risks entered onto the Risk Register with a Currentl Risk Rating of 12+;
- monitoring risks with a residual risk rating of 15+ via the High Risk Tracker;
- taking appropriate executive action in response to escalated risks.

7.3 Governance Sub Boards

Each of the Governance Sub Boards will be responsible through their Terms of Reference for reviewing, agreeing and monitoring actions associated with Risk Register entries relevant to their areas of responsibility where the current risk rating is 12 or above. They will report monthly to the Hospital Management Board, to provide assurance on the monitoring of 12+ risks and to inform of any new 12+ risks.

7.4 Audit Committee

The Audit Committee is responsible for reviewing the adequacy of the Trust's risk management arrangements, as detailed in its Terms of Reference. The Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities. In carrying out this work the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these and may also seek reports and assurances from directors and managers as appropriate.

7.5 Quality and Safety Committee

The Quality and Safety Committee has risk management related responsibilities as detailed in its Terms of Reference, through the receipt and review of reports concerning the operation of the Trust's clinical governance systems and processes at a corporate and Divisional level, compliance with relevant national

standards and regulatory requirements; and progress against actions to mitigate quality and safety risks on the Risk Register in line with the Board's risk appetite.

7.6 Divisional Boards

Divisional and Directorate governance structures are in place in order to facilitate service-line reporting of risk within each service and act as the conduit for risk management and escalation between each service and the Trust's governance sub-board structure.

8. ACCOUNTABILITY AND DELEGATED RESPONSIBILITY

8.1 Chief Executive

As Accountable Officer, the Chief Executive has overall responsibility for ensuring that an effective risk management system is maintained within the Trust, so as to support completion of the Trust's Annual Governance Statement.

8.2 Executive Lead for Risk Management

The Director of Nursing is the Executive Lead for Risk Management and has responsibility for managing the development and implementation of clinical and organisational risk management.

The Director of Nursing has executive responsibility for the system of risk management in the Trust and for ensuring that the Hospital Management Board, Audit Committee, Quality and Safety Committee and Board of Directors are kept appropriately informed in relation to the operation of the Risk Management system and key risks affecting the Trust, achieving this not least through production of the High Risk Tracker.

The Director of Finance has delegated responsibility for ensuring an annual review of risk management activity is incorporated into the Annual Governance Statement.

The Chief Operating Officer, Executive Directors, Chiefs of Division, Divisional Operational Directors, Divisional Nursing Directors and the Divisional Clinical Services Director have delegated responsibility for managing the implementation of risk management and governance within their respective areas of responsibility.

8.3 Risk and Patient Safety Manager

The Risk and Patient Safety Manager and team will be responsible for:

- providing advice, support and training to relevant staff in undertaking risk identification, assessment and response;
- ensuring a co-ordinated and consistent approach to risk management;

- maintaining the Trust's Risk Register, ensuring appropriate risk related reports are produced as required so as to keep the governance sub-boards and divisional boards appropriately informed on risks related to their areas of responsibility;
- to monitor the implementation of this Strategy and associated Policy within the Trust;

8.4 Trust Board Secretary

The Trust Board Secretary will be responsible for maintaining the Board Assurance Framework.

8.5 Divisional Management Teams

The Divisional Management Teams have a delegated responsibility to understand and implement the Risk Management Strategy throughout their Divisions. The Divisional Management Teams will ensure the development of specific action plans that demonstrate that an effective risk management process is established, and will report immediately to the Executive Director with responsibility for the area/service concerned those risks identified as requiring escalation.

8.6 Operational/Service Managers and Service Directors

Operational/Service Managers and Service Directors have a delegated responsibility for co-ordinating risk management activities at departmental level on behalf of the Divisional Management Teams. They will ensure risk assessments are undertaken and that risk management is a standing item on their relevant Directorate meetings agendas. They will manage risks that are within their level of competency and budgetary constraints, developing and implementing appropriate treatment plans, and escalate to Divisional Management Teams where risks are beyond the control of local management.

8.7 Ward and Departmental Managers

Ward and Departmental Managers have a delegated responsibility for the management of risk relating to the staff they supervise and the workplaces they control, including any bank, agency, locum or other contracted personnel. They will manage risk within their level of management competency and within the financial constraints of their budgets, and will escalate elevated risks to the relevant Operational/Service Manager and/or Chief of Service as appropriate.

8.8 All staff

In addition to professional and moral obligations to promote the safety and welfare of patients, and contractual duties to promote risk management, quality, good governance and health and safety, all staff also have a statutory requirement to take care of their health and safety and that of others who may be affected by their acts or omissions at work. As part of satisfying this statutory obligation, all staff must act in accordance with this Strategy, training, instruction, policies and procedures of the Trust.

8.9 Emergency Preparedness, Resilience, Response (EPRR) and Business Continuity Lead

The EPRR & Business Continuity Lead will ensure that structures, policies and processes are in place to ensure continued service provision in the event of a major incident or threat to business continuity in accordance with the Civil Contingencies Act 2004. This will be achieved by training appropriate staff and facilitating (as a minimum) the required number and format of exercises to test emergency responses and business contingency plans.

8.10 Head of Compliance Governance

The Head of Compliance Governance will ensure that structures and processes are in place and are implemented to monitor and demonstrate compliance with existing statutory and other good governance requirements as set by external regulatory bodies, by:

- ensuring appropriate governance and internal self-assessment processes are in place;
- supporting the production of the annual governance statement; and
- providing reports and updates as required on compliance with existing statutory, regulatory, Care Quality Commission and Department of Health requirements, and performance issues pertinent to quality and risk assurance and related to internal control.

8.11 Senior Information Risk Owner (SIRO)

The SIRO is responsible for:

- Ensuring that an overall culture exists that values and protects information within the organisation.
- Owning the organisation's overall information risk policy and risk assessment process, testing its outcome and ensuring that it is used.
- Advising the Chief Executive on the information risk aspects of the organisations statement of internal control.
- Owning the organisation's response to information incidents.

8.12 Health and Safety Advisors

The Health and Safety Advisors are responsible for undertaking health and safety audits and providing advice on remedial measures required to ensure an environment of safety for patients, staff, visitors and other stakeholders.

8.13 Local Security Management Specialist

The Local Security Management Specialist (LSMS) is responsible for ensuring that the Trust meets the requirements of the Secretary of State's Directions for Security Management and the requirements of NHS Protect. The LSMS will advise on actions required to meet current and new security guidance and act as a link to the Police in managing violent and abusive incidents. The LSMS will monitor violence and security incident trends and investigate incidents to ensure

that the Trust is taking appropriate action with respect to security related incidents.
The LSMS also provides advice and leadership on the Trust's approach to preventing and countering fraud and the risk of misuse of Trust assets and resources.

8.14 Contractors, Agency and Locum Staff
All contractors, agency staff, and locums are expected to work in accordance with the Trust Risk Management Strategy and associated policies. The responsibilities of these staff with regard to Risk Management will be communicated to them via the manager responsible for their engagement.

9. IMPLEMENTATION OF THE RISK MANAGEMENT STRATEGY

9.1 Implementation
The Risk Management Strategy will be implemented through procedures and processes to be set out in a Risk Management Policy available to all staff through the Trust Intranet and on the Trust Docs system. This Risk Management Policy will set out the process for identification, assessment and management of risk on an on-going basis, along with reporting and monitoring arrangements.

9.2 Training
As part of the Trust Corporate Induction Training, all staff joining the Trust will receive Risk Management Awareness training to ensure that the implementation and delivery of the Trust's Risk Management Strategy is supported across all areas.

Designated staff within each service will undertake Risk Assessment training, to ensure that all service level risks are assessed and escalated in accordance with the Trust's Risk Management Policy.

10. AUDIT AND REVIEW OF THE STRATEGY

Compliance with the Risk Management Strategy will be subject to review and audit as set out in Appendix 1. It will be reviewed annually by the Board of Directors.

11. COMMUNICATION

This Strategy will be made available to all staff via the Trust Intranet, and publicly through the Trust website.

12. EQUALITY IMPACT ASSESSMENT

The Trust aims to design and implement strategy and policy documents that meet the diverse needs of our services, population and workforce, ensuring that

none are placed at a disadvantage over others. It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all. This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

Appendix 1. Monitoring Compliance / Effectiveness Table

Element to be monitored	***Lead Responsible for monitoring*** *(Title needed & name of individual where appropriate)*	***Monitoring Tool / Method of monitoring***	***Frequency of monitoring***	***Lead Responsible for developing action plan & acting on recommendations***	***Reporting arrangements*** *(Committee or group where monitoring results and action plan progress are reported to)*	***Sharing and disseminating lessons learned & recommended changes in practice as a result of monitoring compliance with this document***
Delivery of Risk Management in line with strategy, with specific regard to Risk Appetite, Risk Response and Risk Assurance.	Risk Manager, Lyn Taylor	Internal Audit review	Annually	Risk Manager, Lyn Taylor	Hospital Management Board Audit Committee Quality and Safety Committee	The Lead responsible for developing the action plans will disseminate lessons learned via the most appropriate committees

Appendix 2 – Associated Documentation

The Risk Management Strategy is informed by:

(i) Care Quality Commission (CQC) regulations.
(ii) NHS Litigation Authority (NHSLA) risk management standards.
(iii) NHS Foundation Trust Code of Governance (Monitor, 2014).
(iv) Audit and Risk Assurance Committee Handbook (HM Treasury, 2013).

And Trust documentation:

- Incident Reporting & Management (Including serious incidents) Policy & Procedure
- Incident Reporting System (Datix) User Guide
- Investigation Policy & Procedure
- Major Incident Response Plan & associated plans
- Business Continuity Plans
- Standing Financial Instructions
- Complaints Policy & Procedure
- Health and Safety Policy & Procedure
- Moving & Handling Policy & Procedure
- Prevention & Management of Work-Related Stress Policy & Procedure
- Raising Concerns Policy & Procedure
- Being Open Policy & Procedure
- Supporting Staff Policy & Procedure
- Clinical Audit Policy & Procedure
- NICE Guidance Implementation Policy & Procedure
- National Confidential Inquiries/Enquiries Implementation Policy & Procedure